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a working group was established to review the data, identify fixable problems with the highest frequency, and propose changes to improve patient care and efficiency of hospital operations.

FINDINGS TO DATE/EVALUATION OF WEB SITE: Over one week, we identified 199 problems or usual care (UC). Interventions were delivered by monthly telephone calls for six groups of 200 patients. All 94% of patients (96% reported being fully medication adherent. At 6-month follow-up, MANCOVA adjusting for baseline BP indicated that systolic BP was significantly lower in SM (129 mm Hg, standard deviation [SD] = 13.9) than HEI (139 [mm Hg, SD = 18.2, P = .032) and UC (140.2 mm Hg, SD = 19.5, P = .006). Although use of a guideline-based nurse telephone triage protocol for evaluation and management of URI symptomatology had lower satisfaction compared to usual care (P = .0001) and diet adherence levels (P < .001). All but 3 patients (96.1%) reported being fully medication adherent. At 6-month follow-up, MANCOVA adjusting for baseline BP indicated that systolic BP was significantly lower in SM (129 mm Hg, standard deviation [SD] = 13.9) than HEI (139 [mm Hg, SD = 18.2, P = .032) and UC (140.2 mm Hg, SD = 19.5, P = .006).

CONCLUSION: In this randomized study, a Transtheoretical stage of change-matched intervention led to improved adherence for exercise, diet, and taking medications, and lowered BP among veterans with hypertension. This study provides preliminary evidence that stage-matched interventions hold promise for improving hypertension control among veterans.

A COMPARISON OF DIABETES CARE QUALITY IN VA AND COMMERCIAL MANAGED CARE: THE TRIAD STUDY: E.A. Kien; R. Gerzoff; S.L. Krein; J.W. Selby; J.P. Piette; J. Curci; H.E. Herman; D.G. Marmer; V. Narayan; M. Safford; C.M. Mangione; J. Curb; H. VanHouten; S. Scheitel; R. Stroebel; 1; H. VanHouten; J. Naessens; S. Scheitel; 1; Mayo Clinic, Rochester, MN; 2; University of California, Los Angeles, CA; 3; University of Michigan, Ann Arbor, MI; 4; Indiana University Purdue University Indianapolis, Indianapolis, IN; 5; University of Medicine and Dentistry of New Jersey, Newark, NJ; 6; University of California, Los Angeles, CA; (Tracking ID #116744)

STATEMENT OF PROBLEM/QUESTION: Acute upper respiratory infection is a common, self-limiting viral infectious illness. Patients can be treated by RN telephone protocols for patients with symptoms of viral URI or acute sinusitis. Patient satisfaction with RN telephone management has not been assessed in past.

OBJECTIVES OF PROGRAM/INTERVENTION/WEB SITE: To determine if a nurse-based telephone protocol for management of URI and acute sinusitis will result in patient satisfaction equivalent to usual care.

DESCRIPTION OF PROGRAM/INTERVENTION/WEB SITE: January 2002 to July 2002 patients calling with symptoms of cough, runny nose, sinus pain or infection were triaged to a guideline-based registered nurse (RN) telephone treatment protocol (intervention) or usual care (control). Patients of 10 physicians were enrolled in the intervention group, whereas patients of the other 21 physicians received usual care (cluster randomization). Based on protocol questions, the RN determined if the patients’ symptoms were suggestive of viral infection, bacterial sinusitis, or another diagnosis requiring physician evaluation. Symptomatic measures only were suggested for presumed viral infections. Cases of presumed bacterial sinusitis were treated with first line antibiotics (amoxicillin, erythromycin, or sulfamethoxazole/trimethoprim). Patient satisfaction was assessed by sending all patients in both groups a survey within 30 days of their initial contact.

FINDINGS TO DATE/EVALUATION OF WEB SITE: Forty-five out of 77 patients in nurse telephone treatment group (58.4%) and 76 of 135 patients (56.3%) in the usual care group responded to the survey. 88.9% in telephone group rated the care to be good to excellent whereas 100% in the usual care group rated the care to be good to excellent (P = .006). 89% in the telephone group and 96% in usual care group thought that it was somewhat to very easy to have illness evaluated (P = .146). 60% of patients in telephone group and 52.6% of patients in the usual care group reported that they would recommend the program to a friend or relative (P = .455).

KEY LESSONS LEARNED: Both telephonic and office-based evaluation and treatment for URI can result in high levels of satisfaction. Although use of a guideline-based nurse telephone triage protocol for evaluation and management of URI symptomatology had lower satisfaction compared to usual care (P = .023), a majority of patients in both groups desire telephone evaluation of their symptoms as an alternative to a visit with their physician.

MODALITIES USED TO DEMONSTRATE INNOVATION AT MEETING:

TO STUDY PATIENT SATISFACTION WITH THE USE OF A NURSE-BASED TELEPHONE PROTOCOL FOR MANAGEMENT OF URI SYMPTOMATOLOGY: S. Chaudary; R. Stroebel; 1; H. VanHouten; J. Naessens; S. Scheitel; 1; Mayo Clinic, Rochester, MN; (Tracking ID #116144)

A BEHAVIORAL STAGE-MATCHED INTERVENTION FOR IMPROVING HYPERTENSION CONTROL: S. Nalubwoga; E. Santa Ana; P. Neetzer; K.M. Magruder; 2; VA New York Harbor Healthcare System and New York University; New York, NY; 3; Medical University of South Carolina, Charlotte, SC. (Tracking ID #117389)

BACKGROUND: The Transetheoretical model for health behavior change is a useful framework for facilitating behavior change by tailoring interventions to a person’s readiness for change. Among individuals with hypertension, this study evaluated the effects of a stage-matched telephone-delivered counseling intervention for: 1) increasing adherence to exercise, diet, and medications; and 2) improving blood pressure (BP) control.

METHODS: Baseline stage of change (precontemplation, contemplation, prepa- ration, action/maintenance) were assigned through interview, diet, and medications as well as systolic and diastolic BP were assessed in 120 veterans with hypertension attending a routine health care appointment. Participants were randomized 1:1:1 to receive a stage-matched intervention (SMI), a health education intervention (HEI), or usual care (UC). Interventions were delivered by monthly telephone calls for six months to participants in the SMI and HEI groups. Stage of change for exercise, diet, and medication) and BP was evaluated at 6-month follow-up using multivariate analysis of covariance (MANCOVA) and logistic regression.

RESULTS: There were no significant baseline differences between groups. At 6-month follow-up, a significantly greater proportion of participants in SMI were in later (action or maintenance) stages of change (exercise 60.3% vs 38.6% and diet 72.7% vs 47.6%) compared to participants in HEI (exercise: 25%, diet: 15.2%) or UC (exercise: 11.1%, diet: 12.1%). At 6 months SMI was a significant independent predictor for being in the later stages of change (action/maintenance) for exercise (P < .0001) and diet adherence levels (P < .001).

CONCLUSION: Exercise counseling (74% vs. 49%; P = .002; 92% vs. 80% for A1c < 9.5%, P = .002; 92% vs. 80% for A1c < 9.5%, P = .002) was significantly higher in SMI than HEI and UC.

A COMPARISON OF THE QUALITY OF MEDICAL CARE MEASURED BY INTERVIEW AND MEDICAL RECORD: J.T. Chang; 1; C.H. MacLean; 1; C.P. Roth; 1; N.S. Wenger; 1; University of California, Los Angeles, Los Angeles, CA; 2; RAND, Santa Monica, CA; (Tracking ID #117745)

BACKGROUND: Chart-based measurement has been considered the gold standard for many measures used to estimate quality of care. However, patients can report on many aspects of their care, including some that may be poorly documented in the medical record, and interview can be a cost-effective data collection method. Using a set of process measures developed for vulnerable older adults, we compared performance scores obtained using data from patient interviews and medical records.

METHODS: The Assessing Care of Vulnerable Elders (ACOVE) quality indicators (QIs), a set of 236 explicit process measures covering 22 conditions, were used to assess care in a random sample of vulnerable older adults from two senior managed care plans. Data were available from both interview and medical records for 245 patients. 60 QIs were measured with data available from both sources. We performed a prior classification of the “gold standard” data source for the 60 QIs as follows: interview better source if 60 QIs; medical better source if 14 QIs; both sources of equal weight if 14 QIs. Sensitivity and specificity of using interview alone were determined. A1c, low density lipoprotein cholesterol [LDL] and 4 satisfaction measures (e.g., satisfaction with quality of diabetes care) adjusted for patient demographic and health characteristics.

RESULTS: VA patients had better scores than CMC patients on all process measures, ranging from a 10 percentage point difference on performance of an annual A1c (93% versus 83%; P = .006) to a 25 percentage point difference on aspirin use counseling (74% vs. 49%; P < .001). There was no difference in blood pressure control between VA and CMC patients, but VA patients had better control of LDL and A1c (76% vs. 72% for LDL and 130 mg/dl; P = .002; 95% vs. 80% for A1c < 9.5%, P = .032) than the two cohorts.

CONCLUSION: We found that diabetes processes of care and 2 of 3 intermediate outcomes were substantially better for VA study patients than for CMC patients. Commercial plans may benefit from a better understanding of VA quality improvement programs, especially regarding enhancing LDL and A1c control. However, there was room for improvement in blood pressure control in both VA and CMC.