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## **“In our corner”: A Qualitative Descriptive Study of Patient Engagement in a Community-based Care Coordination Program**

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### **Abstract**

The purpose of this study was to explore participants’ experience in the Health Quality Partners (HQP) Care Coordination Program that contributed to their continued engagement. Older adults with multiple chronic conditions often have limited engagement in health care services and face fragmented health care delivery. This can lead to increased risk for disability, mortality, poor quality of life, and increased health care utilization. A qualitative descriptive design with two

focus groups was conducted with a total of 20 older adults enrolled in HQP's Care Coordination program. Conventional content analysis was the analytical technique. The overarching theme resulting from the analysis was "In our corner," with subthemes "Opportunities to learn and socialize" and "Dedicated nurses," suggesting that these are the primary contributing factors to engagement in HQP's Care Coordination program. Study findings suggest that nurses play an integral role in patient engagement among older adults enrolled in a care coordination program.

### Keywords

Community Based Care; Health Promotion; Older Adults; Nursing Intervention; Qualitative Research

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### Background

The number and proportion of Americans living with multiple chronic conditions is rapidly growing and projected to reach 157 million by 2020 (Anderson, 2010). Older adults largely account for the increasing prevalence, with 73.3% of people ages 65 and older having two or more chronic conditions (AHRQ, 2015; Vogeli et al., 2007). Vulnerable older adults often have limited engagement in health care services (Coleman, 2003) and face fragmented health care delivery (Bodenheimer, 2008). Given these problems, many cannot fully participate in managing their own health and are at increased risk for disability (Loza, Jover, Rodriguez, & Carmona, 2009), mortality (Byles, D'Este, Parkinson, O'Connell, & Treloar, 2005), poor quality of life (Byles et al., 2005; Loza et al., 2009) and increased health care utilization (Schneider, O'Donnell, & Dean, 2009). Caring for these individuals in community settings often requires the use of specially trained teams (Hong, Siegel, & Ferris, 2014).

There are many examples of complex care management teams, typically comprised of nurses, social workers and other clinicians who collaborate with primary care clinicians to meet the needs of older adults with multiple chronic conditions living in the community (McDonald et al., 2007). These teams identify and engage older adults at risk for poor outcomes, perform comprehensive health assessments, coordinate care with families, other caregivers, and the rest of the primary care team, and rapidly respond to changes in health to prevent avoidable hospitalizations (Brown et al., 2012; Hong et al., 2014).

An essential component of complex care management is patient engagement, defined as "actions individuals must take to obtain the greatest benefit from the health care services available to them" (Gruman et al., 2010). The Patient Engagement Behavior Framework, developed by Gruman et al. (2010), is a comprehensive compilation of active behavioral tasks in which patients must engage when managing their own health and healthcare to receive optimal benefits. According to the framework, when patients engage in chronic disease self-management, they evaluate and manage treatment options and identify services that support changing behavior. In addition, these patients actively monitor and manage their symptoms to meet health goals and clinical targets specific to their chronic conditions (Gruman et al., 2010). These tasks may place a substantial demand on older adults who often are coping with multiple health and social risks. Although some patients effectively

meet these challenges, some require guidance and support to optimally engage and manage their health needs.

The Centers for Medicare and Medicaid Services (CMS) acknowledge that care coordination is a critical component of chronic care management contributing to better health outcomes and cost reduction (Centers for Medicare and Medicaid, 2015). In the Coordinated Care Demonstration Project, CMS funded 11 organizations to test disease management and care coordination programs (Brown, Piekes, Chen, & Schore, 2008; Brown et al., 2012; Peikes, Chen, Schore, & Brown, 2009). Four of these programs reduced hospitalizations up to 33% among fee-for-service Medicare beneficiaries (Brown et al., 2012). Six features distinguished care coordination programs that reduced hospitalization rates: 1) frequent in-person contacts between the patient and nurse, 2) physician engagement and collaboration, 3) acting as a communications hub for providers, 4) delivering evidenced-based patient education, 5) providing timely and comprehensive transitional care, and 6) comprehensive medication management (Brown et al., 2012).

Health Quality Partners (HQP), a not-for-profit health care delivery organization located in suburban and rural areas of Southeastern Pennsylvania (Brown et al., 2012; Coburn et al., 2012; Health Quality Partners, 2016), is one of the demonstration programs that significantly reduced the number of hospitalizations for high risk enrollees over an extended time period (Centers for Medicare and Medicaid, 2001; Toles et al., 2015). The program provides a community-based nurse care management model to improve health outcomes in chronically ill older adults.

Between 2002 and 2014, CMS (through a contract with Mathematica Policy Research) conducted randomized controlled trials of 15 programs to evaluate the impact of care coordination interventions, including the HQP model. Traditional, fee for service Medicare beneficiaries with Part A and B services were eligible to participate in the HQP study if they lived in eastern Pennsylvania; were 65 years of age and older; diagnosed with heart failure, coronary heart disease, asthma, diabetes, hypertension, or hyperlipidemia; and received care at a primary care practice agreeing to work with the HQP program. Exclusion criteria included a diagnosis of dementia, end stage renal disease, schizophrenia, active cancer, life expectancy less than 6 months, and residence in a long-term care setting. The control group received usual care (no care coordination) and had no further contact with HQP, while the intervention group, received the HQP Care Coordination program (Coburn et al., 2012). Compared to the control group, the intervention group experienced 25% lower relative risk of death (unadjusted hazard ratio [HR] 0.75 [95% CI 0.57–1.00],  $p=0.047$ ) (Coburn et al., 2012).

The HQP program incorporates several evidence-based preventive and care management interventions delivered by community-based nurse care managers in collaboration with local health care and social service providers (Coburn et al., 2012). Each participant in HQP is assigned one nurse manager who is their primary program contact and is responsible for providing individualized care. Care managers are carefully screened and recruited for their nursing experience and their expressed passion for direct patient care and patient education. The HQP participants also are offered several group interventions based on their needs and

readiness to engage in such care delivery strategies. Group interventions included disease-specific education and self-management skill development (e.g., for cardiovascular disease and diabetes), and lifestyle behavioral change programs for promoting weight loss, physical activity and exercise.

Patient engagement in care coordination programs such as HQP's has received little research attention, thus limiting our ability to explain how program services support older adults and improve health outcomes. What is known from prior research is that increased face-to-face nursing contact in care coordination programs has been associated with decisions that older adults make to remain in the program (Toles et al., 2015). This study also found that more in-person nursing contacts and greater nurse continuity contributed to sustained enrollment in the program (Toles et al., 2015). Our present study extends this earlier quantitative research by eliciting HQP participants' perceptions of clinical and other supports in the HQP program related to their sustained participation. Study findings have the potential to uncover factors that might be less obvious in a clinical trial or a chart review. The specific aim of this study was to explore participants' experience in the HQP program and the factors they perceived contributed to their continued participation. Insight gained from this study can guide future efforts to promote patient engagement in care coordination programs and, ultimately, improve the coordination of care for older adults with multiple chronic conditions.

## Method

### Design

A qualitative descriptive study design (Kim, Sefcik, Bradway, 2016; Sandelowski, 2000) was selected to gain insight from the participants about their experience in the HQP program. Rather than individual interviews, two focus groups were convened, because the use of groups is recognized as instrumental in examining the perceptions and beliefs of a collection of individuals who share a common experience and who can assist each other in generating a range of ideas (Hennink & Leavy, 2014). Thus, we anticipated that insights from the focus groups would reveal varied factors that influence participants' engagement in the HQP program (Krueger, 2000). In addition, demographic information was collected from participants using a brief, self-administered survey prior to the group sessions.

### Setting and Participants

Patients in the HQP program were recruited for the study from one suburban and one rural region in Eastern Pennsylvania to achieve geographical variation. Inclusion criteria for the focus groups were that participants were currently enrolled in the HQP program, willing to participate, and provided written informed consent. Purposive maximum variation sampling was used to obtain a sample for each group that was heterogeneous in terms of age, education, primary diagnosis, time enrolled in the program, and assigned nurse care manager. Patients who were seriously ill or would have had difficulty leaving their home to travel to the site of the focus groups were not eligible. For each focus group, there was an initial list of ten potential participants and five alternates provided by HQP's clinical leaders. Eligible patients first received a letter from the research team describing the focus group's

purpose, inviting them to consider participation, and informing them that a team member would be calling them to explore their interest in participating.

**Participant characteristics**—Participants in the two focus groups (N= 20) were all 65 and older and 70% were aged 75–84 years. Sixty-five percent were female, and 80% were married. All of the participants had completed high school, 15% had college degrees, and 30% had graduate degrees. Participants were white and non-Hispanic (see Table 1).

### Data Collection

The University of Pennsylvania approved this study. The focus groups were conducted during the summer of 2013, scheduled at a convenient location for the participants, and held in a conference room for privacy. The lead author moderated the focus groups with the assistance of two investigators (DP & MS). The three group moderators were co-investigators and masters prepared nurses who were doctoral students with geriatric nursing and qualitative research experience. These moderators were not associated with the HQP program. All received two hours of training from the principal investigators (HM & MT) on leading focus groups. A structured interview guide, developed by the research team, posed four major open-ended questions: (1) “What led you to enroll in the care coordination program?” (2) “Tell us about your experience with the care coordination program,” (3) “What has been helpful or not helpful about your interactions with the nurse care manager?”, and (4) “Have you ever thought about dropping out?” Possible probing questions were also included in the interview guide for group leaders to use as needed to elicit more discussion.

Before the focus group discussions, participants completed the process for written informed consent. Ground rules for the meeting, including confidentiality of participants’ responses, also were discussed. The focus groups averaged 55 minutes in length. A \$20 gift card was given to participants as a token of appreciation for their time. Pseudonyms were used within this paper for the protection of participants’ identities and the identities of their nurses about whom they spoke.

### Coding and Data Analysis

Focus groups were digitally audio recorded and transcribed verbatim by a professional transcriptionist. Transcriptions were reviewed line-by-line against the audio files to assess for accuracy. Data were stored, managed, and analyzed using the qualitative software Atlas.ti.7.

Conventional content analysis, a systematic process of classifying text and identifying patterns in qualitative data, (Hsieh & Shannon, 2005) was the analytical technique. Three of the investigators (JS, DP & MS) read the transcripts in their entirety independently to acquire a sense of the interviews (Graneheim & Lundman, 2004). Line-by-line open coding was completed independently by the two investigators (JS & DP), followed by them meeting to discuss the initial codes. An initial codebook with definitions for the codes was derived by consensus of the research team. The two investigators then independently used the codebook to categorize data from both transcripts, and recoding was completed to reflect the

agreement achieved through consensus. Full team meetings followed each of the steps of the coding process to discuss initial impressions of the data, the code book, and the major theme identified: “In our corner.”

### **Trustworthiness**

Steps taken to maintain the rigor of the data collection and analysis procedures included debriefing, investigator triangulation, maintenance of an audit trail, and member checks (Lincoln & Guba, 1985). To ensure credibility of the findings, two investigators (JS & DP), who were coding and making analytical decisions, participated in several debriefing sessions with the principal investigators and other members of the research team (Shenton, 2004). The lead author also participated in peer debriefing and critique sessions within an Advanced Qualitative Collective group, which brought fresh perspectives to the work, challenged assumptions, and gave the investigator the opportunity to refine her work (Polit & Beck, 2008; Shenton, 2004). This group, not involved with the study, was composed of faculty, pre-doctoral students, and post-doctoral fellows.

To enhance quality during coding and analytic decision making and to reduce the possibility of biased conclusions, two team members (JS & DP) worked together for investigator triangulation (Polit & Beck, 2008) and maintained an audit trail (Shenton, 2004). Furthermore, four member checks (with HQP program participants who attended the focus groups) were completed to establish the credibility of the qualitative data (Polit & Beck, 2008). Selection criteria for member checks included participants being willing able to have a conversation on the phone and obtaining a range of ages, medical diagnoses, and representation of both men and women from the two groups. Through individual telephone conversations, the participants validated the preliminary findings and salient points that were presented.

## **Results**

### **Main finding: “In Our Corner”**

HQP participants attributed their continued involvement in the HQP program and improved health outcomes to perceiving opportunities, resources, peers, and HQP clinical staff all “In our corner”. The participants discussed the benefits of being enrolled in the HQP program itself and also talked favorably at length about the HQP care coordination nurses. Two subthemes emerged that we labeled “Opportunity to learn and socialize” and “Dedicated nurses.” We describe the subthemes in-depth below.

### **Opportunity to learn and socialize**

The HQP program provided the participants with unique opportunities to increase health-related knowledge, practice self-care skills, and participate in a health-focused peer community. The participants’ perceptions of having the HQP program in their “corner” was exemplified by one participant, Patty, who stated: “...groups or churches or whatever have let the senior citizens fall through the cracks, and Health Quality Partners have lifted us up, and made us important”. Participants discussed the benefits they received from being enrolled in the HQP program, including the routine that it has provided for them and their

exposure to wellness promotion. Since enrolled in the program, participants stated they felt that they had “gained a lot” from the program, had reduced visits to their doctors, and had avoided frequent emergency room visits.

Participants described themselves as ill, frail, and with multiple health issues upon entering the HQP program. They recalled histories of poor health habits, including unhealthy eating and limited daily exercise. Through the support of the program, most participants said that their health status and health behaviors were better after enrolling in the program.

Participant’s length of time in the program varied; for example, at the time of the focus groups, some participants had been enrolled for years while, others had recently enrolled in the program. One participant stated, “I’m very new in it and my health’s improved.”

Participants attributed the success of their current health status and increased positive health behaviors to their access to the HQP program and all that it had to offer them. A participant (John) explained, “I went from a walker to a cane to, to where I am today, and I play golf again. That’s all attributed to good physicians, but also, I feel much more confidence in my life because of Health Quality Partners.”

HQP participants especially enjoyed health-related programming such as exercise classes and walking groups, courses on nutrition and healthy eating, a continuing maintenance program for weight loss, and lectures offered by the HQP Health Wellness Center on topics such as how the heart works and fall prevention. Participants also mentioned benefitting from health education material such as self-learning programs and brochures specific to their health needs. These programs left positive impressions on the focus group participants; for example one participant shared, “I’m still continuing to use everything that I learned.” Participants communicated that they have learned the importance of having a routine exercise program, what to order when eating out at a restaurant, and what healthier options to buy at the grocery store after learning how to read packaging through the wellness promotion programming.

Participants also described that, through the group classes, they had opportunities to socialize and valued the new relationships they developed with other participants. One participant (Karen) stated, “We even have occasional buffets where everybody brings something that’s supposed to be from what we’ve learned. So, we’re instructional. We’re social. We’re comrades.” For some, exercise class was a way to temporarily escape life stressors and an opportunity to take care of themselves while being able to socialize. Phyllis offered the following description of the exercise class she attended,

...the social aspects of it is very important. I mean, a lot of people in the group don’t really have that much family anymore and when you get to be as old as we are, your circle of acquaintances is dropping, it’s a social thing.

Relationships built among participants also extended outside of group classes for some of the participants. As Jennie conveyed “...a few of us meet outside of classes now, and go to breakfast, or-or get together, and it ... we just love each other.”

## Dedicated nurses

Most of the focus group discussions revolved around how important the HQP nurses were for the participants. Peggy described the nurses as the core of the program, “The program is the nurses, without those nurses bringing to us all that they have learned over the years, and have dedicated themselves to, we wouldn’t have a program.” Discussions centered on how extraordinary the HQP nurses were, and participants referred to them in affectionate ways such as “super,” “fantastic,” and “truly an angel.”

Several participants stated that a primary benefit of the program was routine, in-person (at least monthly) contact with their assigned nurse. Betsy explained, “The program is based on everybody being assigned a nurse who’s like having their own private nurse who is aware of all your health problems.” The importance of a monthly one-on-one meeting with their nurse was mentioned by several participants as they spoke of the nurses reviewing their weight, blood pressure, heart rate, and medications during the routine visits. The scheduled visit with a nurse was described by Anne as an

...incentive to make sure that I was doing well, and because I’d come in here, and she questioned me on diabetes, on the asthma whether I’m taking stuff, and it always was in my mind that well, I’ve got to see Theresa or I’ve got to go see Catherine, and I better make sure that I’m right, keeping things down as best I could.

Participants viewed their nurses as a coach, someone ‘in their corner’ to inspire them to initiate and continue healthy behaviors. Participants explained that expectations were built for next visits, creating situations where the participants want to take care of themselves and show the nurses that they were eating healthier, maintaining a better range of their blood sugars, or performing other health-related tasks in which the nurse had been coaching them. They knew that their nurses cared about them and were routinely monitoring their health, which helped them be incentivized and focused to do what they “should be doing.”

Nurses also were described as providing assistance with reconciling medication orders and following up on health promotion behaviors. One female participant offered an example about her nurse checking to make sure she had a recent mammogram. Participants reported that the nurses would even take a trip to the grocery store with them to teach them how to read nutritional labels. Their nurses also make recommendations about when they should see their physicians and topics that should be discussed. In some situations, the nurses would call the participants’ physicians or attend physician visits with participants to facilitate patient-physician communication.

Participants felt they could always lean on their nurses for help during difficult times and that the nurses were always available to call at any time with questions or concerns. Participants added that they are given the time and attention they need, and that their nurses listened and eased their concerns, which was not their experience with other clinicians outside of the HQP program. Participants explained that the nurses would spend up to an hour with them during home visits and their nurses did not create a situation which made them feel that they were being rushed. The nurses instead created a feeling for the participants that they were being put “first” and that they were just as important as the



nurses' own family members, "like we're one of their own children or one of their own from their own families". As Eva described,

That's the virtue of this program. I think all of us feel we can also ask our nurse anything. She's always willing to listen, she's never too busy, she never makes you think you're stupid [laughs] to ask such a question. You know, they, it's, she's just somebody you can always talk with about any concern.

Participants discussed how challenging and overwhelming it was for them to navigate the healthcare system, particularly while being acutely ill or after a hospitalization. Participants expressed that their nurses were their primary support when they were confused about their health care during these transitions and did not have another knowledgeable person, such as a spouse, to assist them. Betty gave this example:

...I had nothing, no idea what was going on with doctors and nurses or anything when I first got sick. And, it got-seemed that every time I went into a hospital, I came home, they never had my right prescriptions or dosages. They had me on things that I wasn't on or never even heard of. Everything was all confused. She'd [the HQP nurse] just take my papers from me, go over the hospital or the doctor, and then she'd come back, and it would all be straightened out.

Through interactions with the nurses, relationships and bonds were developed between the nurses and the participants. This bond was even extended in some cases to participants' spouses. As John stated, "I think my wife looks forward to seeing Robin [HQP nurse] as much as I do." The participants saw their nurses beyond the role of a healthcare provider and saw them as a close friend or a family member who is coaching and inspiring them to manage their chronic conditions. As Sue explained the visits with her nurse,

It's just like visiting uh-uh, how can I say it, she's part of my family. I just feel like I'm getting a warm hug every time I go to see her. And she's so, she's just so interested. You really count as a person to her, and she's very interested in your wellbeing. She's full of good suggestions, and she doesn't um, uh, what's – how can I put it? She doesn't put you down at all. She always lifts you up.

Some participants talked about their nurses calling them to follow up with them if they "had a bad day" or if they weren't feeling well. As Blanch described the feeling she gets when her nurse calls her to check on her: "It really makes you feel good, when you're down in the dumps or something, and somebody will call and really express that they are really worried about you, and want to know what's going on." The nurse's action of calling to check-in or follow up was expressed to be particularly important for participants who live alone. As one participant phrased it, "*we have somebody in our corner.*"

## Discussion

By definition, patient engagement involves numerous self-care activities such as symptom monitoring and treatment management (e.g. medication adherence, following dietary recommendations, exercising) (Gruman et al., 2010). Our results reveal that participants' perception that someone was "in their corner" was a primary contributing factor to engagement in the HQP Care Coordination program. Prior research similarly demonstrates

that the amount of in-person contact with registered nurses improves care coordination program outcomes (Peikes et al., 2009). However, in addition to emphasizing the importance of the nurses, members of the focus groups also demonstrated a positive group culture as they discussed their participation in the HQP program. Thus, the perception of having someone in their corner also appears to be fostered by the sense of community that emerged as members formed relationships with others in the care coordination program. These findings indicate that the tailored HQP program encouraged patient engagement in the program and their own health through two primary mechanisms: (1) a health and learning focused peer community of older adults created by participation in the various aspects of the HQP Care Coordination program and (2) optimized contact with registered nurses that developed relationships over time. Thus, optimizing nursing contact and creating a peer community may be critical strategies for replicating the effective participant engagement and improvement in health outcomes in the HQP Program (Brown et al., 2012).

An interesting finding of our work is that creating a health and learning focused sense of community contributed to participants' engagement in this particular care coordination program. This has important clinical implications as this can be replicated in other programs to benefit older adults. Social isolation is a multidimensional problem for older adults. From a theoretical perspective, social networks provide opportunities for social support and social engagement, which impact health through behavioral (e.g. diet, exercise), psychological (e.g. self-efficacy), and physiological (e.g. hypothalamic-pituitary-adrenal (HPA) axis) pathways (Berkman, Glass, Brissette, & Seeman, 2000). Studies consistently show that living alone and social isolation place older adults at risk for poor health, poor diet, low levels of physical activity, impaired functioning, falls, poor mood, and mortality (Cornwell & Waite, 2009; Kharicha et al., 2007; Steptoe, Shankar, Demakakos, & Wardle, 2013). Fostering social networks among members of care coordination programs may be a key component to improving physical and mental health outcomes in community dwelling older adults. Additional research should be done to further examine this finding.

Our results highlight the central role of nurse-patient relationships in care designed to engage patients with chronic illnesses in programs to promote behavioral change and care coordination. They also build on previous quantitative research (Peikes et al., 2009; Toles et al., 2015). Toles and colleagues found that 11% of HQP program participants dis-enrolled from the program; a greater proportion of in-person nursing contacts (vs. telephonic) and more nurse continuity was related to lower disenrollment (Toles et al., 2015). Our findings support and help to explain these findings with patient descriptions of the specific nursing interactions that promoted their engagement in the program.

Our findings are also consistent with other studies demonstrating the importance of nursing contact and how nurses are an invaluable resource during transitions. For example, the Nurse-Family Partnership, a highly effective program, uses in-home nurse visitation to improve maternal and child health outcomes (Olds et al., 1997; Olds et al., 2014). Similarly, a systematic review of twenty-one transitional care interventions for chronically ill adults concluded that nine interventions effective in reducing hospital readmissions all used nurses as the clinical leaders, and six of the nine used in-person nursing visits to patients' homes (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). Collectively, these studies

demonstrate the effectiveness of in-person nursing contact in the attainment of outcomes related to positive patient outcomes.

Our study suggests that nurses were central to the achievement of patient engagement in two areas—patients' continued participation in the program and their engagement in managing their own health. However, one might question whether nurses are uniquely qualified compared to other healthcare professionals to provide the in-person contact needed to enhance patient engagement. Although certain tasks in the HQP program could be performed by a non-nurse (e.g., nutrition courses/reading nutritional labels), this program was designed intentionally so that one health professional would be accountable to coordinate a patient's needs. When designing the HQP program, the leaders recognized that many of patients' needs centered on health concerns and required advanced knowledge of health conditions and treatments, and therefore nurses had the best skill set and educational background to function effectively. Other studies have supported the conclusion that nurses are best suited for home visitation. For example, the impact of home visitation by nurses versus non-nurse paraprofessionals was compared in the Nurse-Family Partnership, and outcomes were best when visitation was with a nurse (Olds et al., 2002). Using nurses rather than non-nurse professionals may increase the cost of care coordination programs; however, research to date suggests that although HQP has not produced net-savings, it is at least cost-neutral (Peikes et al., 2009). Future research should further examine the economic return of this approach to community based care and the costs of using nurses versus non-nurses in particular.

Other research has shown that low health literacy has been associated with more hospitalizations, poorer overall health status and higher mortality rates among older adults (Berkman, et al., 2011). Some suggested strategies to improve health literacy include teach back techniques, jargon-free verbal communication, understandable written materials and follow-up telephone calls with tailored messages (Cloonan, Wood, & Riley, 2013). Participants in this study described how nurses in this program not only provided them with education (i.e. through classes or distribution of educational materials), but also provided personalized self-care skills training during home visits, or as some participants described, through a trip to the grocery store for real-life practice reading nutritional labels. These findings highlight important clinical implications of not only providing education on *what* participants need to do, but also using behavioral strategies to show them *how* to implement changes in a personalized manner, thereby encouraging engagement in the desired health behavior. Our findings are consistent with both theoretical and research literature, indicating that interventions combining educational and behavioral approaches are most likely to improve engagement in health promotion and disease management behaviors (Whitehead, 2001a, 2001b).

## Limitations

Despite the focus group leaders' use of multiple probes to elicit stories where members had a negative experience with the program, all participants were completely satisfied with the program. As one participant in the first focus group communicated, "And, because we're a very positive group, you're not going to get much negativity out of us." Therefore, we have

not heard from participants of the HQP program who have had a negative experience. All participants who attended the focus groups had been enrolled in the HQP program at the time, and our sample did not consist of any participants who had made the decision to drop out of the program. Future research should include interviewing participants who disenrolled from the HQP program to explore their experience and decision.

Members of the focus groups reflected limited socioeconomic diversity, were white, had access to transportation, and had more than half the sample had at least some college education. It is possible that the individuals in our study were better able to capitalize on the opportunities provided through the program compared to individuals from less socioeconomically advantaged groups and from other racial groups. Unfortunately, there is a lack of racial diversity in the region where the focus groups were held, as well as in the HQP program at the time of the study. Thus, we were constrained by the lack of diversity among the participants available to us. Replication of this study with more diverse populations enrolled in care coordination programs is needed. Additionally, all participants in the focus groups had the ability to transport themselves to the meeting or arrange for transportation. Older adults who did not have access to transportation or who were too ill to leave their home were excluded from the study, and they may represent patients who are more socially isolated and vulnerable. Thus, our findings may not be pertinent to these individuals, who could benefit the most from a program like HQP.

## Conclusion

This qualitative descriptive study explored participants' experiences in the HQP Program that contributed to their continued participation in the program. Our analysis revealed an overarching theme of "In our corner," with subthemes "Opportunities to learn and socialize" and "Dedicated nurses," indicating that these were the primary contributing factors to engagement in HQP's Care Coordination program. Nurses played an integral role in promoting patient engagement among older adults in our sample. Based on our findings, future research is warranted that focuses on both educational and behavioral strategies, incorporating in-person nursing contact.

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**Table 1**

## Demographic Information

Variable name	Frequency (%)
Age, years	
65–74	4 (20)
75–84	14 (70)
>85	2 (10)
Gender	
Male	7 (35)
Female	13 (65)
Race and ethnicity	
White	20 (100)
Non-Hispanic	20 (100)
Marital status	
Married	16 (80)
Widowed	3 (15)
Divorced	1 (5)
Education levels	
Completed high school	9 (45)
Some college/Associate degree	2 (10)
College degree	3 (15)
Post-graduate degree	6 (30)

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