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Correlates of observer-rated active involvement in psychiatric treatment visits

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ABSTRACT

Among people with serious mental illness, increased patient activation has been linked to a range of key recovery outcomes. To date, patient activation has been measured largely through self-report. The present study investigated correlates of a new tool that assesses active involvement through rating audio-recordings of treatment visits. The key domains of patient activation assessed in visits included: patients asking questions, discussing with providers instances of being active in managing illness outside the session, talking about goals, bringing up concerns, making evaluative statements about treatment, setting the agenda for the visit, and making requests about the course of treatment. The new coding scheme proved to be a feasible and reliable method for identifying multi-faceted behavioral indicators of patient activation. Contrary to our hypotheses, in a sample of 166 people diagnosed with severe mental illnesses, self-reported activation and observer-rated indices of activation were often not correlated or correlated in unexpected directions with the new behavioral measure of patient activation. This suggests the nature of patient activation may be complex and work is needed to understand how observer-rated and self-rated activation may predict differential recovery outcomes.

1. Introduction

Healthcare research and policy efforts have focused on the collaborative management of chronic illnesses, including severe mental illnesses, as a critical process through which patients work with providers to identify areas of concern, set goals, and follow-up with appropriate treatment (Storm and Edwards, 2013). One facet of collaborative management focuses on patient involvement in treatment (i.e., patient activation), which refers to the skills, knowledge, and confidence needed for patients to participate in managing a chronic illness (Hibbard et al., 2004). Within mental healthcare, patient activation has been linked to improved illness self-management, increased recovery orientation and retention in outpatient care, and enhanced patient-doctor communication (Alegría et al., 2008, 2009; Green et al., 2010; Kukla et al., 2013; Salyers et al., 2009b).

Patient activation is frequently assessed in both general and mental health care with the patient activation measure (PAM) and its adaptations (Green et al., 2010; Hibbard et al., 2005, 2004). There is evidence that the PAM adapted for mental health, the PAM-MH, is valid and reliable in assessing patient activation in patients with severe mental illnesses (Bonfils et al., 2014; Green et al., 2010; Salyers et al., 2009b). However, the PAM-MH does not provide direct information about behavioral involvement by patients within specific mental health treatment visits. One alternative method for examining patient-provider dynamics is to audio record appointments, which are then assessed by trained raters. This method is becoming increasingly prominent and has been used to examine the processes of agenda-setting (Frankel et al., 2013) and shared decision-making in psychiatric visits (Fukui et al., 2014; Goss et al., 2008; Matthias et al., 2014).

To our knowledge, behavioral measures of patient active involvement in a treatment context have rarely been examined, and extant studies have used different methodologies. An early example of this type of method is Roter's Interaction Analysis System (RIAS; Roter, 1977), which focuses on questions asked by the patient; this method has been subject to criticism (e.g., see Sandvik et al., 2002). Other behavioral coding schemes have been developed more recently. For example, one study in primary care used the PACE Coding System to examine patient participation (Cegala and Post, 2009) and another used the Active Patient Participation coding scheme to rate audiotaped visits for active behavior (Street and Haidet, 2011). Using a novel approach to behavioral coding, Salyers et al. (2009b) qualitatively coded psychiatric visit transcripts to explore ways patients were active in

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treatment. This study found four overarching ways that patients displayed (or did not display) active involvement: building a partnership, seeking and displaying competence, directing treatment, and missing opportunities. Each transcript was also rated for patient involvement in three areas: negotiation about treatment, interest in mental illness management, and involvement in controlling symptoms. These three ratings did not significantly correlate with patients' ratings of activation (with the PAM-MH), illness self-management, or medication attitudes. While this study took an innovative approach to investigating patients' active involvement in treatment, results were limited by a small sample; further, the study did not investigate variables influencing the qualitative themes of active involvement, and transcript ratings of involvement were based on subjective, global ratings rather than the presence or absence of specific behaviors.

In order to improve upon this prior work, we had several goals for the current investigation. First, we aimed to expand and refine the qualitative coding scheme to assess distinct patient behaviors that reflect active involvement in treatment. Second, we were interested in understanding correlates of these behavioral indicators of patient activation with a larger sample. We were interested in three types of potential correlates: patient-provider relationship factors, proximal communication outcomes (i.e., agreement between the provider and patient as to the primary concern expressed during the visit), and patient recovery factors.

Patient-provider relationship factors include patient-reported trust in the provider and perceptions of patient-centeredness. Though minimal research has explored the link between trust and patient activation, one study in primary care found a direct link between higher patient trust in their provider and increased healthcare activation (Becker and Roblin, 2008). Moreover, increased trust in one's provider is associated with greater disclosure of information, help-seeking and follow-up, and treatment adherence (Bova et al., 2006; Hall et al., 2002; Safran et al., 1998). Similarly, although additional research in mental health samples is needed, we expected perceptions of patient-centeredness to be associated with greater activation. Extant research in primary care indicates greater perceptions of patient-centeredness are associated with increased patient-centered communication in audiotaped visits and improved health outcomes (Stewart et al., 2000). Further, increased patient activation in chronically ill patients has been found to be associated with greater perceived quality of interpersonal exchanges with physicians and increased out-of-office contact (Alexander et al., 2012). Patient active involvement in a given session has also been associated with greater understanding from the physician in terms of the desire for partnership, indicating patient activation may assist healthcare providers in appropriately supplying patient-centered care (Street and Haidet, 2011).

A second area where we expected to see associations with active involvement relates to the quality of communication between the provider and patient during the visit. Communication and agreement between patient and provider is integrally important but may be difficult in this population. Patients are not always aware of their illness or symptoms, and providers may hold stigmatizing beliefs against those with more severe disorders (Hasson-Ohayon et al., 2017). Patients who are actively involved may be better able to communicate needs and preferences. This is in line with literature indicating that primary care patients who exhibit greater active involvement in treatment visits have physicians with more accurate understanding of the patient's health beliefs (Street and Haidet, 2011) and with work showing significant associations between increased patient activation and improved patient-provider communication in a telephone survey (Alegría et al., 2009). In mental healthcare, a recent study of therapeutic alliance in community mental health clinics found that agreement on tasks/goals significantly predicted increases in patient activation scores over time (Allen et al., 2017). A further study matched patient's and provider's perceptions of the primary concern of a psychiatric visit for patients with severe mental illnesses (Bonfils et al., 2014), finding that providers and patients did not agree on the primary visit concern 50% of the time, with an additional 30% displaying only partial agreement. This low rate of agreement highlights the importance of examining factors that may influence providers' understanding of patients' concerns. Behaviors reflecting active involvement in treatment likely influence communication throughout a visit – if a patient is more active, he or she may be more likely to set an agenda, be more vocal about concerns, or be directive about treatment options, potentially giving the provider more opportunities to correctly discern the patient's most important treatment concern.

A final domain where we would expect to see associations with active involvement is subjective recovery, or a patients' view of their life with respect to mental illness, often referencing the ability to pursue life goals despite symptoms or potential for relapse (Roe et al., 2011). Research has shown positive relationships between self-reported patient activation and recovery and hope (Green et al., 2010; Kukla et al., 2013; Skolasky et al., 2008, 2011). Further, one study showed that patients' recovery perceptions significantly predicted treatment engagement, above and beyond quality of life, age, ethnicity, and diagnosis (Gudjonsson et al., 2011). Although few studies have directly examined the relationship between subjective recovery and observed involvement in treatment sessions, recovery does correlate with empowerment, a construct tapping aspects of self-efficacy and a perception of shared power with others (Rogers et al., 2010), both of which are important to active behavior in psychiatric visits. It is likely that as patients come to take more control in their own lives and feel less defined by their mental illness, thereby developing greater hope and a sense of recovery, they feel more capable of taking an active role in their treatment.

Building on prior research showing ways that patients display active involvement in treatment (Salyers et al., 2009b), we replicated and extended the work to a larger sample, using a more detailed coding system and more extensive investigation of potential correlates. In addition to creating a systematic and replicable measure of active behavior in treatment sessions, we explored several hypotheses – that active behaviors would be associated with 1) higher scores on the PAM-MH; 2) greater trust in and perceived patient-centeredness of the psychiatric provider; 3) higher concordance about the primary concern as an indication of communication quality; and 4) greater levels of hope and perceived recovery.

2. Methods

2.1. Participants

Data for this investigation came from baseline psychiatric visits and interviews in a study investigating CommonGround, a software program designed to optimize shared decision-making in psychiatric treatment (Deegan et al., 2008). Participants (N = 166) were recruited from four outpatient clinics in one community mental health center where they were receiving services from one of four psychiatric providers (two psychiatrists, two nurse practitioners). Participants had to agree to have three psychiatric visits audio-recorded and be fluent in English, willing to participate in a longitudinal study, and receiving treatment for severe mental illness (schizophrenia-spectrum, bipolar, or major depressive disorder) in one of these four clinics. If patients were in crisis (according to staff) or planned to discontinue services, they were not eligible to participate. More than half of the participants were men (94, 56.6%), never married (94, 56.6%), living independently (91, 54.8%), and Black (91, 54.8%). Participants' mean age was 44.2 years (SD = 10.4) and most had completed high school or further education (97, 58.4%).

2.2. Procedure

Eligible participants were approached upon arrival for an