



User preferences for service delivery along chronic care pathways: results from a discrete choice experiment

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Abstract

Research highlights the importance of studying user experience as a dynamic phenomenon along multiple touchpoint journeys. This is particularly important in healthcare where users have experience of services till the birth to the end of life. In this sector, considering the user perspective along pathways is essential for designing “life-changing” journeys.

Using a discrete choice experiment, involving a representative sample of 2550 residents in Italy, this study was designed to gain deeper understanding of citizens’ preferences for the organizational model of service delivery along the chronic pathway, in relation to 1) reference provider; 2) relational continuity; 3) multi-specialist team; and 4) coordination of the pathway.

Our results indicate that teamworking is the most important attribute both for mild and severe chronic conditions. After that, continuity is the main relevant attribute for mild chronic patients: being cared by the same professional appears the most important aspect. However, in the case of severe chronic patients, the importance of coordination is more relevant, as the relational continuity.

This confirms the importance of gaining a more comprehensive view of the user experience along the journey considering all direct and indirect interactions users have with service at various touchpoints over time.

Keywords

User experience; User journey; Healthcare service; Chronic patient; Discrete choice experiment

1. Introduction

User experience has been gaining momentum in both contemporary management practice and services research (McColl-Kennedy et al., 2015)

Research highlights the importance of studying user experience as a dynamic phenomenon along multiple touchpoint journeys. In service marketing, the importance of the user experience over numerous service interactions cannot be overstated. A recent definition of customer experience included the concept of customer's journey as a collection of different touchpoints, i.e., individual contacts between the firm and the customer at distinct points in the experience (Lemon & Verhoef, 2016). Organizations cannot limit their attention to a particular service and its core dimensions (Voorhees et al., 2017). In order to establish and sustain strong, positive, and long-lasting relationships between provider and user, the experience should be improved (Gustafsson et al., 2015; Ostrom et al., 2015), taking into account the entire pathway of a user across all touchpoints within a service encounter (Bolton et al., 2014; McColl-Kennedy et al., 2015).

This is particularly important in healthcare where users have experience of services from the birth to the end of life. A "life-changing" journey, built considering needs and preferences of users, must include continuity of care, quality of services and experiences, and value provided along the pathway (Berry, 2019). In the public healthcare sector, retaining users, cultivating loyalty, and upholding positive relationships over time are important (Fisk et al., 1990; MacStravic, 1987; Peltier et al., 2002). Trust can have an impact on consumer loyalty and commitment (Melewar et al., 2017; Morgan & Hunt, 1994), which may have an impact on the use of healthcare services and patient adherence to recommended therapies at the individual level, and on the identity of the healthcare system at the system level (Pennucci et al., 2018). A positive experience with care is essential not only for fostering public trust, increasing access to care, and increasing chances for wellbeing and good health, but also for equity reasons (Bonciani et al., 2020). A research on the maternal care pathway showed that some group of vulnerable 'acquired users' at the first touchpoint of their pathway (namely, migrant women) are mainly unretained and are defected for other services along their journey, so losing key opportunities for health and representing a potential future waste of resources for the system (Bonciani et al., 2020).

Nevertheless, it is rare for healthcare organizations to have a full understanding of the patient journey (Nutti et al., 2017). This especially important for chronic patients, who have frequent contact with healthcare services in different settings and are high-cost frequent users. Health treatments for these conditions involve a number of contacts and activities that patients engage in as they move through the healthcare system (Mahdavi et al., 2021). For instance, a journey taken by a cancer patient and family members may involve a complicated network of brands, technologies, and services (Hamilton & Price, 2019).

As underlined by Berry (2019), healthcare services are a combination of complexity and importance, since these services are potentially life-changing or life-threatening, unlike other complex services, and are also consequential. In the "Five C's of Cancer Service", Berry underlined the need for coordination of services, orchestrating experience clues, enabling connection, valuing care continuity, and creating community partnerships.

Providing care to patients with multiple chronic conditions requires a comprehensive and focused-person approach, which means considering episodes of care as part of the life-course, instead of taking care of single disease and requires integration and coordination of health care services (Starfield, 2011). To this end, continuity and coordination represent two fundamental dimensions in the organization of services for chronic patients. Continuity of care includes informational, relational, and management continuity (Crump et al., 2017; Reid et al., 2002). It

is perceived as one of the most important dimensions regarding the strength of PC process service delivery (Kringos et al., 2010; Pavlič et al., 2015; Schäfer et al., 2019), even if continuity of care is not valued by all patients or across all settings (Oliver et al., 2019; Pandhi & Saultz, 2006). Research shows that relational continuity is highly valued by many patient groups, such as people with chronic and psychological conditions, older people, and those with poorer health status, as it is usually associated with trust and quality of communication (e.g., Freeman & Hughes, 2010). Longitudinal continuity, in terms of maintaining the relationship with the same doctor over time, is often used as an indicator for relational continuity (Murphy & Salisbury, 2020). Repeated interactions with the same professional enable secure trust to develop for patients (Tarrant et al., 2010). For chronic and multi-chronic patients, it is important that the general practitioner (GP) is aware of their history, to be able to give consistent advice, taking responsibility, trusting the patient and respecting him (Murphy & Salisbury, 2020). Patients prefer not to have to “repeat their story” to multiple professionals, which is cited as the primary reason for patients to prefer a trusted healthcare professional (Freeman & Hughes, 2010). Relational continuity significantly increases the perception of self-management of chronic and multi-chronic patients, and it is associated with greater patient satisfaction (Vainieri et al., 2018). Moreover, relational continuity has a positive impact on the patient’s sense of security, confidence and understanding, and on the experienced quality of healthcare (Wodskou et al., 2014). It is also considered a factor leading to better outcomes in the case of diabetes (Van Loenen et al., 2016). For some patients’ groups, it is important that care is provided by as few professionals as possible, that is consistent with the patient’s needs, and it is uninterrupted for as long as the patient requests it (Freeman & Hughes, 2010). The fragmented nature of the healthcare system becomes apparent to patients when they need to contact multiple professionals to coordinate care, errors occurred during transitions between different care settings, or when professionals disagree with each other about care and necessary services (Wodskou et al., 2014). The interaction with different health services, possibly in different settings, can have an impact on the patient experience and outcomes produced. Coordination of care reflects the organization of services between different types and levels of care to ensure that patients receive services that are appropriate to their needs and coherent across care settings and over time (Crump et al., 2017; Hofmarcher et al., 2007). In some studies, continuity is positively associated with coordination (e.g., Christakis et al., 2003); however, it can happen that relational continuity, mainly with the GP, is not associated to coordination of care or what is sometimes called the case management (Parkerton et al., 2004).

The presence of a care coordinator (or case manager) is often cited as a solution to ensure continuity and coordination in the care of chronic patients. The care coordinator represents the person in charge of patients’ care, and, according to them, his functions, should include: serving as an easy-to-access point; coordinating the different types of health and social services that the patient needs; acting as a contact with patients and their families or caregivers, to have regular exchanges with them, book follow-ups, offer guidance on symptom management and provide assistance in everyday activities (Boye et al., 2019; Lawless et al., 2020; Wodskou et al., 2014). The care coordinator can vary between different types of patients, based on different preferences and health conditions. Care coordinators in the literature range from healthcare professionals to social workers. Some elderly patients with long-term pathologies cite their nurse. Indeed, nurses have been identified as a valuable source of information due to their ability to provide comprehensive and understandable advice (Lawless et al., 2020; National Voices, 2013; Wodskou et al., 2014). However, the majority of patients report that they prefer to receive information from a primary care professional, typically the GP (Bonciani et al., 2018; Butterworth & Campbell, 2014; Sheaff et al., 2017). Indeed, traditionally, GPs represent the professional figure that comes closest to the role of care coordinator but, according to patients, they must be able to broaden the boundaries of their activity, especially in terms of sharing

information and teamwork (National Voices, 2013). Other studies, instead, show that patients prefer contact with specialists due to previous negative experiences with family doctors, who provide insufficient information to address their specific health problems (Lawless et al., 2020). The design approach for healthcare services insufficiently engages the stakeholder groups, their needs, and their involvement (De Rosis et al., 2019a; De Rosis S., 2019b). Despite the growing collection of patient or user experience feedback in healthcare, their application is still limited (Gleeson et al., 2016). Considering the ‘post-pandemic’ momentum that is shedding light on the need for healthcare services re-thinking and providing resources for it, innovative strategies should be based on a careful vision of the whole journey and a customisation of services according to people’s needs and preferences.

The aim of this study is to provide preliminary evidence on how to design the service journey that chronic patients and their families undergo, in the people perspective. Using a discrete choice experiment, this study was designed to gain deeper understanding of citizens’ preferences for the organizational model of service delivery along the chronic pathway, in relation to 1) reference provider; 2) relational continuity; 3) multi-specialist team; and 4) coordination of the pathway.

2. Methodology

This work uses data from a cross-sectional study carried out between February and March 2021, based on a web-based survey administered on the Qualtrics Platform. The study was conducted in Italian to a representative sample of adult Italian citizens. The observational part of the study included socio-demographic questions; the PROMIS® (Patient-Reported Outcomes Measurement Information System) scale; and some reporting questions, with multiple or single answers, regarding experience with public healthcare services or chronic care pathways. The experimental part of the survey was represented by two Discrete Choice Experiments (DCEs). The method is based on consumer choice theory (Lancaster, 1966), which assumes that (1) the utility of goods can be defined by different characteristics (i.e., attributes) and that (2) each attribute varies systematically with different specifications (i.e., levels). Individuals evaluate the overall desirability of the service based on these attributes, making compromises between of them. Thus, respondents are asked to choose the most preferred option between two or more alternatives (i.e., choice sets) generated by the various combinations of attributes. Thus, preferences are revealed indirectly through the respondents’ choices, determining which attributes drive individuals’ preferences and how changes in attributes and levels affect the respective preferences (Lancsar & Louviere, 2008). It is considered as the most widely used type of conjoint analysis, as it comes very close to real-world decision making (Hainmueller et al., 2014).

The two DCEs of this study evaluated individual preferences for the following attributes: 1) reference provider; 2) relational continuity; 3) multi-specialist team; and 4) coordination of the pathway. The attributes adopted and the respective levels are summarized in Table 1 and were chosen after a previous literature review.

Since the GP is always chosen by patients, on the one hand the combination “on duty GP” is impossible; on the other hand, “trusted GP” is a incorrect concept in Italian, because it should imply also a “not-trusted GP”. Consequently, “type of professional” was designed with 3 levels, with one empty level exclusively used for the combinations that includes “GP” as the “reference figure”, in order to avoid the impossible combinations with “GP”.

Table 1: Attributes and levels

| Attributes | Levels |
|----------------------|---|
| Type of professional | Specialist |
| | General practitioner (GP) |
| | Nurse |
| Trusted professional | Trusted (not for GP) |
| | On duty (not for GP) |
| | -empty level- (only for GP) |
| Type of work | Working alone |
| | Working in a multi-specialist team |
| Type of activity | Providing information on care pathway |
| | Organizing and coordinating my care pathway |

Respondents were shown a scenario introduced by this sentence: “Now we ask you to put yourself in the shoes of a person suffering from a mild chronic disease” (“severe” in the second scenario). Respondents were offered a definition of a mild and severe chronic condition in terms of frequency of contacts with various health professionals: twice a year for mild chronic conditions, once every 2/3 months for severe chronic conditions.

The reference population of this study consists of people over 45 years old resident in Italy (in January 2020, c32 million individuals. ISTAT, 2020). The sample size was calculated stratifying the population according to area of residence (North-West, North-East, Center, South, Islands) and age group (45-55, 56-65, 65-74, 75+). By considering a reference level of 95% and margin error less than 8%, a theoretical sample size of 2224 was estimated. The sample size was estimated considering a response rate of 30%. Respondents were recruited by the Qualtrics Company.

The authors carried out 1) a descriptive analysis of the sample and 2) a preliminary analysis of DCE data, coded as dummy variables and to be analyzed through conditional logit modelling using STATA 15 software (Hauber et al., 2016). Additional analysis will be conducted using conditional logit that relates the probability of choice among two or more alternatives to the characteristics of the attribute levels defining those alternatives. So, respondent preferences can be identified with respect to the different levels characterizing the attributes. Subsequently, a postestimation analysis can be computed, to create predicted values, considering different combination of attributes’ levels, in order to compare their preferences. Also, respondent preferences can be identified with respect to interaction effects considering the characteristics of respondents and the experience they reported in the observational section of the study.

3. Results

Descriptive analysis

The total sample of respondents was composed by 2550 individuals, stratified as in the following Table.

Tabella 2: distribution of respondents among geographical areas and age classes

| Age class | North West | North East | Center | South | Islands | Total |
|-----------|------------|------------|--------|-------|---------|-------|
| 45-54 | 200 | 176 | 173 | 191 | 94 | 834 |
| 55-64 | 344 | 170 | 225 | 212 | 117 | 1068 |

| | | | | | | |
|----------------|-----|-----|-----|-----|-----|------|
| 65-74 | 122 | 124 | 93 | 124 | 62 | 525 |
| Over 75 | 27 | 32 | 25 | 30 | 9 | 123 |
| Total | 693 | 502 | 516 | 557 | 282 | 2550 |

The sample follows the distribution of the Italian population in the different geographical areas; however, there is an oversampling of respondents aged between 55 and 64 years old, while there is an underestimation of people aged over 75 years. A comparison with national statistics can be found in Appendix C.

Respondents are equally distributed between men and women, with a slightly higher percentage of women (52%). Most of the sample suffers from at least one chronic disease (63%). Most of respondents have medium/high educational attainment. The main characteristics of respondents are summarized in Table 3.

Tabella 3: characteristics of respondents

| Variables | Categories | Values (%) |
|---------------------------------|---|-------------------|
| Area of residence | North-East | 20% |
| | North-west | 27% |
| | Centre | 20% |
| | South | 22% |
| | Islands | 11% |
| Sex | Female | 52% |
| | Male | 48% |
| Age | 45-64 | 33% |
| | 55-64 | 42% |
| | 65-74 | 21% |
| | >74 | 5% |
| Highest education qualification | No educational qualification / elementary education | 4% |
| | Middle school | 15% |
| | High school | 57% |
| | Graduate or postgraduate | 24% |
| Citizenship | Italian | 96% |
| | Not Italian | 4% |
| Chronicity | Not chronic | 37% |
| | One chronicity | 36% |
| | More than one chronicity | 27% |

Experiment analysis

Our preliminary results indicate that all attributes have a significant impact on respondents' decisions, in both mild and severe disease scenarios.

The analysis of the data from DCE for mild chronic conditions reveals that, other things being equal, the odds that patients prefer a certain type of chronic care service design increase by 4% when the reference figure is the specialist rather than the GP (not significant), decrease by 62% when the reference figure is the nurse rather than the GP ($p < .001$), rise by 60% when the reference figure is trusted rather than on duty ($p < .001$), increase by 85% when the reference figure collaborates in a team made up of professionals with different specializations rather than working alone ($p < .001$), 31% when the reference figure organizes and coordinates the care pathway (e.g. sets appointments on the checks to be done, establishes the frequency of tests to

be carried out, interacts with other professionals) rather than give information about the care path ($p < .001$).

The analysis of the data from DCE for severe chronic conditions reveals that, other things being equal, the odds that patients prefer the service design increase by 83% when the reference figure is the specialist rather than the GP ($p < .001$), decrease by 41% when the reference figure is the specialist rather than the GP ($p < .001$), rise by 55% when the reference figure is trusted rather than on duty ($p < .001$), rise by 131% when the reference figure collaborates in a team made up of professionals with different specializations rather than working alone ($p < .001$), rise by 54% when the reference figure organizes and coordinates the care pathway (e.g. sets appointments on the checks to be done, establishes the frequency of tests to be carried out, interacts with other professionals) rather than give information about the care path ($p < .001$).

All the attributes have the same effect on respondents' choice in the two DCEs (all positive effects except for the nurse as reference figure). The preference for the specialist as reference figure is statistically significant only for patients with severe chronic conditions, while in the mild chronic condition the preferences of respondents are not statistically different between GP and specialist. In both DCEs, in terms of main effect, team-working results to be the strongest determinant as shown by the OR. After team-working, for patients with mild chronic conditions, continuity is the most important attribute, followed by coordination. For patients suffering from severe chronic conditions, the importance of coordination increases, reaching the same relevance of continuity.

4. Discussion

This article is the preliminary output of a research aiming at developing a stronger understanding of chronic patients experience and journey.

The results of this research confirm the importance of the team working, as a key feature of the organizational models greatly moving the preferences of citizens. Team-working can be seen as structural integration of groups of professionals, meant as a cross-setting and/or cross-service integration, enhancing the ability of patients to get oriented along their care journey (Kerrissey et al., 2017), or the placement of services in the same structure as “multidisciplinary clinic” (Bonciani et al., 2017; Berry, 2019). Over the past two decades, healthcare reforms in Western Europe have promoted the cooperation among GPs as well as the improvement of inter-professional collaborative team works as a means to spread knowledge, facilitate accountability and, ultimately, improve patient care with limited resources (Rico et al., 2003; Saltman et al., 2006; Seghieri et al., 2014). Our results on citizens' preferences also confirm the recent Italian primary care reforms, which has moved towards a more comprehensive and team-based approach. In this setting, professionals from various disciplines (i.e., GPs, specialists, out-of-hours doctors, nurses, physiotherapists, psychologists, social workers) provide a broad range of medical and community services covering diagnostic, curative and palliative care, disease prevention, rehabilitation, home care and patient education and self-management interventions (Seghieri et al., 2014).

This research highlights the importance of relational continuity, especially for mild chronic patients. As reported by other scholars (Cheraghi-Sohi et al., 2008; Hole, 2008; Rubin et al., 2006; Seghieri et al., 2014), being cared by the same professional appears a key feature of health care services for patients with chronic conditions. The relational continuity is related both to the trust, which is a key aspect in the care journeys, and to the reassures of having a trusted individual of reference who can guide the patient along the pathway having all information at the hand. However, it is worth pointing out that, for severe chronic patients, the importance of coordination became more relevant for people: having a referent it is not so important if s/he

only provides information but is not a real coordinator of each step along the pathway. People need a ‘guide’ along their care journey, not only an ‘informer’.

Subsequent analyses can go deeper in highlighting what matters most to patients between continuity and coordination. In a context in which it is necessary to invest in new models of chronic care, it can be interesting to study the trade-off, in the citizens’ perspective, between continuity and coordination of care, to understand what is worth more when these two elements are not combined in the case of mild and severe chronicity.

5. Conclusions

As written by Berry (2019), “Few, if any, services influence people’s quality of life more than healthcare”. The contribution of academics, researchers and scholars in healthcare innovation can be really relevant.

Care for chronic patients is more about considering episodes of care as part of the life-course, instead of taking care of single disease and requires integration and coordination of health care services. For these patients, it is therefore essential to organize health services in terms of a journey across multiple touchpoints. This research is aimed at providing insights for the re-organization of chronic care pathways, by adding evidence on the people preferences on how to re-define ‘the complex constellation of services’ a chronic patient and his/her family undergo along his/her journey.

Using data from two experiments, this research provides preliminary evidence on some attributes that chronic care services should have from the people point of view. Under this perspective, it may contribute to the design of more effective and patient-centered services.

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