Translating the Evidence to Improve Older Adults' Experience in a Care Coordination Program

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With a focus on health care value, nurse leaders can design and evaluate programs for care coordination using dimensions related to costs, health outcomes, and patients' experience of care. This article identifies evidence related to care coordinators' actions and attitudes, and what older adults do on their own to manage their experience in care coordination. By translating the findings, the author describes strategies that nurse leaders can implement to improve the experience of older adults in a care coordination program.

To meet the burgeoning demands of the population of older adults with multimorbidity, organizations have developed new models of care delivery including Program of All-inclusive Care of the Elderly (PACE), Medicare Advantage plans, Chronic Care Management (CCM), and other care delivery models that aim to pay for value associated with managing care across the continuum rather than traditional payment for isolated services provided by only 1 entity. In these models of care, value is generally consistent with the Triple Aim: a balance of low costs, healthy outcomes, and a positive experience by older adults. Care management or care coordination is a component. By coordinating the care across the continuum, organizations have developed care coordination programs (CCPs) to decrease unnecessary emergency department visits, hospital admissions or readmissions, and other costly health care services and potential for adverse clinical outcomes.[1]

KEY POINTS

- **A dedicated care coordination program (CCP) for older adults with multimorbidity can improve value for the provider organization and improve the older adults' patient experience.**
- **Older adults' experience is related to caregiver attitudes and actions that encourage self-management and are personalized to meet older adults' unique needs.**
- **CCPs that partner with older adults' primary care provider will also improve their experience.**

CCPS are holistic, meaning that they address the physical, mental, and psychosocial needs of older adults with multimorbidity and aim to create value by integrating care and services from multiple providers over a period of 6 months to several years. The overarching goals of CCPs is typically associated with reducing costs of care for older adults with multimorbidity. Older adults with chronic health conditions, such as hypertension, other diseases of the heart, respiratory disease, arthritis, and diabetes, account for 84% of all health care spending in the United States and are the most expensive and largest group of health care service users.[2] CCPs with a track record of reducing costs provide the following: face-to-face patient contact (about once a month), physician cooperation, patient education, a "communications hub" usually through a shared electronic record, formalized transition management for patients discharged from the hospital, and assistance with self-management of medications.[3] Although the focus of CCPs is typically reducing costs, nurse leaders intuitively know that there is more to the value equation than costs, and that attention to older adults' experience is essential. Yet little is known about older adults' experience with care coordination programs. The purpose of this article is to translate the findings from a mixed methods study of the experience of older adults in a CCP organized by a primary care corporation, so that nurse leaders can design and develop CCPs that improve older adults' experience with their chronic illness care. The recommendations in this article provide nurse leaders with patient-centered strategies for care that meet the intent of value-based reimbursement

and the integration of nursing services across the continuum.

DISCOVERY RESEARCH ON OLDER ADULTS' EXPERIENCE IN A CCP

To learn more about the experience of older adults in a CCP, a mixed methods study was conducted.[4,5] For detailed research methods, see Scholz Mellum and colleagues.[4,5] Results identified that older adults' experience in a CCP was directly related to the professional actions and attitudes of the CCP team members. The evidence from the study identified that older adults want care coordination actions that include communication with the older adult, coordination of their care, recommendations for their care, and providing actions that address patient's unique fundamental problems. They also wanted care coordination that is delivered by providers with positive and encouraging attitudes. From these results, researchers inferred that tools to measure the experience of older adults in a CCP should include measurement of these factors associated with the actions and the attitudes of the care coordination team members. Furthermore, although they knew the limits of their multimorbidity, the older adults in this study aimed to expand their existing limits with grit, determination and a positive mental attitude. The evidence from these studies provide lessons for nurse leaders in designing a CCP that improves older adults' experience.

TRANSLATION OF THE EVIDENCE

The evidence from this study provides recommendations for the design and evaluation of CCPs for improving older adults' experience with care coordination. These recommendations provide generalized considerations for CCPs, yet the evidence indicates that care coordination approaches tailored to the individual will lead to the best patient experience outcomes.

Clarify Care Coordinator Role

Examples identified by participants of nurse-delivered care coordination actions included helping manage daily insulin injections based on blood sugar readings, and advising older adults on appropriate assistive devices such as wheelchairs. Actions that improved experience included both medical actions, such as prescribing appropriate medications, as well as nonmedical functions that may be best delivered by a registered nurse. Older adults did not seem to differentiate actions of care coordinators by roles or licensure.

Ambiguity of the roles of various professionals participating in care coordination may lead to potential disintegration of the CCP.[6] Some of the older adults participating in this study were not able to identify their care coordinator. One participant identified that his care coordinator was really his primary care physician and felt that the care coordinator was not authentic and just followed a script, and that her recommendations were meaningless. Other research identified that ambiguity of the care coordinator role led to inefficiencies in a CCP and ineffectiveness of care coordination processes.[7] Participants in this study who were able to identify their care coordinator and explain the relationship they had with the care coordinator seemed to have had a better experience.

Hire Care Coordinator for Attitude

Actions and attitudes of care coordinators were both identified as having an impact on older adults' experience, yet attitudes associated with CCP team members may not be easily identified as the priority for hiring for care coordination positions. The actions that patients said made up their experience included communication, coordination of services, and addressing patient's fundamental problems. These actions are traditional clinical competencies of registered nurses and important to older adults' experience.

This study identified that although actions are important to older adults' overall experience in a CCP, attitudes are equally, if not even more, important. Older adults identified that care coordinator's attitudes that made a difference in their experience included compassion, professionalism, mutual respect, and being positive. Nurse leaders may have existing strategies to train someone to provide appropriate care coordination actions. Yet, it may be more difficult to train someone to deliver care with appropriate attitudes for working with a multimorbid older adult population. Therefore, assessment of the care coordinators' attitudes is essential when making hiring decisions.

Teach Patients How to Self-Manage Their Medications

This study identified that taking their medications was often the older adult's primary strategy for managing their multimorbidity. Participants in this study typically had complex medication regimens associated with their multimorbidity and took several medications at various times throughout the day. Several patients even identified the routine they used to make sure they were accurate in their medication regimen. Intuitively, members of the care coordination team know how important medication adherence is to the plan of care for the multimorbid older adult. Identification of strategies to help older adults successfully manage their medication regimen may improve adherence and provide a sense of mastery for the older adult in self-managing their chronic conditions.

Provide Guidance to the Family Unit

The older adults in this study identified the importance of care coordination that included the older adult's family members, especially those who lived with the older adult. Supporting the family unit was especially poignant for several of the older adults in this study. For instance, one woman had serious mobility difficulties, and her husband had cognitive decline. The couple seemed to be able to balance each other's deficiencies and work together to stay in their own home. Yet if something happened to either spouse, it seemed that the care coordination program would need to manage the changed family unit, even if the change was not caused by the older adult in the CCP.

Another woman negotiated with her physician's office to decrease her regular visits from every 3 months to every 4 months, which meant 1 less visit a year and 1 less ride from her daughter. Others mentioned how their children cooked them meals, did their grocery shopping, and gave them their meds. Still others mentioned how much phone calls with their children meant to them. The evidence provided by the participants in these studies suggest that changes in the level of support provided by family members would alter the older adult's need for care coordination, which may also affect their experience with their CCP.

Help the Older Adult be in Control of Their Health and Living Arrangements

Several older adults described how they were in control of their health, and several identified how they exerted control over their health care services. They identified that they lived within the limits associated with their chronic conditions. In fact, one man who lived alone said he was his own care coordinator. Another identified the plan he developed for recovery from hip surgery to avoid a nursing home stay. Most of the participants described how they were not passive receivers of health care services, rather they were active participants in efforts to maintain physical and mental strength. Several identified how they kept abreast of the latest information about health by reading magazines and books, and a few seemed particularly interested in information about diet and what to eat to manage a particular symptom or achieve improved health.

The evidence points to the need for care coordinators to listen to the older adult and treat them like a partner in the co-creation of plans of care. This will help the older adult with their self-management while providing new ideas to sustain or improve their physical and mental health. Furthermore, the evidence suggests that older adults want to maintain control of their health and the choice of their living arrangements. Threaded throughout the themes were desires to manage their own living arrangements and stay out of a nursing home or rehabilitation facility. One woman identified that her long-term goal was to stay in her own home and mentioned that the CCP was helping her achieve that goal. When care coordinators help older adults stay in control, actively engage in life, and manage their own living arrangements, they will have a better experience.

Incorporate Networking Opportunities for Older Adults

Older adults in these studies identified that they talked to others with similar conditions to learn what worked for them, attended support groups to learn about their own conditions, and rationalized how their situation was better or worse than their peers. The evidence suggests combining older adults' primary care provider visits with group meetings for older adults to meet and discuss issues of mutual concern. Mutual issues of concern may include how older adults manage their limited energy or how they coped with certain situations. Knowledge that older adults compare their situation with that of their peers suggests potential benefits of developing networking opportunities for older adults as part of a CCP. Previous studies identified that combining primary care visits with group meetings or a lecture on a health topic improved older adults' experience of their primary care appointment.[5] Some hospital systems offer "coumadin clinics" for the routine checks of blood coagulation. What might be possible if nursing leaders offer an educational or networking session at the same time as these regular visits?

Easy and Frequent Accessibility of Care Coordination Services

Evidence from these studies showed how much patients wanted and needed support and attention from their providers. They appreciated face-to-face visits and phone calls. Some of the older adults mentioned they valued the personalized phone calls from care coordinators, and one woman noted that she appreciated the daily phone calls she received after a new diagnosis of diabetes. Older adults appreciated the personalized care they received from an expert by phone during regular office hours, and the availability of primary care services after normal office hours and on the weekends. Older adults also appreciated being called by name at appointments and identified that they appreciated the planning of future services and help with getting needed equipment such as wheelchairs.

However, for patients without extensive health care needs, this advanced level of personalized service may not warrant the expense associated with a dedicated CCP. In fact, one participant indicated he did not think care coordination services were necessary for his conditions and felt that care coordination was meaningless. Costs of the CCP, especially associated with the care coordinator's time, can be extensive therefore the focus

of the CCP should be on older adults who will benefit most from coordinated care.

Partner With Primary Care

Based on the evidence, nurse leaders should engage not only older adults and their families in care coordination activities, but also primary care providers, especially physicians. Perhaps this is the most important recommendation for nurse leaders in developing a CCP for their organization. In this study, participants had a deep and long-lasting relationship with their primary care providers and assumed and expected that any care coordination activities centered on their primary care physician. Most of the older adults in this study listened to their primary care physician, trusted them, and relied on their advice, even more than on the advice from their care coordinator or specialist physician. Therefore, the relationship older adults have with their primary care physician should be encouraged and supported to achieve patients' positive experience.

Although this relationship is so important, primary care physicians are beginning to realize they need help with managing the older adult population. Physicians are challenged with managing chronic illness care and simply do not have the time to manage the psychosocial and non-medical needs of their patients with chronic illness. It is fortunate that Medicare reimbursement for care coordination provides new options for primary care providers including payment for advanced practice nurses and payment for chronic care management services between primary care office visits. Examples of these chronic care management services include helping older adults with self-management of medications, personalized guidance for health goals, coordinating visits with other providers, and access to care providers 24 hours a day.[8]

Partnerships with primary care will decrease confusion among the physician community about the intents of a CCP and clarify concerns about costs and payment for care coordination. When older adults see and understand the partnership model between primary care and other providers, they will probably have a higher level of trust with the CCP. The partnership between primary care, hospitals and nursing will most likely increase older adults' acceptance and engagement in the CCP and thus increase their adherence to the care coordinator's recommendations.

Design a Way to Evaluate Older Adults' Experience With Care Coordination

As pay-for-performance strategies for Medicare providers continue, a way to measure patients' experience is needed to ensure that programs are meeting patients' needs from their perspective. There are a variety of tools available to measure patient experience with primary care. Yet few, if any, of these existing tools measure the attitudes of team members and the interrelationships associated with a dedicated care coordination program. This study suggests that an instrument to assess patient experience in a CCP should include items about: communication with patient, coordination of all activities related to the well-being of the older adult, how the older adult's unique problems were addressed, and the attitudes of their care coordinator and other team members. Participants in this study wrote in answers to questions even though not specifically requested. Therefore, open-ended questions added to a survey may provide additional rich data for the CCP's improvement. However, in some cases, a face-to-face conversation may provide even more meaningful feedback to understand the CCP from the older adult's perspective.

SUMMARY

The translation of the evidence associated with this study on older adults' experience of CCP provide strategies for nurse leaders when designing or evaluating a CCP. By focusing on older adults' experience rather than focusing on reduction of costs, nurse leaders have improved ways to meet and exceed all aspects of the Triple Aim. Key findings from the study of older adults' experience with a care coordination program highlight the needs of providing services that incorporate appropriate actions and attitudes of care coordinators, as well as providing care that encourages self-management through older adults use of grit and living within the limits associated with their chronic illnesses. Although nurse leaders must consider the actions and what goes on with the delivery of the care coordination processes, results of this study infer that the attitudes of the care coordinators are equally if not more important to the older adults' experience of care coordination. Furthermore, the evidence identified that older adults with multimorbidity are challenged to live within their limits yet will live with grit. Understanding what older adults do to self-manage their experience creates opportunities for partnering with patients to maximize the individual's personal resources along with the services offered through the CCP.

Although this study identified common themes in older adults' experience and self-management, knowing more about the personalized needs of the individual will likely improve not only their experience with a care coordination program but will probably improve other outcomes. Older adults relied on their own grit and self-managed the limits associated with their chronic conditions, so it behooves care coordinators to recognize an older adult's ways of operating and build on their strengths to improve outcomes. Translation of the evidence showed that older adults' experience was improved with caring processes that gave attention to their wholeness and alignment of their mind, body and spirit. Older adults in this study did not simply rely on the

medical plan of care, their experience was also related to care associated with their functional, cognitive, and psychosocial resources, and how their care was individualized to meet their specific situation. They valued the care coordinators' intentional caring consciousness, consistent with recommendations in Watson's Philosophy and Science of Caring.[9] Findings from this study remind nursing leaders of the importance of shifting focus to caring for the individual and the essential nature of human caring and holistic values. By implementing care coordination programs that foster holistic care and self-management of chronic conditions, nurse leaders have the power to move beyond the status quo and implement a CCP that improves older adults' experience. Using the evidence from this study and shifting the focus to the individual rather than the providers of older adult care gives nurse leaders new opportunities to develop chronic care management programs that meet all 3 of the goals associated the Triple Aim: reduced costs, improved population health, and improved patient experience.

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