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Abstract

Patient engagement has been identified as both a goal and strategy to lower health care costs and improve health care outcomes. However, a lack of consensus and clarity exists as to how the process of patient engagement is implemented in clinical practice. Research addressing the underlying and crucial components of effective patient engagement is limited, leaving a significant gap as to how providers engage patients as active collaborators in their health and health care.

This study provides specific, detailed insight and description into the processes through which advanced practice mental health nurses engaged low-income depressed mothers in a mental health intervention. The Interactive Care Model (ICM), a patient engagement framework, was used to examine and illuminate the key processes and partnership roles of patient engagement. Using a directed content analysis approach, we completed a secondary analysis of nursing narrative data using the 5 key processes and 7 partnership roles of the ICM to guide our analysis. The ICM demonstrated great utility in capturing the processes through which advanced practice nurses enlisted, engaged, and retained low-income depressed mothers in the mental health intervention. Additionally, the nursing narrative data provided specific detail and description as to how the ICM's components were operationalized in practice. The ICM was validated by the nursing narrative data and provided sound organizational structure for the specific verbal and non-verbal engagement interventions nurses employed. Findings from this study can expand the knowledge base and understanding of the process of patient engagement and can help guide providers in executing behaviors that engage traditionally unengaged patients as active collaborators in their health and health care.

Keywords

Directed content analysis, Interactive Care Model, patient engagement, patient centered care

Introduction

In the past decade, health care providers put much effort into addressing the triple aim -- better patient care experiences, improved health outcomes, and containment of health care expenditures[1] by encouraging patients to become more engaged in their health and health care. Patients who engage (i.e., take purposeful action towards improving their health and health care) have better health care experiences, better health outcomes, and lower healthcare costs than patients who remain unengaged.[2-8] As yet, however, a substantial lack of consensus and conceptual clarity remains as to what patient engagement is, what its key components are, and importantly, how engagement is operationalized during patient-provider interpersonal relationships and interactions. [11-14]

Significance

The Patient Protection and Affordable Care Act (PPACA) expanded health care access for approximately 32 million Americans, many of whom were low-income. [15] Low-income individuals, a historically underserved population, are 4.2 times more likely to forgo or delay needed medical care, encounter barriers to care, and receive poorer quality care than those at higher-income levels. [16,17] The insurgence of low-income Americans into the health care system created an urgent need to understand the process of effective patient engagement within the context of the provider-patient relationships in which care exchanges occur. A clearer understanding of the *process* of patient engagement can guide providers in executing behaviors that engage traditionally disengaged patients as active collaborators in their health and healthcare. Moreover, knowledge about the process of patient engagement can direct health care dollars and efforts toward the provision of more efficient and effective health care services.

The purpose of this study was to clarify the process underlying patient engagement and to determine how nurses operationalized components of patient engagement in relationships and interactions with low-income mothers. Specifically, through secondary data analysis, we explored and examined advanced practice nurses' perceptions of interpersonal strategies they used to engage low-income mothers with depressive symptoms in a mental health intervention. Additionally, our study added empirical support for the Interactive Care Model, a patient engagement framework, which shows promise in illuminating components of patient engagement. Outcomes from this study expand the limited body of knowledge on specific patient engagement practices that are effective with a historically underserved population.

Theoretical Framework

The Interactive Care Model (ICM)[18] is a patient engagement framework first published in 2015 pinpointing the fundamental interpersonal interactions between patient and provider during care. A general model with wide application to various care settings and clinicians, the ICM outlines, describes and explains steps and strategies to engage patients fully in the care of their health. [18]

At the core of the ICM is the vital interpersonal relationship among person, family, and providers. [18] Five bi-directional key processes surround the core, indicating the interactions required for the patient and provider partnership to develop and for engagement to progress: 1) assessing a person's capacity for engagement; 2) exchanging information and communicating choices; 3) planning between person and providers; 4) determining appropriate interventions; and 5) evaluating regularly.[18] Woven throughout the five key phases of engagement are seven key clinician and person/family partnership roles (e.g., coaching, intentional presence, knowledge exchange, among others), which help to facilitate and advance the process of patient engagement (Figure 1).[18]

Figure 1. The Interactive Care Model
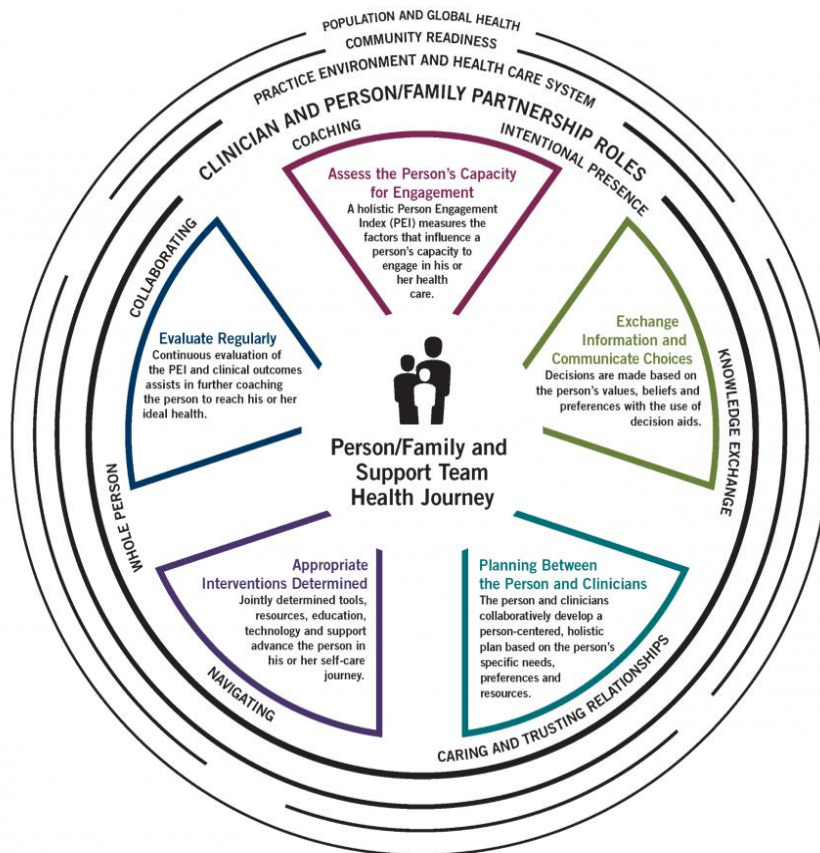
Source: O'Neil Center

Original Study

This study is a secondary analysis of data from a 2010 randomized controlled trial, Reducing Depressive Symptoms in Low Income Mothers (HILDA; NIH R01MH065524). In the original study, 226 mothers were recruited from six Early Head Start programs in the southeastern and northeastern US. Investigators invited mothers who had a positive screening test for depressive symptoms to participate. The intervention group received ten face-to-face, home-delivered Interpersonal Psychotherapy (IPT) sessions from advanced practice psychiatric mental health nurses. The same nurse visited the same mother for each of the ten visits. After every session, the nurses recorded narrative notes, providing detailed data and unique perspectives about the home setting and atmosphere, interactions and specific exchanges with the mothers and family, and interpersonal strategies and techniques used to establish a relationship, engage, and retain the mothers in the intervention.[19]

Study Design

For this analysis, we used directed content analysis to examine how advanced practice mental health nurses described interpersonal strategies used to engage the depressed mothers. Directed content analysis is a method used to support, validate, or conceptually extend an existing framework or theory and add further clarification about the constructs and their interconnections.[20] The goal of this methodology is to identify significant themes and categories within the narrative data, and to describe the social reality created by those themes and categories as they are lived out.[20] Results of qualitative content analysis can support the development of new theories and models, as well as validate existing theories.[21]

Data Analysis

Using MAXQDA, a qualitative and mixed methods software program, we purposefully sampled and analyzed thirty cases of individual nurse's narrative data using directed content techniques, comparing their narratives with the five phases and seven partnership roles of the Interactive Care Model. The core coding scheme consisted of the five key processes and seven patient-provider partnership roles from the ICM. When consistent with the conceptual definitions, we organized specific engagement strategies within the ICM processes and partnership roles.

Results

We first address each of the five key processes (Table 1) and then the seven partnership roles (Table 2) of the ICM.

Key Process #1: Assessing a person's capacity for engagement

Assessing a person's capacity for engagement is when the provider considers the myriad of influences that can affect a persons' capacity to engage in their health and health care and gauges their readiness to become an active participant in their care. (18) Nurses' narratives provided data supporting the ICM phase of assessing the patient's capacity for engagement. Assessing the mothers' capacity for engagement was a complex endeavor requiring proactive, persistent effort and flexibility. Nurses were persistent in gaining initial contact with mothers, often calling, leaving multiple messages, sending notes or driving by the mothers' home. Nurses' persistence was paired with consistently flexible accommodation in recognition of the multiple demands competing for mothers' time and energies. By meeting face-to-face in a non-clinical setting, the nurses observed and documented factors influencing the mothers' capacity to engage such as the home environment, her activation/motivation to participate in the intervention, her health literacy, disease burden, and the adequacy of her psychosocial supports.

Key Process #2: Exchanging Information/ Communicating Choices

In Exchanging Information/Communicating choices, nurses used therapeutic communication and decision aids to help mothers identify their values, preferences, and beliefs in order to make informed decisions about their health.(18) The nurses' narratives supported the exchanging information /communicating choices phase of the ICM as the nurses were intentional in paying particular attention to the mothers' stories, their realities, and their words in an effort to understand their circumstances and preferences for care. Nurses often used silence as an engagement strategy noting the mothers needed "time to collect, organize, and reflect on her thoughts" and "time to engage." Mothers often led the dialogue, sharing difficult histories of significant loss and hardship (e.g., rape, reoccurring violence, racism, spousal incarceration, losing loved ones to HIV, family death, abortions, paternity issues, giving up children, abandonment by significant others). Mothers' personal stories and experiences provided important historical information, helping to illuminate her present values, beliefs, and subsequent preferences.

As Mom spoke about the rape, I suddenly understood why this paternity test is even more loaded than usual for her. Even though she displayed no emotion about this she was willing to talk about it and I was glad. I listened, asked a few questions, and at the end of the story said that I was very sorry that she had to go through that. We explored some options about getting that guy's DNA but Mom said that it didn't matter as she was prepared to raise her baby on her own anyway.

Table 1: Summary of Key Findings ICM Processes and Nurse Generated Engagement Practices

Key Process of Interactive Care Model	Examples of How Nurses Demonstrated Aspects of the ICM in Practice
Assessing a person's capacity for engagement	• Pre-engagement contact • Flexible, accommodating scheduling • Social conversation • Assessment Circles • Health literacy • Disease burden • Psychosocial support • Activation/motivation
Exchanging Information/ Communicating Choices	• Mother's history • Competing demands • Intentional presence • Listening • Silence • Disclosing limitations • Anticipatory warnings • Exploration
Planning	• Contracts • Mutually developed and agreed upon goal setting
Determining Appropriate Interventions	• Skill sheets • Cognitive Reframing • Problem solving • Refocus/redirect • Confrontation • Summarizing
Evaluate Regularly	• Depressive Symptom Inventory • Mothers' self-report • Nurse assessment

Nurses' narratives had several examples in which shared decision making evolved between the nurses and the mothers when describing mothers' viable options, feasible and actionable change, and the risks and benefits of taking action versus inaction. For example, nurses and mothers addressed complex issues such as choosing to have multiple sexual partners, wanting to divorce an incarcerated spouse, facing eviction or Child Protective Services (CPS) investigations, being unemployed, and resolving child support issues. These discussions set the stage for collaborative sharing in the decision-making process.

Key Process #3: Planning
Each week the nurses described in their notes the process of arriving at mutually determined goals and outcomes of the intervention with the mothers. The nurses and mothers co-created and agreed on plans that they wrote down on paper, a visual and tangible record of consensus used for reference at future meetings. At times, planning between the nurses and the mothers was routine and simple, such as setting and agreeing to a time and date for subsequent meetings. At other times, however, planning was unconventional and complicated. For example, formulating a plan for one mother to regain custody of her children required development of parenting solutions and

Table 2: Summary of Key Findings ICM Partnership Roles and Nurse Generated Engagement Practices

ICM Partnership Roles	Examples of How Nurses Demonstrated Aspects of the ICM in Practice
Whole person	• Aromatherapy • Spirituality • Faith
Intentional Presence	• Silence • Permission • Gesture • Control of intensity • Facilitation of catharsis • Physical touch • Facial expression • Gratitude
Caring and trusting	• Cultural specification • Self-disclosure • Empathy • Facilitation of Grieving • Gift giving
Knowledge Exchange	• Knowledge Exchange
Collaboration	• Role play • Reflection • Problem solving • Review • Questioning
Coaching	• Letter writing • Praise • Self-reflection • Encouragement
Navigating	• Referrals

behavioral alternatives to reflexive physical violence, and strategizing to work effectively with Child Protective Services. Notably, nurses did not describe setting goals for mothers each week, but rather: "helped [the mother] set goals for herself."

Key Process #4: Determining appropriate interventions

Determining appropriate interventions required using tools, resources, education, and support to advance mothers' health journey.[18] Nurses described the key process of determining appropriate interventions,

capturing in their narratives the collaborative work of the intervention. Nurses used printed and customizable skills sheets to work on common problems such as a dispute over separating from spouse (skill sheet *Getting Back Up When Someone Lets You Down*), communicating with an Early Head Start director (*Resolving Disputes*), and parenting rambunctious children (*Know Yourself, Know Your Child; Breaking Bad Patterns*). Skill sheets provided structure for the mental health and parenting interventions, simultaneously facilitating engagement while delivering education and support. Significant others would sometimes join in the sessions and as a group, the nurse,

mother and significant other would focus on topics specific to couples, communication, and parenting strategies.

Throughout the intervention, nurses faced significant challenges in maintaining mothers' attention and focus on problem solving because the mothers were distracted by their children, by family or friends in the home, or the television. Nurses used strategies such as refocusing, confrontation, clarification, suggestion, and summarization to keep mothers engaged and on task, which facilitated and advanced the work of the intervention. In one instance, when the mothers got sidetracked or when the mothers' *"venting became unproductive,"* the nurses would redirect the conversation and shift the discussion to address behavioral change and improvement.

Key Process #5: Evaluate regularly
At each encounter, nurses evaluated the mothers' level of engagement and their depressive symptoms. Specifically, after every meeting, the nurses assigned adherence ratings, indicating how well the mothers were executing the co-created plans from the previous week and completing the assigned skill sheets. The mothers' adherence ratings indicated the nurses' perceptions of how well mothers were using the interpersonal skills and strategies in their everyday lives and relationships. Additionally, evaluations were essential in planning and navigating future meetings.

Partnership Role #1: Whole Person
To promote the mothers' holistic health and healing, nurses used alternative therapies such as aromatherapy, mindfulness, nutrition, yoga, meditation, relaxation techniques, and focused on faith. One nurse often introduced aromatherapy to the mothers as a way to enhance their psychological and physical well-being by reducing stress levels, improving concentration, and enhancing mood and memory.[22] Aromatherapy and other holistic approaches to care offered a complementary approach to the interpersonal psychotherapy in addressing the mothers' depressive symptoms.

Partnership Role #2: Intentional Presence
Nurses indicated their intentional presence — being fully aware and present[23] — with mothers in an effort to heal and build a genuine, trusting relationship; the nurses described "looking intently" at the mothers, "listening," "nodding," and communicating non-verbally her "attention to and investment in the mother." Simple alterations and exaggerations in body language, volume, and pace of speech were intentional and subtle behaviors used by the nurses to indicate to the mothers that what the mothers were sharing was important and meaningful.

Silence was highly represented in the nursing narratives as an effective engagement strategy. For example, when one mother described her behavior as "crazy" after "hunting down" her teenage son when he was out partying, the nurse reframed her behavior positively as a demonstration of "protective behavior". Silence was a strategy nurses used frequently to allow time for "cognitive reframing to settle into mother's thoughts" or "to allow mother time to engage". Additionally, silence was often used to "honor the heaviness of the topics" and provided time for the mothers to work through their innermost thoughts, feelings, and life perspectives.

Nurses described being deliberate in asking for mothers' permission, such as "Can I come upstairs?" "Can I give the child a cookie?" "Can I sit here?" As guests in the mothers' home, the nurses described asking permission to underscore both acknowledgement and respect for the mother's role as hostess. Similarly, nurses expressed gratitude to the mothers for their time, honesty, hard work and effort in meeting with and discussing sensitive and sometimes painful memories, thoughts, and feelings.

Partnership Role #3: Caring and trusting relationship
Throughout the intervention, nurses demonstrated caring through their expressions of concern to the mothers when the mothers missed appointments, did not return phone calls, or were distraught during challenging circumstances. Nurses offered empathy when appropriate, noting they may not know fully the realities of mothers' day to day lives. Nurses acknowledged mothers' cultures and traditions (e.g. taking off shoes; modifying language), recognizing the importance of respectful, culturally competent, and patient centered care.

Although not specifically cited in the ICM, nurses described humor and "hands on help" as strategies to enhance the interpersonal connection with mothers. The intimate home setting and repetitive nature of the nurses' visits afforded multiple opportunities for sharing in humor or offering help. For example, as a particularly stressed mother was counting to 10 as a relaxation strategy, the nurse suggested, "You may have to count to 50", and noted, "We both laughed". Nurses offered to help mothers in tasks such as holding the baby, folding laundry, sweeping the floor, tutoring, washing the dog, repairing drywall, or mailing letters.

Partnership Role #4: Knowledge exchange
While the nurses held valuable expertise and knowledge about health and health care, the mothers held expertise and knowledge as to her health conditions and symptoms, their care goals, their children's behaviors, and their responses to their own current circumstances. Nurses facilitated the knowledge exchange process, encouraging mothers to share their current health status and circumstances, past history, current thoughts and feelings, and care goals. Nurses often used self-disclosure, admitting their lack of knowledge about what the mothers' lives were like.

Partnership Role #5: Collaborating
The nurses and mothers formed collaborative partnerships characterized by joint problem-solving, role playing and otherwise working together toward improving aspects of mothers' lives, including improving mothers' confidence in handling interpersonal conflict effectively and parenting safely.

She then brought up her parenting in the past- the incidents that got reported to Child Protective Services. This was the first time she had ever volunteered it or taken responsibility for it (it had always been 'they say that I do this or that'). We discussed each incident and looked at the places where the 'holes' were that created danger for the boys.

Partnership Role #6: Navigating
Nurses acted as navigators, leading and partnering with the mothers to ensure they understood what health care and support resources were available to assist them, when they should seek these services and how to access them. For example, nurses commonly referred mothers to WIC programs, housing alternatives, food stamps and Medicaid programs for prescription refill assistance, and helped them make the necessary phone calls or obtain the necessary paperwork.

Partnership Role #7: Coaching
The partnership role of coaching was clear; nurses gave direction and positive feedback regularly to mothers via praise, encouragement and letter writing when mothers actively engaged in the intervention, and in their health and health care. In what would become a predictable cycle, nurses would coach mothers to set small attainable goals for the week (e.g. walk around the block once a day, take a few minutes to listen to music, deep breath, replace yelling with taking away a star on the behavior chart, give a warning before an actionable consequence). When mothers reached those goals, mothers and nurses would celebrate efforts towards improvement and then the cycle would repeat.

Discussion

In this study, we demonstrated that the process of engaging a traditionally underserved population was a complex endeavor not explained completely by any one nursing skill, strategy, or action. The Interactive Care Model was a good descriptive model of patient engagement and demonstrated utility in capturing the process of patient engagement of low-income depressed mothers in a mental health and parenting intervention. The 5 key processes (i.e. assessing a person's capacity for engagement, exchanging information and communicating choices, planning, determining appropriate intervention, and evaluating regularly) and the 7 clinicians -person and family partnership roles (whole person, intentional

presence, caring and trusting relationship, knowledge exchange, collaborating, coaching, navigating) were validated by the nursing narrative data. The ICM fully captured the specific verbal and non-verbal nursing interventions used to engage mothers in the intervention. A strength of this study is that the data was collected for another purpose, yet still fit the ICM well. Limitations of this study include using a small sample size, and as a secondary analysis, was limited to only the perceptions of the nurses.

Implications for nursing practice include specific engagement strategies (Table 1 and Table 2) that can help guide providers in specific engagement strategies and interventions to fully engage persons in their health and health care. Future studies can build and expand upon our work and trial how the ICM captures the process of patient engagement with different populations and in different contexts. Further research is needed to examine the timing and dosages of patient engagement strategies with traditionally underserved populations.

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