TAP TO GO BACK TO KIOSK MENU

Inter-Visit Management of Pts with DM2: Synchronized Phone Calls

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Barbara Rosato DNP, RN, CNP, CDE; Jessica Koval MSN, RN, CNP., Candace Reynolds, RN Avae Thomas, MPH

Introduction/Problem

- The US health care model continues to struggle in providing comprehensive and cost-effective care to patients who require chronic disease management (1)
- Innovation focusing on improving care delivery systems to bridge this gap will be necessary to improve chronic care in the US
- This QI project took place at Healthcare Associates (HCA), a large academic primary care practice in Boston, MA. There are over 40,000 total patients in HCA and 4,500 of these patients (between the ages of 18-75) have diabetes
- Pts with type 2 diabetes (DM2) were selected as the focus on this innovation project as in at least ¼ of the patients in HCA with diabetes blood sugar control was deemed not in glycemic control
- There is a relationship between kept visits and poor DM2 control noted in analysis of clinic data and academic articles (2)

Aim/Goal

Implement a system providing protected synchronous time for the patients and the NP to engage in follow up care after a clinic visit and between clinical visits

The Team

- Maura Moran Brain DNP, RN, CNP, CDE
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The Interventions

Primary Objectives and Implementation of the intervention will lead to:

1. Telephone calls between NPs and patients occur as scheduled
2. Patients enrolled are more engaged in care and more likely to keep upcoming appointments
3. Patient glycemic control is improved through reducing challenges with patient follow up
4. Patients and NPs show measurable increased satisfaction with care
5. Feedback provides feasibility of dissemination of this intervention through practice

METHODS

The scope of this project was to enroll patient's in calls who meet following inclusion criteria

- Scheduled with an HCA nurse practitioner for medical care
- Diagnosis of diabetes type 2 not in glycemic control
- Through the use of motivational interviewing techniques with scheduled provider patient is able to identify 1 to 3 steps to improving glycemic management
- Patient had a working telephone number and agreed to the call

Measures

- Visit and telephone call auditing
- Pre/post staff questionnaires,
- Pre/post DTSQ questionnaires for patients,
- HbA1c results before and after intervention

Tools

- Diabetes Treatment Satisfaction Questionnaire (DTSQs)
- IHI tool to measure provider satisfaction with care delivery system (created by Tantau &Associates)

For more information, contact:
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Results

- The first patient was enrolled in this intervention on 9/5/17 and the last patient was enrolled on 7/23/18 in HCA, 7 NPs were trained in and participated in patient enrollment
- 71 pts were enrolled in project, 10 of these initial patients did not meet implementation criteria or had incomplete information so they were excluded. Data was collected on 61 patients. 7 of these patients did not have a second HbA1c documented as of 11/03/2018
- 39 patients were female and 22 were male. Age range 37–80 years, mean age of 61. Average initial HGA1c= 9%. Self reported race was recorded from OMR and 16 patients identified as white, 43 as black/African American, 1 as Asian, 1 as not specified. 29 patients had private insurance and 31 patients had public insurance, 1 had no insurance listed. 34 patients were on insulin and 27 were not
- Chart review revealed 55 patients had documentation of receiving synchronized calls. 6 patients had no documentation of receiving calls or no completed call documented between provider and patient.
- The average HbA1c was reduced by 1% in all patients enrolled in this project
- There was a 3% reduction in cancelled and no show visits in all patients enrolled in this project from 7/17 to 5/18 when compared to these patient's visit history from 7/16 to 5/17.
- 61 pts completed the pre-test and 23 pts completed the post test DTSQ. All pts who were enrolled in the study used the English DTSQ Questionnaire. See chart 3 for breakdown of responses
- NP Satisfaction surveys demonstrated no appreciable changes before the start of the project and the completion of this project

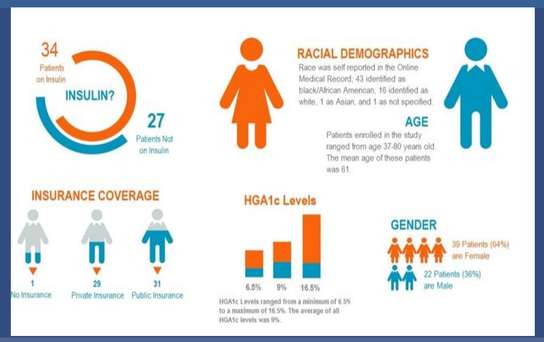
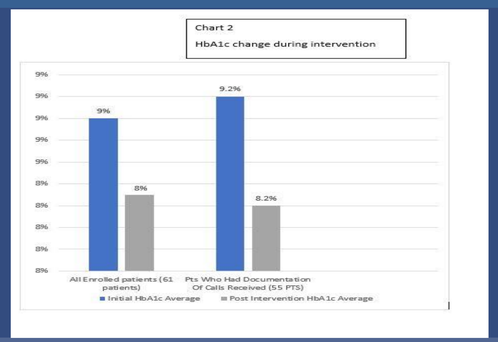


Chart 1 Patient Demographics



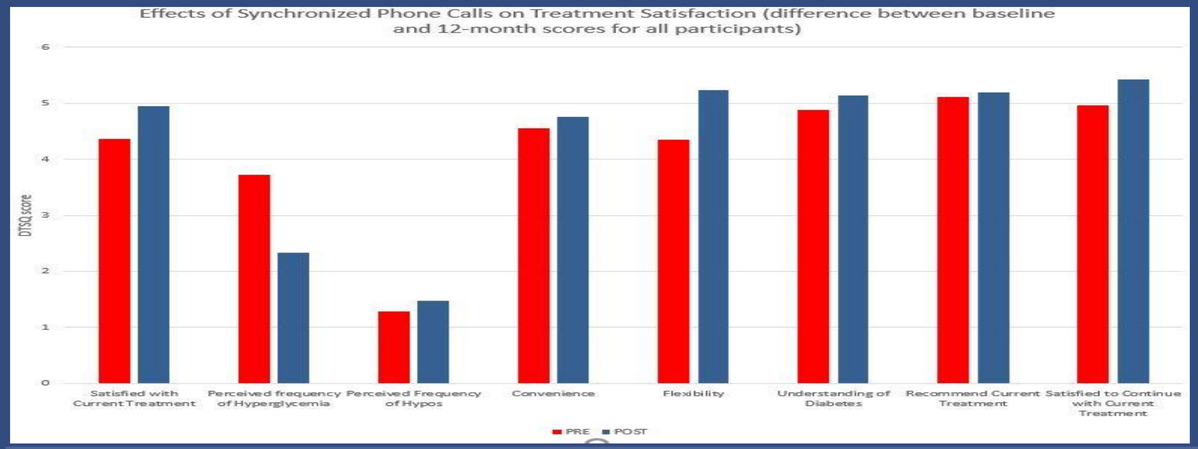


Chart 3 - Pre and Post test DTSQ Questionnaire score

Lessons Learned

- This QI project suggests that NPs and patients can successfully communicate through synchronized calls between clinic visits, 90% of scheduled calls were completed
- Post-project surveys were difficult to collect from pts despite numerous outreach attempts on part of the PI
- Formal strategies for embedding these types of interventions into clinicians daily schedules can be difficult to sustain without flexible systems able to support scheduling of virtual visits not linked to traditional billed visits

Next Steps

- Compare outcomes between patients who receive usual care (clinic visits) with patients who receive additional support (inter-visit calls, emails, or text messages) on Hba1c readings
- Consider future surveys that could be done electronically or over phone to improve survey response rates

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