



Provider Perspectives

Tele-health: Lessons and strategies from specialists in poison information

Erin W. Rothwell^{a,*}, Lee Ellington^a, Sally Planalp^b, Barbara Insley Crouch^c^a College of Nursing, University of Utah, Salt Lake City, USA^b Department of Communication Studies, University of Texas-Austin, USA^c College of Pharmacy, University of Utah, Salt Lake City, USA

ARTICLE INFO

Article history:

Received 20 August 2010

Received in revised form 9 February 2011

Accepted 14 February 2011

Keywords:

Tele-health communication

Focus groups

Poison control centers

Patient adherence

ABSTRACT

Objective: The use of the telephone for providing healthcare is growing. The aim of this exploratory study was to describe tele-health lessons and strategies as discussed by specialists who provide information and recommendations on poison control hotlines.

Methods: Three focus groups of 25 participants who work as specialists in poison information in poison control centers were conducted. Group discussions were analyzed using qualitative content analysis.

Results: Themes that emerged from the data on strategies for telephone communication include: taking control of the call, developing a therapeutic relationship, tailoring communication to fit each caller, preventing information overload, confirming caller understanding, and hands-on training for the development of telephone communication skills.

Conclusion: Specialists in poison information identified challenges specific to communicating with patients over the telephone and reported several types of strategies they used to manage them.

Practice implications: Telephone communication training may be needed to assist health care providers in improving their communication skills.

© 2011 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Poison control centers provide poison information and clinical toxicology consultation over the telephone, and they can serve as a model for understanding tele-health strategies that may promote adherence to healthcare recommendations. In the U.S. and Canada, the majority of callers to poison control centers are laypersons who have concerns about a poisoning or toxic exposure. Poison control centers are staffed by specialists in poison information who are trained pharmacists and nurses with previous clinical experience. Staff members have to efficiently assess the situation over the phone to decide whether the caller needs to immediately seek in-person medical care or if the incident can be managed over the phone. This tipping point of emergency versus self-care is the driving force for assessing the situation as efficiently as possible, while also developing a therapeutic relationship to promote caller adherence to risk recommendations. In addition, in the absence of visual cues additional strategies must be applied to gather the essential information [1].

There has been little research examining communication strategies in poison control centers or other tele-health services in general. Therefore, the purpose of this article is to describe strategies

used by specialists in poison information that may lead to better patient adherence as identified through focus group discussions.

1.1. Adherence to healthcare recommendations

Nonadherence across numerous health care contexts causes preventable morbidity and mortality and places unnecessary financial and resource burdens that are estimated to cost our health care system 100 billion dollars annually [2]. Most research on adherence has been studied within the context of an ongoing face-to-face patient-provider relationship. With the growing use of brief, single-encounter tele-health interventions, research is needed to address nonadherence to recommendations that are made over the telephone [3,4]. Preliminary tele-health research indicates that there are unique strategies for phone communication that promote caller adherence [1], but it remains clear that additional research is needed to further understand this growing area of healthcare [1,5,6].

Communicating risk in ways that promote adherence is a teachable skill that is receiving increased attention in public health and clinical care [7–9]. Effective communication of risk has been noted as essential for vaccinations [10], emergency department physicians [11], clinical pharmacy services [12], telenursing [1] and poison control centers [13].

Communicating risk and health information over the telephone poses challenges beyond those of face-to-face interactions because it occurs without visual and tactical cues, de-contextualizes the

* Corresponding author at: College of Nursing, University of Utah, 10 South 2000 East, Salt Lake City, UT 84112, USA. Tel.: +1 801 581 5407; fax: +1 801 585 9838. E-mail address: erin.rothwell@nurs.utah.edu (E.W. Rothwell).

clinical encounter, and cannot rely on an ongoing relationship between provider and patient. For most tele-health services, an essential component of the clinical encounter is to determine the degree of urgency of the clinical problem and whether the individual needs to be referred to healthcare facilities [5]. This is a time-sensitive clinical encounter and requires the healthcare worker to focus on the clinical problem and to conduct a rapid and accurate risk assessment.

It appears that telephone-only healthcare may be heavily relied upon by the aging population and by those living in more rural/frontier areas [14]. For example, new technologies and enhanced symptom management for chemotherapy are focusing on telephone-linked care to alert providers to deliver immediate clinical care over the telephone for unrelieved symptoms that persist for more than 24 h among older cancer patients [15]. Understanding how to improve telephone communication will be essential to use of these new technologies effectively and efficiently.

1.2. Poison control centers

Poison control centers are ideal settings to assess and understand strategies for effective tele-health encounters that aim to promote adherence. The second leading cause of injury related death in the United States is poisoning [16], and U.S. Poison control centers receive more than 4 million calls about poisoning episodes each year [17]. These services provide treatment recommendations to the lay public and clinical toxicology consultation to health care professionals. Poor adherence to treatment recommendations can put people at risk for serious injury or death, especially those who refuse recommendations to seek treatment in a health care facility. [2]. In addition, poor adherence may lead to unnecessary utilization of health care services, which increases costs [18].

Thus, poison control centers can serve as a rich and valuable resource for understanding effective tele-health strategies and challenges to tele-health that are essential for identifying effective phone communication skills that promotes adherence to health-care recommendations. To understand the strategies used by specialists in poison information for communication of risk information, focus groups were conducted among specialists in poison information.

2. Methods

2.1. Approach

Due to the limited understanding of this important health topic, a qualitative approach to generate data was adopted [19]. Qualitative descriptive designs allow the researcher to sample a broad range of cases to gather in-depth details as described in the participants' own words [19,20].

2.2. Participant selection

Three focus groups were conducted with a national sample of specialists in poison information at the annual North American Congress of Clinical Toxicology (NACCT) meeting in October 2007 in New Orleans, LA. Institutional Research Board approval was received from the researchers' university. Participants were recruited prior to and during the conference through flyers and national email listserves. The recruitment materials asked for help from specialists in poison information to identify communication barriers, strategies and training needs.

The NACCT conference coordinator was contacted to obtain information on SPI attendance. There are approximately 1150 SPIs in the United States and Canadian Poison Control Centers and

approximately 181 attended the conference (L.J. Sandler, personal communication, October 4, 2010). This resulted in 16% of the targeted population available for recruitment, and of those who attended the conference, approximately 14% volunteered for this study. Factors that might have influenced attendance could be the proximity of the conference, available funding to pay for attendance, or personal interest. See Table 1 for participants' characteristics.

2.3. Conducting the focus group

Each discussion lasted approximately 90 min and was held in a private room in the conference hotel. Before the start of the discussion, consent was obtained, and each participant provided demographic information by completing a brief questionnaire. The focus group format followed recommendations by Krueger and Casey regarding preparation, engaging participants, and moderating the discussion [21].

The goals and objectives of the focus groups were explained at the beginning of the sessions. Open-ended questions were presented that invited participants to identify communication challenges and specifically how they dealt with those challenges. The questions used during the focus groups: (1) were crafted to evoke conversation, (2) used words the participants would use when talking about this issues, (3) were concise and open ended, and (4) followed a logical questioning route [21]. For example: "Can you tell me about general types of communication issues that you experience in answering calls?" "What skills and strategies have you developed to handle challenging calls?" "What types of skills and strategies do you use in routine clinical calls?" and "What do you do to help them understand what they need to do next?" (A complete list is included in the appendix.)

Each of the discussions was audio-recorded and transcribed by a professional transcriptionist. A member of the research team verified all transcription work by listening to the recordings and reading the transcripts.

2.4. Analysis

A qualitative content analysis was used to analyze the data. Instead of a priori coding schema, the researcher read and re-read the transcripts to develop the initial coding scheme using the participants' own words. Then the codes were systematically applied to one of the transcripts with the possibility of adding additional codes (open coding) that may have been missed with the development of the codebook [22]. All coded data were retrieved, reviewed and verified by the research team through an iterative process. This allowed the research team to make any changes to the codebook through a consensus decision making process and changes were then made to the coding strategy. Finally, the codes were applied to all of the transcripts, summarized and recontextualized within the data to identify

Table 1
Participant characteristics (n=25).

Age	Mean = 45.96 years (range 30–60 years of age)
Sex	76% Female
Ethnicity	92.0% Caucasian
Years as a SPI	12.9 years (range 2–32 years)
Location of work	West 16%, central 40%, southeast 24%, northeast 20%
Prior clinical experience	Nurse 68%, pharmacist 24%, other 8%
Education	AA 32%, BS 40%, masters 8%, Ph.D. or PharmD 20%

Download English Version:

<https://daneshyari.com/en/article/6153851>

Download Persian Version:

<https://daneshyari.com/article/6153851>

[Daneshyari.com](https://daneshyari.com)