Self-Management Perspectives of Heavily Comorbid Primary Care Adults

William Corser, PhD, RN, NEA-BC, and Katherine Dontje, PhD, FNP-BC

ABSTRACT

Purpose: This exploratory study investigated the personal self-management perspectives of a sample of heavily comorbid primary care adults with at least four chronic health conditions. The study was specifically designed to explore the perceived health care needs of adults with numerous comorbid conditions by focusing on their self-management practices and relationships with primary care providers.

Primary practice setting: Midwest academic-based family medicine primary care clinic lacking any formal patient education, case management, or phone follow-up services.

Methodology and sample: A total of 18 heavily comorbid focus group participants described the complexities of their self-management practices and frequently frustrating office visit interactions with primary care providers.

Results: Four core themes and nine subthemes were identified concerning participants’ ongoing self-management practices when attempting to navigate health care delivery systems and interact with providers. Future case management practice and research implications are discussed.

Implications for CM practice: Case managers have an opportunity to fill the gaps in care for patients with multiple comorbid conditions. The case manager has the potential to address several of the issues identified by the patients in this study by helping comorbid patients develop self-management skills and tailoring supportive primary care interventions to meet individual patient needs.

Key words: comorbidity, primary care, self management

Although there is currently no “gold standard” with which to measure a primary care adult’s comorbidity or multimorbidity, this phenomenon is generally considered a function of both the total number and the severity of chronic health conditions he or she possesses (Gijzen et al., 2001). An adult’s composite comorbidity level has most often been calculated in terms of the index condition for which he or she is currently receiving the majority of health care services (Bayliss, Edwards, Steiner, & Main, 2008; Fortin et al., 2004; Gijzen et al., 2001). The increasing influence of comorbid chronic health conditions on many primary care adults’ self-management perspectives and experiences with office visit providers has been demonstrated in the literature (Bayliss et al., 2008; Corser, 2004; Corser, 2006; Fortin et al., 2004).

The self-management of an adult’s health-related needs has been conceptualized as an interactive phenomenon in which the patient develops and maintains health behaviors within the contexts of his or her relationships with providers, family or social roles, and personal emotions (Lorig & Holman, 2002). Adults who possess more than three chronic health conditions have been considered to be heavily comorbid (Charlson, Szatrowski, Peterson, & Gold, 1994). Although effective self-management has become a growing expectation for all adults receiving primary care, little research has been conducted regarding how heavily comorbid adults may individually approach their self-management needs (Bayliss et al., 2008; Boyd et al., 2008).

BACKGROUND AND SIGNIFICANCE

A clearer understanding of heavily comorbid primary care adults’ perspectives concerning their self-management experiences is particularly needed due to the growing number of health care resources being consumed when providing them formal health care (Fortin et al., 2004; Parchman, Noel, & Lee, 2005; Seeman, Merkin, Grimms, & Karlamangla, 2010). The majority of comorbid adults frequently

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receive conflicting recommendations for their individual chronic conditions, leading to their inefficient use of health care services and extreme frustration (Corser, 2006; Lorig & Holman, 2002; Parchman, et al., 2005). Primary care providers often struggle to understand or meet the self-management needs of their heavily comorbid adults during typically rushed office visits (Bayliss et al., 2008; Fitzsimmons et al., 2007; Fortin et al., 2004; Lorig & Holman, 2002; Parchman et al., 2005). Case managers within primary care settings can serve to meet the needs of these individuals to improve quality of care by helping to coordinate services and facilitate self-management (Pomerantz, Toney, & Hill, 2010; Schaefer & Davis, 2004; Sutherland & Hayter, 2009).

Although multidisciplinary team approaches have been proposed to better coordinate comorbid adults’ primary care needs, the actual implementation of such programs has continued to be slow (Bayliss et al., 2008; Fortin et al., 2004; Parchman et al., 2005; Oliva, 2010). Many primary care providers find themselves forced to react to emergent care demands imposed from adults’ index conditions that frequently compete with their other chronic condition needs (Fortin et al., 2004; Lorig & Holman, 2002; Parchman et al., 2005). As a result, the feasible translation of primary care self-management interventions for heavily comorbid adults has been especially challenging (Braithwaite, Concato, Chang, Roberts, & Justice, 2007; Parchman et al., 2005). One of the major obstacles for providers in smaller practices relates to the more limited resources available to implement practice guideline recommendations for those with multiple comorbidities. In a system set up on a fee-for-service basis, the coordination services for those with multiple comorbid conditions remains a special challenge (Bayliss et al., 2008; Boyd et al., 2008; Burton, Murphy, & Riley, 2010).

The majority of research concerning heavily comorbid adults has concerned the prevalence, measurement, and health outcomes experienced by hospital patients (Braithwaite et al., 2007; Corser et al., 2008; Gijsen et al., 2001). There remains a paucity of research investigating how heavily comorbid adults perceive their self-management of multiple chronic conditions or their relationships with primary care providers and health care systems (Bayliss et al., 2008; Corser, 2006; Lorig & Holman, 2002; Seeman et al., 2010). Improved knowledge of how adults self-manage their multiple comorbid conditions could assist case managers and other members of the health care team in providing more targeted and effective services.

**Purpose of Study**

This exploratory study investigated the self-management perspectives and office visit experiences of a sample of heavily comorbid primary care adults with at least four chronic health conditions. The study was specifically designed to explore the perceived needs of adults with numerous comorbid conditions by focusing on both their self-management practices and relationships with primary care providers. To gain a fuller understanding of interview patients’ (hereafter referred to as participants) comments, data concerning participants’ respective clinical, sociodemographic characteristics, and prior use of health care services were also collected during structured chart audits.

**Research Questions**

For this study, the following research questions were investigated:

1. What type(s) of personal self-management practices do heavily comorbid adults develop and use to meet their health-related needs between scheduled office visits with primary care providers?
2. What types of perceived experiences do heavily comorbid adults have during routine office visits with primary care providers?

**Sample and Setting**

Interview participants were recruited from a Midwestern academic-based family medicine clinic. It is important to note that this clinic facility lacked any formal patient education, case management, or phone follow-up services at the time of this study and that these types of services had not apparently ever been considered due to the prevalent reimbursement restrictions of major insurers in this part of the country.

In this setting, a total of 15 physicians and 3 nurse practitioners provided primary care services, with approximately 52% of clinic adults covered by Medicare or Medicaid at the time of the study. During 2008, a
total of 190 clinic adults who were identified as possessing at least two chronic cardiac, pulmonary, or endocrine health conditions were sent a study recruitment letter from the clinic medical director.

Eligible participants each had a history of at least two of the following documented health conditions diagnoses at time of enrollment: (1) diabetes (type 1 or type 2), (2) chronic pulmonary disease (i.e., asthma, chronic obstructive pulmonary disease, chronic emphysema), (3) congestive heart failure, (4) coronary artery disease, (5) osteoarthritis or musculoskeletal disorder, and/or (6) ongoing cancer/neoplasm. They also required to have English as their primary language and to have completed at least three office visits during the prior 12 months.

Exclusion criteria included (1) being under 21 years of age, (2) demonstrated current psychiatric or cognitive impairments, or (3) having been admitted to a hospital during the 3 prior pre enrollment months. Formal approval for all of the study recruitment, consenting, and data collection processes was obtained from the university institutional review board before any participant data were collected.

**METHODOLOGY**

**Design**

The data collection activities of the study included (1) participant eligibility assessments and enrollment surveys, followed by (2) semi-structured participant focus group interviews, and (3) retrospective structured electronic medical record (EMR) chart audits. The focus group interview format was selected due to the largely unexplored nature of the study phenomena and the ability of focus groups to facilitate participants’ sharing of perspectives and experiences (Krueger & Casey, 2000).

**Participant Focus Groups and EMR Chart Audits**

Once the enrolled participants consented, they were scheduled to attend a 2-hour focus group interview session. During the focus groups, an undergraduate nursing student Research Assistant (RA) first collected individual participant data regarding the six sociodemographic and clinical items that were later validated during the chart audits. Participants were each paid an incentive of $20.00 to participate in a focus group session. Participants’ comments were generated from an interview script of five open-ended questions. Each of the series of six focus groups was audi-taped and transcribed into a word processing program to facilitate later analyses.

After the completion of all focus groups, conducted structured chart audits were conducted of each participant’s EMR from the prior 12 preenrollment months to obtain quantitative data concerning their (1) overall composite comorbidity and (2) number of completed clinic office visits and office phone calls before their respective focus group. During the chart audits, participants’ composite comorbidity and individual condition severity levels were calculated using the modified form of the 14-item Cumulative Illness Rating Scale (CIRS), which has been validated in numerous primary care settings to gauge both the existence and severity of a total of 14 chronic health conditions (Fortin et al., 2004; Hudon, Fortin, & Vanesse, 2005).

**Focus Group Protocol**

Observing established focus group principles, the first author functioned as the moderator with the RA also present at each of the focus groups (Krueger & Casey, 2000). The moderator encouraged interview comments and group discussions by posing a series of open-ended questions concerning participants’ preenrollment perspectives regarding their self-management practices and office visit experiences. Participants were asked the five following open-ended questions:

1. Please introduce yourself to the group and tell us about the different chronic health conditions that you have had diagnosed.
2. How do you currently work to manage your chronic health conditions between scheduled office visits at the [name of clinic]?
3. How do you currently prepare for scheduled office visits at the [name of clinic]?
4. What has either prevented or helped you from managing your chronic health conditions between or during your office visits at the [name of clinic]?
5. What one main thing could we do as health care professionals to help you better manage your chronic health conditions between scheduled office visits?

Although some participants offered spontaneous comments during later focus group discussions, the great majority of comments were elicited from the five
chronic conditions to enroll in the study, each of the 18 participants (9.5% of total eligible patients sent a recruitment letter) in the interview sample actually possessed at least four chronic health conditions. We therefore interpreted each participant in the study to be heavily comorbid.

Although we were unable to guarantee that we had reached an adequate level of theoretical saturation (Krippendoff, 1980) from the interview sample, we opted to conclude our recruitment efforts after 3 months. This decision was made as a result of (1) the large proportion of similar interview comments that had been obtained to date during the first six focus group sessions and (b) the increasingly complex logistics of contacting, (re)scheduling, and providing for the access and physical needs of these heavily comorbid participants.

The quantitative sociodemographic, comorbidity, and prestudy health care service use data of participants are summarized in Table 1. Fourteen of the participants (77.8%) were white women, with participants possessing an average of slightly fewer than six chronic health conditions. Greater than 50% of participants had some documented form of diabetes, asthma, or other chronic pulmonary condition and at least one type of cardiac condition. Their overall composite comorbidity scores sample were somewhat higher than samples from earlier related studies (Bayliss et al., 2008; Boyd et al., 2008; Corser, 2004). Chart audit data indicated that participants had been prescribed an average of about 14 medications. Table 1 also shows that participants’ number of prestudy office visits, office phone calls, and so on during the prior 12 months varied considerably.

Core Conceptual Themes and Subthemes

During the data analysis sequence, we came to readily identify four core themes and nine subthemes emerging from the interview data. We initially assessed approximately 10% of the comments to fall under one theme or subtheme, with consensus regarding final comment placement reached for greater than 95% of comments. Approximately 2% of comments regarding various unrelated topics were concluded to be uncodable and excluded from the analyses.

A total of 499 analyzable interview comments were collected during the six focus groups. Figure 1 depicts the overall theme of self-management with multiple chronic health conditions with four core themes and nine subthemes. Table 2 lists the frequencies of comments placed under each of these core themes and subthemes. The four core themes included the following:

1. Experiencing limitations
2. Multiple information sources
3. Communication challenges
4. Billing and reimbursement difficulties

Results

Although one inclusion criterion for participants specified that they had to possess at least two chronic conditions to enroll in the study, each of the 18 participants (9.5% of total eligible patients sent a recruitment letter) in the interview sample actually possessed at least four chronic health conditions. We therefore interpreted each participant in the study to be heavily comorbid.

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3. Interacting with providers and systems
4. Self-management strategies

In this paper, several of the subthemes have also been further broken down into subcategories for clarity. The following discussion provides a representative sample of exemplar comments under each core theme and subtheme concerning different aspects of participants’ self-management experiences.

**Core Theme 1. Experiencing Limitations** (47 Comments, 15 Participants)

Most participants identified having experienced some form of limitation or loss related to their management of multiple chronic conditions. This core theme will be discussed further under two subthemes: (a) losses in physical functioning and (b) fear and facing death.

**TABLE 1**

Sample Patient Characteristics (n = 18)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
<th>Percent of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>Mean 63.7 (SD 13.4), range 34–83</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>N = 4</td>
<td>22.2</td>
</tr>
<tr>
<td>Female</td>
<td>N = 14</td>
<td>77.8</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>N = 15</td>
<td>83.3</td>
</tr>
<tr>
<td>African American or other minority</td>
<td>N = 3</td>
<td>16.7</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently married</td>
<td>N = 11</td>
<td>61.1</td>
</tr>
<tr>
<td>Not currently married</td>
<td>N = 7</td>
<td>38.9</td>
</tr>
<tr>
<td>Years of completed education</td>
<td>14.78 (SD 2.9), range 11–23</td>
<td></td>
</tr>
<tr>
<td>Total number of chronic health conditions</td>
<td>5.83 (SD 1.4), range 4–8</td>
<td></td>
</tr>
<tr>
<td>Total number of prescribed scheduled medications</td>
<td>13.8 (SD 4.7), range 7–25</td>
<td></td>
</tr>
<tr>
<td>Composite CIRS comorbidity score (possible range 0–54)</td>
<td>15.17 (SD 3.3), range 8–23</td>
<td></td>
</tr>
<tr>
<td>Number of office visits during prior 12 months</td>
<td>9.0 (SD 5.5), range 2–24</td>
<td></td>
</tr>
<tr>
<td>Number of phone calls to office during prior 12 months</td>
<td>8.78 (SD 9.2), range 0–28</td>
<td></td>
</tr>
</tbody>
</table>
Some say maybe a year and a half. Well if that’s right on your mind too, it’s just hard.... I mean no one knows when you are going to die.

I am scared of that to the point that in my pocket I carry a whistle with me.

Core Theme 2. Multiple Information Sources (124 Comments, 16 Participants)

Participants identified various sources of information that they had received concerning the management of their documented health conditions. This information had come from both formal and informal sources. This core theme will be discussed under three subthemes: (a) information from multiple providers and sources, (b) understanding multiple conditions, and (c) lab and test results.

a. Subtheme: Information from Multiple Providers and Sources (25 Comments)

Almost all participants described how various providers and information sources had influenced their developed self-management practices. Some information had provided them positive motivation, while other types of information had either been contradictory or frustrating.

They send you to another doctor (than they ask you) how did it go, I’m like well don’t you know? Don’t you guys talk with each other?

The biggest thing for me is conflicting information. Well it’s like a social calendar. I look at my calendar and it’s got doctor, doctor.

b. Subtheme: Multiple Conditions and Medications (81 Comments)

Most participant comments mentioned the challenges imposed by multiple health conditions and medications as having affected their ability to self-manage at home.

I am on about 11 medications so I take my pills when I am supposed to in the morning and in the evening. They have no answers for some of the questions we (patient and spouse) have (re: chronic conditions). The doctor office calls every week and tells me the change (my medication) from 3 pills to 4 pills. I make my own little color codes of what I have to do with the pills.

Many participants described having attempted to understand what factors may have caused their chronic conditions or affected their self-management of these conditions. Many had apparently developed flawed conclusions regarding these relationships from trial and error, informal advice, or personally interpreting available information.

TABLE 2
Core Conceptual Themes and Subthemes

<table>
<thead>
<tr>
<th>Core Theme 1. Experiencing Limitations</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>(47 comments, 15 participants)</td>
<td></td>
</tr>
<tr>
<td>a. Losses in physical functioning</td>
<td>31</td>
</tr>
<tr>
<td>b. Fear and facing death</td>
<td>16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Theme 2. Multiple Information Sources</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>(124 comments, 16 participants)</td>
<td></td>
</tr>
<tr>
<td>a. Information from multiple providers and sources</td>
<td>25</td>
</tr>
<tr>
<td>b. Multiple disease processes and medications</td>
<td>81</td>
</tr>
<tr>
<td>c. Lab results and tests</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Theme 3. Interacting with Providers and Systems</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>(216 comments, 18 participants)</td>
<td></td>
</tr>
<tr>
<td>a. Different provider behaviors and attitudes</td>
<td>188</td>
</tr>
<tr>
<td>1. Supportive providers</td>
<td>32</td>
</tr>
<tr>
<td>2. Nonsupportive providers</td>
<td>156</td>
</tr>
<tr>
<td>b. Limitations of health care system</td>
<td>28</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Core Theme 4. Self-Management Strategies</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>(112 comments, 16 participants)</td>
<td></td>
</tr>
<tr>
<td>a. Prioritizing symptoms/conditions/behaviors</td>
<td>31</td>
</tr>
<tr>
<td>b. Making behavior changes</td>
<td>81</td>
</tr>
</tbody>
</table>

Note. A total of 11 out of 499 (i.e., 2.2%) of comments were found to be uncodable.
I became a diabetic through worry and stress. The best thing to do is to sucker it (metabolism) by exercising and then it thinks it needs a lot more calories. My GERD [gastroesophageal reflux disease] has been helped by my drinking wine.

c. Subtheme: Lab Results and Tests (18 Comments)
Almost all participants described how their efforts to keep track of their lab results and tests/procedure results had become more complicated. Their attempts to interpret and coordinate lab reports among providers in different settings were mentioned as one practice to improve their self-management or formal care.

He [the doctor] will show you when you had the last [labs]... he will show you something to see on a trend. The doctor keep track of the mean (blood) sugars, all the numbers once every three months, I keep track of them daily.

When I go to the lab I make sure that my primary [doctor] gets one [a copy] and I make sure that I get a copy.

Core Theme 3. Interacting with Providers and Systems (216 Comments, 18 Participants)
The third core theme concerned how participants had interacted with clinic providers and established health care delivery systems and how these interactions had influenced their self-management efforts. Almost all participants could generally categorize their providers as being either supportive or nonsupportive of their daily self-management practices.

a. Subtheme: Different Provider Behaviors and Attitudes (188 Comments)
1. Supportive Providers (32 Comments)
Several participants cited specific provider behaviors that they had found to be especially supportive of their own perspectives and management efforts.

He doesn’t belittle me, he makes me feel like he is concerned.

They pay attention to my emotional and mental problems, I feel safe.

It seems they are doing the best they can for me with what all has happened.

Most participants described fairly pragmatic approaches they had developed to have more satisfying or productive interactions with office providers.

If I have more than one question I try to ask about the most important first.

I participate a lot more, so I get a lot more out of it.

They talk to my wife and she, she’s got a mind like a steel trap and she remembers these things...so I rely on her considerably.

2. Nonsupportive Providers (156 Comments)
Almost all participants could easily describe provider behaviors that they had experienced as nonsupportive during earlier office visits.

Manners.... I call it etiquette, some of them need to go back to school to talk and treat people.

She should be more concerned with what’s wrong with me than pushing more pills.

She gives me depression pills but it doesn’t do any good because she is the one depressing me.

My doctor is always hollering “get out and do more exercise,” but without being able to walk very well it’s not real easy to go out and exercise.

The entire sample also made at least one comment concerning how their perspectives concerning their health conditions differed from those of their office providers.

She thinks she knows more about what’s my problems [are] than I do and she can’t possibly know how I feel.

I try to talk to her about it and she says it’s nothing just forget about it. Well you can’t forget about it when it hurts.

I think she is more for pills than she is really going in and helping a person.

I talk to her about where it hurt and she looks at my bedsore.... It’s like you have to tell her what to do. You tell the doctor what to do.

b. Subtheme: Limitations of Health Care Systems (28 Comments)
Each participant could identify one or more limitation(s) of formal health care systems that they thought had impeded their self-management efforts or care access.

Many participants described having attempted to understand what factors may have caused their chronic conditions or affected their self-management of these conditions. Many had apparently developed flawed conclusions regarding these relationships from trial and error, informal advice, or personally interpreting available information.

You never know when you are going to end up having to go to a new doctor of some kind ...If you’ve got all your old records, you can more or less say well here they are.
Even though there is a growing emphasis on providing patient centered care, our nation’s health care reimbursement systems place increasing emphasis on seeing multiple patients within a short amount of time, which may be contrary to effectively supporting recipients’ self-management needs and practices.

I am worried as I get older that I won’t be able to reach them ... they do have someone on call ... but basically they cover their butts and saying well if you feel you need to go to emergency or urgent care just go.

Not enough money, not enough nurses.

We are ruining our health care and our health because they are putting on too many procedures.... They are riding a dead horse.

Core Theme 4. Self-Management Strategies (112 Comments, 16 Participants)

Participants discussed a variety of self-management strategies that they utilized to help them manage their chronic conditions. The subthemes in this core theme were (a) prioritizing symptoms/conditions/behaviors and (b) making behavior changes.

a. Subtheme: Prioritizing Symptoms/Conditions/Behaviors (31 Comments)

Most all participants described having made some effort to mentally prioritize or balance their self-management activities as their chronic conditions had increased or worsened.

Having a stroke or anything to do with that is my main focus.... I try to focus on issues that relate to stroke.

I am learning to control fatigue, if I don’t control the fatigue, if I don’t watch what I eat ... don’t sleep, then I end up in the hospital.

So it is like, well which one do I work on this time?

My health seems to be on a rolling change ... it is like playing health roulette.

b. Subtheme: Making Behavior Changes (81 Comments)

Most participants described changes they had made in their daily routine behaviors to better manage their health.

If I get tired, well OK I am going to sit down you know.... If I need to go to sleep, I will go to sleep and when I wake up I will finish whatever is left.

The only thing you can really do is eat lean meats and vegetables.

You learn to adjust yourself, but it is hard, very hard.

The majority of participants described having personal attitudes or beliefs that had affected their self-management perspectives.

I have learned to deal with a lot of things and it is a lot to deal with ... some people are worse off than I am.

I did do it step by step so that, you know, like any long term project.

I feel that is the only way that I am here is through fighting through.

Well I say a lot of prayers. God hears me and that helps and I know it has helped.

The thinking about diets and all this stuff it has shifted over the years and is still shifting so I am pretty cynical.

Quantitative Chart Audit Data

Data from the EMR chart review shown in Table 1 indicate that the health care service use patterns of participants during the prior 12 prestudy months had varied considerably, suggesting that participants had developed quite different approaches (e.g., more phone intensive or office visit intensive) toward interacting with the health care system to meet their personal needs. Still, no statistically significant relationships among participants’ major sociodemographic characteristics or total number of prescribed medications could be identified with their respective health care service use rates.

Discussion

This exploratory study comprises one of the first systematic investigations of the qualitative self-management perspectives of a sample of heavily comorbid primary care adults. These results may reflect the variable experiences, perceptions, and attitudes that many heavily comorbid patients possess regarding their self-management practices and relationships with health care providers and systems. This level of heterogeneity may explain why so many clinic providers face challenges in effectively tailoring care to meet the varied preferences of their heavily comorbid office visit patients (Boyd et al., 2008; Braithwaite et al., 2007; Fortin et al., 2004). By providing information to case managers about the complex challenges many heavily comorbid adults face and perspectives they have developed, there is the potential to improve the services these individuals receive to better self-manage their conditions and improve their quality of care (Oliva, 2010; Sutherland & Hayter, 2009). Many of the participants in this sample described having experienced profound life changes...
when developing multiple chronic conditions. The variation in service use patterns of these adults suggests that many may have developed personal strategies for navigating health care systems through trial-and-error or less-formal mechanisms. Most interview participants expressed frustrations and fear as they interacted with disjointed or contradictory aspects of formal care delivery systems or providers. How such mismatches may be driven by primary care patients’ emergent comorbid conditions, navigational preferences, patient–provider relationships, or prevalent office practices certainly requires further study (Bayliss et al., 2008; Corser, 2006; Fitzsimmons et al., 2007). Participants’ interview comments certainly represent a consistent preference to be treated in a respectful and courteous manner, suggesting implications for the design of self-management research interventions or case management office visit protocols.

These results should be considered within the context of several study limitations. Since we enrolled a smaller self-selected convenience sample of more heavily comorbid adults from a single practice group clinic, the generalizability of these results to other settings may also be limited. The fact that this setting lacked any type of case management, formal patient education, or phone follow-up services certainly may have affected some participant experiences. The self-management emphasis of the study may also have skewed how some interview participants framed their responses or described their self-management practices. The possibility that depressed or frustrated focus group participants may have prompted other participants to react in an even more animated or negative manner than usual should be considered.

Implications for Case Management Practice

The types of frustrations expressed by many heavily comorbid primary care adults may worsen as the number of those who prefer more individualized treatment (i.e., individualized to their respective combination of comorbid conditions) increases (Bayliss et al., 2008; Boyd et al., 2008). One potential solution may be the increased utilization of case managers within primary care settings to improve the assessment, adjustment of treatment regimens, self-management support, and care coordination for heavily comorbid adults (Oliva, 2010; Schaefer & Davis, 2004; Sutherland & Hayter, 2009).

These study results also suggest that completely satisfying self-management may rarely be accomplished through the perspective of many heavily comorbid adults. These interview comments certainly appear to support the conclusion that the providers of adults with multiple comorbidities need to be able to spend sufficient time with their patients during focused office visits to discuss their variable self-management needs.

Still, the feasibility of individualizing office visit care to include increased time and multiple focuses provides a challenge for providers, depending on the types and number of comorbidities their adult patients may possess (Bayliss et al., 2008; Boyd et al., 2008; Fitzsimmons et al., 2007; Parchman et al., 2005). Even though there is a growing emphasis on providing patient-centered care, our nation’s health care reimbursement systems place increasing emphasis on seeing multiple patients within a short amount of time, which may be contrary to effectively supporting recipients’ self-management needs and practices (Bayliss et al., 2008; Boyd et al., 2008; Parchman et al., 2005)

Case managers have been shown to be integral for optimizing the care of people with chronic conditions by coordinating services in a frequently fragmented health care system (Schaefer & Davis, 2004; Sutherland & Hayter, 2009). Pomerantz et al. (2010) discussed the role of the case manager as someone who, through care coaching, can improve the quality of patient care and decrease health care costs. This is particularly important to the growing population of heavily comorbid adults, who have expressed a need for more individualized primary care in other research settings (Bayliss et al., 2006; Boyd et al., 2008; Corser, 2006). Oliva (2010) identified the need for further research related to what services should be provided during case management and how such targeted services can impact patients’ self-management strategies.

Conclusions and Next Steps

Additional research designs should be conducted to attempt replication of these results with larger patient samples and other types of primary care practices. Designs that systematically compare the experiences of heavily comorbid patients receiving primary care in settings with implemented case management and care coordination systems in place compared to patients in settings without such services are needed. Future studies investigating the possible implications of patient–provider differences of non–English-speaking patients or those insured under different insurance carriers are indicated. The potential use of support staff to provide some degree of routine follow-up for heavily comorbid patients after case management assessment has been recently suggested as more feasible (Bodenheimer & Laing, 2007).

Additional theoretical work is warranted to capture the apparently unprecedented nature of experiences experienced by many heavily comorbid adults now receiving primary care. It is especially notable that few participants in this sample actually expressed a belief that they could readily control the office visit agenda or develop a patient–provider partnership as advocated for more typical adults in the research
literature (Braithwaite et al., 2007; Lorig & Holman, 2002; Parchman et al., 2005). Through case management services, individuals have the potential to increase their level of self-efficacy and ability to participate in shared decision making related to their health conditions (Pomerantz et al., 2010). This suggests the need to conduct further research regarding how best to facilitate and support comorbid patients striving to assume a more active role during typical office visit encounters. Ideally, the results of this initial study can enable case managers working with primary care clinicians and patients to better appreciate the complex self- and (ideally) shared-management challenges experienced by many contemporary comorbid adults.

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REFERENCES


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