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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Why are you here again? Concordance between consumers and providers about the primary concern in recurring psychiatric visits



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ARTICLE INFO

Article history:

Received 20 February 2014

Received in revised form

7 May 2014

Accepted 24 July 2014

Available online 31 July 2014

Keywords:

Severe mental illness

Communication

Patient-centered care

Shared decision-making

ABSTRACT

Patient-centered care has become increasingly important over the last decade, both in physical and mental health care. In support of patient-centered care, providers need to understand consumers' primary concerns during treatment visits. The current study explored what primary concerns were brought to recurring psychiatric visits for a sample of adults with severe mental illness ($N=164$), whether these concerns were concordant with those recognized by providers, and which factors predicted concordance. We identified 17 types of primary concerns, most commonly medications and symptoms, with only 50% of visits showing evidence of at least partial agreement between consumers and providers. Contrary to expectations, consumer demographics, activation, trust, and perceptions of patient-centeredness were not predictive, while greater preferences for autonomy predicted poorer agreement. Our findings highlight the need for interventions to promote a shared understanding of primary concerns in recurring psychiatric visits. Further attention is needed to ensure the provision of patient-centered care such that consumer concerns are acknowledged and addressed within recurring psychiatric visits.

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1. Introduction

Patient-centered care has become increasingly important over the last decade, both in physical and mental health care (Institute of Medicine, 2001; National Research Council, 2006). Patient-centeredness is a multifaceted concept that centers around two components: consumer involvement in care and the individualization of care (Robinson et al., 2008). In line with these components, a key concept is shared decision-making (SDM), where consumers and providers work collaboratively to address treatment needs (Charles et al., 1997). At the most basic level, providers need to understand consumers' primary concerns during a treatment visit (Makoul and Clayman, 2006). If the main concern is not understood, further SDM may be hindered and rapport may be damaged. The purpose of the current study was to explore the

content of primary concerns in psychiatric treatment as reported by consumers and providers, and to examine levels of concordance and the predictors of that concordance.

We found no studies specifically addressing agreement about primary concerns in psychiatry. In general medicine, high levels of agreement between patients and providers are typically found (80–90%) (Boland et al., 1998; Jackson, 2005; Gross et al., 2013), except when comparing patients' reports of events in the appointment with providers' reports in the medical chart (DiMatteo et al., 2003). Although agreement has not been directly examined in psychiatry, related research is informative. One study examined concordance in ranking the importance of treatment goals. Results indicated that psychiatrists tended to value traditional treatment goals (e.g., decrease psychotic symptoms) more highly than consumers who valued practical, tangible goals (e.g., improved capacity for work) (Bridges et al., 2011). Another study showed that more than 40% of psychiatrist-consumer pairings were discrepant in their appraisal of medication adherence, with consumers more

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often identifying themselves as adherent (De las Cuevas et al., 2013). In addition, shared decision-making studies have found 79–87% agreement between consumers and psychiatric providers on a treatment decision as rated by observers from audiotaped sessions (Fukui et al., 2013; Matthias et al., 2013).

Understanding correlates of concordance between consumers and providers is also beneficial. Misunderstanding consumers' main concerns could damage the therapeutic relationship; alternatively, factors of the relationship may instead lead to poor communication and increased chances of misunderstanding the main concerns. One factor that may impact the consumer-provider relationship, patient-centeredness, has repeatedly been linked to improved consumer outcomes such as self-management and satisfaction with care (Rathert et al., 2012). It is possible that higher levels of perceived patient-centeredness reflect higher quality provider-consumer communication which may foster trust and the sharing of information, and in turn, higher levels of agreement on the consumer's primary concerns. In studies outside of mental health, trust in medical provider has been linked to help-seeking and follow-up, consumer disclosure of information, treatment adherence, and satisfaction with care (Safran et al., 1998; Hall et al., 2002; Bova et al., 2006). Research in psychiatry indicates that consumers consider trust in physician to be central to a positive therapeutic relationship and to receiving quality services (Laugharne and Priebe, 2006). Further, poor quality provider communication has been associated with lower trust (Ommen et al., 2011). Consumers with lower levels of trust may have poorer communication with their provider, and we hypothesize lower rates of concordance on their reported primary concern.

Consumer-specific traits may also impact the quality of communication during appointments. Two constructs particularly relevant to the decision-making literature include autonomy preference and patient activation. Autonomy preference is the degree to which individuals wish to be informed about their condition and participate in decisions related to their illness (Ende et al., 1989). Studies in mental health have consistently shown that consumers have a desire to participate in their own care (Hamann et al., 2005; Hamann et al., 2007a; O'Neal et al., 2008), and the broader literature has linked consumer participation in care to a range of positive health outcomes (Guadagnoli and Ward, 1998; Wilson et al., 2010). In addition, physician support for consumers' desired level of autonomy has been associated with improved health outcomes and treatment satisfaction (Williams et al., 1998; Jahng et al., 2005).

While autonomy preference represents the desire to participate, patient activation refers to the skills, knowledge, and confidence needed to participate in managing chronic illness (Hibbard et al., 2004). In mental health, higher patient activation has been linked to improved illness self-management, increased recovery orientation, and retention in outpatient care (Alegria et al., 2008; Salyers et al., 2009; Green et al., 2010; Kukla et al., 2013) in addition to being directly linked to improved communication (Alegria et al., 2009). Consumers who have stronger autonomy preferences and patient activation may have more interests or ability to advocate for themselves during appointments, more clearly describe their concerns, and participate in their own care, resulting in increased agreement about primary concerns.

Consumer demographic characteristics may also impact agreement on the primary concern of a psychiatric visit. For example, there is evidence outside of psychiatry that those who are White (Levinson et al., 2005), female, more educated, and older are more likely to want to engage in shared decision-making with their provider (Say et al., 2006). If consumers' communication styles

vary with certain demographic characteristics, it is possible that agreement about the primary concern will also vary. Finally, agreement may vary based on the severity of symptoms or functional impairment, which could interfere with communication and a shared understanding of primary concerns during a visit. The current study includes consumers who are receiving services from either an Assertive Community Treatment (ACT) team or from an outpatient clinic in a community mental health center. Given that ACT teams provide highly intensive services for those who have histories of difficulty engaging in care (Salyers and Tsemberis, 2007), the type of services being received may predict agreement levels.

The current study explored what primary concerns are brought to recurring psychiatric visits for a sample of adults with severe mental illness, whether these concerns are concordant with those recognized by providers, and which factors predict concordance. We hypothesized that greater autonomy and activation in treatment as well as indices tapping the consumer-provider relationship (trust and perceptions of patient-centeredness) would predict higher levels of agreement about primary concerns. Furthermore, we hypothesized that consumers who were female, older, more educated, and White would have better levels of agreement with their providers, but that those receiving services from ACT teams would have lower agreement (compared to those in outpatient clinics).

2. Methods

2.1. Participants

Data for this study were obtained during baseline interviews of a study on CommonGround, an intervention designed to increase shared decision-making in psychiatric treatment (Deegan et al., 2008; Drake et al., 2010; Stein et al., 2013). Participants included four psychiatric prescribers (two psychiatrists, two nurse practitioners) serving consumers in one of four clinics within a community mental health center (two outpatient teams and two ACT teams). Consumers receiving services in this community mental health center typically see psychiatric providers every one to three months; these visits typically entail medication management and a psychiatric check-in by providers, as well as discussion of any psychiatric concerns brought by consumers. Further involvement in services varies widely across individuals and clinics, but multiple opportunities are available, such as case management, group and individual therapy, addiction services, and vocational support.

For the primary study, consumers were approached and recruited when they arrived for a psychiatric visit, unless clinic staff requested we not approach (e.g., a consumer was in crisis). Consumers were screened for eligibility by trained research assistants before completing an informed consent process with a brief test of understanding. To be included in the study, consumers had to be fluent in English, be willing to be interviewed 3 times over the course of 18 months, and agree to be audio recorded in 3 separate psychiatric visits. Consumers were not eligible to participate in the study if they had imminent plans to leave their treatment team due to the longitudinal nature of the original study.

In total, 307 consumers were approached by the study team. A total of 167 consumers (54.4%) participated in the study. Another 21 (6.8%) consumers agreed to participate but were unable to pass a test of understanding for informed consent. Ninety-three (30.3%) consumers declined to participate, primarily for lack of interest. A further 26 (8.5%) consumers were interested in the study but had conflicts preventing participation (e.g., no time on the day of their psychiatric visit). For this analysis, 3 visits did not have complete data from both consumer and provider, for a final sample size of 164.

2.2. Procedures

Interested consumers were read the informed consent and asked a series of 10 true-false questions about its content. If an individual passed the screening test and consented, the visit with the prescriber was audio recorded. The providers were given a short survey about the consumer before each visit and asked to fill it out immediately after seeing the consumer. After the visit, consumers were

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