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StratisHealth

July 30, 2014

Rural Innovation Profile

Diabetes Telephonic Care

What: A project to increase diabetes patients' understanding of their disease processes and to improve their overall health status.

Who: UnityPoint Clinic, Fort Dodge, Iowa.

How: Using a team approach and remote telephonic nurse management for diabetes support, education, and care management.

Why: To develop sustainable models towards the best outcome for every patient every time.

Key Points

- Collaborate with local partners, making sure everyone is on the same page and sharing the same message. This collaboration adds value to the patient experience, particularly in the rural environment, where it is important to use all available resources to provide ideal patient care.
- Learn how to communicate with patients, make patient communications a priority, and be persistent.
- Train all project staff and anyone else who will interact with patients.
- Tailor staff and provider educational materials/training so they are appropriate for the environment in which care will be provided.

Cooperative Agreement funded by the Federal Office of Rural Health Policy: UB7 RH25011

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BACKGROUND

Eagle Grove, a rural community in northwest Iowa, has a rural health clinic (RHC) that is part of UnityPoint Health, a health care organization located 25 miles away, in Fort Dodge, Iowa. The RHC is staffed with one physician, Dr. Dustin R. Smith, and one nurse practitioner, Charity Hayes, ARNP. Following one of his regular reviews of clinic quality scores and metrics, Dr. Smith decided to focus on improving the health of the clinic's diabetic patients. Dr. Smith said that he made this decision not because the patients' scores were "alarming or worse than other communities" but because he wanted to improve their health and believed that the small size of the community made it an ideal place to conduct a rural diabetes pilot project.

The pilot project aimed to increase patients' understanding of their disease processes, improve their HgbA1c scores and, as a result, improve their overall health status. Because Eagle Grove lacks a hospital and a certified diabetes education program, and because the time allotted for clinic visits at the RHC was not long enough to support effective diabetes education, Dr. Smith reached out to UnityPoint Health for remote telephonic nurse management of the Eagle Grove patients in the diabetes pilot project. UnityPoint Health's commitment to population health made support of this project a natural fit for the organization, and the system funded a pilot project. Clinic providers, all clinic staff (registration, billing, nursing, etc.), telephonic nurse manager, UnityPoint Health administration, and other partners (public health and Trinity Diabetes Center) made up the project team.

PROJECT IMPLEMENTATION

Project implementation began with health care provider and clinic staff education, including (1) Integrated Chronic Care Disease Management (ICCDM) training tailored to meet all clinic staffs' needs, (2) teach-back training for all clinic staff, (3) how to develop action plans specific to diabetes, (4) how to set goals with patients, and (5) education on the diabetes disease process. Although usually a six-hour class, the ICCDM class was changed for the pilot project to several "Lunch and Learn" sessions. Skits were used to help staff learn how to talk with patients and do teach-backs. The Quality team spent five weeks working side-by-side with UnityPoint Health providers and clinic staff to fine tune their skills. Project meetings to support staff education included RHC providers, administrative staff, and the telephonic nurse. These meetings served both for information sharing/education and for relationship building.

Of the identified diabetes patients living in the community, 54 had HgbA1c levels above 8[1] during the 2012 calendar year and were invited to participate in the pilot project. Contact with patients about the pilot began with a letter from the patient's health care provider, introducing the patient to the project and encouraging them to participate. The letter explained the purpose of the project, the relationship between the health care provider and the telephonic nurse, the role of the telephonic nurse, and that the project was a clinic project and not related to the patients' insurance coverage. The letter also stated the project was no cost to the patient. A week to 10 days later, the telephonic nurse mailed a follow-up letter to each patient. This letter introduced the nurse, described the project from a nursing perspective, reinforced the relationship between the telephonic nurse and the patients' health care provider, and reinforced that the project was not insurance related and that there was no cost to the patient. The letter also presented the patient/telephonic nurse communication plan and the nurse's contact information.

"The project really focused on one patient at a time, one experience at a time, and was tailored to each patient's needs."

Doris Hott, UnityPoint Health

After the letters were mailed, the telephonic nurse began patient phone calls to invite patients to participate in the project. The introductory phone call lasted approximately 10 minutes, with follow-up calls once a week during the first month. Once patients were familiar with the project, telephone follow-up occurred every three to four weeks. Based in Des Moines, the telephonic nurse's role was to provide diabetic support, education, and care coordination.

The standard goal set for all patients was:

- HgBA1C < 7
- Pre-meal blood sugars of 70 mg/dl – 130 mg/dl
- Post meal blood sugars < 180 mg/dl
- HgbA1C every three to six months
- Yearly urine test for micro albumin
- Yearly blood test for lipid levels

[1] For someone who does not have diabetes, a normal level can range from 4.5 percent to 6 percent. Source: www.mayoclinic.org.

In addition, patients developed personal goals and action plans with either their health care provider or the telephonic nurse. Examples of goals included "I am going to lose one pound in two weeks" or "I will check my blood sugar every morning for two weeks." A key factor in project success was for all partners to learn how to communicate with the patients and help patients identify personal goals for improvement. Project staff and health care providers used each patient interaction as an opportunity for patient teach-backs, such as "tell me when you want to contact Dr. Smith to report a symptom" or "tell me how many carbohydrates you allow yourself to eat each meal." Regardless of the personal goals selected or the teach-backs used, an individual approach was used for each patient, including the number and frequency of telephonic contacts.

OUTCOMES

Of the original 54 pilot project participants, 3 relocated and 2 are deceased. Of the remaining 49 pilot patients, 29 patients brought their HgbA1c level below 8, and 11 additional members were able to lower their HgbA1c levels, showing 81.6% improvement in this population.

Since the project's implementation, RHC patient charts are reviewed every six months to identify additional patients. Thirty-nine additional patients have been identified to participate in the Eagle Grove program. In March 2014, the program was expanded to Pocahontas, Iowa, 35 miles west, and UnityPoint has plans to expand and support the program in additional communities.

One of the most important lessons that Eagle Grove clinic staff learned was that they do not have to do everything themselves. Collaboration with health care and community partners adds value to the clinic patients' experience. Particularly in the rural environment, it is important to use all available resources to help provide ideal patient care.

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