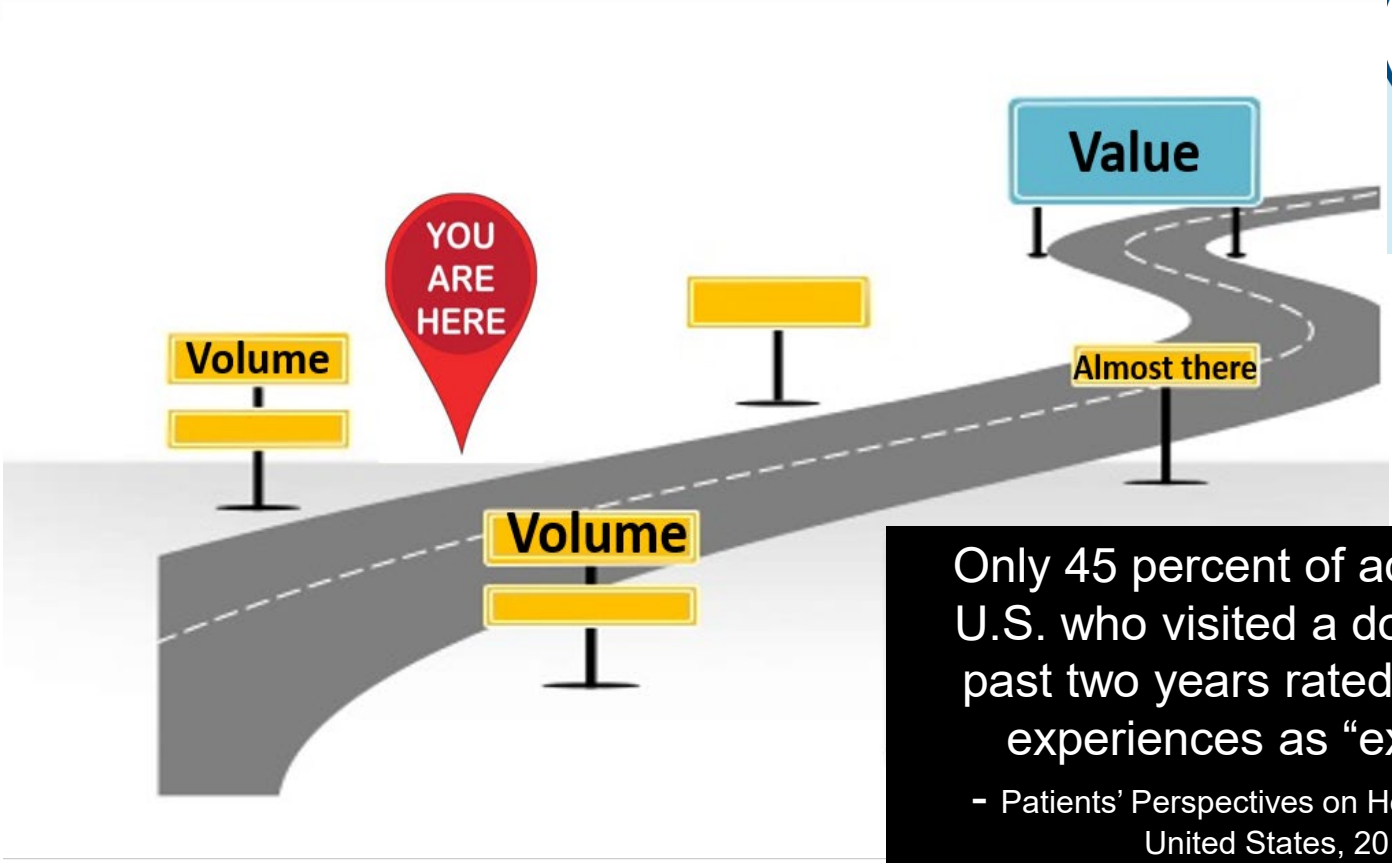
Creative Strategies to Improve Patient Care Experience

Presenters (from the Yale Team)

Ingrid Nembhard, PhD, MS
Associate Professor
The Wharton School
University of Pennsylvania

Yuna Lee, PhD, MPH
Assistant Professor
Mailman School of Public Health
Columbia University

Why Creative Ideas Are Needed

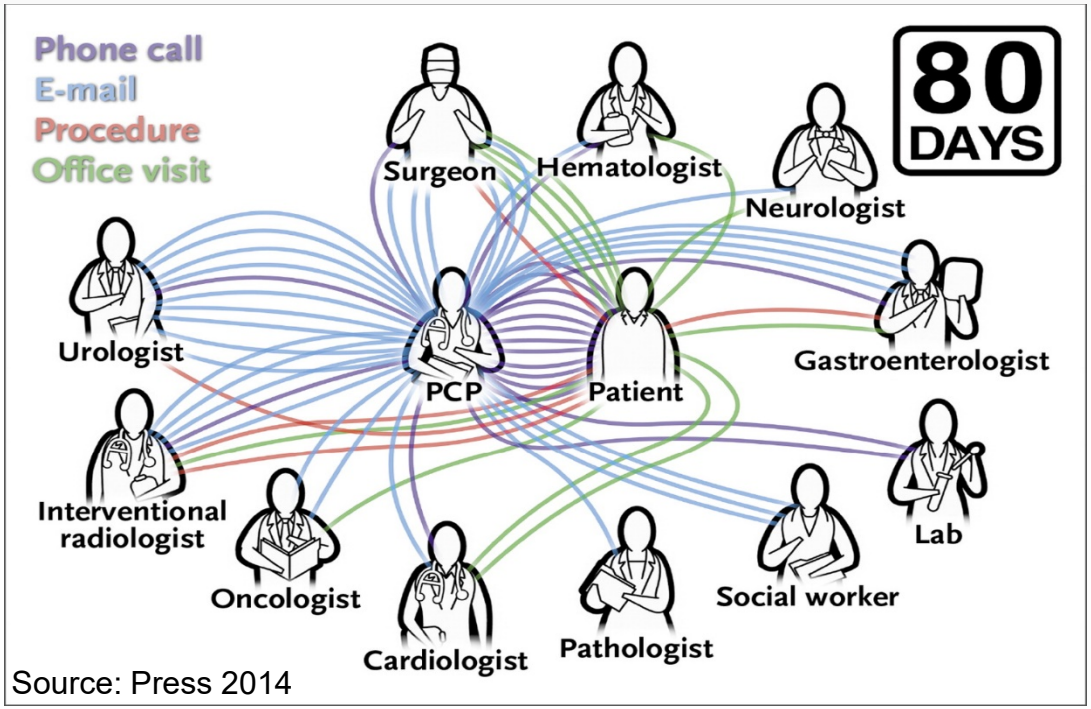


Only 45 percent of adults in the U.S. who visited a doctor in the past two years rated their care experiences as "excellent"

- Patients' Perspectives on Health Care in the United States, 2016

The Imperative For Care Coordination

Interactions within care team for 1 patient in 80 days



Source: Press 2014

The Imperative For Care Coordination

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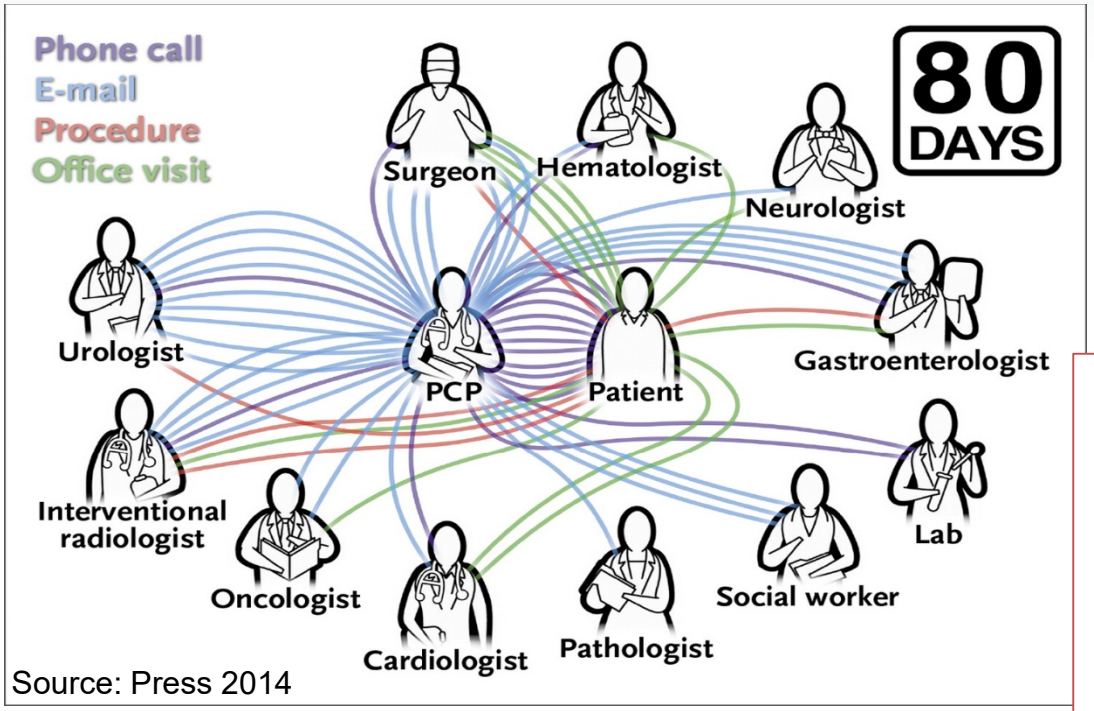
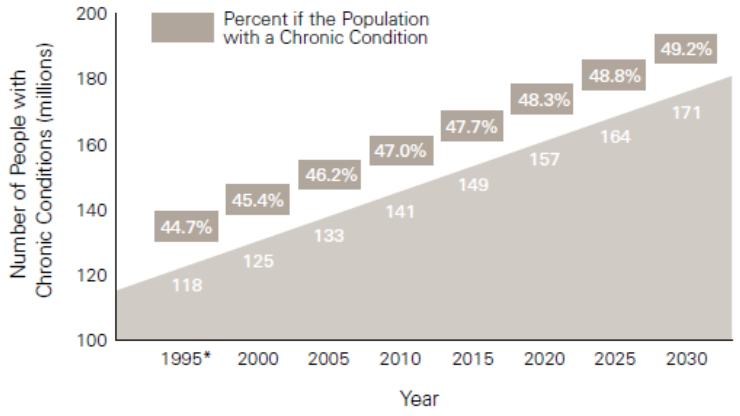


Source: Press 2014

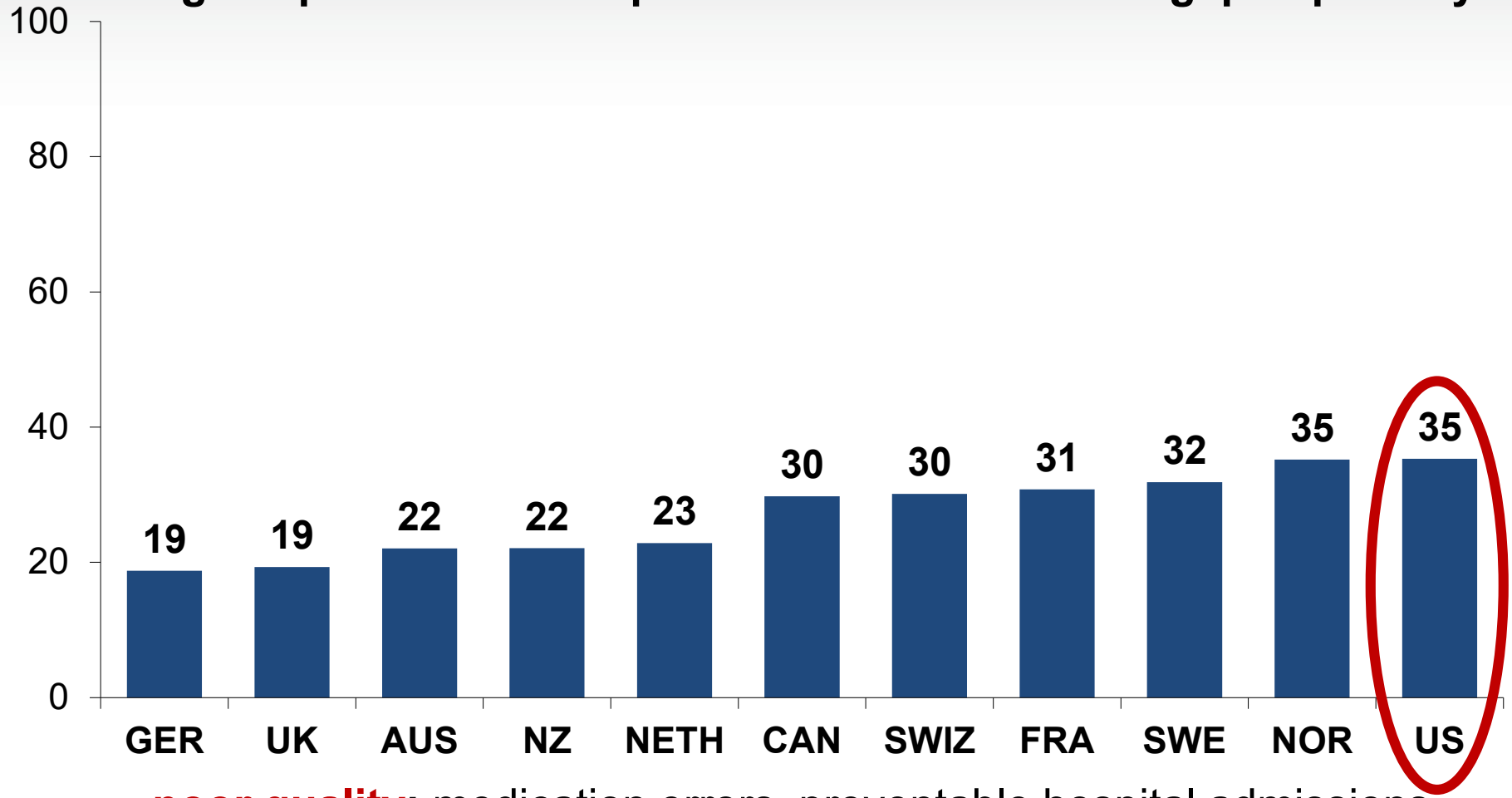
Chart 1: The Number of People with Chronic Conditions is Rapidly Increasing



Source: Wu, Shin-Yi, and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation.* RAND Corporation, October 2000.

Care Coordination Failures Are Prevalent

Percentage of patients who experienced a coordination gap in past 2 years



poor quality: medication errors, preventable hospital admissions, mortality, etc.

high cost: $25-45 billion in wasteful spending due to failures (Burton 2012)

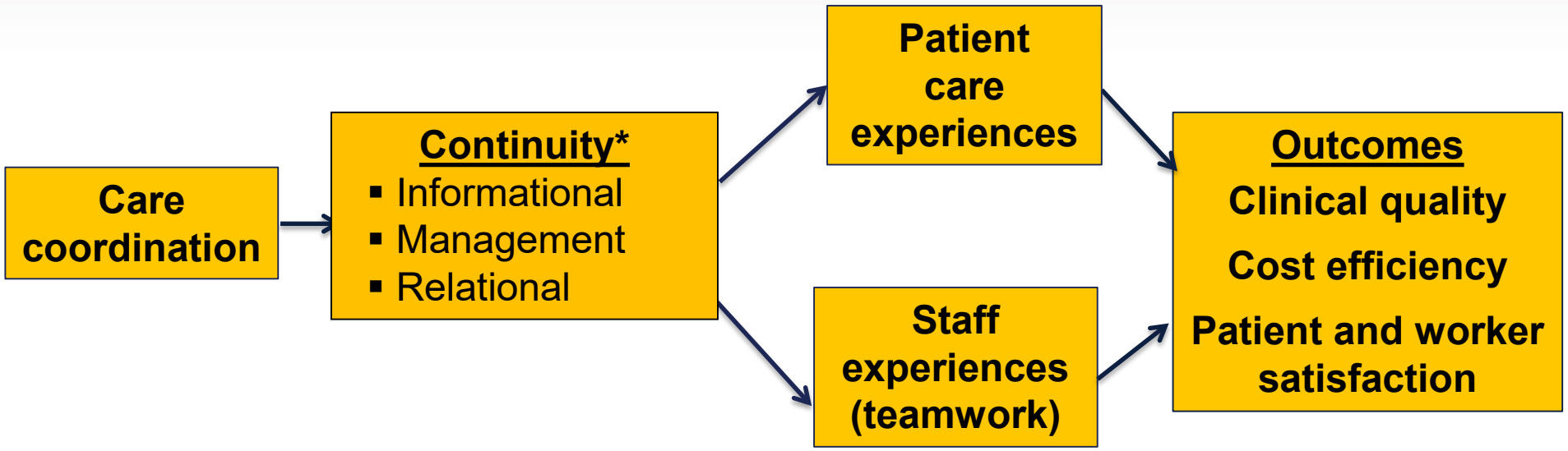
Care Coordination Defined

"the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services" (AHRQ, McDonald et al., 2007)

- **right place, right time, right person**

Source: McDonald KM, Sundaram V, et al. Care Coordination. Rockville, MD: AHRQ, 2007

The Benefits Of Coordinated Care: The Theoretical Model



***Types of continuity** (Haggerty et al. 2003)

- Informational: use of information on past events and personal circumstances to make current care appropriate
- Management: a consistent care management plan across professionals
- Relational: an ongoing relationship between patient and provider(s)

Potential Solution: Nurse Care Coordination

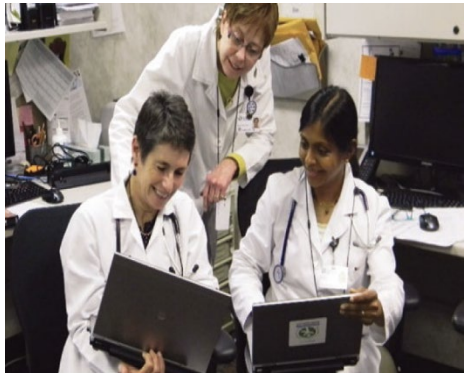
- Nurse engages with *patient* and *providers*, manages care process (development and communication of care plan), and ensures all care needed is arranged and delivered

  (Nutt & Hungersford 2010)

- **<u>Two approaches</u>:**

1. Exclusive-role: sole role is coordination
   - ► Evidence: mixed but growing positive*

     (Bosch et al. 2009; Conway et al. 2017)



2. Added-role: maintains other roles
   - ► Evidence: missing

A Central Question

What is the impact of the added-role approach to nurse care coordination on:

- patient care experiences of high-risk patients and
- clinician experiences of teamwork?

Source: Nembhard et al. 2019. A Quasi-Experiment Assessing the Six-Months Effects of a Nurse Care Coordination Program on Patient Care Experiences and Clinician Teamwork in Community Health Centers. *Working Paper.* Funding provided by AHRQ

Research Setting: Community Health Centers

- 12 centers in one state-wide federally qualified health center (FQHC)
- ~ 140,000 patients use as their medical home
  - Primary Care Medical Home by the Joint Commission
  - Level 3 Patient-Centered Medical Home by the National Commission on Quality Assurance
- 410,000 health visits per year
- ~200 health care providers
- Special commitment to the uninsured, underinsured, and special populations, e.g., patients with HIV/AIDS, diabetes, and chronic mental health issues
- Sample of innovations implemented:
  - Fully integrated Electronic Medical Record
  - E-Consults

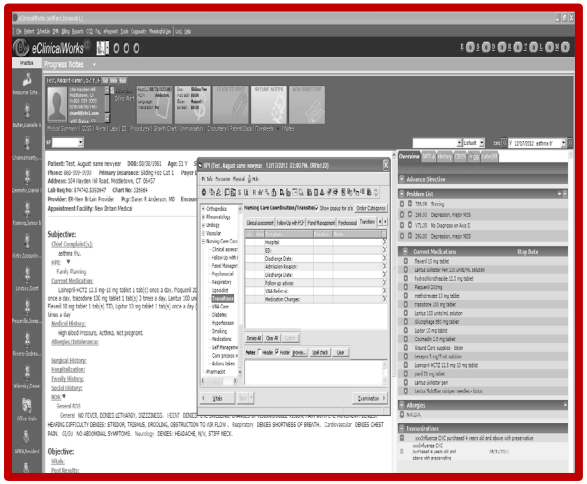
The New Role for Nurses

- **Role:** care coordination for adults with complex care needs
  - ► given responsibility for a key patient group (cost & need)
- **Task: ensure** coordinated care for these patients

  Task: lead a weekly panel management session held with the PCP and mental health staff
- **Implementation:**

23 Hours of Training + "The Playbook" + Dashboard

	Agenda Item	Durati
Topic 1	Review of the CC project and playbook	1 hour
Topic 2	Care Coordination Documentation	1 hour
Topic 3	Panel Management	1 hour
Topic 4	Transition Care Part 1	2 hours
Topic 5	Transition Care Part 2	2 hours
Topic 6	Transition Care Part 3/Medication reconciliation	2 hours
Topic 7	Chronic disease management: HTN management	1 hour
Topic 8	Chronic Disease Management: Diabetes care part 1	1 hour
Topic 9	Chronic Disease Management: Diabetes care part 2	1 hour



Study Design: Quasi-Experiment

- **Design** Clustered, pre-post study comparing intervention and control groups, i.e., centers that implemented CC program versus centers yet to implement (6 vs. 6) after 6 months of program use
  - **Participation:** All nurses were *required to participate*
- **Survey of patients about care experiences** using the CAHPS Clinician & Group Visit Survey (CG-CAHPS) and PCMH Supplemental Item Set, mailed to a random sample of program-eligible adult patients who had had at least one visit with a primary care provider at a center during the prior 6 months
  - Baseline: 3,209 patients (58%) replied; 3,007 met inclusion criteria
  - Follow-up: 2,306 patients (49%) replied; 2,101 met inclusion criteria
  - 113 program enrollees replied (78% of 145 enrollees)
- **Survey of clinic employees about teamwork** using existing scales
  - Baseline: 96 employees (51%) returned usable surveys
  - Follow-up: 135 employees (72%) returned surveys
  - 60 employees with data in both periods

Measuring Patient Care Experiences And Teamwork

AHRQ Agency for Healthcare Research and Quality

For patient care experiences: Sample items ("In the last 6 months, …")

- **Timeliness of care**
- Did you see this provider within 15 minutes of your appointment time?
- Did you get an answer to your medical question that same day?

- **Care coordination**
- Did you get the help you needed from this provider's office to manage these different providers and services?
- Did the provider named seem informed and up-to-date about the care you got from specialists?

- **Support for patient self-management**
- Did anyone in this provider's office talk with you about specific goals for your health?
- Did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

- **Care for mental health**
- Did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?
- Did you and anyone in this provider's office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

For staff experience of teamwork: Sample items from Nembhard & Tucker 2011; Gittell 2001

- Nurses and physicians plan together to make decisions about care for complex patients.
- Open communication between care providers takes place as decisions are made for complex patients.

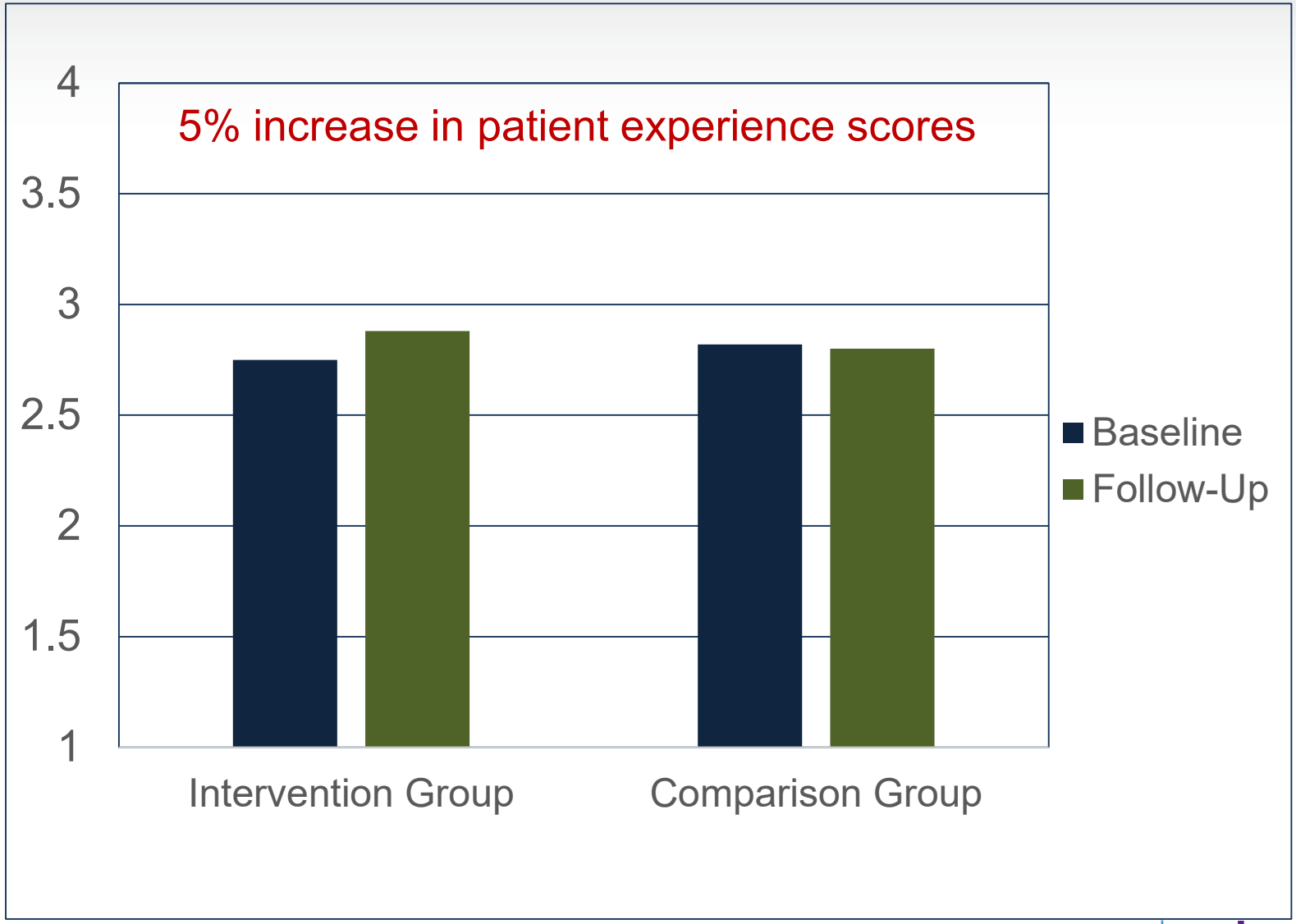
- The people on this team share my goals for the care of patients.
- The people on this team communicate with me in a timely way about the status of patients.

Measuring Implementation And Contextual Factors

- **Implementation: Office visit frequency**
  - CG-CAHPS survey question: "In the last 6 months, how many times did you visit this provider to get care for yourself?"
  - Proxy for accessibility of care, engagement with patients, monitoring, and follow-up to achieve care plan goals
  - Should increase in program's early months to address outstanding care needs and self-management training

- **Contextual factors**
  - Resources: I have the resources necessary to coordinate care for complex patients
  - Training: I have the knowledge necessary to coordinate care for complex patients
  - Compatibility with current work: Coordinating care for complex patients is not compatible with other tasks that I'm required to perform

Finding: Modest Improvement In Patient Experience For Program Enrollees



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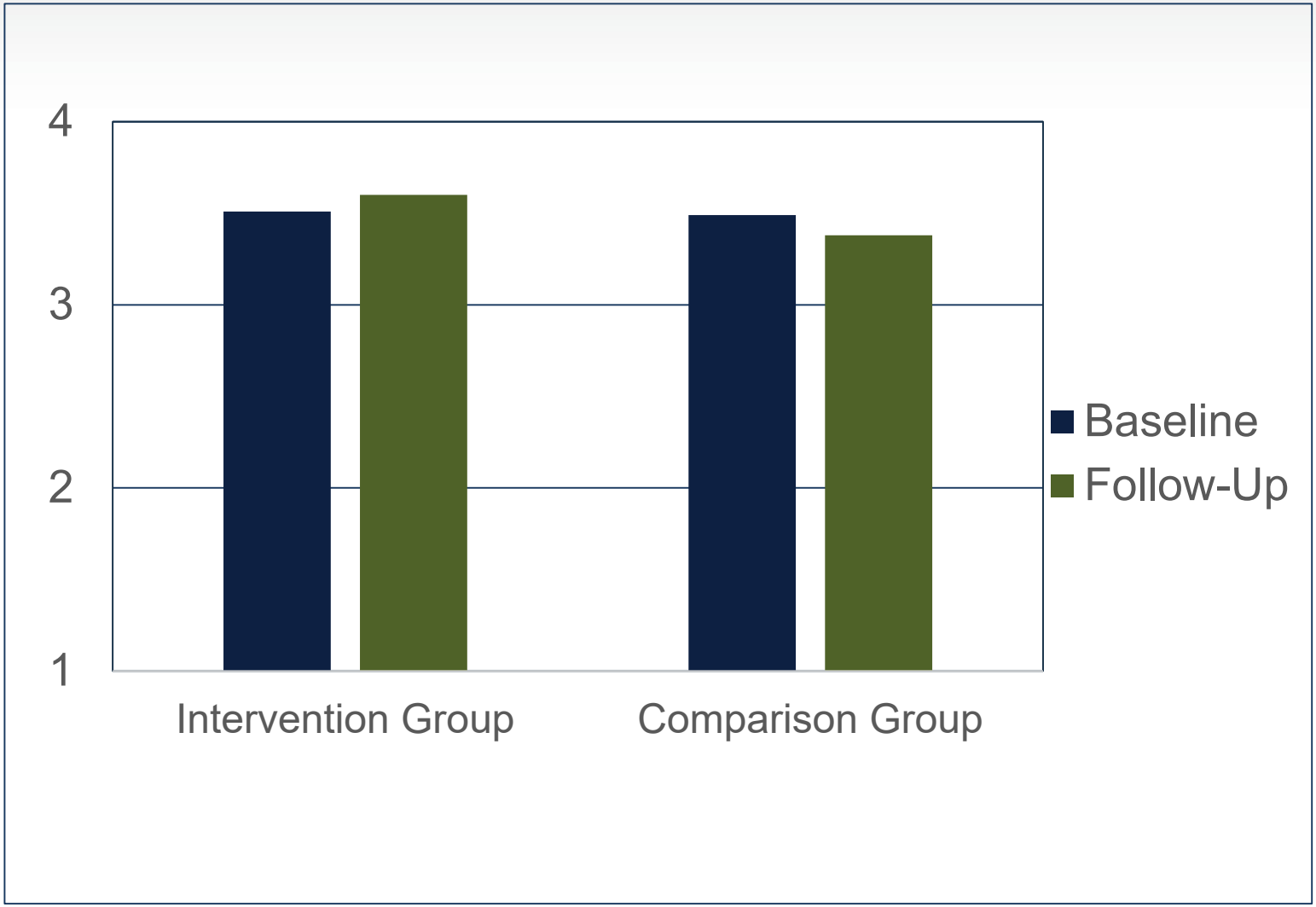
Finding: No Significant Improvement In Clinician-reported Teamwork



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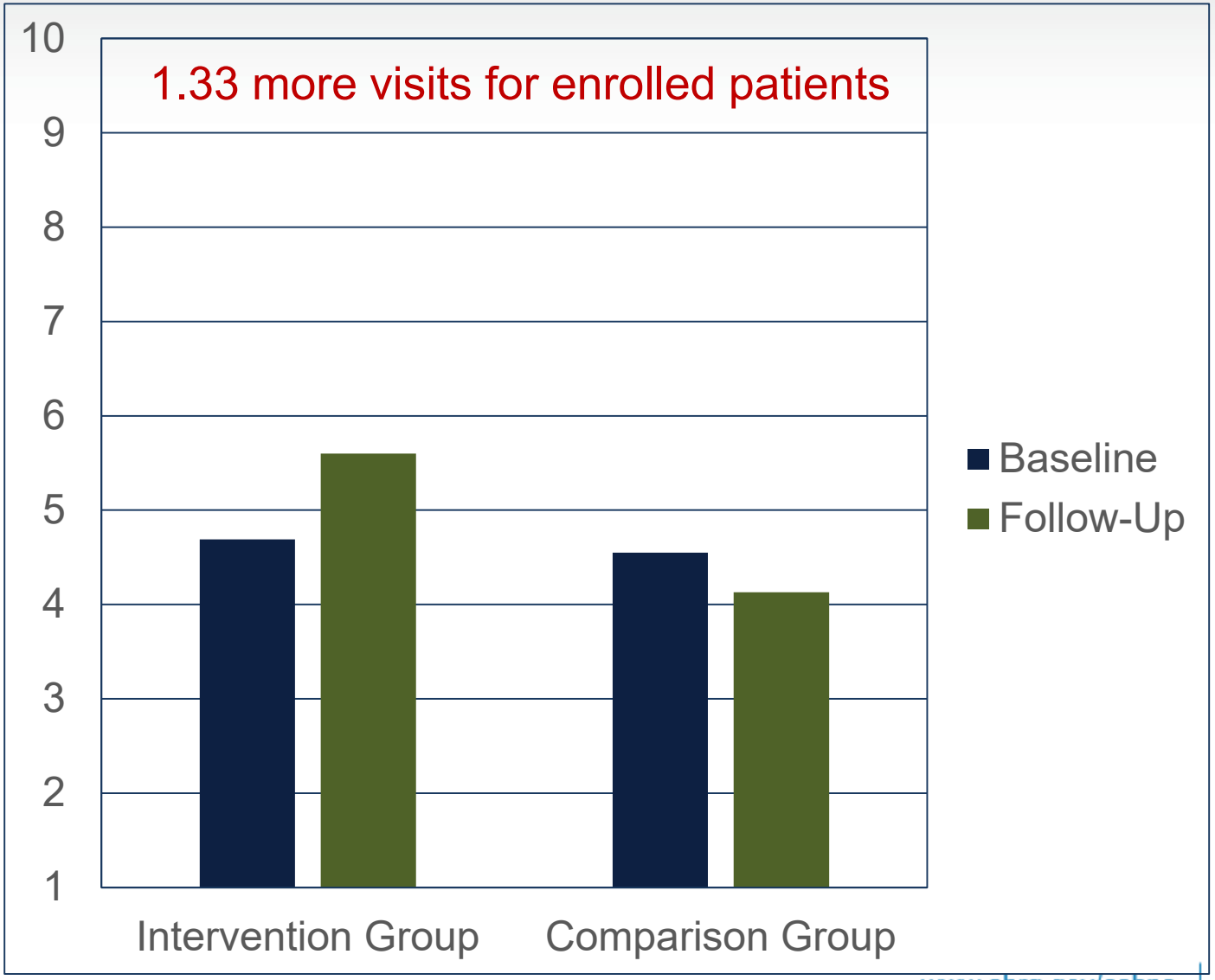
Finding: Office Visits Increase For Enrolled Patients



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Getting Greater Improvement In Patient Care Experiences

Contextual factors	Evidence: % of nurse respondents agreed or strongly agreed that
Resources	75% have the resources necessary 79% have adequate authority to perform the work required
Training	87% have the knowledge necessary
Role compatibility (able to perform care coordination and other job demands)	59% report “Coordinating care for complex patients is not compatible with other tasks that I’m required to perform”

Conclusions About The Added-role Approach

- Some improvement for program enrollees
  - Modest improvement in patient-reported care experiences
  - Increase in access and engagement with providers (visits)
  - No significant improvement in clinician-reported teamwork

- Added-role approach to nurse care coordination holds promise for improving patient care experiences but:
  - Need to address role compatibility for greater gains
  - Need to adjust operations to absorb more office visits

More creative ideas to improve patient experience needed