Improving Patient Engagement in a Medically Underserved Population: The Role of the Interprofessional Collaborative Practice Team

Shannon DeLuca, MSN, CRNP[1]; Dana Mitchell DNP, CRNP[1]; Erin Clarkson, MSW, MPH[1]; Erica Arnold, MSN, CNL[1]; Sarah Coiner, BSN, RN[1]; Ashlea Herrero, LSSGB[2]; Ildiko Nyikos, MA[1]; Vera Bittner, MD[2]; Heidi Burkart, MEM[3]; Lisle Hites, PhD[3]; Connie White-Williams, PhD[2]; Maria Shirey, PhD[1]

University of Alabama at Birmingham School of Nursing[1], University of Alabama at Birmingham Hospital[2], University of Alabama at Birmingham School of Public Health[3]

Nurse-Led Heart Failure Clinic

The Heart Failure Clinic utilizes an Interprofessional Collaborative Practice (IPCP) model to focus on 1) improving transitional care coordination; 2) increasing access to care, and 3) improving quality and safety in medically underserved heart failure patients.

Patients demographics:

- Mean age 46 yrs, Single 41.7%
- < HS education 82.1%
- Reside in temporary housing 32.1%
- Income < $10,000/year 82.1%

Team: Nurse Practitioner, Clinical Nurse Leader, Social Worker, Patient Care Technician, Physician

Fails, Recoveries, and Cautionary Tales

- Fails: No-Show Rate, Disengaged patients, Non-adherence to Treatment Regimen
- Recoveries: Vigilant surveillance by clinic and telephone contact to encourage self care management and clinic attendance
- Cautionary Tales: Health literacy importance (ability to refill prescriptions, read medication labels, use of pill organizer)

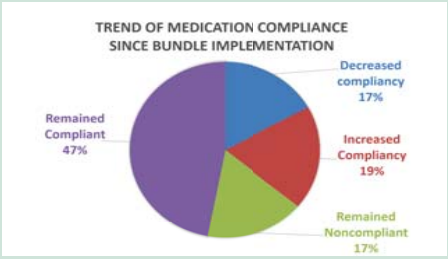
Successful Practices

- Patient care kits: providing necessary tools to support home self monitoring and medication compliance
- Social worker time built into clinic appointments to investigate public and private resources for medication and care access
- Daily Team huddles to improve care transitions
- Student experiences (CNL, NP, Social Work, Public Health)

Medication Reconciliation Initiative

Patients receive:

- Detailed medication reconciliation
- Hands-on education regarding use of a pill organizer at each clinic appointment
- Follow up telephone calls reviewing medication adherence and facilitating medication access



Innovative Teaching and Learning

- Online educational videos scrolling on clinic computers in patient waiting area.
- Support Group for patient education on topics such as diet, exercise, access to care. A heart healthy lunch is provided by the generosity of various donors.
- Student created projects: medication compliance bundle; patient education poster to introduce patients to heart failure guideline therapy
- Community support liaison role to facilitate home visits
- Access to care addressed with an on-call phone for after hours patient calls
- Patient Engagement videos on heart failure available for all patients via internet/phone

Unintended Consequences

- The many social determinants in this underserved population
- Overdependence on clinic resources for self-care
- Unannounced clinic visits for social needs
- Inappropriate referrals
- Patient reluctance to transition to other providers once insurance is established
- Rapid clinic growth resulting in space and resource deficits
- Low usage of patient engagement videos due to internet access

Research Opportunities

- Examine patient engagement using a formal measurement tool such as the Patient Activation Measure (PAM) tool
- Examine if an incentive program will facilitate patient engagement and improve self management
- Explore and compare patient engagement and quality outcomes of this nurse-led heart failure clinic with other clinics
- Determine optimal period for follow-up to sustain patient engagement

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