

Draft proposal to explore the client experience in Colorado's Accountable Care Collaborative

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Background and Justification

In the process of conducting the independent ACC evaluation, we have received numerous indications that expanding the evaluation to include a patient/client component is an important missing element in our existing efforts. The current ongoing evaluation adopts a mixed methods approach to (1) quantitatively examine cost, utilization, and quality measures and (2) qualitatively examine primary care medical practice experience and feedback on the ACC. In the planning phases for the evaluation we had considered including a client/patient component but due to time and other resource constraints, we made the decision to focus our qualitative effort on the PCMPs.

Some practices stated that in order to further enhance care coordination patients would need to see themselves as partners in their own care. Better understanding the existing patient experiences and patient's perspectives of various elements of the ACC could play a valuable role in helping to refine the objectives around how patients should be partners in their own care and the corresponding needs for patient education.

Aim: Explore the patient experience and perspectives on the care they receive in the ACC

Option A: Qualitative interviews with robust qualitative data validation procedures, approximately 100 patient interviews, 12-16 months

This approach would utilize qualitative interviews directed by an interview guide to explore patient experiences and perspectives on the care they have received in the ACC. Given the focus on exploring individual patient experience and perspectives we feel that interviews are more appropriate than focus groups which we feel are better suited to providing group perspectives on hypotheticals or future

proposals. The themes that would be explored would be developed and finalized as part of this project and would incorporate stakeholder feedback. These themes could include patient experience and perceptions on initial points of care for acute illness, experience and perceptions on care and care coordination for chronic illness, patient expectations of the ACC, etc. We would also develop with feedback from stakeholders a sampling frame to ensure we get a representative and diverse sample of patient types. Criteria that could potentially be used include age categories, geographic location, and types and severity of illness.

This analysis would adopt an iterative adapted grounded theory based approach. The budget would allow for approximately 100 interviews that would be distributed based on final sampling categories and data saturation points within those categories. Interviews with patients would be recorded, transcribed, and validated. Transcripts would be formally coded in qualitative research software (Nvivo) and data validation procedures including double coding, coding comparison statistics, and expert validation would be incorporated.

This approach would generate findings related to patient experiences in the ACC and highlight key patient experiences, perspectives, expectations, etc. that would be relevant to ongoing efforts to reform the ACC. The methods outlined here would allow for the publication of these findings in peer-reviewed publications. It would also result in a coded qualitative dataset where additional queries could be run to exam topics of interest related to patient experiences in the ACC. This qualitative dataset could also be combined with future complimentary qualitative efforts to examine qualitatively changes through time.

Option B: Qualitative Interviews with mid-level qualitative data validation procedures, approximately 50 patient interviews, 9-12 months

This approach mirrors that of option A but decreases the number of interviews and scales back on the qualitative data validation procedures. Interviews would be recorded and transcribed but coding would be limited to single coding. This approach would also generate findings relevant to informing ongoing efforts to improve the ACC but the scope and depth of the findings would likely be more limited relative to option A and the data validation procedures would give us less confidence in the findings. This approach is more in line with a quality improvement effort and the methods are not consistent with publication in peer-reviewed journals.

Option C: Focus Groups with mid-level qualitative data validation procedures, 5 to 10 focus groups (30-60 patients), 6 months

Option C utilizes focus groups with mid-level qualitative data validation procedures to explore the client/patient experience in the ACC. As mentioned earlier, we feel a focus group approach is better suited to explore perspectives on hypotheticals and/or new innovations/approaches than exploring individual experiences. However, utilizing focus groups to explore potential innovations might be something useful within the context of the evaluation.

In this approach, focus groups will be recorded but not transcribed. Instead detailed focus group specific memos would be generated and validated by the evaluation team and key themes and findings would be generated from a comparison of findings across focus groups. A major consideration with this approach is the recruitment and scheduling of focus groups which can be very time consuming.