



# Key factors in patient-centered care coordination in ambulatory care: Nurse care coordinators' perspectives



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## ABSTRACT

**Background:** Care coordination within Health Care Homes (HCHs) is an evolving registered nurse role. The purpose of this study was to identify factors influencing nurse care coordination.

**Aims:** The aims are to 1) describe the characteristics of patients perceived by nurse care coordinators (NCCs) to benefit from care coordination and to 2) describe interventions judged by NCCs to be most effective in caring for patients with complex chronic care needs.

**Methods:** This study was an analysis of existing data using a qualitative descriptive design. Experienced NCCs from various practice settings participated in a focus group. Data were analyzed using content analysis.

**Results:** Findings indicate the importance of the cumulative impact of complex health problems, limited social support, culture and language on patients needing care coordination. Effective interventions are focused on providing holistic, relationship-based care.

**Conclusion:** The identification of contextual factors juxtaposed to complex chronic health conditions holds promise as a powerful indicator of individuals needing targeted, individualized interventions.

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## 1. Introduction

Health care system re-design has focused on primary care settings and the development of the health care home (HCH) in response to the rising concerns for improving health and lowering costs of care (Arend, Tsang-Quinn, Levine, & Thomas, 2012; Jackson et al., 2013). The HCH, a patient-centered care model, places an emphasis on care coordination and self-management support rather than disease management. Registered nurses, functioning as nurse care coordinators (NCCs), have proven to be critical members of interdisciplinary care teams in improving patient outcomes (Boult et al., 2011; Boyd et al., 2009); however, little is known about patients who may benefit from care coordination. There is a need to identify the characteristics of patients who benefit from care coordination and the effective interventions used by experienced NCCs. The purpose of this study was to identify key factors in the clinical practice of NCCs. The aims of the study were to describe 1) the characteristics of patients perceived to benefit from NCC services and 2) interventions judged to be effective by NCCs when caring for patients with complex needs.

## 2. Background and conceptual framework

Chronic illness is the leading cause of disability and death in the United States, accounting for more than 70% of total healthcare spending each year—an estimated \$1.2 trillion (Agency for Healthcare Research and Quality). Reimbursement methodologies and traditional primary care practice models have focused on acute health problems with less emphasis on prevention, early intervention, and self-management support, making it difficult to meet the ongoing, complex care needs of older adults with chronic health conditions.

Care coordination within HCHs is a cornerstone of health care reform focused on developing a patient-centered care model. The National Quality Forum has defined care coordination as a “function that helps ensure that patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.” (National Quality Forum, 2012a) Care coordination involves obtaining the care patients need while controlling costs by minimizing unnecessary as well as duplicative services (Marek & Rantz, 2000). Care coordination services ranging from health promotion to individualized skilled nursing care help patients stay in the least restrictive environment (Marek & Rantz, 2000).

Nurse care coordination is an evolving registered nurse role included in HCH initiatives. Specially trained nurses working within primary care teams have effectively improved care for older adults by coordinating care across care settings and providers (Boyd et al., 2007). Numerous studies indicate that nurses are effective in providing care coordination and self-management support in primary

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care and other ambulatory care systems (Boult et al., 2008; Leff et al., 2009). Nurse care coordinators (NCCs) use a variety of strategies such as transition management, self-management support, and lifestyle management (Aliotta et al., 2008) to support older patients with numerous chronic conditions and functional and cognitive impairments to optimize health status and contain health care costs. Outcomes associated with NCC interventions have been reported in recent studies (Boyd et al., 2009; Marek, Adams, Stetzer, Popejoy, & Rantz, 2010; Marek et al., 2005). Older adults receiving care from NCCs demonstrated use of fewer hospital-related resources, lower health care expenses, and less strain experienced by family care givers, improved self-management behaviors, and decreased use of costly health services (Sylvia et al., 2008). Condition specific improvements such as decreased A1C in diabetic patients have also been demonstrated (Taylor et al., 2003).

Computer algorithms using administrative databases consisting primarily of medical diagnoses and prior use of health services are frequently used to identify high risk patients in primary care settings. Algorithms categorize patients into complexity tiers as a basis for focusing HCH interventions (Reid, Roos, MacWilliam, Frohlich, & Black, 2002). Higher tiers reflect more medical conditions and prior use of health services, indicating the likelihood that patients will incur higher costs in the future (Reid, MacWilliam, Verhulst, Roos, & Atkinson, 2001). However, models based on retrospective data found in traditional administrative databases have generally performed poorly, and experts are recognizing that socio-behavioral risk indicators may be more helpful (Kansagara et al., 2011). Traditional administrative databases do not include the characteristics often identified as determinants of poor self-management skills. Although it is recognized that not all patients with chronic health conditions require NCC services, the absence of a way to provide care coordination to those patients who are likely to need it creates a challenge in appropriately using scarce resources. In order to develop the NCC role and deliver NCC interventions appropriately, it is important not only to understand the characteristics of patients likely to benefit from care coordination but also to identify interventions likely to be effective within the context of NCC clinical practice.

Patient-centered care has been described as a multifaceted approach involving a therapeutic interaction that addresses patients' needs and concerns, and patient-centered care is a goal of healthcare systems (Mead & Bower, 2000). The dimensions of patient-centered communication, as proposed by Mead and Bower (2000) include exploration of illness and symptoms, including attempts to understand the illness experience; exploration of the whole person, or understanding the patient within the context of family, work, and culture; and a mutual definition of the issue, including decision-making roles and establishment of treatment goals. Patient-centered care is highly valued in nursing and can be further defined to refer to the content of an intervention that addresses patients' experiences or is responsive to patients' goals or preferences (Lauver et al., 2002).

This study involved identification of the multi-dimensional concerns of individuals with chronic conditions that need to be considered when designing patient-centered approaches such as care coordination. We anticipate that understanding patient characteristics that reflect NCCs' clinical experience will be foundational for informing future research in the development of predictive models leading to targeted interventions to improve health outcomes of individuals with chronic health conditions.

### 3. Methods

As part of a larger practice improvement project, a single focus group was conducted to gain NCC perspectives on their role and the patients perceived to most benefit from NCC. A simple summary of the key points identified by focus group participants was completed for use by a practice improvement team, but the data did not receive systematic analysis in light of a specific research question. This study used a qualitative descriptive design to analyze the de-identified

transcript of this focus group using content analysis (Graneheim & Lundman, 2004; Krippendorff, 2004).

Focus groups are useful for examining concepts in which interaction between group members may generate robust discussion and more examples than individual interviews (Krueger & Casey, 2009). Because of the diverse settings and practices of the study participants, the opportunity to compare and contrast experiences via focus group discussion yielded more robust data than individual interviews or surveys.

#### 3.1. Sample and setting

The participants were 13 nurse care coordinators (NCCs) from clinical sites across the US affiliated with an academic medical center. Inclusion criteria were nurses practicing in a care coordinator role (such as care manager, health coach, or care coordinator) for at least 6 months. Participants were purposefully selected based on identification as an experienced NCC by nurse leaders. Email invitations to participate in the focus group were extended to potential participants; all invited participants accepted the invitation.

#### 3.2. Procedures

The study was reviewed by the IRB and was determined to be exempt from Human Subjects review because the study involved an analysis of existing, de-identified data. The transcripts of the audio recording analyzed for this study did not include any identifying participant information. The focus group was facilitated by one of the investigators (LR) who is experienced in conducting focus groups for research. The facilitator was not involved with the practice improvement project and did not work with the NCCs. A semi-structured interview guide was used to conduct the focus group. Examples of questions that guided the focus group are included in Table 1. No other data were collected. The focus group lasted 90 minutes, was conducted via videoconference, and was audio-recorded and transcribed verbatim. Only the transcript of the audiotape was analyzed for this study. Because these were preexisting data, a determination of data saturation (no new ideas or themes emerged), per se, was not made. Rather, because of the robust interaction and discussion among participants with little prompting from the facilitator and no unexplained or incomplete ideas/themes, the data were deemed credible.

#### 3.3. Data analysis

Qualitative content analysis (Graneheim & Lundman, 2004) was used to analyze the data. Using Nvivo 9 software (QSR International) to aid in sorting and coding the data, the transcript was verified for accuracy and read in its entirety to begin identifying common themes

**Table 1**  
Examples of questions guiding the focus group.

- In your experience, what are the characteristics of patients who most benefited from NCC care?
- How do the published protocols or algorithms for selecting patients for NCC hold up in your practice (do they accurately predict the "right" patients for NCC)?
- What are the NCC interventions that you find most effective in caring for patients?
- Please describe the types of interventions you find yourself using most often or that are the most effective for the common needs of your patient population.
- What are the most common patient/caregiver unmet needs that can be effectively addressed by NCCs?

Note: NCC = "nurse care coordinator."

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