HEARTS TOGETHER: Concordance and the Role of the Healthcare Provider

A Concept Analysis

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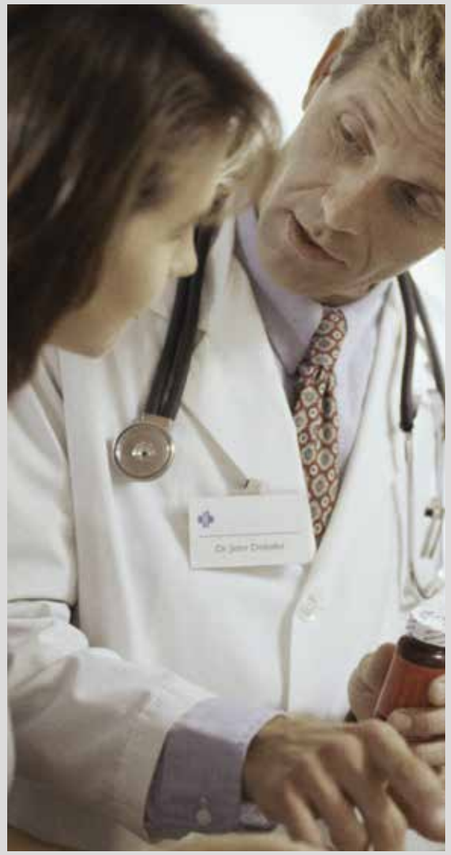
ABSTRACT

Healthcare is an ever-changing field of study. New terminology and colloquialisms are introduced in medical and nursing literature constantly. Concordance is now evident in the vernacular of healthcare literature. The origin, evolution, and use of the term concordance is reflective of patient-centered healthcare. Concordance embraces this ideal and promotes an equal partnership between patients and providers. The creation of concordance correlates to the interactions of patients and healthcare providers. The role and qualities of healthcare providers impact the degree to which concordance is achieved.

KEYWORDS: adherence, compliance, concordance, qualities of healthcare providers, role of the provider, communication skills, microsystem, micro-level factors in healthcare, patient-provider trust, motivational interviewing, health literacy, learning styles, cultural sensitivity, time management, Benner's Novice to Expert Model, Erikson's Eight Stages of Development, Bronfenbenner's Ecological Systems, Model, King's Theory of Goal Attainment, Faye Abdellah, Barbara Artinian's Intersystem Model



Evidence supports the concept that effectiveness and implementation of a patient's prescribed therapeutic regimen correlates to the value of the patient and healthcare provider's relationship (Schoenthaler, Montague, Manwell, Brown, Schwartz & Linzer, 2013; Scott & McClure, 2010). The intention of this concept analysis is to examine what concordance is, how it is used in clinical practice, and how healthcare providers contribute to creating concordance. The background, evolution, and definition of the concept of concordance will be explored. In addition, the fundamental qualities of healthcare providers that construct a supportive, high-value patient/provider relationship will be analyzed. Multiple theories of all disciplines are integrated and applied in this concept analysis. In this body of work, healthcare providers are referred to as the provider or providers. The provider or providers can denote those that practice as an Advanced Practice Registered Nurse, Physician Assistant, or Physician. The concept of concordance and the role of the healthcare provider were evaluated using the guidelines and steps of Walker and Avant's method of concept analysis (McEwen &Wills, 2014).

Evolution of Concordance and Concept Selection

The terms "compliance," "adherence," and "concordance" are mistakenly used interchangeably in healthcare literature and among providers (Gardner, 2014; Flagg, 2010; Snowden & Marland, 2012). The progression of the above-mentioned terminology has been studied extensively. Alikari and Zyga (2014) noted that two physicians, Drs. Sackett and Haynes, first defined the term "compliance" in relation to prescribed medical regimens in the late 1970s. "Compliance" was defined as "the extent to which the patients' behavior (in terms of taking medications, following diets, or following lifestyle changes) coincide with medical advice" (as cited by Alikari & Zyga, 2014, p. 180). Sackett and Haynes' definition of compliance was ill-received due to the assumed negative and autocratic nature of the definition (Alikari & Zyga, 2014; Felzmann, 2012.). Felzmann (2012) described the connotations of the term "compliance" as "paternalistic," while Alikari and Zyga (2014) cited several authors who believed that Sackett and Haynes' definition implied that the patient was "disobedient" (p. 181). Gardner (2014) stated that the term "compliance" is associated with "lack of patient autonomy" and limited patient involvement in decision-making (p. 97).

Due to the negative connotations of "compliance," a shift in the language used to define the degree to which patients followed a recommended therapeutic regimen occurred in the 1990s (Gardner, 2014). The term "adherence" replaced "compliance" (Gardner, 2014). Several definitions of "adherence" are found in the healthcare community. Gardner (2014) quoted the World Health Organization Adherence Project when defining adherence. "Adherence" is "the extent which a person's behavior-taking medications, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from the health care provider" (as cited by Gardner, 2014, p. 98).

The term "concordance" has become evident in recent healthcare literature (Gardner, 2014). The European medical community has particularly used and defined the term "concordance" in recent years to describe their approach to that they call 'medicine taking' (Gardner, 2014). The evolution in the aforementioned terminology represents the progression in healthcare and the shift to patient-centered care (Hobden, 2006a). Multiple articles explain the rationale for using the term "concordance" is based on prioritizing patient knowledge, choice, and partnership with the provider (Cheeseman, 2006; Hobden, 2006a; Snowden, Gilfedder, & Campbell, 2012). Snowden et al. (2012) stated that a culture of concordance provides an ideal strategy for managing medications.

With its modern approach to healthcare, concordance prioritizes the health of patients and patient autonomy, and it supports positive relationships between providers and patients.

Concordance was selected as a concept due to its distinctive, innovative nature and its potential to change how patients and providers view one another. With its modern approach to healthcare, concordance prioritizes the health of patients and patient autonomy, and it supports positive relationships between providers and patients. Although changes occur in healthcare daily, the concept and culture of concordance offers providers a timeless standard to enhance patient care and promote wellness.

Aims of Analysis

Due to the vast number of factors that can challenge and influence concordance, this concept analysis will concentrate on the qualities of providers that contribute to concordance. This concentration was selected to improve the relationships between patients and providers and to promote an outcome that is satisfactory to both. The culture of concordance promotes a positive relationship between patients and providers. Interactions between patients and providers construct the foundation of concordance. Bronfenbrenner's Ecological Systems Model and Theory and micro-level factors in healthcare explain the importance of encouraging and supportive patient/provider interactions.

Overview of Bronfenbrenner's Ecological Systems Model and Micro-level Factors

By integrating Bronfenbrenner's Ecological Systems Model and the World Health Organization's (WHO) definition of micro-level factors, Berben, Dobbels, Engberg, Hill, and Geest (2012) described how micro-level factors impact the patient's adherence to medication regimens (p. 639). Berben et al. (2012) proposed that influences from interactions within the patient's various environments or systems affected their adherence to medications (p. 636). This association can also be applied to the concept of concordance, as the inter-

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actions between patients and providers directly affect concordance. To completely understand how micro-level factors affect concordance, an explanation and description of Bronfenbrenner's Ecological System Model and Theory is necessary, as well as a brief overview of the WHO's definition of micro-level factors in healthcare.

Bronfenbrenner's Model & Theory. Bronfenbrenner believed that a person's behavior is affected by immediate and distant environmental factors (Berben et al., 2012). There are five systems in Bronfenbrenner's Theory. They are: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 1979). The innermost level is the mircosystem, which is where a person experiences face-to-face interactions, and the principle of interconnectedness is initiated (Bronferbrenner, 1979, p. 7-8). Bronfenbrenner (1979) hypothesized that if a child has positive interactions with their parents or teachers, the child will develop positive relationships with their parents or teachers, which presumably enables the child to function to the best of their ability.

Micro-level factors. Micro-level factors in healthcare are face-to-face interactions between patients and providers (Berden et al., 2012; WHO, 2002). The interactions between providers and patients greatly influence the microsystem of patients. Therefore the outcomes of these interactions, which may be positive or negative, affect patients' perception of health, medical treatments, medications, and providers (WHO, 2002). If a patient has positive interactions with their provider, the patient and provider will create a positive relationship, which will facilitate a patient's ability to change unhealthy behaviors and follow a recommended plan of treatment (Berben et al., 2013).

Definitions of Concordance

The etymology of the term "concord" was examined in an effort to better comprehend the origin of concordance. Using the Oxford Latin Dictionary (1968), concord was separated. The prefix, con- is derived from cum-, which means with, together and cor-, which means heart (Oxford Latin Dictionary, 1968). Per Dr. J. Eckenrode, (personal communication, November 22, 2016), a colloquial meaning of "concord," based on its Latin roots, is hearts together with.

Merriam-Webster's online dictionary defines the term "Concordance" (n.d.) as "a state in which things agree and do not conflict with each other. "Concordance" can also refer to "an alphabetical index of the principal words in a book or the works of an author with their immediate contexts," such as the Christian Bible or Quran (Concordance, n.d.). In statistics, "concordance" is the agreement of two variables (Coolen-Maturi, 2014). Taber's cyclopedic medical dictionary (2009) defines "concordance" as "in twins, the equal representation of a genetic trait in each" (p. 504).

"Concordance" is defined in healthcare literature as "the process of enlightened communication between the person and the healthcare professional leading to an agreed treatment and ongoing assessment of this as the optimal course" (as cited by Snowden, Martin, Mathers, & Donnell, 2013, p.57).

Attributes of Concordance

The literature reviewed reveals many prevalent themes or attributes of concordance in healthcare. The six attributes of concordance are as follows: entering into an agreement, mutual partnership, patient knowledge empowerment, creation of congruent plan of care and shared decision-making process, continued correspondences, and value of the patient-provider relationship.

Entering into an Agreement

As previously discussed in the definition section, the "dictionary" meaning of concordance is agreement. Applied to the healthcare context, concordance occurs when the provider and patient enter into an agreement that entails their plan of care (Gardner, 2014). This is the most basic and obvious attribute of concordance.

> The patient's right to choose, be informed, and collaborate in the treatment plan is the goal of knowledge empowerment and is in alignment with the culture and very meaning of concordance.

Mutual Partnership

Snowden and Marland (2012) stated that the term concordance merely means and is characteristic of a "way of people working together" (p. 1354). Concordance implies a partnership or alliance between the provider and patient (Alikari & Zyga, 2014; Cheesman, 2006; Swoden et al., 2013.) The equal partnership of the patient and the provider is the embodiment concordance.

Equal partnership between the provider and patient is often infrequent and difficult to achieve (Snowden & Marland 2012). Snowden and Marland (2012) noted that in healthcare the partnership of a patient and his or her provider is one-sided because the "knowledge expert" is the provider (p. 1355). If the partnership is in any way obstructed or unbalanced, concordance may be hindered (Snowden & Marland, 2012).

Patient Knowledge Empowerment

The culture of concordance empowers the patient and enhances his or her knowledge about their state of health (Cheesman, 2006). The development and expansion of the patient's knowledge is accomplished by informing the patient at length of their treatment options (Cheesman, 2006). It is the responsibility of the provider to inform the patient of current and plausible treatment options (Cheesman, 2006; Felzmann, 2012).

> Concordance is an agreement between a patient and provider that is embodied by a mutual partnership through which the patient is empowered by their provider via the exchanging of knowledge about their particular health issue.

Williams, Low, Manias, and Crawford (2016) found that when working with kidney transplant patients, the provider should encourage patient self-advocacy, by empowering, "not babysitting," patients (p. 2256). Promotion of self-advocacy further pushes patients to become more autonomous in their decision-making process because they have been given adequate knowledge to choose their plan of care (Felzmann, 2012).

Patients are entitled to informed consent. Achieving informed consent is a complex process and is dependent on the provider's ability to divulge and communicate accurate and clear information about the patient's treatment options (Felzmann, 2012). Patients have the right to this knowledge and also have the liberty to express their concern or disagreement with the treatment plan (Alikari & Zyga, 2014). The patient's right to choose, be informed, and collaborate in the treatment plan is the goal of knowledge empowerment and is in alignment with the culture and very meaning of concordance.

Creation of Congruent Plan of Care by Shared Decision-making

Hobden (2006b) stated that patients are more likely to choose a plan that coheres to their lifestyle. Gardner (2014) concluded that the term concordance implied that patients take more responsibility in their care and treatment plan. The provider and patient must devise an individualized plan with goals for the patient to which both parties agree upon and that harmonizes with the patient's daily life. This is achieved by partaking in a shared decision-making process, where both the provider and patient exchange their thoughts about treatment plan options (Hobden, 2006b). The culture of concordance promotes joint decisions in the treatment plan (Cheesman, 2006). Providers should be supportive and accommodating to the patient's thoughts and reservations about the treatment plan, as this will help create the best plan of care (Hobden, 2006b).

> It is the duty of the provider to establish trust with patients. If trust is not established, not only will concordance be inhibited, but the overall health of a patient may be compromised.

Continued Correspondences

During the course of the treatment plan, the patient and provider need to maintain an open line of communication to fortify concordance. Alikari and Zyga (2014) proposed that in order to improve medication compliance, recurrent contact between the nurse and patient was needed. This suggestion also applies to concordance. Changes may need to be made to the treatment plan due to intolerable side effects of certain medications or socioeconomic changes in a patient's life. There must be a set plan between the provider and patient on how to contact one another. Miscommunication and lack of interaction may hinder the achievement of concordance.

Value of the Patient/Provider Relationship

The final attribute of concordance is the value of the patient/provider relationship. Schoenthaler et al. (2014) found that the quality of the patient/physician relationship was imperative in detecting and treating hypertension in underserved populations. A patient's adherence to medications has been associated with fostering, trusting, and supportive relationships with their provider (Berben et al., 2013; Scott & McClure, 2010). These findings can be applied to concordance; a high value placed on the patient/provider relationship directly correlates to the successful realization of concordance and improvement in condition.

Proposed Theoretical Definition

After exploring the defining attributes of concordance, a new theoretical definition can be proposed. Concordance is an agreement between a patient and provider that is embodied by a mutual partnership through which the patient is empowered by their provider via the exchanging of knowledge about their particular health issue. A cohesive and congruent plan of care is created through shared decision-making, which is then implemented and maintained by continued correspondences between the patient and provider resulting in a high value patient-provider relationship.

Antecedents

The antecedents of concordance are focused solely on the provider. Per the implications of

Bronfenbenner's Model and Theory and the definition of micro-level factors in healthcare, interactions between the provider and patient influence the patient's health behavior. Generating concordance is dependent on the provider, as he or she is the gatekeeper or facilitator to healthcare and treatments plans.

Establishment of Trust in the Provider

As previously mentioned, concordance assumes agreement between two parties. That being said, how does one achieve an agreement? Trust is a precondition for an agreement. Ultimately, concordance cannot occur if trust is not established between the provider and patient.

Trust is a basic human instinct that is established during infancy. Erik Erikson, a renowned psychoanalyst, developed an eight-stage model of psychosocial development (McEwen &Wills, 2014; Varcarolis, 2006). The first stage of this model is Trust vs. Mistrust. If a parent does not institute trust with an infant, the infant will withdraw (McEwen & Wills, 2014; Varcarolis, 2006). The child then lacks the ideals of trust, and the child may be unable to trust others in the future (McEwen & Wills, 2014; Vacarolis, 2006). Erikson's theory can most definitely be applied to the patient/provider relationship. If a patient never fully developed the instinct of trust or had previous negative experiences with trusting others, the provider may never be able to enter a partnership with the patient.

The provider must be cognizant of a patient's ability or inability to trust another person. Multiple articles state that a patient must have a high level of trust toward their provider to adhere to their medication regimen (Berben et al., 2013; Schoenthaler et al., (2013); Williams et al., 2016). Williams et al. (2016) found that provider trust was needed in order for patients to feel comfortable with the provider. When the patient felt comfortable with the provider, the patient was able to be truthful about their faithfulness to their prescribed medication regimen (Williams et al., 2013). These findings can be applied to the concept of concordance. The concept of concordance embraces the patient's most innate instinct, that of trust. It is the duty of the provider to establish trust with patients. If trust is not established, not only will concordance be inhibited, but the overall health of a patient may be compromised.

Communication Skills of the Provider

Throughout the literature evaluated, the type of communication utilized and demonstrated by the provider was a significant factor in patient/provider trust, with a strong influence on concordance. Both nonverbal and verbal communication are imperative for establishing the patient's trust in the provider and creating concordance.

Nonverbal communication. After studying the neurologic responses of patients during encounters with doctors, Benedetti (2011) concluded that facial expressions of doctors directly impact patients' ability to trust doctors. The amygdala is activated when assessing if a person's face is trustworthy (Benedetti, 2011). The activity level of the amygdala corresponds to degrees of trust (Benedetti, 2011). For example, if the activity level is low then the patient is likely to find the doctor trustworthy (Benedetti, 2011). In fact, eye contact, posture, and gestures communicate information as much as verbal communication and play an indispensable role in positive social interaction (Benedetti, 2011). Somatosensory input or tactile stimulation was also found to be an integral aspect of nonverbal communication because touch promoted social bonding between two people (Benedetti, 2011).

Verbal communication. Nonverbal communication in patient care is often accompanied by speaking. Effective verbal communication skills of the provider are key to conveying the importance of a diagnosis. Subtle differences in a provider's speech and tone provoked varied positive or negative neurologic responses (Benedetti, 2011). This either strengthened or weakened the patient-provider relationship (Benedetti, 2011). Benedetti (2011) cited a study that found 'certain' statements (statements that were of sureness in nature) of the provider provoked a favorable outcome for the patient and promoted patient-provider trust.

Motivational interviewing. Multiple references suggested the technique of motivational interviewing as a tool for providers to employ when interacting with and assessing patients (Berben et al., 2012; Hamric, Hanson, Tracy, & O'Grady, 2014; Hart, Bird, and Holloway, 2016). Motivational interviewing is aimed at evoking a change in patient behavior that results in a positive outcome (Hart et al., 2016). The provider should allow the patient to talk the majority of the time during their interaction by asking open-ended questions, which grants the provider insight into the patient's true concerns (Hart et al., 2016). Providing the patient with opportunities to reflect on their own thoughts and impart affirmation in a respectful manner are also two aspects of motivational interviewing that were shown to induce a patient's ability to change (Hamric et al., 2014; Hart et al., 2016).

> The creation of concordance may be confounded if the provider is not conscientious to the individualized learning needs of each patient.

Patient Contextualization

The provider may listen to a patient during their interaction, but is the provider really hearing what he or she is saying? The medical issues of a patient can be so complex that often the provider is unable to see the core of the patient's real problem (Weiner & Schwartz, 2016). Weiner and Schwartz (2016) stated that doctors are often focused on diagnosing a rare condition, and in doing so they overlook simple information and insights to the patient's problem. For example, a known diabetic patient repeatedly comes into an emergency room with blood glucose levels that range from 500-700. The provider treats the patient's hyperglycemia but fails to ask why the patient has not been to their primary care provider (PCP) to adjust their insulin regimen. Perhaps, the patient works during the times that their PCP is open, or the patient lost his or her job and cannot afford the new prescription. By acknowledging a patient's circumstances and going beyond the patient's medical problem, the provider will achieve concordance and increase the value of their relationship.

Delivery of Patient Education

One of the defining attributes of concordance is knowledge empowerment of patients. The education of patients is multidimensional and requires special attention of the provider. Each patient learns in unique way. Providers must be aware of the many factors that affect the education of patients. The creation of concordance may be confounded if the provider is not conscientious to the individualized learning needs of each patient.

Language-barriers. Berben et al. (2013) cited multiple studies that noted language barriers between patients and providers led to poor quality of care and unsatisfactory patient health outcomes. The implementation of language interpretation services at Mercy Medical Center in Des Moines, Iowa, improved patient outcomes in pediatric surgical patients (Weldon, Langan, Miedema, Myers, Oakie, & Walker, 2014). An increase in overall satisfaction in care among the patient, patient's family, and the healthcare team was also noted (Weldon et al., 2016). Providers should use language aids and interpre-

tative services when meeting with a patient who does not speak the same language as the provider (Weldon et al., 2014). Not only will this improve the overall care of the patient, but it will also encourage concordance and a strong patient/provider relationship.

Literacy and learning styles. Assessing patients' level of literacy must be a priority for providers. This is as pertinent as the physical and diagnostic assessments. Desmedt and Valcke (2004) found that low health literacy rates are associated with noncompliance of a prescribed regimen and increased mortality. Each patient is from a different educational background, and the provider must be aware of this factor.

Learning styles also vary among patients. The provider must know how the patient prefers to learn. Patients may learn by listening, reading, viewing illustrated materials, demonstrations, or by a combination of the listed learning styles (Giuse, Koonce, Storrow, Kushoor, & Fei, 2012). Providers must be able to recognize the patients' learning style and employ appropriate strategies when educating each and every patient in order to create and achieve concordance.

Timing of education. The timing of patient education should be appropriate to the patient's condition. The provider must be aware of when and where to educate the patient. Williams et al. (2016) found that medication education about immunosuppressant regimens should be presented to kidney transplant patients prior to surgery. Information given to a kidney transplant patient after surgery was not effective and associated with low medication adherence (Williams et al., 2016). Williams et al. (2016) suggested limiting the amount of information presented to the patient and arranging multiple pre-surgery information sessions about immunosuppressant medications. Kidney transplant patients were more likely to understand and adhere to their medication regimen when the information was concise and delivered in an appropriate environment (Williams et al. 2016).

Clear and concise information. The provider may distribute handouts to the patient about medication or diets after deciding on a plan of care. This information should have comprehensible explanations and be coherent with what was discussed during the appointment (Hobden, 2006b). Conflicting information in handouts was found to confuse patients and created distension between the provider and patient (Hobden, 2006).

Cultural Sensitivity

Reverence to the practices of various cultures is necessary in healthcare to provide optimal care. Respecting a patient's cultural practices and beliefs about healthcare strengthens the bond between the provider and patient (Hamric et al., 2014). Hamric et al. (2014) suggested that providers should evaluate his or her personal beliefs and cultural bias. By doing so, the provider can begin to overcome culturally insensitive attitudes and impart culturally competent care to further promote concordance (Hamric et al., 2014).

Time Management and Utilization

Time is a multifaceted antecedent of concordance. Several dimensions of time can be applied to this antecedent. Today's providers have high patient volumes. It is absolutely necessary that providers manage and utilize time with patients efficiently and effectively, as concordance only flourishes if sufficient time is spent with patients.

Length of time spent with patient. Cheesman (2006) stated that a greater amount of time spent with a patient in their first appointment with a new provider encouraged concordance. Wilson and Childs (2002) found that providers were able to identify psychosocial problems when they spent more time with a patient. Increase in the amount of time spent with the patient also showed a decrease in unnecessary prescriptions and increased patient approval of the provider (Wilson and Childs, 2002).

Provider experience. Experience of the provider is directly correlated to time management skills. Konrad et al. (2010) stated more experienced providers had advanced clinical skills that enabled them to utilize time more efficiently. Time management and utilization is a skill that the provider must develop in order to not only be a well-organized provider but to also create concordance with all of their patients.

Follow-up appointments. Follow-up appointments with the same provider are essential to achieving concordance. Williams et al. (2016) found that use of different medical staff in each appointment hindered the development of patient-provider partnerships and medication adherence. Consistency in providers creates rapport with the patient, which encourages concordance.

Fundamental Proficiency

The provider must have the appropriate education, licensure, and credentialing to practice as a healthcare provider in their state or country. This may vary from state to state or country to country. For example, an Advance Practice Registered Nurse must have graduated from an accredited masters level program, maintain his or her licensure and credentialing, and perform an adequate amount of competencies or continued education credits each year to remain in practice (Hamric et al., 2014).

Mastery of Practice

Patricia Benner's Model of Skills Acquisition is applicable to this antecedent. Using Benner's Novice to Expert Theory, the provider will navigate five stages as they gain expertise and experience (McEwen & Wills, 2014). The five stages are: novice, advanced beginner, competent, proficient, and expert (McEwen & Wills, 2014). Throughout a provider's career, according to Benner's theory, he or she will gain the skills and knowledge to become an expert in their field (McEwen & Wills, 2014). Concordance, both the creation and maintenance of it, is very much dependent on the skills of providers. As previously noted, more experienced providers were able to utilize time more efficiently. One can assume using Benner's Theory this is true for other skills, such as communication (McEwen & Wills, 2014).

By learning new skills, such as better ways to communicate with patients and staying informed about current practices, the provider will be able to better educate and treat patients.

Commitment to Professional Growth and Continued Education

In order to adapt to the constant changes in healthcare, the provider must be committed to developing his or her skills in accordance to current healthcare standards of practice. This can be done through joining professional organizations, completing educational contact hours, attending conferences, or obtaining one's terminal degree (Berden et al., 2012; Hamric et al., 2014). By learning new skills, such as better ways to communicate with patients and staying informed about current practices, the provider will be able to better educate and treat patients.

Awareness of Meso-level and Macro-level Factors

Providers must be aware of factors that are beyond the jurisdiction of both patients and providers, as these regulations may affect concordance. Meso-level and macro-level factors also heavily influence the patient's behavior, health, and plan of care. The provider must acknowledge and act in according to these factors to further instill concordance.

Meso-level factors. Meso-level factors are the regulations and practice guidelines of the healthcare organizations in which a patient is treated, such as a clinic or a hospital (as cited by Berben et al., 2013). The guidelines in a clinic most definitely differ from the inner workings of a hospital and vice-versa. In order to comprehensively treat patients, the provider must be aware of the institution's set standards and limitations (Berben et al., 2013).

Macro-level factors. Macro-level factors are based in the health care system itself (as cited by Berben et al., 2013). This includes legislation, insurance coverage, and reimbursement (Berben et al., 2013). The provider must know what legislation may limit their practice, as this may affect patients negatively. The provider should also be familiar with various types of insurances, such as Medicare and Medicaid, which may have restrictions on certain medications and procedures.

Provider's Receptivity to the Culture of Concordance

Misconceptions about concordance may affect providers' receptivity to promoting it. Providers may be reluctant to the culture of concordance; they may not fully comprehend the concept of concordance or may be hesitant to relinquish full control of the patient-provider relationship (Hobden, 2012b). Hobden (2012b) suggested that providers should examine their personal beliefs about concordance and evaluate how concordance can be utilized in their clinical practice.

Patient's Level of Competency

Certain types of patients are not capable of making decisions about their care (Felzmann, 2012). Ethical obligations such has caring for suicidal patients perplex the concept of concordance. Suicidal patients are deemed incompetent to make adequate and safe decisions for themselves, thus the provider must make the decisions about their care, and concordance cannot be exercised (Felzmann, 2012). Providers should evaluate the competency of patients as certain diagnoses or situations may not be applicable to the concept of concordance.

Consequences

Consequences of concordance in the literature reviewed are rated in relation to patients successfully following their prescribed medication regimen, improving condition, and raising the value of the patient/provider relationship (as cited by Snowden et al., 2013). Imogene King's Theory of Goal Attainment is applicable to the consequences of concordance. Satisfaction between the patient and provider will occur if the goals of the plan of care are attained (McEwen & Wills, 2013). Hence, the consequences of concordance can also be based in the satisfaction of both the patient and provider.

The above consequences are positive, but negative consequences can also occur if the provider does not effectively create and nurture concordance. This may include: lack of trust in the provider, misuse of medications, missed treatment appointments, missed follow-up appointments, worsening of condition, new onset of preventable diseases, and lack of or dissatisfaction in the patient/provider partnership.

Case Scenarios

The following case scenarios portray how great of an impact the provider plays in achieving concordance. For

all cases, a nurse practitioner is the provider and the setting is an outpatient clinic. Each case illustrates the process of creating concordance as well as the qualities (or absence of qualities) of a provider that contributes to concordance.

Model Case

Rose has been a nurse practitioner for ten years. During this time, Rose has mastered her practice and continues to further her skill-set by attending several conferences a year. She is currently working on her Doctor of Nursing Practice degree. Rose is an active member of the American Association of Nurse Practitioners. Rose believes her relationships with her patients should be a partnership and be comfortable for both her and the patient.

Rose is meeting a new patient today whose chief complaint is fatigue. Prior to officially meeting Brian, Rose decides to call him and discuss his hopes for the appointment. Rose has a general idea of who Brian is and what his goals are for his health. When Brian enters the office, Rose has him fill out a survey about his learning style and literacy level. Brian is a young, Hispanic male who speaks both English and Spanish.

Rose is prompt and sees Brian at the appointment time. Rose has arranged her schedule for an additional fifteen minutes to meet with Brian. Upon entering the room, Rose smiles and shakes Brian's hand. Rose keeps eye contact with Brian while asking him a few questions. While listening to Brian, she allows him to guide the conversation. Brian says he has been feeling extremely tired lately. Rose asks if he has been getting enough sleep. Brian tells Rose that he has been working extra night shifts for about six months so he can pay his sister's college tuition. He states that he sleeps throughout the day, but often he does not feel rested after awakening. This is a key indicator to Brian's problem. Rose is concerned about his vitamin D levels. Rose then completes a physical exam on Brian. With her findings and expertise, Rose suggests testing his vitamin D levels and few other blood tests that will indicate if there is an underlying medical condition causing this fatigue.

Brian learns best by reading and writing and can understand both English and Spanish information at a high-school level. Rose provides English high-school level information about the importance of vitamin D and guidelines about adapting to nightshift work to Brian. Rose addresses Brian's type of insurance and orders the blood tests in accordance to his insurance regulations. Rose also suggests taking vitamin D in addition to his multi-vitamin. Rose arranges another appointment to follow-up about his tests and regimen of vitamin D. Rose advises Brian to call her office with any issue at the end of the session. As Rose says this to Brian, she places her hand on his shoulder reassuringly.

Rose called the results of Brian's test to him within 48 hours. In the follow-up visit, Brian states he is feeling less tired and has been following his regimen of vitamin D. Both Brian and Rose are satisfied with the outcome and continue to meet as needed.

Borderline Case

Tony has been practicing as a nurse practitioner for three years. He has yet to join any professional organizations but attends one conference a year. Tony is still transitioning into his role as an advanced care provider. Tony is meeting Daisy for the first time. Daisy is a middle-aged, single, Caucasian female with a history of depression. Tony is running about twenty minutes behind schedule. Despite being behind schedule, he feels prepared for the appointment because he spent some time reviewing Daisy's chart yesterday. Today, Daisy wants to talk to Tony about changing her medication regimen for depression. Tony is somewhat apprehensive about prescribing her a new antidepressant, because Daisy admittedly does not normally take her medications as prescribed. She also often stops taking her medications abruptly. Tony knocks prior to entering the room, smiles, and shakes her hand. After shaking her hand Tony sets up his computer, and there is silence between Tony and Daisy. Tony then asks Daisy five or six quick questions in a row. Daisy begins to get flustered, especially with the question of why she has not followed the previous prescription regimens. Tony realizes her frustrations and apologizes. He then asks Daisy if she has any financial troubles. Tony then discovers a key insight to Daisy's daily life. Daisy's mother has cancer, and she has become her primary caregiver. She has also lost her job as a result of being her mother's caregiver. Tony then notes the time of appointment and realizes that he must finish their meeting. He quickly examines Daisy and concludes the appointment. Tony prescribes a generic version of a new depression medication and tells Daisy to ask the front desk for more information about rebates and the medication itself. He adds that she should set up a follow-up appointment and instructs her to set up an appointment with the medical assistant.

Daisy calls the clinic the next day with questions about the prescription, and Tony directs the medical assistant to take the call because he is behind schedule. The medical assistant tries to answer her questions but is unsure of how to answer some of the specific questions about the medication. The medical assistant leaves Tony a reminder to call Daisy back. Tony neglects to call Daisy for one week. Daisy and Tony discuss her concerns and Daisy decides to fill the prescription and take the medication as directed. Tony tries to reassure her over the phone and encourages her to call back with any questions. Daisy is unsure if Tony will answer if she calls again. Daisy fills the prescription and decides she will go to the follow-up appointment only if the pills are not working.

Contrary case

Mark has been a nurse practitioner for seven years. Within this time, Mark has done the minimum to stay credentialed, does not attend conferences, and is not a member of any professional organizations. Mark believes that patients should listen and follow his recommendations without question. Mark believes that he has the "final say" in regards to the treatment plan. Marie is an eighteen-year-old, Asian female who wants to start a form of contraceptive. She was raised in a strict, Roman Catholic household. Marie's mother is opposed to birth control. Marie had previously cancelled this appointment because she was very apprehensive about starting a regimen of birth control. Mark enters the room, does not make eye contact, and focuses on his chart. The first thing Mark says to Marie is that the appointment will take very little time. Mark physically examines Marie and does not ask any additional questions. Mark tells the patient he is prescribing a common oral contraceptive for her. Marie is upset because they never discussed the option of using an intrauterine device, and she will have to hide the pills from her parents. No follow-up was in place after the appointment, nor was any phone calls made to Marie.

Concordance cannot be classified as unsuccessful or successful or ineffective or effective. The essence of concordance is meant to go beyond measurable adherence and compliance to a medication regimen.

Empirical Referents

The concept of concordance is difficult to measure. Concordance cannot be classified as unsuccessful or successful or ineffective or effective. The essence of concordance is meant to go beyond measurable

adherence and compliance to a medication regimen. Rating concordance in two narrow categories like these limits the implications of concordance.

Flagg (2010) noted that very few reliable tools were available to test concordance before the Leeds Attitude Toward Concordance (LATcon) scale. The LATcon scale was first tested and widely used in the United Kingdom (Flagg, 2010). The purpose of the LATcon scale is to measure the attitudes of both of patients and providers about their partnership and satisfaction, as well as the effectiveness of his or her selected medication regimen and treatment plan (Flagg, 2010). The goal is to quantify the degrees to which concordance was achieved and examine both points of views of patients and providers (Flagg, 2010).

Flagg (2010) used the LATcon scale as a guide and created a scale called the Revised United States Leeds Attitude Toward Concordance (R-USLATcon). Flagg (2010) changed certain phrases in the scale to make the R-USLATcon scale applicable to American providers and patients. Examples of a response statements on the R-USLATcon scale are: "During an outpatient visit, the healthcare provider and the patient should treat each other like equal partners," and "Both the patient and healthcare provider should agree on a plan to reach the desired effects of treatment options" (Flagg, 2010, p. 84). The questions and statements on the R-USLATcon scale address health beliefs, expectations, and importance of partnership (Flagg, 2010). This scale most definitely encompasses the many factors that contribute to concordance and can be used as a reliable instrument to measure concordance.

Concordance and Nursing

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Concordance is a concept that is very applicable to nursing. Nursing is rooted in patient-centered care and assumed partnership with patients, as is concordance. The discipline of nursing has many patient-centered theories and practices that support the constructs of concordance (McEwen & Wills, 2014). The concept of concordance is neither new nor groundbreaking in the field of nursing, as many nurses past and present have unknowingly practiced concordance at some point in their career. For example, nursing theorist Faye Abdellah published ten steps in which a nurse could identify a patient's problem, many of which overlap with the attributes and antecedents of concordance discussed in this paper (McEwen & Wills, 2014). Another nursing theorist, Barbara Artinian, developed the Intersystem Model in the 1980s; this model entails both an intrasystem and intersystem. The intersystem focuses on the interactions between nurses and patients in healthcare situations; this is where the nurse and patient communicate, negotiate, and develop a plan of care, which is essentially concordance and supports the importance of positive patient/provider interactions as discussed in this analysis (McEwen & Wills, 2014). Nursing may have not coined the term "concordance" in healthcare, but there is definitely evidence that elements of concordance have been practiced in nursing for decades.

Conclusion

This hearts together culture of concordance will create positive outcomes for patients and will lead to a very satisfactory, high-value patient/provider relationship.

In summary, concordance is a concept that transcends its predecessors of compliance and adherence and is a modern approach to patient-centered care. Concordance is developed and maintained by a unified partnership between a patient and his or her provider. The patient's interactions and experiences with his or her provider greatly impact their willingness to participate in a plan of care and change unhealthy behavior, as made evident by this concept analysis. This hearts together culture of concordance will create positive outcomes for patients and will lead to a very satisfactory, high-value patient/provider relationship.

Providers must be mindful of their influence and role in concordance. Much of the creation and maintenance of concordance is reliant on the qualities, skills, and beliefs of the provider. Although the responsibilities that accompany concordance may be daunting for the provider, he or she is ethically obligated as a healthcare professional to provide the highest quality and safest care to all patients.

This hearts together culture of concordance will create positive outcomes for patients and will lead to a very satisfactory, high-value patient/provider relationship.

Limitations

The provider and his or her role in concordance was the focus of this work. Additional factors that affect concordance should continue to be studied. Other studies could include the role of the healthcare system on concordance or the patient's health literacy in relation to concordance. Concordance is a multi-faceted area of healthcare which must be examined from all aspects to fully grasp its magnitude and applicability.

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