Healthcare xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/healthcare

Original research

Challenges to teaming for pain in primary care

Karleen F. Giannitrapani[a,*], Sangeeta C. Ahluwalia[b], R. Thomas Day[a], Maura Pisciotta[c], Steven Dobscha[d], Karl Lorenz[a,b,e]

[a] Center for Innovation to Implementation, VA Palo Alto Health Care System, 795 Willow Road, Menlo Park, CA 94025, USA
[b] The RAND Corporation, USA
[c] Center to Improve Veteran Involvement in Care, VA Portland Health Care System, USA
[d] Department of Psychiatry, Oregon Health & Science University, USA
[e] Stanford School of Medicine, USA

A R T I C L E I N F O

Keywords:
Chronic pain
Patient centered care
Interdisciplinary teams
Qualitative research
Veterans

1. Background

With approximately 100 million adults in the United States currently living with chronic pain, effective pain assessment and management is an area of vital clinical and public health concern.[1] The National Pain Strategy has recently called for renewed emphasis on "integrated, multimodal, and interdisciplinary" models of pain management,[2] and integrated, interdisciplinary team-based approaches to chronic disease management are increasingly adopted in practices nationwide.[3] Coordinated interdisciplinary care may improve outcomes and satisfaction with care for patients with chronic conditions.[4,5]

The Patient Centered Medical Home (PCMH) model of primary care has emerged in response to the systemic emphasis on interdisciplinary chronic disease management. PCMH represents a team-based approach intended to provide patients with a continuous, accessible, coordinated, high quality care experience.[6,7] Implementation of the PCMH model, however, has seen varied success,[8,9] and has faced a variety of barriers.[8–15] Chronic pain is as an example of a chronic condition that relies on care from multiple providers with diverse expertise[18] and may pose coordination challenges for PCMH teams.[16] Understanding providers' experiences and challenges with caring for patients with chronic pain in an interdisciplinary primary care team-based structure is important to help identify critical needs and opportunities for improvement. As part of preliminary efforts to develop a national randomized control trial for enhanced pain screening and assessment methods, we conducted exploratory focus groups with providers from the various disciplines involved in primary care based chronic pain assessment and management. We employed inductive qualitative methodologies to characterize the challenges to team based pain care that emerged.

2. Methods

2.1. Setting

The Veterans Health Administration (VA) implemented a nationwide transformation of its primary care practices by reorganizing staff into Patient Aligned Care Teams (PACT), which represent the VA's version of the PCMH. In their ideal form, PACTs are composed of a four member core interprofessional group known as a "teamlet" and include a primary care provider (PCP)—who can be a physician, nurse practitioner, or physician assistant—supported by three full time equivalent nursing and administrative staff. Multiple "teamlets" cluster to form the PACT team, which is supported by auxiliary members from pharmacy, social work, mental health, and other disciplines. For pain management, the extended team might include ancillary specialty services such as pain clinics or palliative care (Fig. 1).

2.2. Participants

Key informants included sixty primary care providers (PCPs), registered nurses (RNs), Licensed Practical Nurses (LPNs), clerical associates, psychologists, and social workers.

* Corresponding author.
E-mail address: Karleen@stanford.edu (K.F. Giannitrapani).

http://dx.doi.org/10.1016/j.hjdsi.2017.06.006
Received 18 June 2016; Received in revised form 24 January 2017; Accepted 28 June 2017
2213-0764/ Published by Elsevier Inc.

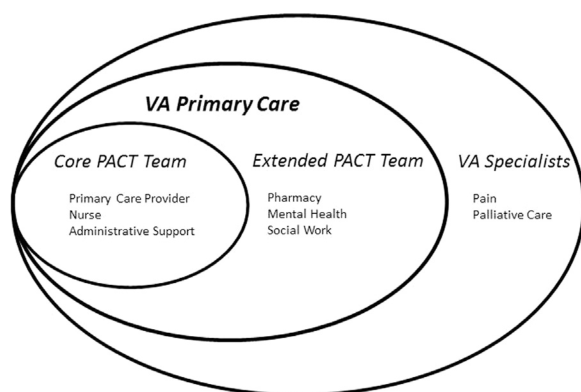

Fig. 1. Structure of VA Providers Involved in Chronic Pain Care.

2.3. Design

Using targeted fliers, we recruited a convenience sample of interdisciplinary PACT team providers at two large academically affiliated VA Medical Centers in two states who participated in a total of nine interdisciplinary focus groups between 2013 and 2014. The large size of the two VA systems allowed us to conduct focus groups with providers in different settings including large hospital medical center facilities, as well as both urban and suburban community outpatient clinics. At least three different provider roles were represented in each focus group in an attempt to generate data representing an interdisciplinary perspective on pain screening and management processes. Each focus group was led by trained facilitators (one MD and one PhD implementation scientist) and lasted approximately 45–60 min. Transcripts were audio recorded, professionally transcribed, and de-identified to remove any identifying information.

This analysis was conducted as part of the Effective Screening for Pain Study, a mixed methods effort to inform improved pain screening and management processes in the VA. Focus groups comprised the first wave of data collection in this larger effort and informed the development of a randomized control trial of enhanced pain screening and assessment methods. Each focus group was led by a trained facilitator using a semi-structured interview guide to elicit provider experiences with screening for, assessing, and managing chronic pain. The guides included probes to capture challenges faced by teams and providers, roles and responsibilities of team members, and interactions between and among providers. The questions in the interview guides assume pain follows a bio-psychosocial model.[17]

2.4. Data analysis

All analyses were conducted using qualitative analytic software ATLAS.ti.(v7). Qualitative analysts (two PhD implementation scientists and two Masters level educated research assistants) evaluated transcribed interviews using constant comparison and produced mutually agreed upon themes and sub-themes. An initial code list was developed by team review of two transcripts. A final code list was confirmed by consensus and systematically applied to all transcripts. Each transcript was coded by a primary coder and reviewed for inconsistencies by a secondary coder. Team meetings with the qualitative analysts and clinician members of our investigator team fostered consensus for code development and facilitated resolutions for coding discrepancies. We presented themes to PACT leadership as a member check for confirmability.

3. Results

Two specific challenges to providing better team-based pain assessment and management emerged: task redundancy and integrating specialists into the team pain care process. Both themes divide into subthemes.

3.1. Task redundancy

Task redundancy describes the phenomenon of having multiple members of a team responsible for the same task (e.g. pain screening.)

3.2. Task redundancy sub-theme 1: Non-redundant nursing assessment can enhance pain care processes

PCPs indicated that having nurses involved in pain screening could save provider time.

"Please take the time into account…I would suggest that some of it has got to be started before they see the provider, and then the provider's got to finish up some of it, but where that split is, I'm not quite sure." [PCP]

Nurses concurred with this understanding.

"Yeah, nurses are here to make it easiest for the provider. Anything they don't have to deal with. Potentially seeing the patient at all. We want to clear the provider's schedule to deal with things that are more important. So I think nurses should always be involved in screening patients for anything." [Nurse]

3.3. Task redundancy sub-theme 2: Redundant nursing assessment does not enhance pain care processes

Some PCPs felt that nurses currently added minimal value to pain assessment process because PCPs have to repeat the assessment themselves.

"It doesn't really matter what the nurse charts, you're going to get your own history, it's just a repetitive operation." [PCP]

Providers also indicated that nurse assessments were not considered in the PCP decision- making process.

"*In terms of what I physically will ask and do that visit, that particular questioning [nurse assessed pain] doesn't necessarily play a role in my decision making process." [PCP]*

Nurse respondents concurred with this perspective.

"*We [nurses] assess as much as we can but, you [PCP] might look at our notes as…the patient told the nurse this, but you will still ask your questions, you will still assess further, you will not base your judgment on our assessment." [Nurse]*

Providers indicated that the task redundancy wasted team resources (nurse time).

"The nurse, I suppose, could take the history but we're going to have to take it again, so why waste their time?" [PCP]

3.4. Task redundancy sub-theme 3: Patients provide inconsistent information to different clinicians

PCPs, Registered Nurses (RNs), and Health Technicians indicated that one of the consequences of task redundancy was that it gave patients the opportunity to provide clinicians with inconsistent information.

"Usually I look at it [nurse asked pain score], but my experience with patients is that they are always giving you two different stories—or three—to different providers. So when a nurse is going to talk or a medical assistant is going to talk or the provider is going to talk or the surgeon is going to talk, they [patient] will give each time another different story." [PCP]

Download English Version:

https://daneshyari.com/en/article/6925749

Download Persian Version:

https://daneshyari.com/article/6925749

Daneshyari.com