She Makes Me Feel like an All-Star: Patients’ Experiences with Self-Management Education in an Intervention for Chronic Musculoskeletal Pain

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Background: Chronic pain is prevalent, costly, and exerts a significant burden on both primary care providers (PCPs) and patients. In this study, we elicited patients’ experiences following completion of a stepped-care intervention for chronic musculoskeletal pain.

Methods: We conducted qualitative interviews with patients who participated in the intervention arm of a randomized controlled trial for chronic pain management at a VA Medical Center. Step 1 of the intervention consisted of analgesic treatment coupled with pain self-management strategies, followed by brief cognitive behavioral therapy in Step 2. A nurse care manager delivered all elements of the intervention via telephone. At the end of this trial, we asked patients open-ended questions about their experiences in the RCT. Interviews were audio-taped, transcribed, and checked for accuracy. Sampling continued until theoretical saturation was reached. We used grounded theory and constant comparative methods to analyze the data.

Results: Patients (N = 26) were 24 to 62 years old; four were women; all had moderate to severe chronic musculoskeletal pain. While patients varied in their descriptions of the stepped-care intervention and the self-management education received in the study, they all spoke of the important role played by the nurse care manager. Three themes emerged related to the nurse care manager’s role in pain self-management.

Theme 1, Finding What Works: Patients appreciated having someone they knew to talk to about different options pain self-management: “The best part is having somebody there to talk to, to go over ideas you have about what works and what doesn’t, and get feedback on your progress.” (Participant 7)

Theme 2, Being Held Accountable: Patients felt accountable to the nurse. They knew she would call them, and they wanted to be able to tell her (truthfully) that they were using their self-management strategies. “It kept me accountable...Usually nobody asks me, ‘Are you walking? Stretching?’ I don’t want to lie to her, so I do it, where normally I’d just do nothing.” (Participant 19)

Theme 3, Motivation/Emotional Support: For some, the nurse’s phone calls provided motivation to continue with their self-management strategies. For others, emotional support was more critical: “When I got off the phone, I felt better. I was more relaxed and I felt that somebody’s helping me. You’re in a bad spot and somebody cares enough to lend a hand. It was a big deal. It’s comforting.” (Participant 25)

One veteran simply valued the personalized attention: “She makes me feel like I’m an all-star.” (Participant 11)

Conclusions: This study highlights the important role played by a nurse care manager in helping patients self-manage their chronic pain. Specifically, the nurse helped patients find different self-management options, held patients accountable in self-management goals, and provided emotional support and motivation to patients. Incorporating nurses into pain management in primary care may potentially alleviate some of the burden on PCPs caring for patients with chronic pain.
Feasibility of Portable Technology to Diagnose Sleep Apnea in Underserved Communities

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Background: Despite high prevalence of risk factors such as obesity and diabetes, Latinos and Blacks are under-diagnosed and under-treated for obstructive sleep apnea (OSA), partly due to decreased access to costly traditional overnight studies. One in four adults have pre-diabetes. Untreated OSA may speed their development of diabetes, both because compensatory mechanisms to compensate for apnea may exacerbate hyperglycemia, and because the associated fatigue may thwart weight loss. Yet, little is known about the prevalence of OSA among pre-diabetics. In addition, portable OSA monitoring devices may improve access to diagnosis among high-risk, low-income populations, but no data exist on portable testing among vulnerable populations. A community-academic partnership in East Harlem, the epicenter of diabetes in New York City, aimed to assess the feasibility and acceptability of portable OSA diagnosis and explore the prevalence in OSA in a pre-diabetic, minority population.

Methods: We recruited a convenience sample of participants who completed a diabetes prevention randomized controlled trial. All participants wore an ApneaLinkPlus® portable monitor overnight and afterwards engaged in open-ended interviews about their experience using the equipment and underlying perceptions about OSA. Those with moderate or severe OSA (>15 AHl per hour) received auto-titrating CPAP machines and returned at 30 days for follow-up. Measurements of health were collected in conjunction with the parent study. We analyzed interview transcripts and calculated means and standard deviations for continuous variables, proportions for categorical variables and group comparisons using chi-square and student’s t-test in SPSS v17.

Results: We tested 52 pre-diabetic, overweight adults. Most were Latino (64%), or Black (31%), uninsured (31%), low-income (50% earned < $15,000 per year), and undereducated (28% with < high school diploma). Use of at-home sleep monitors was feasible in this population: of the 121 approached, 58% agreed to testing, and 100% of those given home monitors returned them promptly. No participants required OSA test in overnight lab, as the home diagnoses were conclusive. Participants found monitors comfortable and convenient (87% would recommend the test). Nearly half (48%) had OSA (> 5 AHl events/hour); 13% had moderate to severe OSA (>15 events/hour) requiring treatment with CPAP. Screening with the commonly used, verbally administered Epworth Sleepiness Scale did not accurately predict which participants had OSA compared to those diagnosed by the ApneaLink Plus (p=.506). Mean systolic blood pressure (BP) was significantly higher in those with OSA (119 vs 109 mmHg, P= 0.01), but BMI, cholesterol and depressive symptoms were not statistically different between those with and without OSA. We interviewed all 18 participants with moderate to severe OSA and found that most had a misconception that OSA would cause them to die in their sleep. However, they were appropriately concerned that OSA could cause progression to diabetes, and thought weight loss could prevent or improve OSA.

Conclusions: At-home sleep monitors represent a feasible and acceptable method for diagnosing OSA in high-risk minorities. The prevalence of mild-severe OSA in this population is much higher than the US average (48% compared 3-28%) indicating need to increase accessibility to OSA diagnosis in this population.
The consequences of good intentions: HIV/AIDS media directed towards African-born persons in the United States

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Background: The number of African-born persons in the US increased by 750% between 1980 and 2009, a period concurrent to the epidemic expansion of HIV/AIDS in sub-Saharan Africa. In spite of this, there is a dearth of research addressing this population's HIV screening needs, and despite a number of culturally tailored screening programs conducted by a local community-based organization, screening rates remain low.

Methods: In order to identify effective strategies to increase HIV testing and referral rates, researchers and community partners conducted focus groups to uncover barriers and potential facilitators of screening. We recruited 39 African-born persons (46% women) residing in New York City, representing a wide range of African immigrants, including taxi drivers, hair braiders, street-vendors, students, mosque and church attendees. Four focus groups were held at a community-based organization and were audiotaped, transcribed, and translated from French and Wolof to English.

Results: Grounded theory analysis using ATLAS.ti® revealed four previously described themes: fear of deportation; fatalistic attitudes; misinformation about HIV treatment options; and HIV stigma. Unexpectedly, we also identified two novel themes: 1) negative responses to public health messaging directed exclusively to Africans as it was viewed as inappropriately associating HIV/AIDS with Africans; and 2) preference for non-African providers so as to decrease the risk of a breach of confidentiality.

Conclusions: We found that current efforts to offer culturally-tailored HIV screening that exclusively targets African immigrants and provision of ethnically similar providers can paradoxically lead to concerns about being stereotyped and loss of privacy. Solutions proposed in the focus groups include public health messaging that portrays both African and non-African individuals, and cultural training for non-African counselors and screeners and anonymous translation services (translation phones) in testing centers.
Reasons for Readmissions in a High-Risk Population

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Background: Hospital readmissions represent a significant cost to the healthcare system and are a burden to patients. There is a paucity of qualitative data regarding the perspectives of patients with multiple readmissions. Furthermore, very little is known about the factors contributing to readmissions in the urban underserved population, who comprise a disproportionate share of readmissions for many academic medical centers. We gathered qualitative data to elucidate the reasons for readmissions in a high-risk population of underserved patients at Yale-New Haven Hospital.

Methods: We conducted semi-structured qualitative interviews of patients receiving primary care services from the Yale Primary Care Center (a low-income health center serving New Haven) who had four or more readmissions in the previous six months and were currently readmitted to the hospital. All interviews were transcribed by an independent company. Two investigators independently generated codes from the primary data and developed a final code list using the constant comparative method. These codes were organized into 11 main themes.

Results: To date eight interviews have been completed. We identified three major themes: “self-triage,” primary care discontinuity, and adequacy of formal services. Patients in the study typically went directly to the Emergency Department when they experienced a change in health status without consulting with their primary provider. Prevalent reasons for this “self triage” included poor telephone access to the Primary Care Center, poor access to urgent visit appointments, and the belief that the Primary Care Center could not treat acute illness. Another contributor to readmission was that patients either could not name their primary provider or stated that they did not have a primary provider. Conversely, every patient reported being able to obtain medications without undue financial burden, and every patient reported receiving adequate formal home services such as visiting nurse services, home health aides, or transportation assistance.

Conclusions: Our results suggest that there may be factors contributing to readmissions in this underserved high-risk population that are not addressed by most current interventions, which are targeted at access to medications and formal home and nursing services. In particular, patients consistently reported using “self triage” stemming from inadequate communication with providers when they had a change in health status. As future interventions are developed for prevention of readmissions, improvement of continuity and communication with outpatient providers should be considered.
Background: Attending physicians are often challenged by the decision of when to allow trainees autonomy in procedural tasks and clinical decision-making. Medical educators have struggled to find ways to evaluate trainees and assist faculty in determining trainees' preparedness to independently perform tasks. The aim of this study was to create a conceptual framework to identify factors determining attending and resident perceptions of trust in clinical decision-making.

Methods: Internal medicine residents and attending physicians were interviewed between January and November 2006, at the conclusion of their Internal Medicine rotation. Participants at a single academic medical center were asked, using the Critical Incident Technique, to describe important entrustment decisions made during their rotation and final call night. Audio-taped interviews lasted on average 45 minutes. All personal and patient data were de-identified during transcription. Interview transcripts were reviewed and analyzed using a deductive approach and the Entrustable Professional Activities (EPA) framework. Data were coded to construct themes of trust, and to identify the factors that promoted, undermined, or otherwise described trust. Two investigators (JMF, KJC) independently reviewed representative portions of the transcripts until consensus was achieved. The inter-rater reliability was calculated using a generalized kappa-statistic (κ). The coding scheme was then applied to the entire set of transcripts.

Results: Eighty four percent (42/50) of residents and 80% (40/50) of attending physicians were interviewed. The analysis yielded 535 discrete mentions of trusting factors, which were coded into 35 sub-themes. The inter-rater Kappa for coding between the two raters was high at 0.84. Four major domains of trust were described, each with specific sub-themes: trainee factors (confidence, recognition of limitations, area of specialty/career plans); supervisor factors (approachability, area of clinical expertise, perception of clinical obligations); task factors (urgency/severity of illness, transitions, level of difficulty, situational characteristics); and, systems factors (workload, duty hours, training philosophy). Supervisors frequently base entrusting decisions on direct observation of trainee performance. Situational factors such as adequacy of support staff and team dynamics were noted to influence the entrustment decisions. Relational factors such as personality characteristics and prior work experience were frequently mentioned. Attendings noted that the career plan or sub-specialty choice influenced their provision of resident autonomy, with those pursuing a sub-specialty perceived as more competent and worthy of trust.

Conclusions: The development of trust is multi-factorial and comprises factors driven by the supervisor, trainee, task and environment. Trust is often driven, despite objective metrics, by subjective conclusions drawn from direct trainee observation. Supervising physicians base decisions on personal characteristics, including honesty, disposition, and self-confidence, which may not correlate with trainee competency. It is important to recognize bias toward sub-specialty bound residents, which may hinder the growth of those planning generalist careers. Future studies should address drivers behind these decisions, correlations with patient outcomes, and tools to enable faculty to justify their entrustment decisions and assess readiness of residents to proceed without supervision.
Using Photo-Elicitation to Identify Sources of Waste In An Academic Medical Center

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Background: Rising medical costs in the U.S. have made health care unaffordable for many patients and force payers to make difficult coverage decisions. Identifying and reducing sources of waste in the medical system is an attractive alternative to limiting necessary health care coverage. Using photo-elicitation, an innovative approach to qualitative study, we sought to identify sources of waste in a large tertiary care academic medical center.

Methods: Participants were recruited from a broad range of departments throughout the hospital via word of mouth and were invited to take up to 10 photos of examples of waste they encountered during their workday. Participants then described the waste they captured in their photos during a semi-structured interview with a research staff member. A standardized interview guide was used; interviews were audio-taped and professionally transcribed. Transcriptions were reviewed independently and iteratively by two study team members and a code book was developed from the transcripts. The code book was revised with each successive interview and organized into pertinent themes. Interviews were conducted until theoretical saturation was reached. Agreement in code assignment between reviewers was assessed.

Results: Eighteen individuals participated in this study and 140 photos were taken; all were included in the study. Participants represented a range of health professionals, including nurses, attending physicians from a number of disciplines, respiratory therapists, administrators and administrative support personnel. Agreement between transcript reviewers reached 85%. Major types of waste described included time and tangible resources such as food, paper and energy. Factors identified in creation of waste included poorly designed or inefficient systems, medical education, poor communication and false economies. Barriers to reducing waste included inertia and regulatory systems. Consequences of waste included sub-optimal patient care and satisfaction as well as physician disengagement. Although some recommendations for waste reductions appeared simple to implement, many were complex.

Conclusions: Individuals working within the health care system can offer unique insights into sources of waste they encounter in their daily routine. Although reducing waste may prove challenging, the results of this photo-elicitation study serve to generate a broad range of testable hypotheses regarding sources of waste existing in a large tertiary care hospital.