Collaborative authenticity: how stakeholder-based source effects influence message evaluations in integrated care

We know from many projects and studies that if a person’s health and well-being is managed holistically and they are involved in decisions about their care and support, they have a positive experience of care and their outcomes improve. Much has been achieved in the past decade or so in that regard. Still, Europe seems to be some steps away from really and truly integrated health and care systems, and the majority of mainstreamed services tend to be firmly located within one or other of either the social care or health-care domains. Thus, much remains to be done if we want to tap the full potential of integrated care for achieving the “quadruple aim” to improve patient experience, outcomes of care, effectiveness of health systems and provider experience; improvements in communication between providers and care consumers based on a better understanding of communication and source effects are an important step in that regard.

As a project coordinator of several EU-funded projects on integrated care programme design, piloting and evaluation, I learned in recent years how important communication and language are, and how much can go wrong in that regard between the various stakeholders involved in integrated care. Admittedly, my first and immediate thought when I started to read the paper was “What has marketing to do with integrated care?” Already after the first paragraph, however, the paper triggered many ideas for my daily work in European projects that aim to better design and scale integrated care provision schemes across Europe. Of course, many of the care programmes designed and evaluated in these projects deal with information and data sharing, as this is one of the key challenges (but also opportunities) of integrated care. However, they are too often about sharing information about rather than with the care consumer. And often, answers are provided on what and by what means information is shared between the different stakeholders involved, but none of the schemes I am aware of ever considered how, for instance, source effects impact the perception of a message. There is much research about patient-centeredness and many (pilot) programmes have been implemented which aim to put the patient at the centre of care, but effects of communication seem not to be considered enough yet if at all, especially when it comes to measuring impacts of communication on care outcomes. Often, seemingly small changes of care pathways, undertaken based on research results like the ones in the paper, have a strong impact on health outcomes and the way a care consumer experiences their care journey. A recent pilot study, for example, revealed that patients tend to perceive that a care professional has spent more time at their bedside when they sit rather than stand (Swayden et al., 2012). Other studies established evidence of positive impacts of altering the geography of consultation rooms – to the effect that patients and physicians sit next to each other rather than opposite each other – on patient–professional relationships.

As coordinator of many implementation projects, I welcome the relevance and practical value of these research results for better shaping the practicalities of a collaborative culture that emphasises team working and patient-centeredness. They can help increase compliance, which is still a tremendous challenge and a complex issue, since human beings
do not act as *homo economicus.* Thus, resultant behaviour measurement and further investigation on how collaborative messaging could look in practical terms would be crucial to further improve integrated care programmes across Europe. In my view, it can provide a catalyst for action and real-world change, especially as little research has been done to measure the quality of integrated care from the care consumer perspective.

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Reference