

“I’m worth saving”: Making sense of medication taking in a care coordination organization

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Abstract

Patients and healthcare providers (HCPs) may communicatively make sense of medication taking in divergent ways. Often, HCPs prioritize medication adherence, the extent to which patients consume medications as prescribed. In contrast, patients may focus on how medications fit in with their everyday lives. Care coordination organizations (CCOs) provide cohesive, interdisciplinary, health services to chronically ill patients and may help bridge the gap between patient and HCP sensemaking. Our qualitative study asked: How do patients and HCPs involved in a CCO communicatively make sense of medication taking? Through thematic analysis, we found three themes related to patients’ sensemaking. Patients ($N = 9$) made sense of medication taking (1) as necessary and important through embodied experiences, social discourses, and interpersonal interactions; (2) as easy when supported; and (3) through building bonds. We also found three themes related to HCPs’ sensemaking: HCP participants ($N = 5$) made sense of medication taking (1) through dialogue with patients; (2) by interacting in patients’ home spaces; and (3) through building relationships with patients. Our final theme explores how communicative sensemaking became more complicated for participants in the context of psychotropic medications. Using Mishler’s Voice of the Lifeworld (VoL) and Weick’s sensemaking, we advance a constitutive perspective on medication taking. We suggest that researchers and HCPs should focus on constructing shared meanings about medication taking through dialogue, rather than on increasing adherence. Our study provides evidence that, by promoting engagement with the VoL, CCOs may facilitate such dialogs.

Introduction

Medication taking is an extensively researched yet poorly understood behavior. Despite thousands of studies examining patient “adherence” or “compliance” (e.g., the extent to which patients follow the medication taking regimens prescribed by their healthcare providers), variables that consistently predict medication taking behaviors have been difficult to identify and medication adherence rates remain low (Abegaz et al., 2017; Vermeire et al., 2001). Patient-healthcare provider relationships are recognized as key mediators of medication taking behaviors (Haskard Zolnieriek & DiMatteo, 2009), yet patients and healthcare providers (HCPs) often make sense of medication in disparate ways. While HCPs tend to take the efficacy of medications for granted and regard medication taking as easy (Hunt et al., 1998; Wens et al., 2005), patients may find their medications expensive, overwhelming, and/or ineffective (Mohammed et al., 2016).

These differences in patient and HCP perspectives on medication taking may contribute to breakdowns in communication. For example, HCPs may focus on educating patients and changing their beliefs about medications, rather than on the systems-level factors (such as lack of transportation and financial strain) that often drive nonadherence (Hunt & Arar, 2001; Sabaté, 2003). HCPs can become frustrated when their efforts prove unsuccessful (Granger et al., 2009). Patients, on the other hand, may resign themselves to nonadherence in secret, afraid that HCPs will chastise them for nonadherence (Mikesell et al., 2016).

This article reports results from an in-depth, qualitative study examining how patients and HCPs involved in a care coordination organization (CCO) communicatively make sense of medication taking. By examining patient and HCP sensemaking processes within an organizational context, we offer a way forward to help integrate patient and HCP perspectives on medications and, ultimately, improve patient-HCP communication. To begin, we review prior research on patient and HCP perspectives on medication taking, critiques of dominant conceptions of (non)adherence, and communication scholars' contributions to this research body.

Patient and healthcare provider perspectives on medication taking

We define “medication adherence”¹ as “the extent to which the patient’s actual history of drug administration corresponds to the prescribed regimen” (Vermeire et al., 2001, p. 332). Broadly, the body of literature on medication (non)adherence suggests that many patients deviate from prescriptions. The World Health Organization (WHO) reports, “in developed countries, adherence among patients suffering chronic illnesses averages only 50%” (Sabaté, 2003, p. 7). Numerous studies have examined why so many patients are “nonadherent,” concluding that many patients have concerns about medications or have experienced side effects, leading them to resist medications (Britten et al., 2010; Pound et al., 2005). While other patients want to adhere, they may become “nonadherent” because they cannot afford their medications, have received conflicting information about medicines, and/or are confused or overwhelmed by the complexity of their regimen (Mohammed et al., 2016). Consequently, patients – particularly those with chronic conditions and multiple medications – often describe their treatment regimens as challenging and burdensome (Mohammed et al., 2016; Sav et al., 2013).

HCPs may be unaware of the burdens associated with medication taking (Granger et al., 2009) and may take an individualistic perspective, attributing nonadherence to patients’ lack of motivation or education (Hunt & Arar, 2001). Furthermore, HCPs may view (non)adherence as a central issue that must be overcome to achieve clinical goals (Hunt & Arar, 2001) and may deemphasize risks or side effects associated with medications – factors that are often critical from patients’ perspectives (Mikesell et al., 2016). Some HCPs view patients’ beliefs or cultural backgrounds as “barriers” to achieving (non)adherence, adding a layer of stigma to the experiences of marginalized patients (Hunt et al., 1998; Saethre, 2013). In short, there are stark differences in patient and HCP perspectives on medication taking, which the present study seeks to address.

Critiques of (non)adherence in patient-provider communication

The discordance between patient and HCP perspectives on medication taking has led many scholars to critique the concept of (non)adherence. These critiques assert that (non)adherence is “a medicocentric concept which obliterates lay knowledge as a nuisance factor” (Britten & Maguire, 2016, p. 83). (Non)adherence research has also been critiqued because most scholars have positioned individual-level factors (e.g., patients’ education levels and beliefs) as the primary determinants of adherence (Vermeire et al., 2001). This research tends to obscure the health system issues which make living with chronic conditions challenging, particularly for marginalized patients (i.e., racial minorities, low-income patients) (Hunt & Arar, 2001; Hunt et al., 1998; Sav et al., 2013). Most research fails to acknowledge problems with medications themselves (Pound et al., 2005), including the risk of adverse drug reactions (Kongkaew et al., 2008), limited effectiveness (Leucht et al., 2015), and potentially flawed evidence (Howick et al., 2020). The totality of this research suggests that a new approach is needed. Rather than focusing on raising adherence rates, scholars and HCPs might be well served by attempting to understand how their patients are making sense of medications and how medication sensemaking relates to treatment burden.

One approach that aims to reduce medication-related treatment burden is care coordination. Care coordination consists of systematic efforts to (1) produce a cohesive care experience for chronically ill patients; (2) facilitate teamwork and knowledge-sharing among HCPs; and (3) promote collaboration among community-based organizations (Ehrlich et al., 2009). In recent years, care coordination has received significant attention from policymakers because it has the potential to improve care for chronically ill patients with polypharmacy² – a fast-growing population whose needs are not effectively addressed by most healthcare delivery systems (Sabaté, 2003, p. XIII). While care coordination may continue to focus on raising adherence rates, the care coordination model does address the critique of (non)adherence which argues that interventions should focus more on reducing treatment burden through health system reform. Thus, this study aims to understand how care coordination provides a context for patient and HCP sensemaking of medication taking.

Using health communication scholarship to promote a constitutive perspective on medication taking

Health communication scholars have made important contributions to research on (non)adherence. Several studies have examined how individual-level characteristics, such as patients’ health literacy (Mayo-Gamble & Mouton, 2018), “cultural beliefs” (Jin & Acharya, 2016), and medical information sources (Linn et al., 2019) may influence medication (non)adherence. Others have identified links between patient-provider communication and medication-taking behaviors (Linn et al., 2016). Street et al. (2008) found that patients whose HCPs used patient-centered communication techniques expressed greater intent to adhere. Scholars have examined how health interventions could increase adherence rates. Krebs et al.

(2015), for instance, examined how patients with tobacco addiction responded to text message-based intervention designed to support adherence and smoking cessation.

Yet, most communication research on medication taking has focused on understanding what drives patient (non)adherence and what can be done to increase adherence rates, linking (non)adherence to individual- and interpersonal-level variables (e.g., patients' health beliefs or HCPs' use of shared decision-making practices). These studies have treated communication as a variable that might affect medication-taking behaviors. Instead, this article offers a new perspective on (non)adherence – proposing a constitutive perspective on medication taking (Craig, 1999; Manning, 2014). A constitutive perspective recognizes that medication taking behaviors are the consequence of communicative sense making, a dynamic process embedded in interpersonal, organizational, and institutional contexts (Craig, 1999; Weick et al., 2005). The constitutive perspective also recognizes that medication taking has meanings for both patients and HCPs that extend beyond the question of whether patients adhere to prescriptions. Thus, taking this perspective enables scholars to engage with HCP and patients' own perspectives on medications, suggesting opportunities at multiple levels through which patients and HCPs can reach shared understandings.

Theoretical frameworks

Organizational sensemaking

Our study is guided by organizational sensemaking as a theoretical lens. This perspective provides tools for understanding how meanings around medication taking are communicatively constituted within organizations. Following Weick et al. (2005), we define sensemaking as “the ongoing retrospective development of plausible images to rationalize what people are doing” (p. 409). Said differently, sensemaking is the way people make meanings about themselves, their relationships, and their actions through communication. Here, communication is more than a variable that can be manipulated. Instead, language, talk, and interaction are the processes through which actions are coordinated, decisions made, and organizations brought into existence (Weick et al., 2005). Organizations play key roles in sensemaking processes, serving as “interpretation systems of participants who, through the back-and-forth of their own understandings, provide meanings for each other via their everyday interactions” (Browning & Morris, 2012, p. 140). Thus, sensemaking is interdependent, with organizational members interacting and communicating to (re)construct accepted roles, duties, and behaviors (Apker, 2001). Additionally, sensemaking is connected with organizational power and social experience – dominant cultural discourses often come to be regarded as more plausible than resistive interpretations (Helms Mills et al., 2010).

Prior communication scholarship on sensemaking has investigated both the processes through which humans construct shared meanings and the local meanings people develop through these processes. For example, Tracy et al. (2006) explored humor as a communicative process employed by human service workers to make sense of their work and identities. Dillon and Basu (2016) illustrate how a sensemaking framework can be used to understand the locally situated meanings people construct about barriers to receiving health care. Building on this scholarship,

we explore both sensemaking processes and the meanings constructed through these processes in this study.

Sensemaking processes are triggered in times of uncertainty, ambiguity, or chaos (Weick et al., 2005). Illness is highly disruptive to patients' routines and identities, making sensemaking an ideal framework for analyzing patient experiences (Harter et al., 2010). HCPs also navigate uncertainty, as they must rely on generalized knowledge and lived experience to make recommendations for the individual patients in front of them. Consequently, sensemaking is a core component of providing health care (Weick et al., 2005). In sum, applying a sensemaking lens contributes to medication taking research by shifting away from a narrow focus on whether patients do (not) take their medications as prescribed. Instead, this lens highlights the webs of meaning patients and HCPs (re)construct as they attempt to organize medication taking behaviors.

The voice of the lifeworld and the voice of medicine

Our second theoretical lens is the Voice of the Lifeworld (VoL) and the Voice of Medicine (VoM). As scholarship on sensemaking suggests that people evaluate their experiences based on existing meaning frameworks, while also constantly revisiting and updating these frameworks (Weick et al., 2005), this lens is also useful in understanding participants' experiences. In Western contexts, meanings of health care are often articulated through the VoM, a sensemaking framework that relies on the biomedical model of disease and strips the meaning of illness from patients' personal and social contexts (Mishler, 1984). In contrast, patients tend to use the framework of the VoL – defined as “the patient's contextually-grounded experiences of events and problems in her life” (Mishler, 1984, p. 104) – to make sense of illness and medicine. Dominant conceptions of (non)adherence tend to rely on the VoM framework, obscuring the issues which may be more relevant to patients taking medications in their daily world (Du Pré, 2002). These VoL-based concerns often include the experience of side effects, the cost of medications, and the labor required to manage treatment demands of living with chronic conditions(s). In sum, the VoM and the VoL are meaning making frameworks which center particular goals, concerns, and expectations. When patients rely on the VoL while their HCPs utilize the VoM, they may come to evaluate the same medication-related behaviors quite differently. Thus, the reliance on disparate sensemaking frameworks may explain disconnects between patient and HCP perspectives on medication taking.

The present study aims to extend existing communication literature on (non)adherence by exploring patient and HCP sensemaking processes in the context of a care coordination organization, highlighting both the meanings people make about medications as well as the processes through which they create these meanings. Specifically, we asked: How do patients and healthcare providers involved in a care coordination organization (CCO) communicatively make sense of medication taking?

Methods

Study context and participants

Mapletown Health Network

The site for this study was a care coordination organization called Mapletown Health Network³ (MHN). MHN is located in a small city in the Great Lakes Region of the United States. Their mission is to improve patient health outcomes and reduce costs through care coordination, which the MHN defines as “the process by which all of a patient’s needs are coordinated on a regular basis with assistance from [MHN] as a primary point of contact.” MHN employs an interdisciplinary team of HCPs who meet several times each week to discuss patients’ health statuses, treatment barriers, and tailored strategies for addressing patients’ needs. According to internal data, the four most common diagnoses among MHN patients at the time of the study were hypertension, diabetes, hyperlipidemia, and depression. After assessing patients’ needs, MHN may deliver a variety of holistic services (see Table 1).

Table 1 Services offered by Mapletown Health Network

At the time interviews took place, MHN employed seven full-time and two part-time staff, which included nurses, a social worker, a dietician, and a behavioral health counselor. Additionally, students from nearby colleges – including the first author – volunteer as “health coaches” who meet with patients in their homes to help patients achieve their health goals. According to MHN records, the year this study took place, over 500 patients were enrolled in the MHN program. To identify patients who may be eligible to participate in MHN, HCPs review the affiliated hospital’s ER admissions records daily. Eligibility is determined through use of a screening tool designed to identify potential risk factors related to the following: (1) socioeconomic status; (2) educational level and cognitive functioning; (3) medical and mental health; (4) adherence potential; (5) psychosocial stressors; and (6) level of support needed. Eligible patients are also identified through referrals from HCPs, community agencies, and individuals (e.g., patients’ family members).

Researcher positionalities

At the time of the study, the first author was an undergraduate student, while the second and third authors are Communication professors. The first author volunteered as an MHN health coach before beginning this study. During this time, she met with two patients and attended a weekly all-team meeting with MHN healthcare providers. Through volunteering, the first author developed familiarity with the culture and daily practices of organizational members (Guba, 1981) – such as how team meetings are structured and how HCPs discuss patients’ goals and challenges. These experiences influenced the first author’s interpretations of data. For example, reviewing interview data triggered memories from personal experience about how MHN healthcare providers had discussed lifeworld concerns during prior team meetings. However, as the research project had not been formulated or IRB approved at this time, these experiences are not shared or analyzed in this article.

All authors have personal and/or family experiences navigating chronic illness. These experiences have motivated our interest in health communication – we each have a personal stake in improving health care for chronically ill patients. At different times, we have attempted to communicate with HCPs through the VoL (Mishler, 1991) – sometimes, this voice has been

heard and embraced by HCPs and sometimes it has not. Thus, we were sensitized to this aspect of patient experience as we analyzed data.

Participants and recruitment

Nine patients and five full-time MHN-affiliated HCPs participated in interviews for this study (see Table 2 for patient demographics). Patient participants (PPs) included two sets of married couples who chose to be interviewed jointly. The organization's director purposively identified potential PPs based on the following criteria: being of sufficient mental health to provide meaningful informed consent, use of polypharmacy, and/or previous difficulties with medication management. This sampling method was effective because it enabled the authors to purposively select patients with complex medication regimens and histories of nonadherence, thereby generating data with participants who had information-rich histories of sensemaking related to medication taking (Merriam & Tisdell, 2016).

Table 2. Patient demographic characteristics (self-reported)

During the consent process, the first author would meet an MHN HCP at the patients' homes. At this time, the MHN HCP would introduce the first author to the patient. If the patient agreed to participate, the MHN HCP would leave the home so the first author could conduct the patient interviews privately. In some cases, the MHN HCP would conduct a regularly scheduled visit with the patient before leaving for the research interview. Typically, these visits lasted between 15–30 minutes and focused on refilling patients' medication dispensers, discussing upcoming appointments with physicians, checking in about symptoms or other stressors, and discussing any medication-related concerns. If consent had been given at this time, the first author would record notes of the interactions between patients and HCPs. Given that these were observations of actual clinical encounters, her notes were recorded with a "light hand" – notes jotted down to capture key moments and communicative patterns (Gill et al., 2014). These observations provided further context about the relationships between patient and HCP participants but were not coded during data analysis.

After completing patient interviews, the first author purposively selected 5 MHN healthcare providers to participate in interviews. HCPs were selected based on their relationship with patient participants: every HCP had regular interactions with one or more patients who took part in the study. In addition, the first author purposively selected HCPs from across the disciplines involved in MHN to ensure that a diverse array of perspectives was represented (Merriam & Tisdell, 2016). HCPs interviewed included two nurses, a behavioral health counselor, a social worker, and a physician. All HCPs participants had been working at MHN for more than a year at the time of their interview.

Data generation

The first author conducted face-to-face interviews. Patient interviews were conducted in patients' homes, while HCPs interviews were conducted in private rooms at MHN's office. Interviews lasted between 40–90 minutes for patients (avg. = 65 minutes) and between 20–60 minutes for healthcare providers (avg. = 45 minutes). Interviews were semi-structured, consisting mainly of

open-ended questions and follow-up probes intended to elicit in-depth responses to a previously determined set of issues (Hunt et al., 1998). In keeping with our conceptualization of sensemaking as a retrospective process of meaning making about actions, events, and identities through interaction and communication, we viewed the interview interaction itself as a site of communicative sensemaking. Interview questions were broad and intended to catalyze reflection, such as “How would you describe your health?” and “How do you feel about taking medications?” HCPs were asked similarly open questions, such as, “What are some challenges your patients face?” and “How do you talk about medications with patients?”

Data analysis

All interviews were audio recorded. The first author transcribed all interviews, viewing transcription as the first step of data analysis (Mishler, 1991). Translating data from the medium of audio into text involves choices about how to convey nonverbal cues, rhetorical emphases, pauses, and other communicative acts and therefore involves choices about how to represent participants (Mishler, 1991). While some nonverbal cues, such as pauses or emphases, were initially included in transcripts, these cues were ultimately removed from quotations in this paper to facilitate readability (Poland, 2011). This transcribing process resulted in 238 single-spaced pages of transcribed data. After transcribing the interviews over roughly forty hours, the first author developed intimate familiarity with data and participants’ distinct voices (Lapadat & Lindsay, 1999), which facilitated data immersion (Braun & Clarke, 2006). To preserve participant confidentiality, we use the gender-neutral pronoun “they” throughout the manuscript when pronouns are referenced outside of participants’ own quotations.

Transcripts were analyzed using thematic analysis and abductive reasoning. Abductive reasoning integrates inductive and deductive approaches by emphasizing the importance of entering research equipped with knowledge in a broad array of theoretical perspectives while also remaining open to findings that are surprising or contradictory to prior theorizations (Timmermans & Tavory, 2012). Consequently, while the first author reviewed prior research and theories of medication taking, she remained attuned to emergent ideas and patterns within the dataset (Timmermans & Tavory, 2012).

To analyze the data, the first author performed repeated re-readings of transcribed interviews (Braun & Clarke, 2006). Next, she coded transcripts into basic segments based on semantic content. For example, two of the most commonly used codes around the topic of medication management included “medications make me feel better” and “following the doctors’ orders.” The first author then arranged codes into matrixes which represented potential themes, or reoccurring patterns across the dataset (Braun & Clarke, 2006). These included “reasons for taking medications” or “reasons for noncompliance.” The first author repeatedly reviewed and rearranged initial themes by moving back and forth between thematic maps and the coded segments of transcripts (Braun & Clarke, 2006). After refining themes, writing this manuscript became the final stage of analysis. Writing provided opportunities to evaluate the significance of each theme as compared to literature and to understand how themes fit together (Richardson & St. Pierre, 2005). For instance, many of the codes and initial themes around medication management became condensed into the themes “making sense of medication taking as necessary and important” and “making sense of medication taking as easy when supported.”

Additionally, during the writing stage, the second and third authors reviewed the results independent from the thematic analysis procedure to question interpretations and probe for additional examples where needed (Dean & Davidson, 2018).

We also applied techniques to enhance the trustworthiness of our analysis (Shenton, 2004). We consulted with experts in the fields of health communication and medical sociology who reviewed findings in comparison to existing literature on patient-provider communication and medication taking (Creswell & Poth, 2018). We also purposively selected a diverse pool of participants to facilitate triangulation. By including both patients and HCP participants and interviewing HCPs with varied disciplinary perspectives, we were able to compare perspectives and construct interpretations based on contributions of a range of standpoints (Shenton, 2004).

Results

In responding to our research question, we first articulate patient participants' (PPs) sensemaking followed by healthcare provider participants' (HCPPs) sensemaking.

Patient participants (PPs) making sense of medication taking

Making sense of medication taking as necessary and important

To begin, PPs made sense of medications by communicatively constructing adherence as a vital task. For example, Patient 2 described taking their medications as prescribed as, "IM-POR-TANT. Very important." Other PPs emphasized this importance by describing medication taking as vital for their wellbeing. Patient 6 said, "If you didn't take it [medications], you'd go wacky ... If you don't take them, it's bad. I'm glad to take them and be as good as I am." Some PPs even constructed medication adherence as a matter of life and death, like Patient 3, who said: "If I don't do it [take medications], then I'll be in and out of the hospital a whole lot more. Or dead."

PPs highlighted the importance of medication adherence even when they said they did not fully understand the purpose of their medications. For instance, Patient 4 showed the first author a prescription bottle and explained the medication was "for my thyroid." However, when asked why they needed thyroid medication, Patient 4 laughed replying, "I have no idea!" Similarly, when asked the purpose of their medications, Patient 1 chuckled and said, "it's [the purpose] been explained, but to remember them now, I can't even pronounce [the medication names], let alone remember." Despite not knowing the medical purposes of their medications, both Patients 4 and 1 emphasized the importance of following prescriptions "faithfully." PPs shared three reasons why taking their medications was necessary and important: (1) their embodied experiences, (2) broader social discourses, and (3) interpersonal interactions.

First, PPs explained that they take their medication because of their embodied experiences. Patient 1 said, "If I don't take my medications, I don't feel good. Just like my stomach pill. If I don't take it, I lay in bed and suffer during the night." In other words, Patient 1 compared their pain and discomfort levels when they took their medication versus when they did not. By comparing embodied experiences to medication taking behaviors, Patient 1 came to make sense of medication taking as a vital way to reduce their pain.

Second, some PPs drew on broader social discourses as they made sense of medication taking. Explaining why they felt taking medications as prescribed was important, Patient 8 said,

My family, none of them lived to be older. My dad did live to be 65, but my mother died when I was 8. And my sister, one sister died when, in her 40s and the other in her 50s. I feel the medications have helped me a lot ... I feel I need the medication to keep me goin!

Here, Patient 8 draws on social discourses that construct medications as effective tools for promoting health and longevity. That is, Patient 8 relies on these discourses to explain why they have lived longer than other members of their family.

Additionally, many PPs said that they felt it was important to take medications in order to “follow the doctor’s orders.” Said differently, PPs integrated broader social discourses about the authority of HCPs with their goals of maintaining positive relationships with their own providers. Patient 4’s experiences illustrate this. Patient 4 explained that they didn’t believe they needed medications prescribed to treat depression. However, they still adhered to their prescription, emphasizing, “I try to follow directions as good as I can ... I don’t follow all directions but, for a doctor, yes. If you’re paying to go get something looked at or taken care of, then, if you don’t follow the directions, well, why go?” Similarly, Patient 1 explained why they trust their doctors to make any adjustments in their medications if they experience side effects by saying their doctors, “have a lot better knowledge than I have, and they know if there’s anything else they can replace it with. And, If I tell them how I’m feelin, it’s for them to decide what to do.” Thus, even though some PPs were skeptical, they continued to take medications guided by the social discourse that “doctors know best” and respect for their HCPs.

Some PPs also noted that when their HCPs were forceful or stern in advocating for medication adherence, they would continue to adhere in order to avoid conflict and maintain a relationship with their provider. Patient 2 described following the “doctor’s orders” as a necessity, “especially with my doctor ... He gets after you. He’s a doctor that comes in and you can’t say nothin to him. He tells *you*, you don’t say thing to him, he tells *you* what to do.” Thus, the social authority wielded by physicians motivated some patients to adhere.

PPs’ statements about their interactions with their HCPs reinforces the third reason they put forward to make sense of medication taking as important: interactions with others. PPs believed it was also important to take medication because of interactions with loved ones. Patient 1 shared that he began following a treatment he initially resisted because his son said, “‘Dad, we want you here for a while longer.’ So. And he’s [son is] good to me and everything. I said, ‘Well, I’ll try it.’” We expand upon the role of interactions with loved ones in patient sensemaking further in the theme, “making sense of medications through building bonds.”

Making sense of medication taking as “easy” when supported

In addition to making sense of medications as “important,” PPs also made sense of medication taking as “easy” because of support from MHN healthcare providers. This was surprising, given that PPs in this study took (on average) 13 medications per day, and all PPs were required to

ingest medications multiple times per day. For some PPs, taking medications was easy because they had been taking their pills for so long that doing so became a part of their routines. Patient 3 stated,

Now I get up. I go to the bathroom, wash my hands. Put my teeth in. Come out, push the button on my coffee pot. Tear off the two parts [from the packaged medication dispenser] I need for my morning pills ... I'm gonna have two pieces of toast and peanut butter with the coffee. And then, with the coffee, I'm gonna take those meds.

For PPs like Patient 3, medication taking had become an accepted and ordinary part of their daily lives. Yet, PPs did not develop and execute these routines alone; nearly all PPs relied on MHN services, community organizations, or family members to achieve their medication routines. For example, only two PPs regularly filled their own pillboxes. All other PPs had their pillboxes organized by a pharmacy, family member, or MHN HCP. This was a critical service provided by MHN for PPs, particularly those with disabilities. The quotes from PP 1 (who experienced arthritis) and PP 8 (who was legally blind) below, whose pillboxes were organized by MHN healthcare providers, demonstrate the instrumental role of MHN in these patients' lives:

It would take me an hour to fill em [pill boxes]. [MHN Healthcare provider] does it in fifteen minutes. Plus, I don't have to use my hands. (PP 1)

I don't think I could [fill the pillbox] now, cause my eyes got a little bit worse. And it takes me forever to do things and where um, I don't think I could do it by myself. (PP 8)

MHN HCPs also arranged for PPs' medications to be refilled and delivered to their homes, answered their questions, corrected pharmacy errors, collaborated with prescribers to simplify PPs regimens. Many PPs expressed they could not accomplish adherence to their routines without the support of MHN HCPs. Patient 7, for instance, noted that, with the number of medications they are prescribed, it would be nearly impossible for them to keep track of all their medications without MHN's support: "Knowing when prescriptions is gotta be redone and reordered and have em here, and you know, there's a lot of times if it wasn't for [MHN HCP] I couldn't do it." Patient 3 explained that they had inadvertently been taking medications incorrectly before they started receiving services from MHN: "[MHN HCP] found out that I had too many pills left over at the end of the month. So, I was thankful for that. I don't know how long I'd been taking them the wrong way." Thus, PPs did not make sense of medication taking as "easy" in isolation. For PPs to make sense of their medication regimens as "easy" they relied on instrumental support and communication with their MHN HCPs.

Making sense of medication through building bonds

Finally, PPs were only able to make sense of medication taking as "important and necessary" and "easy when supported" by *building bonds* with MHN HCPs. Close patient-HCP bonds were evident during observed home visits. Beyond discussing diseases and treatments, patients and HCPs discussed patients' holiday plans, family news, and upcoming church events. During one home visit, an MHN HCP took a break from refilling a pillbox to dance to a holiday song alongside the patient. Moreover, several PPs said they "loved" their MHN HCP and described

them as “part of the family.” PPs said that caring relationships with their MHN HCPs improved their sense of mental wellbeing:

[MHN] lets me know that I’m not out here in the middle of the country, knowing no one and expecting no one ever. And you can’t always tell things to your daughters ... Because they go, ‘Ahhh, shhh.’ And so that’s a nice feature; it helps your mental. (PP 3)

Similarly, Patients 5 and 2 (married couple), described an experience in which an MHN HCP came to visit Patient 5 while they were hospitalized:

PP 5 :[MHN HCP] came in and visited me while I was in the hospital one time. I mean, I was down in the dumps and all of a sudden, look up, there she was.

PP 2 :And I tell you what. That day, when she walked in that room, [PP 5] was grumpy and ‘argh,’ you know? She come in and his disposition changed. I mean, from bad to good!

PP 5 :Nurses can’t even tell it’s me. Changed my attitude.

As these quotations show, patients experienced strong bonds with MHN HCPs, which positively affected their wellbeing and outlook. Yet, these bonds did not only affect patients’ mental and emotional wellbeing; feeling close to MHN healthcare providers helped PPs recognize their own value, feel invested in their health, and, ultimately, encouraged them to follow medication prescriptions. For example, Patient 3 had a history of nonadherence. Yet, this changed when Patient 3 became involved with MHN:

PP3 : I wasn’t doing my nebulizer the way I was supposed to be doing it ... And, I had some other inhalers and I missed them once in a while at night or whatever. But I always had that rescue inhaler to fall back on ... And yeah, I was fooling myself.

Interviewer :What made you realize that?

PP3 :[MHN HCP].

Interviewer :Mhm. What’d she say?

PP3 :She tried to coordinate my pills with [medication refill service]. And, the importance of taking your meds ... If [I don’t take medications], then I’ll be in and out of the hospital a whole lot more. Or dead. I had a choice.

Interviewer :Is that what [MHN HCP] told you?

PP3 :Pretty much. Not word for word ... She implied that, yeah, I’m worth saving.

In short, by building bonds with MHN HCPs, PPs were reminded that their lives had value, which drove them to take their medicines and try to stay healthy. At the same time, MHN also provided material support that enabled PPs to make sense of medication taking as easy, despite challenges related to disabilities and conflicting or confusing medication orders. Having described PPs’ sense-making, we now turn to the ways in which MHN HCP participants communicatively made sense of medication taking.

Healthcare provider participants (HCPPs) making sense of medication taking

Making sense of medication taking through dialogue with patients

First, just as interacting with HCPPs influenced patients' sensemaking, dialogue with patients also affected how HCPPs made sense of medication taking. Similar to PPs, HCPPs constructed medication adherence as critically "important" while also recognizing that many patients have concerns about medications. In such cases, HCPPs initiated conversations with their patients in order to understand how patients were making sense of medications as well as asserting their (the HCPPs) own perspectives on why it is important to adhere. For example, when patients do not want to take their medication, HCPP 4 explained,

We'll talk about the pros and the cons of possibly taking the medication. Sometimes it can take months, years, for somebody to get perhaps the courage to try it ... I don't push, or necessarily encourage people to take medication, but I certainly believe in the combination of therapy and medication, in specific circumstances. So, if it's appropriate at that time to tell a patient I believe that, then I will do that. And I will advocate for that.

However, while encouraging patient adherence was certainly a goal for HCPPs, HCPPs also emphasized the importance of creating shared understandings and negotiating medication regimens that reflected the goals and concerns of patients. One HCPP elucidated,

I can't say is I totally disagree with someone who self-medicates, if they really know themselves. But what I tell them too, is, 'If you're gonna do that, do it in partnership with your doctor. Let your doctor know what you're doing.' ... If you're gonna have the trust of your doctor you have to be honest with em ... so that they can work with you instead of labelling you as a noncompliant patient. (HCPP 1)

HCPP 1's emphasis on honesty, negotiation, and partnership – or, in other words, dialogue – is evident here. Dialogue is a communication practice characterized by authenticity, respect for divergent viewpoints, an openness to being changed through an interaction, mutual care, and a collaborative orientation (Cissna & Anderson, 2008). Other MHN HCPs similarly described their approach to communication with patients about medications as dialogic. For instance, HCPP 3 noted the importance of having open conversations with patients about their concerns:

If you got a real good reason why you shouldn't take this medicine, your friend took it and he died. A parent took it and they died, and you're afraid of it. That's legit. Just tell me that. And then I understand why, and I'll switch to something else. (HCPP 3)

HCPP 3's perspective illustrates a key tenet of dialogic communication: parties enter with a willingness to hear and accept the meanings others make of their experiences. While HCPs relying on the Voice of Medicine might dismiss as "anecdotal evidence" the concerns of patients who wish to avoid a medication due to a friend's experience, HCPP 3 prioritizes honesty and partnership over strict adherence to biomedical logics. Through dialogue with patients, HCPP 3 encounters the Voice of the Lifeworld, can negotiate meanings of medications with patients, and, ultimately, negotiate medication regimens. HCPP 5 also described the importance of engaging in dialogs with patients and emphasized partnership as key to this process:

And reminding them [patients] that they're an active part of the team. If they're just taking the medication because the doctor told them to, or I told them to, that really doesn't work. They need to understand and accept the importance of it, and then we can all work as a team ... And they are gonna be times when they really feel like they're in control and part of that team. And then there are times when they feel they're not. So, in those times where they feel like they need more support, being there to help talk them through and say, "Okay, what do we need to do? Do we need to [talk] to the doctor? Do you need a change? Or do they just need to reiterate to you why they still think this is the best medication for you?"

Thus, dialogue was a central communication strategy among MHN HCPPs. Dialogs exposed HCPPs to patients' lifeworld concerns – such as experiences of family members and the drive to maintain agency over one's medications. By engaging in dialogue, HCPPs were able to make sense of medication taking collaboratively with patients, develop shared meanings about medications, and, ultimately, negotiate medication regimens that honored the Voice of the Lifeworld.

Making sense of medication taking through interactions in patients' home spaces

Second, HCPPs emphasized that space influenced their ability to dialogue with patients and, ultimately, the way they made sense of medications. Specifically, HCPPs voiced that interacting in the space of patients' homes helped HCPPs make sense of (1) barriers to medication adherence and (2) their patients as whole people with complex lives. First, in contrast to healthcare providers in other studies (Granger et al., 2009; Hunt & Arar, 2001), our HCPPs identified a variety of factors that create high treatment burden for chronically ill patients, including stress/confusion, financial burden, and poor communication between prescribing physicians. For example, HCPP 1 tied adherence to patients' mental wellbeing: "If they [patients] start stressing about their confusion, or how poorly they're doing, and they start thinking, 'Oh no. I'm gonna end up in a nursing home,' ... if you can get them to feel confident and comfortable, they do better." Confusion also stemmed from seeing multiple HCPs. HCPP 5 explained, "If they go to a specialist, and then also have their primary care doctor changing blood pressure medications, that causes a problem." Finally, financial costs are another barrier. As HCPP 3 put it, "We have some patients that are takin ten different medicines; their copayments could be twenty-five or thirty dollars a month. That could come up to 300-400 [USD] dollars a month. Most of the patients in this community cannot afford that."

HCPPs explained that they developed awareness of these barriers by interacting with patients in their home spaces. For instance, a HCPP 4 commented that going into patients' homes enabled them to "see the other side." HCPP 4 continued, "They [patients] can only tell you so much via, telephone or in an office visit. When you're in their space, that's where you really get to see what's happening." Similarly, HCPP 2 said home visits facilitated "getting to know the patients, and understand, and see where they're coming from." They explicated, "They'll tell you in the hospital, 'I have help.' Or, 'Oh, I have insurance, and I have a car,' but the reality is, a lot of times they don't have any of that. So, it's kind of nice [at MHN] to do the relationship and get to know the patients."

As HCPP 2's statement indicates, home visits also enabled HCPPs to make sense of patients' behaviors within their broader lives. Through interacting with patients in home spaces, HCPPs came to appreciate their patients as *whole persons with complex lives*:

In the doctor's offices, or hospital, you know, it's like a quick five-minute visit. Give you a prescription and go. And, [MHN's founder] felt that there's much more to a person, health-wise, and that you need to take the time to get to know that. Like, for [patient], for example, you know. You might read, 'diabetes' and all this, but, after you get to meet her, and talk to her, you know, she's got some anxiety. She's got quite a history ... Which is causing her anxiety. And that truly affects everything ... And if you don't get a chance to know that and understand that about her, it would be easy and go in and say, 'Okay. Here's a script.' Or, 'Here, okay we'll get your pill box filled.' But there's more to it.

Further, HCPPs believed seeing patients' in their homes was important because it forced them to reconsider their beliefs about (non)adherence. HCPP 1 shared,

It would be nice if every hospital nurse got to see them [patients] at home—to see that there's a real life going on behind these people. Or that there's real issues, issues besides labeling them 'noncompliant.' It's easy to do that when you're in the hospital. It's easy to hear the doctor say, 'Well, they're not taking their medications. Well, they're a noncompliant patient.' So that kinda puts them in a negative class. You know? 'Well you just, you know, you're just like a bad child. You're just not doing what you're supposed to be doing.' But there's reasons why they're not doing what they're supposed to be doing. And that you get to see ... I think it [home visits] would make every nurse in the hospital approach a person differently, with their education, with just who they are as a person.

In short, home visits helped HCPPs identify barriers and understand patients' complex lives, which ultimately affected how HCPPs made sense of medication taking and (non)adherence.

Making sense of medication taking through building relationships

Like PPs, HCPPs stated they made sense of medication taking through *building relationships* and emphasized that MHN's organizational structure helped them build relationships with patients in ways that would not be possible in traditional office settings. Specifically, HCPPs suggested that MHN's inclusion of home visits, commitment to flexible visit lengths, and emphasis on relationship building resulted in strong relationships. For example, HCPP 2 shared,

I think a lot of times [patients will] tell the doctors and the staff, if they're anxious to get out [of the hospital], they're gonna tell you what you want to hear ... Plus, another piece of that is taking the time to interact with them. You know? As you do with anybody. At that first meeting you don't always get a lot of information, so it's kind of nice [with MHN] ... That relationship piece.

Comparing their experiences at MHN to a different multidisciplinary healthcare team HCPP 5 previously worked for, they said,

The biggest difference, for me now, is not having such specific time constraints. And I'm in someone's home where they may be more comfortable to open-up and tell us things that you might not in a clinic setting, or, you know, with other people surrounding you.

In other words, HCPPs attributed relationship building to MHN's unique CCO model.

However, MHN's organizational structure did not simply enable HCPPs to build strong relationships with their patients, their patients made sense of medication taking as important through those relationships. That is, HCPPs argued that strong patient-healthcare provider relationships influenced patients' sensemaking by making them feel cared for, as HCPP 1 explained,

I think the support and having someone check on them is a big motivator. That someone actually cares about how you're taking your medication. You know? For those that don't have anyone, and if we never got involved with em, and they think no one cares, then, 'Who cares about me?' You know? 'So, why do it?'

PPs and HCPPs making sense of nonadherence to psychotropic medications

Finally, in analyzing how PPs and HCPPs made sense of medication taking, we found that both made sense of psychotropic medications (i.e., medications prescribed to treat mental health conditions) differently than other medicines. While PPs generally expressed few concerns about medications prescribed to treat physical conditions, they did voice concerns about psychotropic medications. Patient 4 said that they initially had not wanted to take their anti-depressant, but eventually agreed to do so out of respect for their HCP's recommendation,

Dr. [Name] gave me most of these [medications]. I think she thought I was depressed ... She kept telling me that I needed to get on something. I says, 'I've taken enough medicine.' And she [physician] says, 'You better take this.' So I took it.

Patient 4 elaborated on why they chose to adhere to the prescription despite their concerns, saying, "I took [the doctor's] word. You know, if Dr. [Name] would have said to me, 'You need to take that.' I would. That's just how I do. If the doctor tells me to do something, I do it."

Patient 7 also voiced concerns about her anti-depressant medication, saying the medication caused fatigue. Rather than continuing to adhere like Patient 4, however, Patient 7 that she decided to "regulate" her prescription,

I'm on [antidepressant], and if I take it as a regular everyday pill, I'm zonked. I don't wanna do anything either. So I'm thinking, I regulate my own [antidepressant]. The doctor says one pill a day, I might take one pill in a week. But it works that way for me.

Patient 7 also explained that she had tried to discuss this side effect with her prescriber, but, “every time I do, he [physician] says I should refill it and start it again.” Eventually, Patient 7 decided to simply start “regulating” her own medication without telling their doctor. When asked what makes conversation with this physician so difficult, Patient 7 explained, “Cause he’s a man and he’s higher up than I am. I think that’s the whole deal.”

These PPs’ experiences illustrate the importance of dialogic interactions to patients’ sensemaking of medication taking. For both patients, their concerns about medications were pushed aside and they were unable to engage in a dialogue with their HCPs about their priorities and concerns. Consequently, neither patient was able to develop a shared understanding about the meaning of these medications with their physician.

HCPPs’ sensemaking around psychotropic medications helps to explain why dialogic interactions around these medicines were difficult to develop. While, in general, HCPPs took a broad view of (non)adherence and were open to negotiating medication regimens with patients, psychotropic medications complicated their approach. HCPPs acknowledged that some characteristics of psychotropic medications (e.g., long latency periods, social stigma) make these medications unappealing to many patients. However, most constructed strict adherence to psychotropic medications as nonnegotiable. HCPPs described patients with mental illnesses as particularly challenging to treat and were sometimes frustrated by the widespread nonadherence they perceived in this patient group:

It’s frustrating when patients look up every potential problem and issue that can come from a medication cause some of them are extremely suggestible. Especially, like I said, working with the mental health population, patients that are convinced that they’re having side effects because they read it, on a bottle. (HCPP 5)

We’ve had a lot of noncompliance issues ... And then, we might go in and do an assessment, and find that they [patients] have some sort of personality disorder. Where they’re—and I don’t wanna make them, you know, make somebody sound bad—but, they have issues of manipulation. They might have issues in their past that helped them to develop a personality disorder. Which makes them naturally noncompliant. (HCPP 4)

Thus, HCPPs made sense of patients with mental illnesses as a challenging, frustrating, and sometimes irrational population. When MHN HCPs make sense of mentally ill patients in this way, there may be material consequences for the care these patients receive. HCPP 4 explained that, in some cases, patients with mental illnesses are dismissed from MHN because of their refusal to accept HCPs’ views on appropriate treatment. They said, “Sometimes, we have to cut strings with people with personality disturbances. Just because, just the matter of who they are makes them unable to make changes.” This suggests that some patients with mental illnesses may be viewed as undeserving of MHN’s services if they do not comply with the health behavior changes recommended by HCPs.

Discussion

In exploring how patients and HCPs make sense of medication taking within the a CCO context, our study offers both theoretical and practical implications for communication research on medication taking and (non)adherence. Theoretically, our study (1) advances a constitutive perspective on communication for medication taking (Craig, 1999) and (2) places communication literature on medication taking in conversation with Weick's (1995) theory of organizational sensemaking and Mishler's (1984) VoL. Practically, our study suggests that CCOs incorporating home-based care may reduce medication-related treatment burden and improve patient-HCP relationships.

Theoretical implications

Most communication studies on medication taking have centered individual- and interpersonal-level factors that may influence patient (non)adherence (DiMatteo et al., 1994; Jin & Acharya, 2016; Mayo-Gamble & Mouton, 2018). These studies typically utilize a transmission model of communication, positioning communication as a variable that influences behavior. Our study advances a constitutive perspective (Craig, 1999) on medication taking by drawing on Weick's (1995) theory of organizational sensemaking. Our constitutive perspective recognizes that communication is not merely a variable that affects behavior, but actually the process through which patients and HCPs make sense of and construct truths about the significance of medications and how they should be taken. Here, it is vital to attend both to the ways in which meanings are communicatively (re)produced and the actual meanings that are generated through these processes. Below, we explicate three of the factors we identified in this study as central to PP and HCPPs' sensemaking. Specifically, we found that participants in this study made sense of medication taking through (1) interaction and communication, (2) within specific organizational contexts, (3) in relation to larger ideologies about illness and medication.

First, we found that both PPs and HCPPs made sense of medication taking and (non)adherence through their communicative interactions with one another, as well as with family and friends. PPs made sense of medication taking as "important" when HCPPs articulated the benefits of medication and openly addressed patients' concerns. Additionally, in order for PPs to become invested in medication adherence, it was crucial for PPs to develop positive identities through communicative exchanges with others (e.g., HCPPs or family members) in which PPs were constructed as valuable and "worth saving." HCPPs also made sense of medication through dialogic interactions with PPs, as HCPPs came to learn about medication-related treatment burden and patients' own medication meanings, goals, and behaviors through these interactions. This finding suggests a need to reconceptualize communication in (non)adherence research. Research that focuses on variables such as HCP communication styles or patients' health beliefs utilizes a transmission model of communication, which does not account for the meanings which emerge dialogically through interaction (Craig, 1999). Instead, conceptualizing medication taking as communicatively constituted – i.e., as a dialogic process of interaction, exchange, and connection through which new meanings and knowledge are co-created (Cissna & Anderson, 2008; Hill Collins, 2003; Weick, 1995) – facilitates a more nuanced understanding of how patients and HCPs make sense of and act in relation to medications. A constitutive perspective may also explain why studies seeking to identify links between patient or HCP variables and (non)adherence have produced mixed findings (Vermeire et al., 2001; Wilhelmsen & Eriksson,

2019), as these study designs do not account for the local meanings about medications that patients and HCPs communicatively construct (Craig, 1999).

Second, our study highlights the importance of organizational context by showing how participants' sensemaking was affected by their experiences with MHN. Building upon prior research demonstrating that organizations influence the sensemaking processes of their members (Weick, 1995), we argue that MHN influenced participants' sensemaking by changing the frames through which they made meanings about medication taking. Frames are the mental models people develop over time to explain experiences, events, and behaviors (Weick, 1995). The VoM – the dominant interpretive system in Western medicine which conceptualizes disease in biomedical, mechanistic terms abstracted from patients' daily lives (Ho & Bylund, 2008; Du Pré, 2002) – then, can be understood as a frame commonly used by HCPs to make sense of medication taking. Prior research has demonstrated that HCPs often rely on the VoM frame to make sense of (non)adherence, as they tend to construct nonadherence as a consequence of patients' lack of health knowledge or “unscientific” lay beliefs (Britten & Maguire, 2016; Hunt & Arar, 2001; Wens et al., 2005) rather than as legitimate responses to patients' everyday life contexts, such as economic barriers, social stigma, or experience of side effects (Foss et al., 2016).

We argue that MHN as an organizational context influenced sensemaking by shifting HCPPs' dominant frame from the VoM to the VoL, an interpretive frame which grounds the meaning of health and illness within patients' personal lives and social contexts (Du Pré, 2002). MHN's design promoted the VoL through home visits, which enabled HCPPs to step quite literally into patients' worlds. In a home (rather than office) space, participants were more open to discussing the meanings of illness and health, including their family structure, values, and hopes for the future. Furthermore, in the home space, HCPPs could observe family photos and easily engage with PPs in conversation about how family members might (or might not) be able to assist them with their medications. Home visits also exposed HCPPs to the lifeworld contexts – such as poverty, lack of transportation, and mobility issues – that can create barriers to medication adherence (Foss et al., 2016; Sankar, 1986; Schmidt et al., 2016). This exposure may explain why, in contrast to HCPs in prior studies (e.g., Hunt & Arar, 2001; Wens et al., 2005), our HCPPs generally recognized and respected their patients' concerns about medications, with some even advocating for changes in patients' medication regimens in light of these lifeworld-based issues. Furthermore, MHN's organizational structure facilitated the dialogic exchanges and development of strong patient-HCP bonds described above. When HCPPs entered PPs homes and were able to engage with patients' lifeworld concerns, PPs and HCPPs built caring, even loving, relationships. In short, MHN's design – including its home visits, reduced time restrictions, and opportunities to tailor treatment strategies to the needs of each patient – promoted the use of VoL as a meaning-making frame. Organizational context has been largely overlooked in prior research on medication taking, which has tended to abstract medication-taking behaviors from healthcare delivery contexts (Foss et al., 2016). Thus, a significant contribution of our study is the insight that organizations influence the frames HCPs and patients use to communicatively make sense of and, ultimately, act in relation to medications.

A third important finding was that participants' interactions and organizational contexts were influenced by broader social ideologies, particularly those related to mental illness. Weick (1995)

describes ideologies as frames that operate at a societal level; he argues that ideologies are sets of beliefs and norms that connect groups of people and enable shared interpretations of the world. Ideologies shape what is commonly accepted and taken for granted in public spheres, thereby affecting which kinds of interpretations are viewed as plausible as individuals and organizational members engage in communicative sensemaking processes (Thurlow & Helms Mills, 2009). The influence of ideology was particularly evident as HCPPs described mentally ill patients as “naturally noncompliant” and manipulative – statements which reflect larger discourses that construct mentally ill people as difficult, irrational, and self-destructive (Pirkis et al., 2006). Perhaps as a consequence of ideologies which construct mentally ill people as deviants (Playle & Keeley, 1998), HCPPs made sense of nonadherence with psychotropic medications differently from other forms of nonadherence – they were far less willing to recognize lifeworld-based concerns about these medications and were largely unwilling to negotiate these medication regimens.

In fact, some HCPPs constructed nonadherent mentally ill patients as less deserving of patience, support, and resources and reported dismissing some mentally ill patients from MHN because of their nonadherence. We argue that the disparate ways in which HCPPs made sense of and acted in response to nonadherence to psychotropic medications versus medications prescribed for physical ailments illustrates the importance of ideologies and social contexts in sensemaking about (non)adherence. This finding is consistent with prior research which has shown that HCPs often perceive nonadherence to psychotropic medications as a sign of mental illness and deviance rather than as a legitimate response to concerns about medications (Britten et al., 2010; Galasiński & Opaliński, 2012).

In sum, our findings contribute to theorizing on medication taking by showing that communication is not only a variable but is, in fact, the way in which patients and HCPs make sense of medication taking (i.e., a constitutive perspective on medication taking). Further, we identify factors key to sensemaking around medications: interpersonal interaction and dialogue, in particular organizational contexts, in relation to broader ideologies.

Practical implications

Our findings also offer practical implications for HCPs, organizational leaders, and policymakers. First, our findings add to a growing body of work that suggests a need to reconceptualize medication taking as a relational, communicatively constructed practice embedded within organizational and ideological contexts (Lutfety Spencer, 2018; Watermeyer & Penn, 2012). From this perspective, HCPs should focus on meanings around medication taking, rather than solely on whether or not patients “adhere” to prescriptions. Emphasizing the meanings of medications aligns well with the concordance model to patient-provider communication (Britten, 2014; Watermeyer & Penn, 2012). The concordance model suggests that, rather than entering the consultation with the goal of promoting adherence, HCPs should focus on engaging in communicative exchanges with patients in which both parties express their perspectives, goals, and concerns (Britten, 2014; Bylund et al., 2010). Through these interactions, HCPs and patients can construct joint meanings about medications, build a therapeutic alliance, and develop a regimen that reflects shared priorities and perspectives (Britten, 2014).

Our findings also carry implications for healthcare delivery and policymaking. While it is important to encourage HCPs to adopt a concordance approach, it is also vital that organizations and policies support HCPs in implementing concordance. Although prior research has examined educational interventions to help patients adopt a concordance approach (Bylund et al., 2010), our literature review identified no prior research on organizational or systems-based approaches for advancing concordance. Thus, this study suggests that care coordination may promote patient-HCP engagement with the VoL and, in so doing, foster trust, open communication, and the development of shared meanings between patients and HCPs. In this way, care coordination involving home-based care may offer a systems-based strategy for facilitating concordance. Furthermore, a surprising finding from this study was that PPs communicated medication adherence as vital and characterized their medication regimens – all of which involved multiple medications taken several times per day – as easy because of MHN’s support. This contrasts with prior research showing that many patients actively resist adherence (Pound et al., 2005) and that managing treatment for chronic conditions involves intensive effort and resources for patients (Foss et al., 2016; Granger et al., 2009). Thus, our study suggests that care coordination may reduce treatment burden for chronically ill patients in addition to promoting patient-HCP bonds and concordance-based communication.

Limitations and future directions

While this study provides initial support for the usefulness of care coordination in fostering patient-HCP engagement with the VoL and facilitating concordance-based dialogs, there are several limitations. First, due to the qualitative nature of the study design, findings reported here are not generalizable. Second, because the first author was introduced to patients by MHN healthcare providers, patients may have been hesitant to criticize the organization during interviews, although great lengths were taken to explain to patients that their feedback would be kept confidential and that the researcher was not associated with MHN. Third, because MHN HCPs were involved in selecting patients for participation in the study, patients interviewed may not be representative of typical MHN patients. Finally, while themes across participant interviews were remarkably consistent, the study’s sample size did not allow for determination of data saturation.

Future research may be useful in addressing these limitations. Larger-scale studies examining the differences in communication patterns in CCOs versus traditional healthcare delivery settings are needed. Such studies might focus on identifying the ways in which the VoM and VoL are engaged with in each setting. Further efforts are also needed to understand how HCPs make sense of nonadherence to psychotropic medications in relation to dominant ideologies. Critically-oriented studies which acknowledge the nuances of patient-HCP dynamics (Scambler & Britten, 2001) in CCOs and which honor patients’ agency, knowledge, and experiences related to medications (Britten & Maguire, 2016) are crucial next steps.

Conclusion

In sum, prior research has identified a problem in patient-HCP communication about medications: HCPs tend to make sense of medication taking through the Voice of Medicine and the discourse of (non)adherence, whereas patients tend to frame medication taking using the

Voice of the Lifeworld in relation to their resources, social and cultural identities, and embodied experiences. Relying on different sensemaking frames can create barriers for communicatively constructing shared meanings about medications. Our study provides evidence that care coordination organizations may be one systems-based intervention to bridge this gap in patient-HCP sensemaking. By systematically introducing the VoL into patient-HCP encounters, CCOs may promote dialogue and the development of shared meanings. Thus, our findings underscore the need to understand medication taking as a communicative phenomenon. Drawing on our expertise in the communicative construction of shared realities, communication scholars can contribute to the development of dialogue around and, ultimately, shared meanings about medication taking for patients and HCPs.

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Notes

1. Some scholars use the term “(non)compliance” interchangeably with “(non)adherence.” In this article, we use “(non)adherence,” as this is the term most widely used among health communication scholars. In addition, we use the more general term “medication taking” when discussing how patients and HCPs think, feel, and behave in relation to medications in ways that may or may not directly relate to their orientation toward (non)adherence.
2. Polypharmacy is the use of multiple medications and has been associated with increased medication burden (Sav et al., 2013).
3. Name changed to protect confidentiality

References

Abegaz, T. M., Shehab, A., Gebreyohannes, E. A., Bhagavathula, A. S., & Elnour, A. A. (2017). Nonadherence to antihypertensive drugs. *Medicine*, 96(4), e5641. <https://doi.org/10.1097/MD.0000000000005641>

- Apker, J. (2001). Role development in the managed care era: A case of hospital-based nursing. *Journal of Applied Communication Research*, 29(2), 117–136. <https://doi.org/10.1080/00909880128106>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Britten, N. (2014). Concordance. In W. C. Cockerham, R. Dingwall, & S. Quah (Eds.), *The Wiley Blackwell encyclopedia of health, illness, behavior, and society* (pp. 299–302). John Wiley & Sons, Ltd. <https://doi.org/10.1002/9781118410868.wbehibs038>
- Britten, N., & Maguire, K. (2016). Lay knowledge, social movements and the use of medicines: Personal reflections. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 20(2), 77–93. <https://doi.org/10.1177/1363459315619021>
- Britten, N., Riley, R., & Morgan, M. (2010). Resisting psychotropic medicines: A synthesis of qualitative studies of medicine-taking. *Advances in Psychiatric Treatment*, 16(3), 207–218. <https://doi.org/10.1192/apt.bp.107.005165>
- Browning, L., & Morris, G. H. (2012). *Stories of life in the workplace: An open architecture for organizational narratology*. Routledge.
- Bylund, C. L., D’Agostino, T. A., Ho, E. Y., & Chewning, B. A. (2010). Improving clinical communication and promoting health through concordance-based patient education. *Communication Education*, 59 (3), 294–311. <https://doi.org/10.1080/03634521003631952>
- Ca, K. N., & Anderson, R. (2008). Dialogic rhetoric, coauthorship, and moments of meeting. In E. Weigand (Ed.), *Dialogue and rhetoric* (pp. 39–51). John Benjamins Publishing Company.
- Craig, R. T. (1999). Communication theory as a field. *Communication Theory*, 9(2), 119–161. <https://doi.org/10.1111/j.1468-2885.1999.tb00355.x>
- Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design* (4th ed.). SAGE Publications, Inc.
- Dean, M., & Davidson, L. G. (2018). Preivors’ uncertainty management strategies for hereditary breast and ovarian cancer. *Health Communication*, 33(2), 122–130. <https://doi.org/10.1080/10410236.2016.1250187>
- Dillon, P. J., & Basu, A. (2016). African Americans and hospice care: A culture-centered exploration of enrollment disparities. *Health Communication*, 31(11), 1385–1394. <https://doi.org/10.1080/10410236.2015.1072886>
- DiMatteo, M. R., Reiter, R. C., & Gambone, J. C. (1994). Enhancing medication adherence through communication and informed collaborative choice. *Health Communication*, 6(4), 253–265. https://doi.org/10.1207/s15327027hc0604_2
- Du Pré, A. (2002). Accomplishing the impossible: Talking about body and soul and mind during a medical visit. *Health Communication*, 14(1), 1–21. https://doi.org/10.1207/S15327027HC1401_1
- Ehrlich, C., Kendall, E., Muenchberger, H., & Armstrong, K. (2009). Coordinated care: What does that really mean? *Health & Social Care in the Community*, 17(6), 619–627. <https://doi.org/10.1111/j.1365-2524.2009.00863.x>

- Foss, C., Knutsen, I., Kennedy, A., Todorova, E., Wensing, M., Lionis, C., Portillo, M. C., Serrano-Gil, M., Koetsenruijter, J., Mujika, A., & Rogers, A. (2016). Connectivity, contest and the ties of self-management support for type 2 diabetes: A meta-synthesis of qualitative literature. *Health & Social Care in the Community*, 24(6), 672–686. <https://doi.org/10.1111/hsc.12272>
- Galasiński, D., & Opaliński, K. (2012). Psychiatrists' accounts of insight. *Qualitative Health Research*, 22(11), 1460–1467. <https://doi.org/10.1177/1049732312450283>
- Gill, R., Barbour, J., & Dean, M. (2014). Shadowing in/as work: Ten recommendations for shadowing fieldwork practice. *Qualitative Research in Organizations and Management: An International Journal*, 9(1), 69–89. <https://doi.org/10.1108/QROM-09-2012-1100>
- Granger, B. B., Sandelowski, M., Tahshjain, H., Swedberg, K., & Ekman, I. (2009). A qualitative descriptive study of the work of adherence to a chronic heart failure regimen: Patient and physician perspectives. *The Journal of Cardiovascular Nursing*, 24(4), 308–315. <https://doi.org/10.1097/JCN.0b013e3181a4be30>
- Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, 29(2), 75–91. <https://doi.org/10.1007/BF02766777>
- Harter, L. M., Patterson, S., & Gerbensky-Kerber, A. (2010). Narrating “new normals” in health care contexts. *Management Communication Quarterly*, 24(3), 465–473. <https://doi.org/10.1177/0893318910370271>
- Haskard Zolnieriek, K. B., & DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: A meta-analysis. *Medical Care*, 47(8), 826–834. <https://doi.org/10.1097/MLR.0b013e31819a5acc>
- Helms Mills, J., Thurlow, A., & Mills, A. J. (2010). Making sense of sensemaking: The critical sensemaking approach. *Qualitative Research in Organizations and Management: An International Journal*, 5(2), 182–195. <https://doi.org/10.1108/17465641011068857>
- Hill Collins, P. (2003). Toward an afrocentric feminist epistemology. In Y. Lincoln & N. Denzin (Eds.), *Turning points in qualitative research: Tying knots in a handkerchief* (pp. 47–72). AltaMira Press.
- Ho, E. Y., & Bylund, C. L. (2008). Models of health and models of interaction in the practitioner–client relationship in acupuncture. *Health Communication*, 23(6), 506–515. <https://doi.org/10.1080/10410230802460234>
- Howick, J., Koletsi, D., Pandis, N., Fleming, P. S., Loef, M., Walach, H., Schmidt, S., & Ioannidis, J. P. A. (2020). The quality of evidence for medical interventions does not improve or worsen: A metaepidemiological study of cochrane reviews. *Journal of Clinical Epidemiology*, 126, 154–159. <https://doi.org/10.1016/j.jclinepi.2020.08.005>
- Hunt, L. M., & Arar, N. H. (2001). An analytical framework for contrasting patient and provider views of the process of chronic disease management. *Medical Anthropology Quarterly*, 15(3), 347–367. <https://doi.org/10.1525/maq.2001.15.3.347>
- Hunt, L. M., Arar, N. H., & Larne, A. C. (1998). Contrasting patient and practitioner perspectives in type 2 diabetes management. *Western Journal of Nursing Research*, 20(6), 656–676. <https://doi.org/10.1177/019394599802000602>

- Jin, L., & Acharya, L. (2016). Cultural beliefs underlying medication adherence in people of Chinese descent in the United States. *Health Communication, 31*(5), 513–521. <https://doi.org/10.1080/10410236.2014.974121>
- Kongkaew, C., Noyce, P. R., & Ashcroft, D. M. (2008). Hospital admissions associated with adverse drug reactions: A systematic review of prospective observational studies. *The Annals of Pharmacotherapy, 42* (7), 1017–1025. <https://doi.org/10.1345/aph.1L037>
- Krebs, P., Tseng, T.-Y., Pham, H., Wong, S., Sherman, S. E., Shelley, D., Furberg, R. D., & Wolfe, H. (2015). Formative evaluation of a text messaging intervention to promote Varenicline adherence among tobacco-dependent persons with HIV. *Journal of Health Communication, 20*(9), 1021–1025. <https://doi.org/10.1080/10810730.2015.1018595>
- Lapadat, J. C., & Lindsay, A. C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry, 5*(1), 64–86. <https://doi.org/10.1177/107780049900500104>
- Leucht, S., Helfer, B., Gartlehner, G., & Davis, J. M. (2015). How effective are common medications: A perspective based on meta-analyses of major drugs. *BMC Medicine, 13*, 253. <https://doi.org/10.1186/s12916-015-0494-1>
- Linn, A. J., Van Weert, J. C., Van Dijk, L., Horne, R., & Smit, E. G. (2016). The value of nurses' tailored communication when discussing medicines: Exploring the relationship between satisfaction, beliefs and adherence. *Journal of Health Psychology, 21*(5), 798–807. <https://doi.org/10.1177/1359105314539529>
- Linn, A. J., Van Weert, J. C. M., Gebeyehu, B. G., Sanders, R., Diviani, N., Smit, E. G., & Van Dijk, L. (2019). Patients' online information-seeking behavior throughout treatment: The impact on medication beliefs and medication adherence. *Health Communication, 34*(12), 1461–1468. <https://doi.org/10.1080/10410236.2018.1500430>
- Lutfety Spencer, K. (2018). Transforming patient compliance research in an era of biomedicalization. *Journal of Health and Social Behavior, 59* (2), 170–184. <https://doi.org/10.1177/0022146518756860>
- Manning, J. (2014). A constitutive approach to interpersonal communication studies. *Communication Studies, 65*(4), 432–440. <https://doi.org/10.1080/10510974.2014.927294>
- Mayo-Gamble, T. L., & Mouton, C. (2018). Examining the association between health literacy and medication adherence among older adults. *Health Communication, 33*(9), 1124–1130. <https://doi.org/10.1080/10410236.2017.1331311>
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation*. John Wiley & Sons, Inc.
- Mikesell, L., Bromley, E., Young, A. S., Vona, P., & Zima, B. (2016). Integrating client and clinician perspectives on psychotropic medication decisions: Developing a communication-centered epistemic model of shared decision making for mental health contexts. *Health Communication, 31*(6), 707–717. <https://doi.org/10.1080/10410236.2014.993296>
- Mishler, E. G. (1984). *The discourse of medicine: The dialectics of medical interviews*. Ablex.
- Mishler, E. G. (1991). Representing discourse: The rhetoric of transcription. *Journal of Narrative and Life History, 1*(4), 255–280. <https://doi.org/10.1075/jnlh.1.4.01rep>

- Mohammed, M. A., Moles, R. J., & Chen, T. F. (2016). Medication- related burden and patients' lived experience with medicine: A systematic review and metasynthesis of qualitative studies. *BMJ Open*, 6(2), e010035. <https://doi.org/10.1136/bmjopen-2015-010035>
- Pirkis, J., Blood, R. W., Francis, C., & McCallum, K. (2006). On-screen portrayals of mental illness: Extent, nature, and impacts. *Journal of Health Communication*, 11(5), 523–541. <https://doi.org/10.1080/10810730600755889>
- Playle, J. F., & Keeley, P. (1998). Non-compliance and professional power. *Journal of Advanced Nursing*, 27(2), 304–311. <https://doi.org/10.1046/j.1365-2648.1998.00530.x>
- Poland, B. D. (2011). Transcription quality. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research* (pp. 628–649). SAGE Publications, Inc. <https://doi.org/10.4135/9781412973588.n36>
- Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G., & Campbell, R. (2005). Resisting medicines: A synthesis of qualitative studies of medicine taking. *Social Science & Medicine*, 61(1), 133–155. <https://doi.org/10.1016/j.socscimed.2004.11.063>
- Richardson, L., & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 959–978). Sage Publications Ltd.
- Sabaté, E. (2003). Adherence to long-term therapies: Evidence for action. World Health Organization.
- Saethre, E. (2013). *Illness is a weapon: Indigenous identity and enduring afflictions*. Vanderbilt University Press.
- Sankar, A. (1986). Out of the clinic into the home: Control and patient-physician communication. *Social Science & Medicine*, 22(9), 973–982. [https://doi.org/10.1016/0277-9536\(86\)90170-X](https://doi.org/10.1016/0277-9536(86)90170-X)
- Sav, A., Kendall, E., McMillan, S. S., Kelly, F., Whitty, J. A., King, M. A., & Wheeler, A. J. (2013). “You say treatment, I say hard work”: Treatment burden among people with chronic illness and their carers in Australia. *Health & Social Care in the Community*, 21(6), 665–674. <https://doi.org/10.1111/hsc.12052>
- Scambler, G., & Britten, N. (2001). System, lifeworld, and doctor- patient interaction: Issues of trust in a changing world. In G. Scambler (Ed.), *Habermas, critical theory, and health* (pp. 45–67). Routledge.
- Schmidt, S., George, M., & Jones, J. B. (2016). Welcome to the neighborhood: Service learning to understand of social determinants of health and promote local advocacy. *Diversity & Equality in Health and Care*, 13(6), 389–390. <https://doi.org/10.21767/2049-5471.100081>
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63–75. <https://doi.org/10.3233/EFI-2004-22201>
- Street, R. L., O'Malley, K. J., Cooper, L. A., & Haidet, P. (2008). Understanding concordance in patient-physician relationships: Personal and ethnic dimensions of shared identity. *The Annals of Family Medicine*, 6(3), 198–205. <https://doi.org/10.1370/afm.821>

Thurlow, A., & Helms Mills, J. (2009). Change, talk and sensemaking. *Journal of Organizational Change Management*, 22(5), 459–479. <https://doi.org/10.1108/09534810910983442>

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, 30(3), 167–186. <https://doi.org/10.1177/0735275112457914>

Tracy, S. J., Myers, K. K., & Clifton, W. S. (2006). Cracking jokes and crafting selves: Sensemaking and identity management among human service workers. *Communication Monographs*, 73(3), 283–308. <https://doi.org/10.1080/03637750600889500>

Vermeire, E., Hearnshaw, H., Van Royen, P., & Denekens, J. (2001). Patient adherence to treatment: Three decades of research: A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics*, 26(5), 331–342. <https://doi.org/10.1046/j.1365-2710.2001.00363.x>

Watermeyer, J., & Penn, C. (2012). “Only two months destroys every- thing”: A case study of communication about nonadherence to anti- retroviral therapy in a South African HIV pharmacy context. *Health Communication*, 27(6), 602–611. <https://doi.org/10.1080/10410236.2011.618436>

Weick, K. E. (1995). *Sensemaking in organizations*. SAGE Publications, Inc.

Weick, K. E., Sutcliffe, K. M., & Obstfeld, D. (2005). Organizing and the process of sensemaking. *Organization Science*, 16(4), 409–421. <https://doi.org/10.1287/orsc.1050.0133>

Wens, J., Vermeire, E., Royen, P. V., Sabbe, B., & Denekens, J. (2005). GPs’ perspectives of type 2 diabetes patients’ adherence to treatment: A qualitative analysis of barriers and solutions. *BMC Family Practice*, 6(1), 20. <https://doi.org/10.1186/1471-2296-6-20>

Wilhelmsen, N. C., & Eriksson, T. (2019). Medication adherence interventions and outcomes: An overview of systematic reviews. *European Journal of Hospital Pharmacy*, 26(4), 187–192. <https://doi.org/10.1136/ejhpharm-2018-001725>