Support (if any):

812

COMPETENCY BASED GOALS FOR SLEEP MEDICINE CURRICULUM IN UNDERGRADUATE MEDICAL EDUCATION IN INDIA: A SURVEY

Puneet Nagendra,[1] lingadevi Thanasekaran[2]

[1]Dr. Chandramma Dayananda Sagar Institute of Medical Education and Research, [2]AYYAPPA CLINIC

Introduction: Sleep is recognized the world over as very important in health and disease. But there is no articulated curriculum in undergraduate (UG) medical education in India. Whence incorporated, these learning objectives serve as an important bridge across multiple medical faculties like pulmonary medicine, neurology, ENT, psychiatry, and basic sciences.

Methods: After obtaining informed consent, a questionnaire-based electronic survey was circulated to clinical/non-clinical teaching medical faculties in December 2020. They were asked to prioritize the objectives of the sleep medicine curriculum for the UG medical education program. The objectives were listed under knowledge and skill-based competencies each having 9 and 10 questions respectively, scale rated 1–5. Objectives were enlisted from the previous studies, consensus statements and modified according to the local needs after face to face meetings with faculties involved in UG curriculum development.

Results: Out of 400 faculty members from different medical schools all over India, 127 had responded. None of the Indian institutions had sleep medicine in their UG curriculum. 112 (88%) members showed their interest to begin a UG program. The suggested sleep medicine curriculum proposes a vertical integration of competency-based goals into the core curriculum with a clinical angle which will require skill and knowledge-oriented modules. Amongst the knowledge-based competency, sleep loss and its health effects (77%) was more preferred than distinguishing sleep in newborns and adults (36%). Whereas in the skill-based competency providing advice on sleep hygiene (71%) was more preferred than sleep disturbances during pregnancy and menopause (33%). When our curriculum gets implemented, it is possible to provide exposure to sleep-related disorders early on for the UG's. This will invoke their interest and thus serve to bridge the lacunae caused by the shortage of trained sleep specialists in India.

Conclusion: From our study, the learning objectives of the sleep medicine curriculum have been prioritized and are ready for implementation. The survey has also created awareness and interest amongst the Indian medical teaching faculty.

Support (if any):

813

PATIENT AND PROVIDER EXPERIENCES WITH CBT-I ADMINISTERED IN-PERSON OR VIA TELEMEDICINE

Paul Gunter,[1] Philip Gehrman,[1] James Findley,[2] Matthew Kayser,[1] Samuel Kuna,[3] Rosemary Frasso,[4]

[1]Department of Psychiatry, Perelman School of Medicine of the University of Pennsylvania, [2]Department of Medicine, Perelman School of Medicine of the University of Pennsylvania, [3]Corporal Michael J. Crescenz VA Medical Center, [4]College of Population Health, Thomas Jefferson University

Introduction: CBT-I is the gold standard treatment for insomnia, but access to in-person care is limited, which has worsened due to the recent COVID-19 pandemic. While providers across spheres of care have rapidly pivoted to telehealth there have been few systematic comparisons of in-person treatments to telemedicine approaches. The current study, launched pre-COVID, aimed to examine the perspectives of patients who were randomly assigned to receive CBT-I in-person or via telemedicine. Additionally, provider reflections were collected.

Methods: Individuals with DSM5 Insomnia Disorder (n=60) were randomized to in-person CBT-I, telemedicine CBT-I or a wait-list control group. CBT-I was delivered over 6–8 weekly sessions by video telemedicine or in-person. This nested qualitative study addressed patient and provider perspectives on treatment approaches. A sample of participants from each group (n=36) were interviewed 3 months post-treatment. Phone interviews were audio recorded, transcribed and analyzed using a directed content analysis approach. Results were organized into thematic categories including 1) participant experience with CBT-I, 2) access issues and 3) accountability issues related to delivery approach. Additionally, participating providers (n=7) were interviewed and shared their reflections on delivering CBT-I in-person vs. telemedicine.

Results: Patients reflected positively on CBT-I, and this did not vary across treatment groups. Patients and providers noted telemedicine benefits related to access that included, but were not limited to, reducing transportation barriers to treatment and improved continuity of care (e.g. not having to cancel an appointment if a patient was traveling). Patients and providers shared concerns they had anticipated pre-treatment about possible telemedicine related technological hurdles and barriers to establishing meaningful rapport on-line. However, they reported that these concerns did not prove to be barriers to effective telemedicine visits.

Conclusion: This qualitative study allowed patients and their providers to reflect on their experience delivering in-person vs telemedicine CBT-I. CBT-I was accepted well regardless of delivery approach. Telemedicine is currently being deployed widely and this study provides a systematic comparison between approaches.

Support (if any): This study was supported by the American Sleep Medicine Foundation.

814

VHA'S TELESLEEP PROGRAM IMPROVES RURAL VETERAN ACCESS TO SLEEP CARE THROUGH EXPANSION OF TELEHEALTH NETWORKS

Kathleen Sarmiento,[1] Samuel Kuna,[2] Eilis Boudreau,[3] Charles Atwood,[4] Lilibeth Pineda,[5] William Thompson,[6] Michelle Zeidler,[7] Barry Fields,[8] Afifa Uzzaman,[9] Annette Totten,[10] connor Smith,[3] Robert folmer,[11] Katherine Williams,[12] Ning Zhang,[12] Mary Whooley[12]

[1]University of California San Francisco, [2]Corporal Michael J. Crescenz VA Medical Center, [3]Oregon Health Sciences University, [4]University of Pittsburgh, [5]Phoenix VA health care system, [6]University of Washington, [7]VA Greater Los Angeles Healthcare System, [8]Emory University, [9]University of Michigan, [10]Oregon Health Science University, [11]Portland VA Healthcare System, [12]San Francisco VA Health Care System

Introduction: Rurality is a known contributor to health disparities, including Sleep medicine. Over 1 million (>350,000 rural, >650,000 non-rural) Veterans who received care from VHA in 2020 have obstructive sleep apnea (OSA). VHA's Office of Rural Health (ORH) TeleSleep Program (FY17-20) aimed to increase access to sleep care for rural veterans by establishing telehealth services at 12 hubs and 63 spokes across the country. The TeleSleep program has three components: (1) Telemedicine; (2) Home Sleep Apnea Testing (HSAT); and (3) REVAMP (Remote Veterans Apnea Management Platform), a web-application for comprehensive sleep apnea care.