PATIENT MANAGEMENT STRATEGY

Barriers and Behaviors that Thwart Patient Compliance

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Chronic diseases are among the most common, most preventable, and most costly of health challenges we face today resulting in approximately seven out of ten deaths each year in America. According to research and reports from the Centers of Disease Control and Prevention, approximately half of adults living in the United States have at least one chronic disease like type 2 diabetes, heart disease, obesity, chronic obstructive pulmonary disease, arthritis, or asthma and, to make matters worse, about one-third of them have multiple conditions, complications, and comorbidities. Treatments, medications, and other care for patients with a chronic disease account for over eighty-five percent of our nation's healthcare expenses.

When it comes to understanding healthcare expenses, we are rather familiar with the costs of care and the multitude of factors that contribute to them. What is often overlooked, however, is the cost of patient noncompliance; namely, the patient does not follow care provider instructions and recommendations in their care plan nor does the patient take actions consistent with those instructions and recommendations. According

to the Annals of Internal Medicine, McKesson, and The Atlantic Monthly Group, seventy-five to eighty-five percent of patients are noncompliant in one or more ways based on their failure to comply with prescribed treatment regimens. Consequently, patient noncompliance, one of the most costly healthcare challenges we face today, accounts for over $300 billion in wasted healthcare spending per year. As a result, patient noncompliance has reached epidemic proportions in the United States.

Besides the wasted spending associated with treatment regimens, medications, and other care in which the patient does not actively participate, patient noncompliance adversely affects the overall quality of patient care, adding needless and often excessive costs to care, while it increases risks for other harmful patient conditions, complications, and comorbidities. What's more, patient noncompliance contributes to patient dissatisfaction and dissociation and the care, care provider, and care team.

PART I
Barriers and Patient Compliance

THE VALUE OF PATIENT COMPLIANCE

In contrast to noncompliance, patient compliance helps advance and achieve optimal clinical outcomes, especially when the patient actively works with their care plan and care team to reach therapeutic goals and objectives. By achieving higher rates of clinical success, by helping the care provider attain evidence-based results, patient compliance, in due course, helps generate greater opportunities for increasing market share, revenues, reimbursement, and growth for the care provider and provider organization.

Advancing and achieving optimal clinical outcomes, patient compliance also works to improve economic outcomes by lowering costs, increasing revenues, and improving profitability. Patient compliance helps reduce the risks and costs associated with patient complications and comorbidities arising out of noncompliance as well it helps reduce expenses and penalties associated with patient relapses and readmissions. Moreover, patient compliance, through value-based purchasing, has been shown to improve economic outcomes with financial incentives, payments, and reimbursements as the care provider and provider organization meet certain performance measures.

Another benefit of patient compliance is that it advances patient satisfaction outcomes; the patient experiences enhanced relations with their care team, improved communications, and expanded resources and, most importantly, the patient experiences better care and outcomes. Patient satisfaction contributes to improved care provider and provider organization reputations for service and care which, in turn, potentially contribute to increases in market share, growth, revenues, and profitability.

All of this is good. Helping patients achieve patient compliance is surely a virtuous endeavor, especially in helping deliver and assure quality patient care. And yet there are costs to compliance; the costs associated with achieving patient compliance must be evaluated with the benefits as a return on investment. There are costs associated with the people, products, and programs, the services and support, and the technology and tools that are used to achieve highly-effective patient compliance. Accordingly, healthcare professionals must determine

what time, energy, and resources are appropriate to invest, if any, relative to the success of their business organization, the people and patients they serve, and the business and marketing goals they intend to accomplish. So, in evaluating the effects of patient compliance and patient noncompliance that concern their business, healthcare professionals need to evaluate the potential clinical, economic, business, and patient satisfaction outcomes of achieving patient compliance. What then are the advantages and disadvantages of focusing on patient compliance or ignoring it? When are patient compliance programs a waste of time, energy, and resources and when are they valuable to growth and revenues? Although it is a worthy healthcare ideal, the bottom line for patient compliance may not be economically feasible or desirable.

The intention of this paper is not to determine the bottom-line value of patient compliance for the patient, care provider, provider organization, insurer, employer, or other interested party. Rather, the intention is to identify and distinguish major barriers to patient compliance and patient behaviors that barriers can bring about; to explain how patient barriers and behaviors can complicate, obstruct, or thwart compliance; to provide some guidance in how to reduce, eliminate, or sidestep barriers; and to effectively and efficiently address patient behaviors in efforts to advance patient compliance. And although we agree it is valuable and essential to achieving optimal outcomes, patient compliance is ultimately a patient management challenge with important clinical, economic, and business implications. As such, patient compliance is principally a question of finances and business management: what time, energy, and resources are required to meet the needs of patients and those responsible for achieving compliance and what are the best practices for effectively and efficiently achieving optimal patient compliance? In the final analysis, it is up to the healthcare professional to determine if patient compliance is valuable and profitable or even if patient compliance is wanted or needed.

BARRIERS TO COMPLIANCE

Patient compliance is a state of engagement, activation, and persistence in which the patient effectively and efficiently manages their health, healing, and wellbeing. For patient compliance to be effective and efficient, the patient must be interested and involved in their life and engaged in their care and care plan. Besides being engaged, the patient must also be moved to take actions consistent with their care plan and the patient must be determined, committed, and persistent in achieving optimal outcomes. In their engagement, activation, and persistence, the patient follows the care provider's instructions and recommendations according to their care plan and takes actions consistent with those instructions and recommendations. In opposition to care, barriers are the conditions, circumstances, or events that arise with the patient that constrain, thwart, or impede their compliance. Often barriers are a matter of patient perceptions and preferences, a matter of patient self-efficacy and self-confidence; or simply a matter of contrary thoughts and feelings, opinions, judgements, and beliefs.

COMPLIANCE AND NONCOMPLIANCE

In the realms of patient compliance and noncompliance, there are two basic conditions related to self-care: first, the patient chooses to take action and takes action and, as such, is compliant; second, the patient chooses not to take action and doesn't take action and, as such, is noncompliant. Patient choice is common in both conditions: patient choice to take or not to take action. Accordingly, patient choice is decisive; it serves as either an access or a barrier to patient compliance.

With *choice as an access* to patient compliance, there are three scenarios that can occur with the patient in their self-care. First, the patient chooses to follow instructions and recommendations and to take action; the patient does not encounter barriers; the patient continues to take action and, as such, is compliant. Second, the patient chooses to follow instructions and recommendations and to take action; the patient encounters barriers; the patient does not continue to take action and, as such, is noncompliant. Third, the patient chooses to follow instructions and recommendations and to take action; the patient encounters barriers, asks for help, works with their care team to reduce, eliminate, or sidestep the barriers; the patient continues to take action and, as such, is compliant.

In all three scenarios, patient choice is decisive as either an access or a barrier to taking action. Even so, the patient, in making choices, is affected by conditions, circumstances, and events that can occur, and often do occur, throughout their care and self-care. The patient makes choices in how they evaluate and process these conditions, circumstances, and events through their filters of thoughts and feelings, opinions and beliefs, attitudes and values, perceptions and preferences relative to their occurring world. As such, the patient encounters and assesses conditions, circumstances, and events; makes choices; and takes actions based on their occurring world established uniquely in their past experiences, education, knowledge, upbringing, familial backgrounds, and social settings.

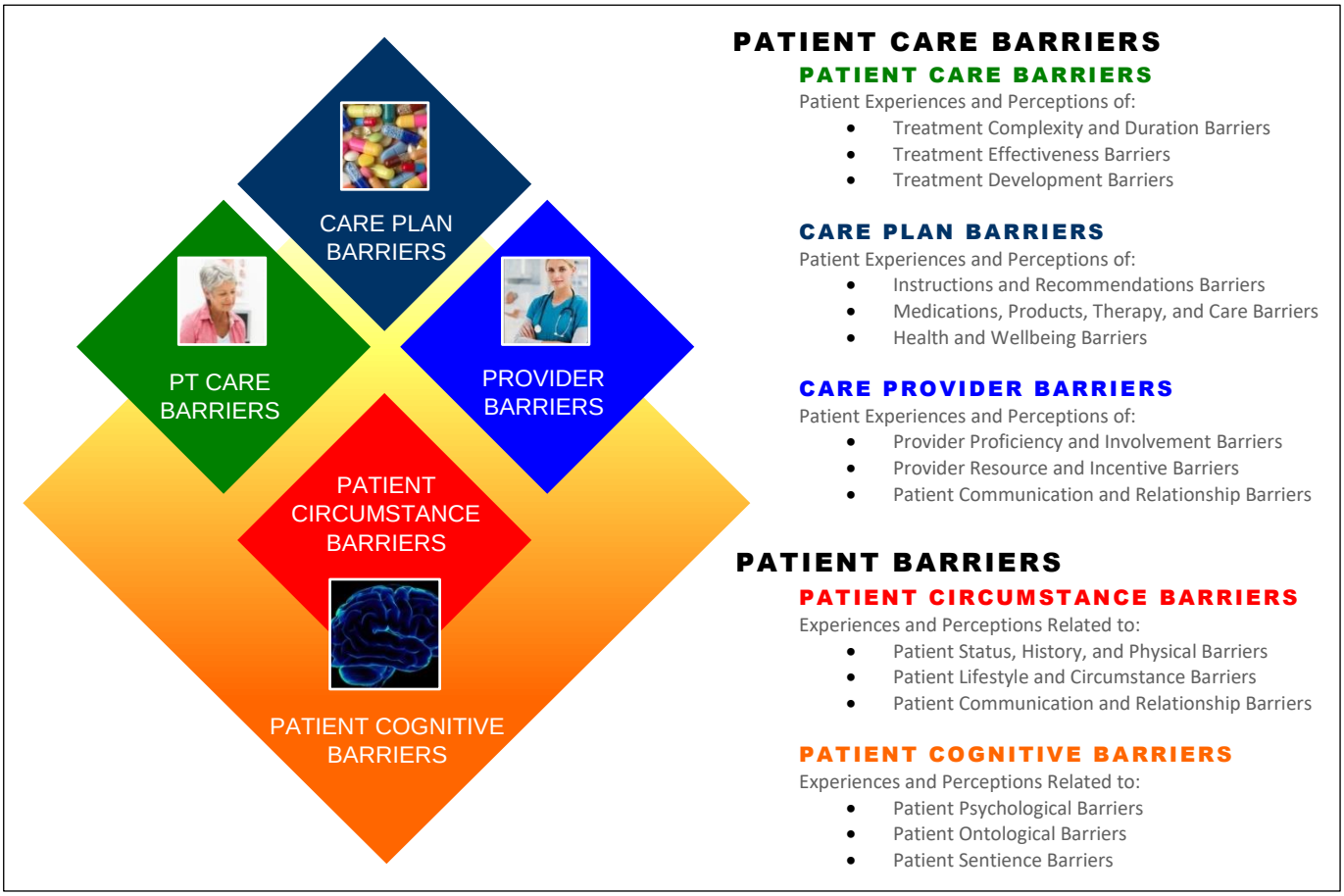
In contrast to *choice as an access*, there is only one scenario that occurs with *choice as a barrier*: the patient chooses not to follow instructions and recommendations and chooses not to take action and, as such, the patient is noncompliant. Here, the patient actually chooses to be at the effect of adverse conditions, circumstances, and events in their life rather than work with their care provider and care team to reduce, eliminate, or sidestep barriers so that the patient can achieve health, healing, and wellbeing.

Because barriers happen, the patient, care provider, and care team must share a mutual intention, as appropriate, to address adverse conditions, circumstances, and events. The patient, care provider, and care team must agree to work together to powerfully resolve any challenges, concerns, and conflicts that may arise. Working together, they should be able to deal with most types of patient barriers and patient perceptions and experiences of their barriers although there will obviously be some instances that may prove to be more challenging than others, some instances that may require extreme solutions, and some instances that are not resolved. What's more, the patient, care provider, and others who are intimately involved in the care of the patient must communicate openly about their beliefs, desires, intentions, and commitment to achieving patient compliance for quality clinical outcomes.

BARRIER DIMENSIONS

There are two fundamental types of barriers; barriers that are associated with the delivery of patient care and barriers associated with the patient. Barriers associated with the delivery of patient care can occur in three ways; first, barriers can arise with patient treatment and care; second, barriers can arise with the instructions and recommendations of their care plan; and third, barriers can arise with the care provider and care team. Besides barriers associated with the delivery of patient care, there are also patient circumstance barriers and patient cognitive barriers. Whether they are patient care barriers, circumstance barriers, or cognitive barriers,

all barriers can offer possibilities and opportunities for some type of solution to reduce, eliminate, or sidestep the barriers in most instances. Here the healthcare professional must evaluate the time, energy, and resources of such solutions relative to the patient and their barrier and determine a return on investment for helping achieve patient compliance with the overall objective of advancing quality clinical, economic, business, and patient satisfaction outcomes for their organization.



PART II

Barriers Associated with the Delivery of Patient Care

PATIENT CARE BARRIERS

Patient Care Barriers can arise with patient thoughts and feelings, opinions and judgements, perceptions and beliefs of treatment complexity, complication, and difficulty; treatment timing, duration, and timetable; treatment developments, complications, and comorbidities; and treatment effectiveness, efficacy, and outcomes. Besides barriers associated with patient treatment and care, barriers can arise with the patient's care plan and its instructions and recommendations and barriers can arise with the patient's care provider and care team members. Let's first turn our attention to *Patient Care Barriers*.

1. TREATMENT COMPLEXITY BARRIERS

Treatment Complexity Barriers can arise when the patient perceives or actually experiences inconveniences, complications, and difficulties in their care and treatment since their treatment might involve multiple or complex therapies; or involve multiple or complex medications and doses; or involve multiple routes of administration or applications of therapy; or involve a high frequency of dosing and so forth. Complicating their care even further, *Treatment Complexity Barriers* can arise when the patient has multiple instructions and recommendations to perform that are often difficult to remember, follow, act on, and accomplish. Accordingly, the patient may be confused, discouraged, and frustrated with the complexity of their self-treatment, the patient may be resigned or angry, all of this inconvenience, complication, and difficulty leading to patient noncompliance.

Treatment Complexity Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the challenges, making appropriate changes to the care plan as needed, and helping establish a workable schedule while simplifying patient self-care. We know that in order to achieve effective and efficient ongoing patient compliance, it must be easy, fast, simple, and convenient for the patient. In addition to revisiting the care plan and making alterations, supplementary patient services and support may also be required as well as patient education and ongoing motivation. Technology may also provide part of the solution with patient prompts and reminders throughout the day.

2. TREATMENT DURATION BARRIERS

Although treatment complexity can contribute to patient barriers, *Treatment Duration Barriers* can also arise. For example, barriers occur when the patient perceives or actually experiences their regimen, routine, and dosing is too tedious, weary, and tiresome; their treatment is too time-consuming; or, perhaps, their treatment has been going on too long and the patient is weary and exhausted with it. Like treatment complexity, the patient feels their treatment might be too involved, intricate, and convoluted and, as such, barriers can arise. *Treatment Duration Barriers* can also arise when the patient has a different understanding or expectation for their treatment period thinking it would be shorter, less time. Likewise, barriers can arise when the patient dislikes or disagrees with the continuous or intermittent use of products, patient care devices, and equipment by rejecting and removing them or by simply refusing to use them altogether.

Taking too much time, being restricted by time, being forced to follow a timetable, having to devote considerable time to their care, and not having enough time, the patient feels they are controlled by time and their treatment impinges on their freedom and lifestyle triggering potential *Treatment Duration Barriers*. Having to deal with these issues of time, timing, and duration, the patient becomes impatient with their treatment; moreover, the patient becomes exasperated, annoyed, and irritated with their self-care and, as such, the patient opts out. By the way, impatience is a direct consequence of the patient's perception of time; accordingly, patient impatience and intolerance usually ensue with *Treatment Duration Barriers*.

One final point to consider: *Treatment Duration Barriers* can arise with the patient as white-coat compliance, meaning the patient is noncompliant most of the time except prior to a scheduled check-up or follow-up appointment or a scheduled test or examination, when the patient resumes their self-care.

Treatment Duration Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the challenges, making appropriate changes to patient schedules and the time it takes to self-care, all helping to simplify their treatment. As a reminder: in order to achieve effective and efficient ongoing patient compliance, treatment for the patient should be easy, fast, simple, and convenient. In addition to reconsidering the timing and duration issues and making modifications where possible, patient education and ongoing motivation as well as supplementary patient services and support may also be required using, for example, technology to establish a schedule and to prompt and remind the patient of their treatment regimen throughout their day. Admittedly, there will be instances when *Treatment Duration Barriers* are not effectively addressed especially for some chronically ill patients requiring treatment over the course of their lives.

3. TREATMENT DEVELOPMENT BARRIERS

As treatment advances, *Treatment Development Barriers* can arise for various reasons; namely, there are changes in patient diagnosis and prognosis, changes in patient treatment, or there are changes in patient condition with, perhaps, additional complications and comorbidities. In response to treatment developments, the patient has to adjust and adapt to changes regarding their condition; the patient maybe develops adverse thoughts and feelings, opinions and judgements, perceptions and beliefs about their treatment, care, care plan, care team, and self; and the patient might feel thwarted, constrained, or blocked leading to their resignation and ultimately their noncompliance.

At times *Treatment Development Barriers* can arise with changes made by the care provider to the care plan. For any number of reasons, the care provider may make alterations, revisions, and amendments to the patient's regimen, routine, and dosing; to the patient's instructions and recommendations; to the patient's specialized care, long-term care, or homecare, and so forth. In consequence, these changes can adversely affect patient perceptions, acceptance, and involvement.

At other times *Treatment Development Barriers* can arise with changes caused by the patient, either intentionally or unintentionally, in encountering an obstacle, impediment, difficulty, or obstruction in their self-care or in making a mistake in their care or having a setback or breakdown in care. In consequence, these changes can also adversely affect patient perceptions and continued involvement.

Treatment Development Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the need for alterations, revisions, and amendments in their care and care plan whether the changes were generated by the care provider or caused by the patient. We know that *Treatment Development Barriers* can arise with change; it is important to make change as easy, fast, simple, and convenient as possible for the patient. In addition to revising the care plan and making necessary revisions, additional patient training and education are needed as well as ongoing motivation along with patient services and support including, perhaps, some form of technology to provide the patient with reminders, prompts, schedules, data, information, education, and encouragement.

4. TREATMENT EFFECTIVENESS BARRIERS

Treatment Effectiveness Barriers can arise when the patient perceives or actually experiences their care is not producing results or not producing results fast enough and, as a consequence, the patient becomes frustrated, dissatisfied, and discouraged opting out of their self-care. Recognizing patient unfulfilled expectations can contribute to *Treatment Effectiveness Barriers*, the lack of results can be very challenging to patient compliance. In addition to an inadequate or imprecise diagnosis, a lack of results can occur from incomplete, ineffective, or inaccurate care; a lack of results can also occur from ineffective, unproductive, unsuccessful care producing minimal or negligible outcomes. Besides these issues, a lack of results can also occur from a care plan that is difficult and inconvenient, troublesome and disagreeable to the patient.

Some factors that give rise to *Treatment Effectiveness Barriers* include a renewed awareness of patient symptoms, sensations, and signs; adverse reactions and side effects; patient discomfort, pain, and anxiety; and patient confusion, dissatisfaction, and depression. All of these can obviously contribute to unfavorable patient experiences giving rise to changes in patient behavior; giving rise to difficulty, complication, and challenges; giving rise to patient resistance and noncompliance. Opposite to experiencing a lack of results, *Treatment Effectiveness Barriers* can also arise when the patient actually experiences results. In fact, the treatment effectiveness of their care produces results that are so good and beneficial for the patient that the patient decides to discontinue or selectively reduce their self-care since they are feeling better.

Similar to other barrier responses, *Treatment Effectiveness Barriers* can usually and effectively be addressed in conversation as well with the patient and care provider reviewing the absence of results and making proper changes to the care and care plan of the patient, as appropriate. Again, it is important to make patient changes easy, fast, simple, and convenient in order to achieve effective and efficient patient compliance. In addition to dealing with the patient's perception or experience of the effectiveness of their treatment, or lack thereof, the care provider needs to provide additional education to support changes in care and to provide patient services and support where and when they are needed including ongoing patient motivation. What's more, the use of tools and technology is considered valuable in monitoring the effectiveness of the patient's condition, care, and compliance; is valuable in tracking and reporting treatment effectiveness and ongoing results.

CARE PLAN BARRIERS

In addition to *Patient Care Barriers* and barriers that are associated with care providers and the care team, there are *Care Plan Barriers*; this section deals with barriers that can arise with the patient's care plan. *Care Plan Barriers* can arise in patient thoughts and feelings, opinions and judgements, perceptions and beliefs about the components of their care plan, namely the instructions and recommendations the patient should adhere to; the medications and healthcare products the patient should use; the continuing treatment and additional care the patient should require; the patient's overall health and recommendations the patient should follow to sustain their energy, strength, stamina, and endurance; and the patient's overall wellbeing and recommendations the patient should follow to sustain their comfort, safety, security, and welfare.

1. PATIENT INSTRUCTION AND RECOMMENDATION BARRIERS

Patient instructions and recommendations define the care plan; they provide understanding and purpose for ongoing treatment and patient care and the use of medications and healthcare products as well they provide guidance and direction for the patient in the actions they take for compliance. Patient instructions are care provider directions and orders which the patient *must follow* while patient recommendations are the advice and suggestions the patient *should follow* in anticipation of enhancing optimal outcomes and wellbeing.

Patient Instruction and Recommendation Barriers can typically arise in the patient's comprehension and understanding of instructions and recommendations and in the patient's ability to remember and follow them. This is especially true when the patient perceives or actually experiences their instructions and recommendations in ways that are confusing and complicated, extensive and difficult, or if the patient simply thinks they are inconvenient. In contrast, *Patient Instruction and Recommendation Barriers* can also arise when the patient comprehends and understands their directions and advice but does not accept or agree with them, for any number of reasons, particularly if the patient perceives or experiences any unfavorable or unpleasant changes in their lifestyle, routine, or habits, contributing then to patient noncompliance.

Patient instructions and recommendations can also contribute to unfavorable or unpleasant changes in other ways affecting patient independence, quality of life, personal relationships, and activities of daily living. Moreover, patient instructions and recommendations can cause changes in patient behavior, conduct, and ways of being. And, there are other unfavorable or unpleasant changes brought on by care plan instructions and recommendations; changes in patient diet and nutrition, patient exercise and recreation, patient rest and sleep, and patient inability to work, drive, or do other things. All of these changes engender *Patient Instruction and Recommendation Barriers*.

Besides changes brought on by care plan instructions and recommendations, barriers can arise with alterations, revisions, and amendments to the patient's original care plan caused by either the care provider or the patient. For example, *Patient Instruction and Recommendation Barriers* can arise with care provider changes in regimen, routine, medications, dosing, and other changes in instructions and recommendations; or, barriers can arise with patient breakdowns, setbacks, and mistakes in self-care which may require the care provider to make changes in the care plan. These changes can create further patient frustration and confusion, patient despair and discouragement leading to resignation and noncompliance.

Patient Instruction and Recommendation Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the causes of noncompliance and making appropriate changes as necessary. Keep in mind, instructions and recommendations should be as easy, fast, simple, and convenient as possible for the patient in order to achieve effective and efficient patient compliance. In response to patient perceptions and experiences of unfavorable or unpleasant changes in their lifestyle, routine, or habits, the care provider needs to restate the intentions of the care plan and provide additional information and education to support and serve the patient and provide additional ongoing patient motivation. Technology should also be considered in providing patient information and education, offering inspiration and motivation, and reinforcing the need for continuing care and compliance.

2. PATIENT MEDICATION AND PRODUCT BARRIERS

Patient drugs, medications, devices, healthcare products, instruments, personal care products, and equipment are decisive in the care plan providing a valuable means for treatment, care, and therapy. And although the use of medications and products are distinguished in the instructions and recommendations of the care plan, *Patient Medication and Product Barriers* can arise regarding their use and reuse, fill and refill, purchase and replenishment, operation and maintenance, storage and disposal; *Patient Medication and Product Barriers* can also arise for other related reasons as well. For example, barriers can arise when the patient perceives or actually experiences adverse conditions, circumstances, and events associated with their medications and healthcare products, equipment and devices, like medication side effects and reactions or patient discomfort and pain, patient fear and anxiety, patient despair and depression, to name a few. *Patient Medication and Product Barriers* typically arise after the patient begins their therapy, experiences adverse reactions, and diminishes or discontinues use of their medications and products; however, barriers can also arise before the patient begins their therapy if they have already had adverse prior experiences with the same or similar medications and products.

Patient Medication and Product Barriers can also arise over time with the introduction of extra instructions and recommendations for the use and application of additional medications and other healthcare products, equipment and devices. What's more, barriers have been known to also arise with the introduction of extra instructions for the use of apps, technology, and wearable or implantable devices designed to manage patient self-care with prompts and reminders, monitoring and tracking capabilities, drug delivery and dosing, and patient data and reporting of medications, activities, and conditions.

Making appropriate changes to medications and products as necessary, *Patient Medication and Product Barriers* can usually and effectively be addressed in conversation with the patient and care provider reviewing the causes of noncompliance. The patient and care provider need to review all medications and products, determine patient concerns and problems, seek workable solutions, develop alternatives, and negotiate compromises. They also need to pay particular attention to addressing medication side effects and reactions as well as issues associated with patient discomfort and pain, fear and anxiety, despair and depression. Often extra instructions and recommendations and additional medications and products add to patient noncompliance; accordingly, it is recommended that medications and products, as appropriate, are easy, fast, simple, and convenient for the patient to use. One final point: if there are changes in medications and products, the patient will require additional training and education as well as ongoing motivation and, quite possibly, additional patient services and support to reinforce their self-care and compliance.

3. PATIENT CARE AND THERAPY BARRIERS

Patient Care and Therapy Barriers can often arise with the patient during the continuation of their care plan, most notably when there is an additional need, beyond the patient's ongoing primary care, for specialized care, long-term care, homecare, or other care including patient rehabilitation; physical, occupational, or other types of therapies; and so forth. Although ongoing patient treatment and care are a major component of the care plan and directly related to patient instructions and recommendations, barriers can arise with the patient requiring additional diagnostic tests, examinations, screenings, treatment, and therapies; requiring the need for

scheduling other initial, follow-up, and check-up appointments; requiring patient transportation; and keeping and making patient appointments on time, to name a few contributing causes of patient noncompliance.

Patient Care and Therapy Barriers can also arise with the patient in their need of other specialized clinicians, second and third opinions, dieticians and nutritionists, trainers and therapists, counselors and coaches, and skilled nursing and companion care specialists. Moreover, barriers can arise with the patient in planning and preparing for their continuing treatment and care; for their need to order special programs, services, and support; for their need to order special products, devices, appliances, and equipment; for their need to arrange homecare nursing and skilled services; for their need to coordinate additional clinical and personal support; and for their need to prepare, organize, and outfit their residence, as appropriate.

Thankfully social workers and discharge planners can often provide valuable assistance in these and other areas of need and yet, to the patient and their family, this can all be overwhelming, confusing, and frustrating. Having complications with their continuing treatment and care, having to adjust to new routines, having to follow new schedules, and having to plan, prepare, and make arrangements for additional services, care, and support, the patient often perceives or actually experiences all of this as very difficult, impracticable, and often unmanageable leading to their frustration, bewilderment, and resignation, leading ultimately to noncompliance.

Patient Care and Therapy Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the causes of noncompliance, offering practical solutions and recommendations, making appropriate changes when and where they are necessary, and providing additional clinical services and patient support. Often, continuing treatment and care, beyond the patient's primary care, can add complications, inconvenience, and difficulty causing the patient to opt out. Because of this possibility, it is recommended that the care provider and care team work to streamline additional patient treatment and care, to make it easier and simpler, and to make the additions to their primary care somehow more convenient. As honorable and virtuous as this is, however, additional patient treatment and care is sometimes absolutely necessary, unchangeable, and unavoidable. As appropriate, the patient will require additional training and education correlated to their needs as well as ongoing motivation; the patient might also require additional services and support to reinforce their compliance.

4. PATIENT HEALTH BARRIERS

In addition to treating the patient's condition, the general health of the patient is also a concern and, as such, a major component of the care plan directly related to patient instructions and recommendations. Accordingly, *Patient Health Barriers* can arise with the patient having unfavorable perceptions or experiences with care provider instructions and recommendations related to diet and nutrition, activities of daily living and exercise, work and recreation, rest and sleep, travel and other patient directives and advice. Barriers can arise, as we know, with patient resistance in making unfavorable changes to patient behaviors, habits, and lifestyle; or strict changes that can potentially contribute benefits to patient strength, fitness, energy, and endurance; or any other changes that can contribute to the health of the patient that the patient does not want or feel are unnecessary. For example, barriers can arise with patient resistance in making changes to their home and work environments; changes to where the patient lives and works; or even changes to their dental or eye care; or

changes to their skin, hair, and personal care. Moreover, barriers can arise with patient resistance in making changes in their abuse or addictions to food, alcohol, tobacco, drugs, and other substances and dependencies. When the patient resists care provider instructions or recommendations for their health and healing, barriers can arise and, as a result, the patient becomes noncompliant. Besides noncompliance, when the patient resists care provider instructions and recommendations for overall health, complications and comorbidities can arise.

Although they can be very challenging to accomplish, *Patient Health Barriers* need to be addressed since the overall health of the patient is critical to managing the patient's condition while diminishing the probability of complications and comorbidities. *Patient Health Barriers* can usually and effectively be addressed in conversation with the patient and care provider reviewing the causes of noncompliance, offering practical solutions, making appropriate changes even if they are small changes, and providing additional clinical and patient services and support with the help of nutritionists and dieticians, therapists and trainers, counsellors and coaches, and others. Furthermore, *Patient Health Barriers* can be effectively addressed with additional patient information and education; patient seminars and coaching sessions; behavioral modification programs, smoking cessation programs, and addiction recovery programs; as well as other patient support and services to help advance patient health and healing while reinforcing patient compliance. Admittedly, some of the causes of *Patient Health Barriers* are very challenging and some barriers, unfortunately and regrettably, are overwhelming. The patient, care provider, and care team need to openly and responsibly address these barriers together seeking workable solutions where and when they are possible.

5. PATIENT WELLBEING BARRIERS

In addition to treating the patient's condition and focusing on the patient's overall health, patient wellbeing is likewise a concern and major component of the care plan and it, too, is directly related to patient instructions and recommendations. As a result, *Patient Wellbeing Barriers* can arise with patient interests, concerns, and challenges relative to the emotional, intellectual, and spiritual wellbeing of the patient; relative to the comfort, safety, security, and welfare of the patient. Barriers seldom occur as a result of receiving ongoing information, education, and motivation and yet if the patient is not continually informed, inspired, and motivated; or if the patient is not feeling connected, appreciated, and cared for by others; or if the patient is not feeling safe, secure, and comfortable; barriers can arise. In addition, barriers can arise if the patient is not receiving the services and support they believe they should to be getting from their care team; if the patient is not getting the attention they believe they should to be getting within their care circle or care community; if the patient is not getting the attention they believe they should to be getting from their spiritual leaders and community; and if the patient is withdrawn, isolated, out of communication, and feeling alone in their care.

Patient Wellbeing Barriers can usually and effectively be addressed by maintaining strong connections and communication lines with the patient and by continuously providing patient information, education, and motivation as well as other patient services and support. *Patient Wellbeing Barriers* can also be addressed by helping establish a care circle for the patient, by involving immediate family members, friends, loved ones, care team members as appropriate, and other support like clergy, social workers, and helping neighbors. Additionally, *Patient Wellbeing Barriers* can also be addressed by enrolling the patient in being part of a larger care community comprised of other patients with the same condition in which community members share their

interests and concerns; share their thoughts, tips, and tidbits to powerfully and effectively manage their shared condition. Finally, it must be emphasized that nurturing good patient communications and relationships are absolutely critical to compliance and to addressing *Patient Wellbeing Barriers* as well as the other barriers associated with the delivery of care as we have seen.

CARE TEAM BARRIERS

In addition to patient care and care plan barriers, *Care Team Barriers* can arise with patient thoughts and feelings, opinions and judgements, perceptions and beliefs regarding their care provider and care team. Patients have perspectives, form perceptions, and develop preferences for people who they like, trust, and believe in; for people who they want to connect, associate, and relate to. Besides care providers and care teams, barriers also arise with patient perceptions and preferences regarding other clinicians and healthcare professionals namely dieticians, nutritionists, trainers, therapists, counselors, and coaches. Even barriers can arise with patient perceptions and preferences regarding family members, friends, and other support who the patient distinguishes as care providers. What's more, *Care Team Barriers* can arise with patient perceptions and experiences of provider expertise and skill, provider communications and relations with the patient, provider interest and involvement, provider facilities and resources, and provider benefits and incentives in delivering patient care.

1. PROVIDER PROFICIENCY BARRIERS

Provider Proficiency Barriers can typically arise when the patient perceives or actually experiences a lack of care provider and care team knowledge, skills, experience, and expertise to meet the needs of the patient. The patient thinks and feels the care provider and care team do not have the ability to deliver the level of care the patient expects and deserves and, consequently, the patient resists or rejects the care provider and does not comply with their instructions and recommendations relative to their care plan. Although the patient might appropriately enquire into the reputation, history, past performance, clinical results, and delivered outcomes of the care provider, the patient is usually more concerned with the capability, confidence, and conviction of the care provider and members of the care team relying on their personal interaction and experiences with them. The patient's perceptions and experiences of care provider proficiency give rise to *Provider Proficiency Barriers* and noncompliance.

Often, *Provider Proficiency Barriers* can be challenging to distinguish and identify since the patient might not share their perceptions and experiences with their care provider keeping their thoughts and feelings, opinions and judgements to their self. As their relationship continues, the patient's adverse perception of their care provider or a care team member might grow leaving the patient frustrated and resigned and ultimately noncompliant. Accordingly, the care provider and care team need to regularly check in with the patient to determine if they are meeting or exceeding the needs of the patient and if they are helping to generate patient satisfaction in their treatment and care.

Provider Proficiency Barriers can usually and effectively be addressed in conversation with the patient and care provider reviewing the causes of noncompliance, if any patient concerns and issues are truly exposed and addressed with forthright conversation. In addition, barriers can be addressed by offering practical solutions

and recommendations, by making appropriate changes in personnel when and where they are necessary, and by providing additional clinical and patient services and support to augment patient issues and concerns. In some instances, replacements or substitutions of care team members might need to implemented including specialty clinicians, healthcare professionals, therapists, nutritionists, dieticians, trainers, counselors, and coaches. In other instances, recommendations for the patient to get a second opinion or third opinion might be appropriate. And yet in other instances, recommendations for the patient to change their care provider might be the most appropriate solution. Forthright, honest, nothing withheld conversation is important to resolving patient issues and concerns relative to patient perceptions and experiences of the knowledge, skills, experience, and expertise of the care provider and care team members. Without mutual understanding and determination, without the conversation to address and remedy the problem, the patient will be noncompliant.

2. PROVIDER COMMUNICATION BARRIERS

Besides the care provider's knowledge, skills, experience, and expertise, the patient is also concerned with the care provider's communication and their ability to show interest and concern for the patient; their ability to listen and really hear the patient; their ability to deliver clear, concise information, education, and training to the patient; and their ability to share the decision making process with the patient regarding its risks and rewards. In addition, the patient is concerned with their care provider's ability to motivate and inspire them and their ability to recognize and acknowledge the patient's performance and progress. Another important part of communication is the ability of the care provider to facilitate conversations especially with motivational interviewing techniques to enhance patient enthusiasm, inspiration, incentive, and change in health behavior. If the patient perceives or actually experiences a lack of interest in helping to effect change and a lack of care provider attention and enthusiasm, provocation and acknowledgement, *Provider Communication Barriers* can arise. Moreover, if care provider conversations are incomplete, brief, or abrupt; if the care provider limits sharing and patient expression, freedom, and full self-expression; if the care provider neglects or ignores open, honest conversation; barriers frequently and typically arise. Also, inadequate, incompetent, or mediocre care provider communications are some of the leading reasons for barriers occurring which can result in patient noncompliance.

Everything in life and in health care is accomplished and resolved in conversation. *Provider Communication Barriers* must be effectively and efficiently addressed with conversation that is open, forthright, honest, nothing withheld. All barriers and behaviors the patient perceives or actually experiences require the patient, care provider, care team, and others involved in the delivery of care to responsibly and respectfully address with powerful, productive, and fully self-expressed communication.

Provider Communication Barriers can usually and effectively be addressed in open conversation with the patient and care provider reviewing the challenges they perceive in their expression and exchange, in their listening and hearing, in their comprehension and understanding, in their respect and response making appropriate changes and helping establish an optimal line of communication. We know that in order to achieve effective and efficient patient compliance, it must be easy, fast, simple, and convenient for the patient. Besides that, there must also be open, honest, productive communication and, as such, the patient and care provider must commit to this in their relationship.

3. PROVIDER RELATIONSHIP BARRIERS

Simply put, *Provider Relationship Barriers* always and continuously arise out of communication problems and challenges. Barriers arise in the care provider's lack of ongoing communication, in their lack of being open and comfortable with the patient, in their lack of being related, and in their lack of mutual commitment to the patient's health, healing, and wellbeing. Care providers cause *Provider Relationship Barriers* to occur when their connection, association, and interaction with the patient is perceived or actually experienced by the patient as insufficient, incompetent, insensitive, or indifferent. As we know, *Provider Relationship Barriers* are directly connected with patient perceptions of care provider proficiency and communication. What's more, care providers also cause *Provider Relationship Barriers* to occur not only in their relationship with the patient but also their relationship to care team members which, in due course, can and often affect the patient's relationship to the care provider and care team members. All of this can eventually result in patient noncompliance.

One major contributor to *Provider Relationship Barriers* is access and availability to the care provider. When the patient perceives or actually experiences these difficulties and obstacles, the patient, more often than not, critically assesses their relationship with their care provider, and care team and this too can eventually result in patient noncompliance. Another major contributor to *Provider Relationship Barriers* is when the care provider and patient have not commonly established a background of relatedness based on mutual like, trust, and belief; based on reciprocal integrity and workability, responsibility and reliability; based on a shared commitment. Creating a background of relatedness requires work, conversation, and sharing of mutual interests and intentions. Often, the lack of relatedness eventually results in patient noncompliance.

Provider Relationship Barriers can usually and effectively be addressed in conversation that is forthright, open, and honest defining the problem and seeking a respectful solution. We communicate to relate and, as such, the patient and care provider need to review and share their challenges and concerns, determine how they can respectfully work through them, make appropriate changes, and establish an optimal line of communication. Keep in mind: all barriers and behaviors the patient perceives or actually experiences require the patient, care provider, care team, and others involved in the delivery of care to responsibly and respectfully resolve them in communication and to responsibly and respectfully nurture solutions in their relationship. At times, however, we know there might not be a workable, productive solution other than one to involve change in the care provider or a member or members of the care team. In the final analysis, patient perceptions and experiences of their care provider proficiency, communication, and relationship have a most profound effect on patient compliance and noncompliance.

4. PROVIDER RESOURCE BARRIERS

Involving people, services, programs, technologies, buildings, products, and patient support required for the delivery of quality patient care, *Provider Resource Barriers* can arise with care provider resources, or a lack thereof. For example, *Provider Resource Barriers* can arise when the patient perceives or actually experiences difficulties or problems in accessing their care provider, care team, or other healthcare professionals; in receiving clinical services, programs, and patient support; in acquiring the latest, state-of-the-art technology; in

accessing clinical trials; in acquiring innovative healthcare products; in obtaining referrals and getting timely appointments; in getting to their provider's facilities; and other challenges associated with their care.

Provider Resource Barriers can arise if the patient perceives or experiences care provider facilities, technologies, programs, and staff are inadequate, insufficient, or incompetent. For instance, resource barriers can arise out of adverse perceptions or experiences of the facilities including patient waiting rooms, examination rooms, and lavatories; adverse perceptions of equipment and furnishings including imaging equipment, diagnostic tools, and examination tables; adverse perceptions of patient process, procedures, and administration; adverse perceptions of patient information, training, and educational materials; adverse perceptions of staff including recommendations made by the primary care provider for other clinicians in other practices; and more.

All resources connected with the care provider, offered by the care provider and recommended by the care provider, are potential sources for causing the patient to opt out of care and to be noncompliant. An important point to mention regarding provider barriers is that the patient judges and assesses care provider resources for overall usefulness, effectiveness, convenience, benefit, and value; for orderliness and organization; for up-to-date technologies and cutting edge innovation. The patient even evaluates the housekeeping and maintenance of care provider facilities and equipment. Adverse patient perceptions and experiences of provider resources often result in patient noncompliance. As such, the patient's assessment of provider resources is exactly like the patient's patient assessment of provider proficiency; both have a profound effect on patient involvement and compliance.

Conversation regarding provider resources is good and important in resolving patient concerns and issues; it provides an opportunity for the care provider to understand the patient's perspective of their organization; the patient's perspective of their efficiency and effectiveness; the patient's perspective of their processes and practices. The patient and care provider need productive conversations to enhance patient interactions and experiences relative to all care provider resources making them easy, simple, and convenient for the patient, making them beneficial and valuable without any patient concerns and distractions.

Provider Resource Barriers can usually and effectively be addressed in conversation by distinguishing patient concerns and causes of noncompliance; by offering practical solutions and recommendations, by making appropriate changes as required, and by helping the patient to realize the overall value of their care provider's contributions and resources. In some instances, changes in the staff, changes in services and programs, changes in technologies and products, and changes in patient support might be appropriate and necessary; also, changes in procedures and process might be appropriate to consider as well. In other instances, however, changes might not be appropriate or possible, like changes in location or facilities although changes inside the building, changes in maintenance, housekeeping, and other changes like those are possible and necessary.

One final point to consider with *Provider Resource Barriers* is the application of innovation and technology as a valuable resource which needs to be used to remind and prompt the patient; provide patient information, education, and motivation; report and track patient activity; provide patient data and analysis,; and monitor the effectiveness of the patient's condition, care, and compliance.

5. PROVIDER INVOLVEMENT BARRIERS

Provider Involvement Barriers are closely linked to *Provider Communication Barriers* and *Provider Relationship Barriers* because care provider interest, commitment, and active participation are correlated to the care provider's ability to communicate and relate to the patient. When the patient perceives or actually experiences a lack of care provider interest, commitment, and participation, *Provider Involvement Barriers* can arise. Positive scheduling, punctuality, and patient convenience as well as care provider accessibility, availability, and interaction clearly affect patient perspectives and perceptions of provider participation, enthusiasm, and involvement.

Patient distance and travel time to the care provider facility, as we know with *Provider Resource Barriers*, can also affect patient perspectives and perceptions of provider involvement if, for example, the patient makes a considerable effort to see their care provider but the patient's time with their care provider is brief and significantly limited. The patient may perceive or actually experience a lack of care provider interest and involvement contributing then to *Provider Involvement Barriers*.

Provider Involvement Barriers can usually and effectively be addressed with success, like other barriers, with conversation. It is important for the care provider to reestablish communication and relationship; to listen and really hear the patient; to show interest and concern; to motivate, inspire, and acknowledge patient performance and progress. What's more, it is important for the care provider to remain involved and interested checking in regularly with the patient, having care team members also check in regularly, all to encourage and assist patient compliance. Besides ongoing positive and productive communication, additional patient information, education, and motivation augment care provider involvement, as noted in research, especially if the care provider actually hands those materials specifically in print to the patient rather than a staff member providing them. Additional communication and information contribute considerably to patient compliance.

6. PROVIDER INCENTIVE BARRIERS

When the patient perceives or actually experiences issues associated with the care provider's lack of satisfaction in their career, lack of rewards and incentives in providing care, lack of growth and advancement in their practice, and lack of gratitude and acknowledgement for their compassion and care, *Provider Incentive Barriers* can arise with the patient in some sense of mutual symbiosis. The patient perceives and empathizes with care provider disappointment, detachment, and disincentive in providing care and, in their identification, the patient lives into similar feelings, engendered by the care provider, grounded in fear.

Here's how *Provider Incentive Barriers* arise; the patient picks up a lack of incentive and satisfaction in conversations with their care provider and in observations of the care provider's ways of being: how their provider interacts with the patient and others, how their provider behaves while performing their duties; how their provider responds or reacts to challenges. Moreover, the care provider may, either intentionally or unintentionally, project their discontent and disappointment with the pressures of their practice, the challenge of their patients, the difficulties of their claims and reimbursement, the problems of their risks, and the absence of rewards, just to name a few. As a result, care provider concerns bring about an effect on the patient, on their

self-care, and ultimately on their compliance. The patient feels frustrated, perhaps discouraged, perhaps fearful, because their care provider is not fully engaged, or because their care provider is preoccupied, or because their care provider is dissociated, to name a few causes. What usually happens then in these circumstances is the patient experiences a decline in their like, trust, and belief in the care, care provider, and care team influencing their belief, desire, and expectation for health, healing, and wellbeing. The patient opts out of care and becomes noncompliant.

Admittedly, *Provider Incentive Barriers* rarely occur quite possibly because the circumstances are infrequent, uncommon, and concealed from patients, or because they are difficult for the patient to distinguish and define, or because the barriers involve complex emotional reactions and consequences. In view of that, *Provider Incentive Barriers* can arise with patient disillusionment and disappointment in their provider losing respect, reverence, and appreciation for him or her; or, *Provider Incentive Barriers* can arise with patient identification with their care provider that results in cynicism, hopelessness, and resignation; or other consequences. Whatever the source of the barrier, the patient usually has difficulty in articulating the exact reason why they got stopped in their compliance other than their disillusionment and disappointment in their care provider. *Provider Incentive Barriers* often resemble or mimic *Provider Relationship Barriers* when the patient attributes their noncompliance to their relationship with the care provider.

Provider Incentive Barriers can be addressed with some moderate success; the care provider needs to take responsibility for the circumstances they create in conversation, performance, and in their ways of being. In working together, it is important for the care provider and patient to reestablish communication and relationship; to listen and really hear each other; to show interest and concern; and to articulate their mutual intention for patient health, healing, and wellbeing. What's more, it is important for the care provider to acknowledge patient concerns and to remain involved and interested in the patient encouraging their compliance. Besides ongoing positive and productive communication, the use of additional patient information, education, and motivation can further advance patient compliance. Because *Provider Incentive Barriers* can be a challenge, it might be necessary at some time for the patient to work with a different care provider and care team if the relationship is not optimally restored.

PART III

Barriers Associated with the Patient

PATIENT CIRCUMSTANCE BARRIERS

Patient Circumstance Barriers arise in the meaning and implication the patient attaches to their thoughts and feelings, opinions and judgements, perceptions and beliefs about their existence and being, their mind and body, their conditions and circumstances, and their status and significance. The patient creates meaning in considering patient circumstances and, as such, the patient's thoughts and feelings have a profound implication on patient compliance and noncompliance. As such, *Patient Circumstance Barriers* can arise with patient perspectives, perceptions, and preferences regarding their age, gender, physical condition, lifestyle, and personal standings including social, marital, professional, and financial status. *Patient Circumstance Barriers* can

also arise with patient perceptions regarding their level of education, health literacy, religious and cultural beliefs, and other personal circumstances. What's more, *Patient Circumstance Barriers* can arise with patient ability or inability to communicate and to relate with others.

Besides barriers associated with patient circumstances, the patient may also experience *Patient Cognitive Barriers*. Based on the thoughts they are thinking and the feelings they are feeling, barriers, breakdowns, and setbacks can arise with incidents or occurrences the patient perceives or actually experiences. In other words, *Patient Cognitive Barriers* arise in patient opinions and judgements, viewpoints and beliefs, imaginings and memories, sufferings and resignations, and other adverse thoughts and feelings influencing their perspectives, perceptions, and preferences; influencing their choices and decisions regarding their care, care plan, and care team. Those adverse thoughts and feelings also influence patient self-confidence, self-awareness, and self-efficacy for their ability or inability to follow instructions and recommendations and to take actions consistent with those instructions and recommendations. What's more, *Patient Cognitive Barriers* can also arise with the patient in adverse or detrimental ways of being, attitude, and the value or lack of value the patient places not only on their health, healing, and wellbeing but also on the meaning of their life and their work as well as their family, friends, and loved ones.

When all's said and done, barriers associated with the delivery of patient care and barriers associated with just the patient arise in how the patient perceives life and processes their occurring world – the events, circumstances, and conditions associated with their disease, their treatment, and their care – plus, the meaning, relevance, and value the patient assigns to their experiences in managing their disease, their treatment, and their care: whether they are good or bad, right or wrong, positive or negative, true or false. In view of that, barriers can arise as an event, circumstance, or condition that is perceived by the patient as bad and wrong or barriers can simply arise as something missing that, if it were present, it would make a meaningful, significant difference for the patient, their life, and their compliance.

While some patient barriers occur in the realm of reality (that which is physical, tangible, and measurable), all barriers occur in the realm of concept (that which is intellectual, intangible, and immeasurable). As such, patient barriers are an expression of patient thoughts and feelings and can be broadly defined and summarized as patient cognitive barriers. Accordingly, all barriers are a matter of patient perspectives, perceptions, and preferences which, in the end, have a profound effect on patient behaviors, choices, and actions.

1. PATIENT COMMUNICATION BARRIERS

Patient Communication Barriers can arise when the patient does not openly and freely share their thoughts and feelings, beliefs and desires, interests and concerns regarding their condition and care with their care provider and care team or when the patient does not share their intentions, expectations, and commitment to health and healing. What's more, *Patient Communication Barriers* can arise when the patient does not address their breakdowns, setbacks, and obstacles considering how important it is for the patient to agree, from the start, to follow instructions, to be coachable, and to stay in communication. Rather, the patient is frustrated or irritated with their self and their inability to express their uncertainties and concerns; their shortcomings and limitations;

their mistakes and breakdowns; and, as such, the patient withdraws and withholds, the patient goes undercover and eventually opts out.

Often, *Patient Communication Barriers* arise for other reasons as well; for instance, when the patient does not communicate their inability to retain and recall information, their inability to follow instructions, their inability to understand their care provider in verbal or written instruction, and, more importantly their inability to say they do not understand their care provider. Finally, *Patient Communication Barriers* arise when the patient is excluded in participating in the decision-making process, in making personal choices, in voicing their interests and concerns, in understanding their options, and in knowing the risks and rewards of their care and compliance or noncompliance.

Like *Provider Communication Barriers*, *Patient Communication Barriers* must be effectively and efficiently addressed with conversation that is open and forthright. Communication is the solution to a lack of communication and the barriers it provokes. As a reminder, everything in life and health care is accomplished and resolved with conversation. All communication barriers require the patient, care provider, care team, and others involved in the delivery of care to responsibly and respectfully engage in expression and exchange, listening and hearing, comprehension and understanding, acknowledgement and appreciation. Without positive, productive communication, there is no compassion and care, commitment and compliance.

2. PATIENT RELATIONSHIP BARRIERS

Patient connections and interactions, or a lack thereof, with the patient's care provider, care team members, and other support including family members, friends, and loved ones contribute to the rise of *Patient Relationship Barriers*. Barriers can often occur when the patient perceives or actually experiences a lack of warm, friendly, and caring communication that is respectful, emotionally supportive, and demonstrates true interest and concern. What's more, barriers can occur when the patient senses they are not heard. The patient needs to know they are listened to and really gotten; they need to know their interests and concerns are valid, and they need to know they are appreciated and acknowledged. The patient also needs to know they have established with their care provider, care team members, and others a background of relatedness rich in mutual like, trust, and belief; rich in mutual acceptance and agreement; rich in integrity, reliability, and workability.

Occasionally the patient may perceive or actually experience a lack of compassionate service and care, a lack of quality, a lack of access, and a scarcity of time with care team members which can, in part, affect relationships. Accordingly, *Patient Relationship Barriers* arise under these and other similar circumstances. One final aspect of *Patient Relationship Barriers* worth noting is the patient may not want a relationship or the patient may not like their care provider or a member of the care team; the patient may not want to connect and interact with others and, because of their dissociation or dislike with their care professionals, may opt out and be noncompliant.

Patient Relationship Barriers must be addressed if patient compliance is to occur; barriers are addressed with conversation that is forthright, open, and honest defining the problem and seeking a solution. As mentioned, and it cannot be overstated enough, all barriers and behaviors the patient perceives or actually experiences require the patient, care provider, care team, and others involved in the delivery of care to responsibly and

respectfully resolve them in communication. Sometimes, the solution to *Patient Relationship Barriers* may involve a change in the care provider or a member or members of the care team. At other times, the solution may be a suggestion for the patient to seek a second opinion or care from another provider.

3. PATIENT HISTORY BARRIERS

Patient History Barriers can arise with patient thoughts and feelings, opinions and judgements, perceptions and beliefs in their desire or lack of desire, approval or lack of approval, belief or lack of belief, ability or lack of ability, to comply with care provider instructions and recommendations based on patient characteristics, circumstances, conditions, customs, culture, and credence relative to the patient's age, gender, language, ethnicity, education, religion, and health literacy. For example, the patient refers to their age as a reason not to comply suggesting they are too old to change their ways or too old to follow instructions. Or, the patient refers to their gender or ethnicity as reasons suggesting men of their culture or background are sturdy and strong and, as such, they do not want to be told what to do and they do not want or need the care.

Every so often too, *Patient History Barriers* can arise with a patient lack of basic education as well as a patient lack of health literacy and understanding. Lastly, barriers can also arise with patient cultural and religious beliefs whereas a patient may cite their statements of belief, principles, and creeds as a reason not to comply, or cite their ethnic traditions as a reason not to comply, or their faith (or lack of faith) as a reason not to comply. *Patient History Barriers* arise with many characteristics, conditions, philosophies, judgements, reasons, viewpoints, and emotions requiring the patient and care provider to define the exact cause for a breakdown prior to seeking a solution if, indeed, a solution is possible.

Patient History Barriers can usually and effectively be addressed with understanding the causes and if those barriers cannot be completely addressed, then there may be a compromise that can be had. Sometimes, additional education and patient services and support are all that are needed to overcome the barriers and other times the help of care managers, family members, friends, neighbors, or others are needed to influence and motivate the patient to get past their obstacles.

4. PATIENT STATUS BARRIERS

Like *Patient History Barriers*, *Patient Status Barriers* can arise with patient thoughts and feelings, opinions and judgements, perceptions and preferences in their belief and desire for optimal compliance and outcomes, or lack of belief and desire, relative to their personal status and marital status, social standing, finances, and profession. In some ways, patient statuses are like cultural and religious beliefs, where the patient's identity is expressed in how the patient thinks, speaks, behaves, acts, and interacts with others in their various roles and responsibilities whether they are personal, familial, professional, commercial, social, or spiritual roles defining and describing who they are in their self-image, who they are to others. For example, the status of husband and man of the house may adversely affect patient compliance especially if it is viewed as a cultural weakness or social obedience. For similar reasons, the status of business leader may also adversely affect patient compliance. Perhaps the most common of all *Patient Status Barriers* arises in financial status; the patient cannot afford the care, the patient cannot afford the medications.

In life, the patient develops their identity from their background and upbringing, their experiences and education, their skills and accomplishments, their physical appearance and more. Looking good is a high priority for most people. Moreover, the patient strives in life to answer who they are and their life means. The patient also develops in life their thoughts, emotions, opinions, judgments, and beliefs; their perceptions and preferences for things they like and don't like, for things they perceive as good and bad, right and wrong, and so forth. All of these factors contribute to who the patient says they are defined in their status and standing, their importance and prestige, which makes *Patient Status Barriers* often be difficult to define and overcome. Nonetheless, *Patient Status Barriers* can be effectively addressed with understanding the importance the patient places on their status and the effect it has on their health, healing, and wellbeing. What's more, people, regardless of their status and background, don't like to be told what to do or be told they must adhere to certain instructions.

5. PATIENT PHYSICAL BARRIERS

Patient physical characteristics, circumstances, and conditions relative to the patient's weight and body mass index, posture and height, pulse and blood pressure, respiration and temperature, can contribute to noncompliance. *Patient Physical Barriers* arise out of patient physical characteristics, circumstances of health, and conditions of the body. Accordingly, *Patient Physical Barriers* also arise out of existing patient disorders, disabilities, difficulties, diseases, and challenges. For example, patient mobility, ranges of motion, function, energy, strength, and stamina, or lack thereof, can contribute to noncompliance. Even other patient problems and impairments like vision, hearing, breathing, walking, sitting, bathing, eating, exercising, sleeping, and other deficiencies can contribute to noncompliance. In addition we should not overlook other patient challenges that can contribute to patient noncompliance like patient ability or inability in reading labels, remembering instructions, holding and opening bottles, swallowing medications, and the list goes on. *Patient Physical Barriers* can also arise out of patient physical sensations and experiences of pain, cramping, tingling, numbness, coldness, burning, and other feelings as well as patient fatigue, exhaustion, anxiety, discomfort, panic, irritation, lethargy, and confusion to name a few.

Patient Physical Barriers can arise in the conditions and circumstances of the patient established in the healthiness and physicality of the patient, or a lack thereof. *Patient Status Barriers* can usually and effectively be addressed with the patient and care provider identifying and understanding the source of noncompliance; the circumstances, conditions, or events that give rise to the barriers. By identifying the physical barriers, solutions or alternatives to the barriers can be explored and discussed. In addition to physical obstacles, impediments, and difficulties, *Patient Physical Barriers* can also arise in the thoughts and feelings, opinions and beliefs the patient has regarding their healthiness and physicality; those barriers, which are actually *Patient Cognitive Barriers*, can then be addressed and, as appropriate, be overcome.

6. PATIENT LIFESTYLE BARRIERS

Patient Lifestyle Barriers are closely related to *Patient Physical Barriers* in that lifestyle choices not only affect the mind but also the physical body. Patient ways of thinking, being, speaking, and acting contribute to patient characteristics, circumstances, and conditions; their choices, conduct, behaviors, habits, and obsessions in life evidently influence their physical and emotional wellbeing which affect the patient's quality of life which affect

the patient's ability for self-care which eventually set up the potential for patient noncompliance. For example, if the patient uses or abuses alcohol, if the patient uses tobacco products, if the patient is addicted to drugs, or if the patient is dependent on other substances, these lifestyle choices influence and involve patient health and patient compliance. Even a lifestyle choice of overeating has negative consequences; the patient is likely overweight affecting their physical condition, affecting their quality of life, affecting their ability to self-care.

Patient Lifestyle Barriers don't always arise with current lifestyle choices; previous life choices or experiences can have a profound effect on patient tendency to be noncompliant. For example, it has been shown that adverse childhood experiences contribute to patient noncompliance; barriers more often than not arise with the patient who experienced physical, sexual, psychological, emotional, or spiritual abuse as a child in the same way barriers arise with the patient who experienced aggression, hostility, and violence; who lived in a dysfunctional family, or who was ignored, unloved, or neglected as a child. In addition to adverse childhood experiences, *Patient Lifestyle Barriers* arise with current life experiences ranging from abuse and neglect to dysfunction and aggression, affecting the physical, psychological, spiritual, and emotional wellbeing of the patient.

Patient Lifestyle Barriers can be decidedly difficult to address considering the additional need for professional services and support to effect patient transformation, the need for counselling and psychotherapy sessions, the need for behavioral modification programs, smoking cessation programs, addiction treatment and recovery programs, other twelve-step programs, and more. Occasionally, *Patient Lifestyle Barriers* can be addressed somewhat effectively with supplemental patient information, education, and motivation and ongoing communication with encouragement and patient assistance as appropriate.

7. PATIENT CIRCUMSTANCE BARRIERS

When life happens, it can create circumstances that hinder, delay, or prevent patient compliance. These *Patient Circumstance Barriers* can arise out occurrences and situations the patient encounters like a lack of personal assistance and patient support, a lack of connectivity and communication, a lack of transportation or access to meeting patient needs, and so forth. Or barriers can arise with living and working conditions, or issues related to home location, setting, and environment, or weather conditions, or other unpredictable or irregular circumstances. Perhaps, *Patient Circumstance Barriers* arise unexpectedly with unenthusiastic support from a family member or friend or other adverse influence; *Patient Circumstance Barriers* can also arise with pessimism or cynicism from others; with family culture, customs, or traditions; with religious beliefs, principles, or values.

Moreover, *Patient Circumstance Barriers* might be more serious in nature than those mentioned like patient or family unemployment and poverty, separation and divorce, homelessness and mental illness, to name a few. Also contributing to patient noncompliance, other circumstances which the patient might experience, even more serious, include incidents of violence, abuse, neglect, dysfunction, crime, or the loss of a loved one. *Patient Circumstance Barriers* are conditions, circumstances, and events that occur arbitrarily, randomly, suddenly without warning; circumstances that require the patient, care provider, and care team to work together to find solutions for optimal patient compliance under the circumstances.

Patient Circumstance Barriers can be successfully addressed, first, with identifying the circumstance and, second, by understanding the effect of the circumstance on the patient and their ability or lack of ability to self-care; and, third, with patient, care provider, and others coming together to work through possibilities and solutions. Obviously, some patient circumstances may disrupt patient compliance altogether leaving the patient hopeless and resigned to their condition with no belief or desire for their health, healing, and wellbeing.

PATIENT COGNITIVE BARRIERS

Patient Cognitive Barriers arise with how the patient thinks and feels about their self. Breakdowns, setbacks, and obstacles arise in the opinions, judgements, viewpoints, beliefs, imaginings, memories, forgetfulness, sufferings, resignations, and other adverse thoughts and feelings of the patient eventually influencing patient perceptions, preferences, beliefs, desires, and choices for their care, care plan, and care team as well as their health, healing, and wellbeing. Besides adverse thoughts and feelings that also influence patient self-confidence, awareness, and efficacy, *Patient Cognitive Barriers* also arise with the patient in detrimental ways of being, attitude, and the value, or lack of value, they place not only on their health, healing, and wellbeing but also on their life and loved ones.

Patient Cognitive Barriers surface in patient reasoning or lack or reasoning, as well they surface in patient recall and memory, patient forgetfulness and lack of memory, patient invention and imagination, and patient expression and language or lack thereof. *Patient Cognitive Barriers* can be organized into three classifications: *Patient Psychological Barriers* which arise with patient awareness of thoughts and feelings or lack thereof; *Patient Ontological Barriers* which arise with patient awareness of being and existence or lack thereof; and *Patient Sentient Barriers* which arise with patient awareness of self and sense impressions or lack thereof.

1. PATIENT PSYCHOLOGICAL BARRIERS

Patient Psychological Barriers are the breakdowns, setbacks, and obstacles that arise in patient thoughts and feelings, opinions and judgements, beliefs and viewpoints, as well as patient memories and imaginings, cynicisms and resignations, sufferings and forgetfulness, and other adverse states of mind. Whether they are in the realm of reality or the realm of concept, barriers are, in the final analysis, framed in the mind of the patient. It is in their thoughts and feelings, perceptions and preferences, love and fear, beliefs and desires that the patient chooses to be or not to be compliant with their care; that the patient chooses health, healing, and wellbeing and so chooses life and love.

As states of mind, *Patient Psychological Barriers* are an expression of adverse thoughts and feelings, opinions and beliefs, attitudes and values affecting patient perspectives, perceptions, and preferences and patient choices and behaviors for not choosing care, for not following instructions and recommendations, and for not taking actions consistent with them. Besides patient thoughts and feelings, patient memories also contribute to *Patient Psychological Barriers* with the patient recalling and remembering adverse experiences and wanting to avoid them again in their life. Beyond patient memories and reminiscences, *Patient Psychological Barriers* also arise with the patient conceiving and creating adverse thoughts and feelings about their care, care provider, care team, and self-care; the patient imagines something that could possibly be adverse and, in considering it, it

becomes the “truth” when, in fact, it is nothing more than a thought. Nonetheless, a great many of patient memories and imaginings contribute to *Patient Psychological Barriers* in the choices the patient makes.

Simply put, the patient chooses compliance and chooses noncompliance in their beliefs and desires. Those choices are established in the two basic human emotions of love and fear, as we know, from which all other human feelings originate. Accordingly, the patient chooses compliance in love, chooses noncompliance in fear; the patient chooses compliance in hopefulness, chooses noncompliance in despair; the patient chooses compliance in peace, chooses noncompliance in turmoil; and so on. To go a step further in this comparative assessment, the patient chooses compliance in integrity, chooses noncompliance in illusion, the illusion of their adverse thoughts and feelings, opinions and beliefs, memories and imaginings.

Patient Psychological Barriers always arise with patient adverse thoughts and feelings recalled and remembered or imagined and created based in patient misinterpretations and misunderstandings, in patient dislike and distrust, in patient criticism, cynicism, and resignation. With that in mind, we should never underestimate the dominance and authority of *Patient Psychological Barriers* in affecting patient noncompliance. With every barrier the patient encounters, with every breakdown, hindrance, and setback, the patient processes the barrier; the patient develops their thoughts, feelings, opinions, beliefs, attitudes, and values regarding the barrier; the patient develops their perceptions of good or bad, right or wrong, positive or negative, true or false, like or dislike, and so forth reinforcing their preferences; reinforcing their behaviors: and reinforcing their choices and actions. Accordingly with every barrier the patient encounters, every barrier has, *de facto*, an adverse patient psychological component integrated in the barrier since the very nature of a barrier is an obstacle, impediment, difficulty, and obstruction to the patient’s progress and growth.

In the end, *Patient Psychological Barriers* can be effectively addressed by defining and understanding the barrier which the patient needs to identify and articulate, by addressing the nature of the barrier, by addressing patient thoughts and feelings regarding the barrier, and by exploring possibilities and opportunities to overcome or lessen the effect of the barrier on patient noncompliance.

As a reminder, everything in life and health care is accomplished and resolved in conversation. *Patient Psychological Barriers* can be effectively and efficiently addressed in open, forthright, nothing withheld conversation. In addition, *Patient Psychological Barriers* can also be addressed with the patient and care provider reestablishing their line of communication, their relationship, and their mutual commitment to the care, care plan, and compliance with the expectation of achieving optimal outcomes. This is not to suggest *Patient Psychological Barriers* are not difficult and challenging. They are. But in the interest of advancing optimal patient compliance and outcomes, it is important for the patient and care provider to generate conversation in their mutual effort to address and resolve patient barriers.

2. PATIENT ONTOLOGICAL BARRIERS

Patient Ontological Barriers are comparable to *Patient Psychological Barriers* in that they arise in patient thoughts and feelings, opinions and judgements, beliefs and viewpoints, attitudes and values. Ontological barriers are grounded in the nature and study of human existence and being; ontological barriers arise in

adverse thoughts and feelings of how the world occurs to the patient and how those thoughts and feelings influence their beliefs and desires, behaviors and choices, their compliance and noncompliance.

Life happens; situations, events, circumstances, incidents, and conditions occur. *Patient Ontological Barriers* arise in how the patient perceives and experiences their life and their occurring world. Consequently, barriers arise in how the patient owns and processes life events, circumstances, and conditions or how the patient resists and rejects life events, circumstances, and conditions as bad and wrong, negative and undesirable. With adverse perspectives and unfavorable experiences in their occurring world, the patient can expect *Patient Ontological Barriers* to arise above all in the absence of seeing any possibility or opportunity in their life, condition, or circumstance. As such, the patient does not realize possibility or opportunity, in the least, for their health, healing, and wellbeing and, to make matters worse, the patient is typically frustrated and discouraged, feels defeated and dejected, and is resigned to their condition and circumstance adding further to their sense of hopelessness and despair. The patient suffers; the patient is a victim; the patient operates in a world of turmoil, fear, and illusion; and, as such, the patient experiences life at the effect of their circumstances.

Patient Ontological Barriers also arise with the patient in their positive, negative, or ambivalent ways of being in their care either intentionally or unintentionally. For example, the patient, in their condition and circumstance, in their way of being, might be fatalistic, cynical, and doubtful; or the patient in their way of being might adopt an identity of being frail, sickly, disabled, and unwell; or the patient might label their self as a hopeless and pitiable victim or sufferer; all of this creating *Patient Ontological Barriers* and, after some time, influencing their ability to ever be compliant. In contrast, however, the patient could actually create empowering ways of being, generate possibilities for health and healing, and commit to being responsible and compliant.

Patient Ontological Barriers further arise in the thoughts and feelings, words and language the patient generates and the effect of their words on their world; the effect of their words on their health, healing, and wellbeing; the effect of their words on compliance and outcomes. Accordingly, *Patient Ontological Barriers* arise in the language of the patient. Patient thoughts and feelings influence patient words and language; patient words and language influence patient ways of being and behaviors; patient ways of being and behaviors influence patient choices; patient choices drive patient action or inaction; and so patient action or inaction result in compliance or noncompliance.

Patient Ontological Barriers arise from a lack of patient integrity, responsibility, workability, and commitment; patient thoughts, feelings, behaviors, and words engender integrity, responsibility, workability, and commitment. Barriers arise if there is no integrity; that is, the patient giving their word and doing what they said they would do when they said they would do it. Barriers also arise if there is no patient responsibility for their choices, actions, and care. And barriers arise if there is no workability in managing the care, addressing the barriers, and finding practical solutions. Finally, patient barriers arise if there is no commitment to the care plan, care team, and to achieving optimal outcomes.

One final note regarding *Patient Ontological Barriers*: problems, difficulties, complications, and obstacles will always arise when the patient lacks love, belief, and desire. Essential to their compliance, patient love, rather

than fear, gives way to health, healing, and wellbeing. Love gives way to life and to living life powerfully and free, satisfied and fully self-expressed. It is often said that everything in life, in this world (and in health care), occurs in love or in the absence of love. Finally, love gives way to belief and desire. Entirely essential to their compliance, patient belief is about patients liking, trusting, and believing in themselves, their ability to make right and good decisions, their ability to manage their care, and their ability to respond to treatment, recover from illness, and heal accordingly. Patient belief begins with patient acceptance and agreement in their diagnosis and disease, their care, care plan, care team, and those things that are associated with their therapy regimen. Before the patient forms their belief, however, they must have a strong, powerful desire for health, healing, and wellbeing. It is not enough for the patient to simply articulate their hopes, dreams, and desires; the patient must powerfully choose them and act on them immediately, in the moment, as urgent wants or needs. Patient love, belief, and desire always, without exception, drive patient engagement and activation, persistence and compliance.

Patient Ontological Barriers can arise without patient awareness, interest, knowledge, or understanding; they are in a category of what the patient and care provider don't know they don't know. *Patient Ontological Barriers* can be effectively addressed by creating awareness and understanding of ontological matters that influence patient compliance. Thereafter, the patient and care provider need to identify the barrier, address the nature of the barrier, address patient thoughts and feelings regarding the barrier, and explore possibilities and opportunities to overcome or lessen the effect of the barrier on patient noncompliance. It is important to identify these ontological matters and to also create cognizance and appreciation for patient ways of being; patient possibility in their occurring world; patient integrity, word, and language; patient commitment, responsibility, and workability; and patient transformation in achieving compliance in these matters. *Patient Ontological Barriers* can be effectively managed with additional communication, enhanced relationships, and mutual commitment to the care, care plan, and patient compliance.

3. PATIENT SENTIENT BARRIERS

Patient Sentient Barriers arise in the absence of patient awareness and attention, in the absence of the patient being alert and responsive; the absence of patient mindfulness. Patient mindfulness is when the patient is present, in the moment, to what is occurring in their treatment and care, in their health and healing. *Patient Sentient Barriers* especially arise when the patient is not present to their condition, not present to the signs, sensations, and symptoms of their disease or lack thereof and, as a result, the patient is not attentive to managing their care and care plan; the patient forgets or neglects to follow instructions and take medications; or the patient doesn't think they need to follow instructions and take medications; or any number of other circumstances which can lead to noncompliance. What's more, *Patient Sentient Barriers* arise when the patient is unintentional and unthinking, acting automatically and making choices unconsciously. For example, the patient goes through their routine for the sake of doing their routine rather than actively managing their condition. Tired and discouraged with their routine, the patient, in due course, becomes resistant and resigned.

Patient Sentient Barriers also arise when the patient lacks self-confidence and self-sufficiency feeling as if they are incapable and unreliable in their care; barriers also arise when the patient is feeling apprehensive, nervous, or fearful. As a result, the patient gets stopped in taking action because of their thoughts and feelings of

uncertainty and doubt, skepticism and cynicism. As we know, the lack of patient self-efficacy is a major contributor to patient noncompliance. *Patient Sentient Barriers* arise when the patient loses their self-confidence, self-assurance, self-reliance, self-esteem, and self- sufficiency and so, in their withdrawal, the patient also loses their independence, their ability to ask questions and seek help, their dignity, respect, and self-worth. *Patient Sentient Barriers*, such as these, are challenging to overcome for the patient often feels helpless and hopeless. Moreover, the patient is missing their power and freedom, happiness and satisfaction in life and lacking a voice in the matter of their health, healing, and wellbeing.

Besides a lack of self-confidence, patient procrastination also contributes to *Patient Sentient Barriers*. As a lifestyle choice, usually in response to authority, patient procrastination is indirectly learned early in life and is often established in an absence or scarcity of patient self-confidence as well as patient esteem, discipline, knowledge, interest, understanding, and ability. Procrastination is a patient deficiency of choice and action in the moment; but more importantly, the patient needs to understand that each moment is important; each moment is an opening to achieving health, healing, and wellbeing; each moment is an opportunity to make healthy choices and take healthy actions. In contrast to the precious present, the gift of now, procrastination obliterates possibility. Like self-confidence, *Patient Sentient Barriers*, which arise in procrastination, are challenging to address requiring substantial breakthroughs and patient transformation rather than mere motivation and simple change which are regrettably transitory and impermanent in nature.

Lastly, *Patient Sentient Barriers* arise in patient discernment and choice. Often, the patient comes to a decision and the decision is resolute and fixed in contrast to the patient actively and ongoingly making choices, keeping all options open all the time. The word decide comes from the Latin *cidere* meaning to kill off or strike down; thus, we have the words homicide, suicide, insecticide, pesticide, and others and we have the word decide. By making a decision rather than choosing, the patient kills off or strikes down any future possibility and further opportunity and, as such, *Patient Sentient Barriers* arise. The distinction of choosing is important to compliance. The patient chooses to follow instructions and recommendations and take actions; the patient chooses their care, care plan, and care team; the patient chooses health, healing, and wellbeing; and the patient chooses their condition rather than resisting it or denying it. After all, what choice does the patient have in their condition but to own it and deal with it powerfully? Choice, rather than decision, gives the patient freedom, faculty, and control in their circumstance.

Clearly, *Patient Sentient Barriers* can be complicated to understand and to address since every patient is unique in their thoughts, feelings, opinions, judgements, attitudes, and values. Like ontological barriers, *Patient Sentient Barriers* are barriers that arise without patient knowledge or understanding: patients don't know what they don't know. Accordingly, the care provider and the patient need to create awareness and understanding for sentient matters that influence patient compliance and noncompliance; they include awareness and understanding for patient presence and intentionality or lack thereof; patient alertness, attentiveness, and responsiveness to their condition or lack thereof; patient self-confidence and self-sufficiency in their care or lack thereof. The care provider and the patient also need to create awareness and understanding for patient procrastination or lack of making health choices and taking healthy actions in the moment as well as patient choice rather than patient decision.

PART IV
Barriers and Patient Behaviors

BARRIERS AS BEHAVIORS

Barriers shape patient behaviors. The patient encounters, and sometimes creates, a barrier or barriers along the continuum of their care: perhaps, from the onset in their examination and diagnosis, or later in patient engagement and activation or even later in patient assessment stages of their therapy, or quite possibly in their advanced stages of care after some time has passed. The patient generates thoughts and feelings, opinions and judgements, beliefs and viewpoints, attitudes and values, perceptions and preferences regarding their obstacles, breakdowns, and setbacks whether they are barriers associated with their care, care plan, or care team; or barriers associated with their condition or circumstances; or barriers associated with events or occurrences in the patient's life. All the more so, the patient generates thoughts and feelings, opinions and judgements, beliefs and viewpoints for barriers associated with what the patient is thinking or feeling, judging or believing, imagining or remembering. Those barriers are patient cognitive barriers, the psychological, ontological, and sentient barriers generated by the patient.

Often when the patient encounters a barrier, the patient processes the barrier, meaning the barrier is what happened and so the patient, in their occurring world, assesses and interprets the barrier; the patient assigns their thoughts and feelings, opinions and judgements to the barrier; and the barrier, as a result, conforms ultimately to the patient's way of thinking and, thus, the patient's perspectives, perceptions, and preferences. This process, called a vicious circle, is what happened and the thoughts and feelings the patient assigns to what happened and it goes round and round assessing and reassigning. So, whether the barriers are associated with the delivery of patient care or associated directly with the patient; whether the barriers are circumstance or cognitive; or whether the barriers are in the realm of reality or the realm of concept, the patient processes the barriers whereas the barrier and their thoughts and feelings about what happened descend and diminish into what the patient believes and perceives as their truth. Accordingly, patient barriers reside in the thoughts and feelings, words and language of the patient.

Since barriers reside in patient thoughts and words, the patient either chooses or decides their relation to obstacles, impediments, difficulties, and obstructions either responding or reacting to their barriers in what they think and say about them.

In their decisions about barriers, the patient is noncompliant in their reaction to being thwarted by making excuses, justifying their behaviors and decisions, inventing reasons not to continue self-care, coming up with explanations for noncompliance, and defending their lack of action. In their choices about barriers, however, the patient is compliant in their response by seeking and asking for help, by inventing possibilities and creating opportunities, by working towards solutions.

Life happens and barriers happen. Barriers influence patient thoughts and feelings; patient thoughts and feelings influence patient ways of being; and patient ways of being influence patient ways of speaking. Patient

ways of being and speaking influence patient behaviors and patient choices; patient behaviors and choices influence patient deeds and actions or inactions which then determine patient compliance or noncompliance.

To successfully address patient barriers, the care provider must work with the patient to change noncompliance by changing patient choices and patient behaviors. The care provider does this by helping change patient ways of being and speaking and by helping change patient thoughts and feelings about their barriers. Moreover, the care provider does this by creating powerful patient possibilities and opportunities; by creating solutions for quality patient care, compliance, and outcomes; and by creating optimal patient health, healing, and wellbeing.

IN CONCLUSION

Solutions to patient barriers are as varied as the causes, circumstances, conditions, and events that give rise to them, the different obstacles, impediments, difficulties, and obstructions that patients encounter in their care. Even so, solutions begin with quality communications and relationships and build from there; they are the foundation for furthering patient compliance. In addition to quality communication and relationships, patient access and connectivity are important to compliance as well as ongoing patient information, education, and motivation. As appropriate, additional patient services, programs, and support are also needed to advance patient compliance; for example, services for patient therapeutic exercise, diet and nutrition, and more; programs for patient coaching and counselling; support for patient lifestyle change and behavioral modification, and so forth. There are many different approaches to addressing patient noncompliance which unfortunately cannot be listed here as they fall outside the scope of this paper but are certainly worth additional investigation.

Mentioned at the beginning, the intention of this paper was to identify and distinguish major barriers to patient compliance and patient behaviors that barriers may bring about. In addition the intention was also to explain how patient barriers and behaviors can complicate, obstruct, or thwart compliance; provide some guidance in how to reduce, eliminate, or sidestep barriers and how to address patient behaviors in an effort to advance patient compliance. There is general agreement among healthcare professionals for applying time, energy, and resources to advance patient compliance since it is valuable and essential to achieving optimal clinical and patient satisfaction outcomes as well as quality economic and business outcomes.

In the final analysis, the major questions for management regarding barriers, behaviors, and compliance remain: first, what time, energy, and resources are required to meet the needs of patients and those responsible for achieving patient compliance; second, which patients should time, energy, and resources be directed to in managing them and finding effective and efficient solutions; and three, what affect do patient compliance initiatives have on their business organization and market share, on their growth, revenues, and profitability? As such, the matter of compliance and noncompliance rests on management and healthcare professionals to explore and determine its overall delivered value and, at the same time, generate effective, sustainable solutions that advance health, healing, and wellbeing.

PART V

Barrier Dimensions

A. Barriers Associated with the Delivery of Patient Care
    1. Care Patient Barriers
        a. Treatment Complexity Barriers
        b. Treatment Duration Barriers
        c. Treatment Development Barriers
        d. Treatment Effectiveness Barriers

    2. Care Plan Barriers
        a. Patient Instruction and Recommendation Barriers
        b. Patient Medication and Product Barriers
        c. Patient Treatment and Care Barriers
        d. Patient Health Barriers
        e. Patient Wellbeing Barriers

    3. Care Provider Barriers
        a. Provider Efficacy Barriers
        b. Provider Communication Barriers
        c. Provider Relationship Barriers
        d. Provider Resource Barriers
        e. Provider Involvement Barriers
        f. Provider Incentive Barriers

B. Barriers Associated with the Patient
    1. Patient Circumstance Barriers
        a. Patient Communication Barriers
        b. Patient Relationship Barriers
        c. Patient History Barriers
        d. Patient Status Barriers
        e. Patient Physical Barriers
        f. Patient Lifestyle Barriers
        g. Patient Circumstance Barriers

    2. Patient Cognitive Barriers
        a. Patient Psychological Barriers
        b. Patient Ontological Barriers
        c. Patient Sentient Barriers