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Meeting the Triple Aim of Population Health Vs Actual DSH Patient Experience

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Abstract

Structured Abstract Statement of the Problem/Significance. Many current proposals to investigate the quality and value of healthcare delivered to highly vulnerable populations focused on health equity with substantive reasoning. Clinically vulnerable and socially disadvantaged clients were given healthcare insurance access through the expansion of Medicaid via the healthcare reform. The provision of healthcare insurance to highly vulnerable Medicaid beneficiaries without sufficient navigation of managed care system or fully meeting the beneficiaries' social determinants of health (SDH), obstructs the "Triple Aim" of population health. Failure begets failure. The focus of health improvement requires a shift from the physical determinants of health (PDH) model to a social and physical determinants of health model. The PDH model implies clients are the sole cause of their health status and bear the total responsibility for their fate. Without addressing the social structures that influence health choices and health outcomes of highly vulnerable populations a negative goal cycle will prevail. Study Design. A focused ethnographic study was conducted to explore, identify, and understand the transitional experience of a cultural group of 20 post-ACA Medicaid beneficiaries (adults with persistent asthma) who rely upon a faith-based DSH (Mercy Fitzgerald Hospital in Delaware County, Pennsylvania) for healthcare. Within the theoretical framework of Meleis' Transitions theory, the challenges and obstacles of transition from the state of being uninsured to the complexities of Medicaid managed care were explored as well as the behaviors and attitudes adopted to overcome these challenges. Thematic analysis of ethnographic findings presented the voice of the Pennsylvania Medicaid beneficiaries and the future direction of nursing practice, nursing education, nursing research, and health policy. Constant comparison in data sources centered on the PAMB role changes as it affected their health beliefs, health practices, and personal health responsibility. Sampling Method.

Twenty study participants were purposively selected from the medical surgical floor of Mercy Fitzgerald Hospital (MFH) census to participate in the focused interviews. Fifteen of the twenty PAMB interview participants also participated in a structured interviewing method, free listing, to identify the PAMB's extent of certain cultural, cognitive domains that required further investigation. Participant recruitment followed institutional review board approvals from the Catholic University of America and the Mercy Health System. Participant identification as a PAMB occurred through self-identification to the primary investigator following the notification of the research study from an advertisement flyer, referral by MFH/SML Wellness Center HCP administration, or through PAMB word of mouth. Moderators and Mediators Study variables underscored the role of the participants as the moderators and mediators of their healthcare transition. Professional power and PAMB Powerlessness. Based on the HCP respect toward PAMB, and the communication between the two, found in the PAMB data suggests that HCP power was disproportionate to participant involvement in shared

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clinical decision making and clinical discourse in general. Participants experienced powerlessness during hospitalizations due to illness, socioeconomic factors, and misalignment of HCP team goals.

At the time of discharge, participants felt confusion about treatment plan, medications to discard or retain, and an inability to meet the HCP goals for participant health outcomes. Lack of implementation of health behaviors due to participants' competency issues caused loss of self-efficacy related to failure to perform recommended behaviors. Some participants (P 15, P10) felt abandoned by HCP after they returned home from hospitalization. Participants described a sense of disconnection with HCP stemming from the inability of HCP to relate to participants' socioeconomic challenges. This disconnection led to PAMB-reports of unrealistic discharge goals. Failure to meet HCP treatment goals undermined the participants' self-confidence and prompted disengagement from future adoption of positive health behaviors. Negative Goal Cycle. HCP and participant goals at discharge were often misaligned because of unclear or incomplete clinical discussion. The disconnect was based between HCP directions and what the participant knew he/she could realistically accomplish at home. An incomplete HCP understanding of PAMB ability to achieve the goals of the action plans was formed from the insufficient clinical discussion with PAMB. If PAMB did not express any difficulty in completing the clinical objectives of asthma/COPD therapy or describe socioeconomic status obstacles to prescribed medications, HCP presumably were unaware of them. The negative goal cycle encouraged low participant goal achievement, compliance with treatment plans, low self-confidence, and poor performance on Health care Effectiveness Data and Information Set (HEDIS) clinical indicators. Participants will not likely meet goals that are unknown or unachievable for them. Stigma. PAMB's experience of internalized and externalized stigma related to Medicaid insurance negatively mediated their self-care integration and self-advocacy efforts. Some participants refrained from clinical decision-making and did not question the HCP-developed action plan. PAMB's experience of stigmatization reflected a sense of shame and inequality, and correlated to their reliance on a historically stigma-associated public health insurance program.

The inability to procure private health insurance for oneself adversely affected PAMB sense of autonomy creating variance in the power distribution between HCP/case managers and PAMB. Most participants were in poor health at the time of data collection, which may have further added to their sense of stigma. PAMB with multiple chronic diseases often interpreted a HCP's abrupt manner of speaking, or resistance to listen fully to their description of current illness, as negative. Nevertheless, only one PAMB self-identified illness as a source of stigma. Public insurance is associated with stigma-related experiences and assumed yet plays an important role in healthcare for low-income adults Allen (2014). Regardless of the source, these negative stances were perceptible to the PAMB while receiving care at both MFH and in the community. Evidence from the PAMB interviews and CCD free-listing suggested that externalized stigma was experienced more commonly than internalized stigma. This signals a need for behavioral changes in HCP and case managers' approaches to PAMB in order to reduce stigmatization. PAMB stigma experiences influenced their decision-making ability, confidence levels, and health-seeking behaviors. Allen (2014) recommend a rebranding of Medicaid insurance to combat stigmatization and increase utilization of the proper levels of healthcare. The recent expansion of Medicaid initiated a normalization of Medicaid insurance to some extent through the allowance of beneficiary employment. The means to care for one's health and contribute to society through taxation mitigated the effects of previous undesirable images of Medicaid beneficiaries to some extent. By increasing eligibility to individuals with low-paid employment, new Medicaid enrollees have contributed to their own health plan via payroll deduction (taxes). A healthier individual increases the chances of a healthier society.

Keywords: Physical determinants of health; Health care; Asthma

Abbreviations: PDH: Physical Determinants of Health; SDH: Social Determinants of Health; MFH: Mercy Fitzgerald Hospital; HCP: Health Care Practitioner; COPD: Chronic Obstructive Pulmonary Disease; HEDIS: Health Care Effectiveness Data and Information Set; CCD: Confraternity of Christian Doctrine; PAMB: Protected Area Management Board; IHI: Institute for Health Care Improvement; MMC: Medicaid Managed Care; ACA: American Cichlid Association; PPACA: Patient Protection and Affordable Care Act

Introduction

The "Triple Aim" of population health was first described as simultaneously improving population health, improving the patient experience of care, and reducing per capita cost by the Institute for Healthcare

Improvement (IHI) Nolan (2012). The Triple Aim has since become the organizing framework for the US National Quality Strategy, for strategies of public and private health organizations around the world influencing the construct of Health Equity within the Affordable Care Act (2010) Nolan [1] (2012). The low-income, chronically ill population of Delaware County, Pennsylvania has received all they expected from the expansion of Medicaid…to be able to get healthcare services and to have them paid for. "The most valued aspect of quality care was simply having it available to them.""Now when I go to the doctor, all I have to do is hand them my card." This research study presents the story or voice of the PAMB of Delaware County, PA's healthcare transition experience to Medicaid Managed Care (MMC) within a disproportionate share hospital (DSH). From this entry into Pennsylvania Medicaid beneficiary culture the healthcare community gains insights to the challenges and obstacles newly enrolled Medicaid beneficiaries faced within clinical settings and when discharged to home in the community. When one looks into the eyes of the poor and they freely offer their trust, one is compelled to tell their story their experience. Raising their voice is –Mercy. Addressing health policy and social structures to meet health needs is Justice, leading toward health equity.

Statement of the Problem

The ACA provided for the largest reform of Medicaid since its 1965 Centers for Medicare and Medicaid implementation, providing funding for both low-income and disabled citizens. The additional amount of Medicaid beneficiaries increased the complexity and effectiveness of an already struggling, massive and bureaucratic government program. From a beneficiary perspective (emic perspective), Medicaid as a federal agency, is far from "user-friendly". This problematic complexity remains despite ACA-induced Medicaid reform. Thus, despite new eligibility for Medicaid services, a client may still face unresolved health concerns due to system-based or client-based obstacles to effective Medicaid utilization. Without key information from Medicaid beneficiaries, the U.S. may continue to face financial challenges, fragmented care, and increasingly poor outcomes among "at-risk" populations. In essence, a significant disconnect exists between eligibility and access to Medicaid, effective utilization of Medicaid-funded healthcare, and positive health outcomes.

Research Questions

The overarching question of this ethnographic research study is "What is the Medicaid transition experience of adults with asthma/COPD who receive healthcare from a faith-based DSH?" Additional research questions included:

a. What obstacles/challenges do study participants experience in their transition to Medicaid-funded healthcare?

b. What behaviors and attitudes do the study participants adopt in an attempt to overcome these obstacles/challenges?

c. Were they successful in doing so?

d. How do cultural values and health beliefs influence the Medicaid transition and asthma/COPD self-care practices?

e. How do the study participants describe the healthcare provider–client relationship(s) in a faith-based DSH setting?

f. How is Medicaid transition experienced by study participants who have experienced significant life challenges?

A Description of the Research Methodology

A multi-method, focused ethnographic study design was selected to gain deep insight into the transition experience of 20 Pennsylvania Medicaid beneficiaries (PAMB) to Medicaid services. The inductive design of ethnography acutely elicited PAMB challenges and obstacles to positive healthy transition, and the measures taken to overcome them. Three main instruments of data collection (semi-structured interviews, sociodemographic data sheets, and a cultural cognitive domain analysis activity) ensured full capture of relevant transitional data. A pilot test assured cohesion/coherence between the interview guide questions and the study research questions. Thematic analysis of ethnographic findings presented the voice of the PAMB and the future direction of nursing practice, nursing education, nursing research, and health policy. Constant comparison in data sources centered on the PAMB role changes as it affected their health beliefs, health practices, and personal health responsibility. PAMB's meaning of transition was identified in the data by emerging patterns, explanations, causal flows, themes, and propositions. Triangulation of data sources assisted in learning how members of the culture of transitioning PAMB assign meaning to health beliefs and behaviors. Coding analysis occurred in two cycles-exploratory coding then domain and taxonomic coding. Common participant experiences were categorized and coded for convergence and divergence uniquely and collectively. Following reflection of participants' interviews, documentation of conclusions were written in summary notes for each interview.

An Explanation of the Results of the Research

Although the 2010 ACA-induced Medicaid reform increases the opportunity for Medicaid eligibility, it does not necessarily ensure access to quality healthcare for Medicaid beneficiaries [2,3]. A significant disconnect remains following Pennsylvania Medicaid expansion between eligibility and access to Medicaid, effective utilization of Medicaid-funded healthcare, and positive health outcomes. The resolution of this disconnect in DSH may be resolved through establishing and maintaining a connection with PAMB once they are discharged to home in the community. PAMB's experience of internalized and externalized stigma related to Medicaid insurance negatively mediated their self-care integration and self-advocacy efforts. Some participants refrained from clinical decision-making and did not question the HCP-developed action plan. PAMB's experience of stigmatization reflected a sense of shame and inequality, and correlated to their reliance on a historically stigma-associated public health insurance program. The inability to procure private health insurance for oneself adversely affected PAMB' sense of autonomy creating variance in the power distribution between HCP/case managers and PAMB. The social determinants of health (SDH) are likely to impact PAMB' health outcomes greater than PAMB' non-adherence to treatment plans, clinical appointments, or utilization of the appropriate level of healthcare. Society will benefit from aggressive strategies to improve and safeguard the health of highly vulnerable individuals (e.g. infection control, herd immunity).

A place-based and physical determinant model of population health can more effectively guide appropriate nursing interventions to mitigate the effects of imbalanced social structures. Given the often-overwhelming prevalence of socioeconomic needs facing Medicaid populations (e.g. including housing, transportation, and adequate nutrition), aligning social services with healthcare is critical. The place-based approach builds off of extensive public health research that shows changing health behaviors is most effective when paired with changes to the broader environment that enable those behaviors. In practice, this often involves removing barriers to services and increasing access to successful interventions. For example, when a health system invests in community health initiatives for a low-income neighborhood or a state aligns enrollment systems for health coverage and food assistance, barriers that prevented people from making healthy eating choices are lessened or removed. Pennsylvania legislature recognized the connection between the SDH, healthcare utilization, and outcomes, but has yet to adopt a SDH/physical determinant of health model of health policy. Findings indicate that the transition of PAMB participants at MFH and SML Wellness Center is in the early phase of forming. Participants easily enrolled (with the help of a third party) in MMC but have received minimal assistance in navigating the new system of healthcare. With the financial goal met, PAMB were highly satisfied upon initial assessment. These barriers lie in inequitable social conditions and deficient determinants of health.

Difficulty entering clinical conversations

Obstacles and challenges to Medicaid transition are known and unknown to participants. Participants expressed a desire to collaborate with physicians in clinical decision-making (CDM) and were gaining confidence in the recognition of the signs and symptoms of persistent asthma/COPD. However, some participants (4/20) remain reluctant to engage in CDM with physicians about choices for better health because past negative experiences inhibited their confidence growth. Nearly 93% of the participants (14/15) received negative changes to their treatment plan (generic medication) due to Medicaid financial constraints. This included a generic drug replacing a previous medication that provided better relief from respiratory symptoms. Effected participants expressed a distrust and concern for the change of medications and the uncertainty of future emergent respiratory needs.

Risk of public trust

Public trust is critical to optimize the health and wellbeing of individuals, communities, and societies Ward [4] (2017). Public trust is earned by anticipating future health needs, minimizing health crises, and enhancing health outcomes for all. The concept of power within interpersonal relationships, such as client and HCP, extends the definition of trusting others to include acceptance of risks associated with interdependence (PAMB) (Collins, 2012). The changing power bases of DSH's HCP and Pennsylvania Medicaid program has the potential to erode PAMB trust in sustainable Medicaid benefits and the provision of quality healthcare. HCP and health policy makers had high expectations for transitioning PAMB. Without education or modeling, PAMB were expected to break connections to former health-seeking patterns/behaviors. Following the disconnection with former health routines, PAMB were expected to build trusting, durable relationships with multiple HCPs. In the study sample, PAMB met with their PCP every 9 months and were given appointments with resident physicians for subsequent appointments. The process of relationship-building presented as an obstacle for most of the study participants (19/20) and because of the frequency of PCP visits and the amount of quote filling in that PAMB needed to provide to PCP from quarterly visits with residents and specialist physicians. Participant 17 stated, I like to get the feel for the doctor before taking medical advice or going along with the plan.

Unresolved power differential

Deference of participants toward physician affluence, position, and education compelled them to conform to the physician treatment plan from fear of being labeled difficult Frosch [5]. The doctor has a medical degree, so I pretty much have to listen to what he says. Physicians, it appears from the findings, are not aware of ways to create a safe environment for open communication that facilitates shared decision-making (SDM) Frost (2012). Few participants (2/20) reported that they were not respected, understood, or heard because their physicians did not provide an opportunity to engage in CDM. Meleis [6] transitions theory (2010) and Cline's [7] concept of vulnerability in transition (2016) support the participants' experience of powerlessness in attempts to overcome dominance in clinical discourse for the following reasons: PAMB must disconnect from former venues of seeking healthcare, develop durable, trusting relationships with multiple HCP, and engage in self-care agency and self-advocacy while adapting to the adverse effects of chronic disease progression.

Participants reported decreased ability to articulate physical symptoms or environmental influences on persistent asthma/COPD at HCP visits. With actual or perceived inability to comply with asthma/COPD action plan, PAMB experience a sense of failure and shame. Participants were reluctant to speak up, which led to unidentified health concerns needing attention. Participants exhibited decreased ability to change healthcare beliefs related to skepticism of treatment plan or mistrust of HCP. HCP have not fully assessed the rationales of why participants did not adhere to treatment plan. HCP did not have a comprehensive knowledge of all aspects that PAMB face when making clinical decisions-personal and socioeconomic variables. Participants expressed increased fear or anxiety related to the changing landscape of healthcare with the present congress' deliberation on repealing and replacing the PPACA.

Social determinants of health not fully considered

PAMB identified that HCP do not assess the environmental, societal, or economic factors that impact participants' respiratory health (20/20 negative response). Without social knowledge of PAMB living environments, HCP expectations of PAMB may be groundless. HCP expect usual therapeutic responses to treatment from clients under normal community environment conditions, and negative health outcomes may occur from un assessed individual harmful environmental factors of the participants. In this instance, the inability to follow HCP action plans was perceived as non-adherent by HCP. Time and Energy of Learning about Asthma/COPD. PAMB referred to preparation/research for health appointments as work. The work outside the clinical encounter is insurmountable for most participants. About 27% of participants (4/15) researched medical conditions/issues or treatment options and deliberated over desired choices (Millenials). For some of the participants, work is not spoken of since they do not want to put the HCP on the defensive by asking questions during the visit. Some participants (3/20) felt compelled to continue research before and after each appointment since it validated the HCP's decisions.

Insufficient time for HCP appointments

Participants experienced short amounts of time with HCP as many other clients are waiting their turns. Participants feel that the PCP does not always receive all the information they need from them, and depend on specialists to make informed suggestions to PCP. Participants expressed guilt at taking the time from other clients if they had more questions to ask. During the visit, participants had limited time and difficulty formulating exact questions to address their health concerns or seek guidance in the clinical discussion. Some participants stated that the only way to get a referral appointment is to "do your homework."Most participants wanted to learn everything they could about persistent asthma/COPD to be able to have intelligent discussions about their condition. Some participants (2/20) found that doing outside research made a positive difference not only for decision-making but also for improved clinical outcomes. Other participants found that they could not rely on their HCP to help them understand treatment options.

Summary of Conclusions

Medicaid has become a major point of contention in the US political arena, due to the intensive efforts by Republican leaders to repeal and replace the Affordable Care Act Shankar [8]. The findings of this dissertation study do not support Grogan and Park's conclusions that stigma related to Medicaid has been eliminated through PPACA-induced expansion of Medicaid eligibility. Many instances of residual internalized and externalized stigma are noted in Chapter 4. Given an opportunity to reflect on healthcare transition, the PAMB of Mercy Health System MFH provided an inner view of multiple factors which impact their health. PAMB realized that they could be different in regard to their health conditions and acquisition of health equity. Transition does not close once PAMB enroll and navigate Medicaid managed care (MMC). The full Medicaid transition is not within PAMB 100% control, and necessitates both supplemental intervention and advocacy from HCP.

Implications for Nursing Practice

Communication tool

A need for a communication assistance tool or Tunes App to increase PAMB confidence in entering the clinical discussion with HCP, more effectively engage in clinical decision-making and gain a sense of empowerment. Nurses would be able to analyze PAMB clinical decision-making, assist PAMB with exploration of clinical problems, and search for viable options.

Screening tool for place-based assessment

PAMB participant responses in Chapter Four (Perceived Lower-Quality Care with Medicaid Insurance Status) indicated a need for HCP screening of home and community for environmental triggers of asthma/COPD exacerbations. Nurses are well positioned to witness the confluent health effects of the social gradient (e.g. inequalities in population health status related to inequalities to inequalities of social status) of place on PAMB health status.

Nursing discharge intervention

Nurses can encourage clients to share any inabilities to engage in action plans and treatment regimens with the HCP before discharge, and empower clients to prepare for upcoming HCP appointments. Any potential misalignment of client and HCP goals can be identified and modified before PAMB return home after hospitalization.

Epidemiological research practice

Healthcare organizations such as the SML Wellness Center need nurses capable of gathering and analyzing population-level data to identify role supplementation nursing therapeutics for transitioning PAMB.

Nursing advocacy for PAMB stigmatization

In response to the high level of stigma which PAMB continued to encounter, nurses can advocate for PAMB with positive representation of Medicaid as a stepping stone to improved community health. Stigma is reduced when associated situations are substantiated as means of responsible health stewardship that benefits the community as a whole. By keeping the vulnerable/marginalized at optimal health, the community as a whole is positioned to experience optimal health. Promote inclusion of PAMB in community-based support Networks such as Circle of Friends on the Campus of MFH and SML.

Implications for nursing education

The passage of the PPACA (2010) places an increased emphasis on population health as a new focus for healthcare. Nursing education programs must be equipped with appropriate pedagogy, knowledge, skills, and attitudes to approach the inequity and inequality of healthcare. A full understanding of the SDH/PDH, and the effects on health outcomes needs, to be incorporated into all levels of nursing curricula (diploma, ADN, BSN, MSN, DNP, AND PhD) where nurses can develop nursing interventions that will appropriately lessen the negative bias of the social gradient of health. Specialty nursing exams also should address measures to lessen the effects of insufficient social structures that impact PAMB health outcomes.

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