

Pushing the Envelope- Medical Care Outside of the Office:

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The purpose of the IDEALL Project (PI: Dean Schillinger, MD) is to develop, implement and evaluate the effects of tailored disease management strategies on health outcomes for diabetes patients in a large public delivery system. In particular, we are interested in comparing the degree to which interactive technology vs. interpersonally-oriented interventions can engage patients and improve diabetes outcomes. In a randomized controlled trial, the IDEALL project compares (a) automated telephone diabetes management (ATDM) to (b) empowerment-based group medical visits to (c) usual care. Patients have been enrolled from San Francisco General Hospital's Family Health Center and General Medical Center, Silver Avenue Family Health Center, and Chinatown Public Health Center.

Our ATDM system involves a series of 39 weekly automated calls made to each patient's phone. Patients choose their own preferred time, day and language (English, Spanish or Cantonese).

Calls consist of a series of queries regarding self-care behaviors. For example:

- *Please enter the number of your last blood sugar. For example if your blood sugar yesterday was 256, you would press 2-5-6.*
- *In the last 7 days, how many days did you check your feet? Press the number of days.*
- *If you've been thinking about quitting smoking and you would like someone to call you back with information about how to quit, press 1. If you are not interested, press 2.*

Calls also include health education. Some are connected to the queried responses while others are free standing vignettes. For example:

- patient responds "0" to number of times checked blood sugar this week
The 1st step to checking your blood sugar is having all the right tools! You need a machine that works, batteries, test strips, lancets, and to know how to use them correctly. If you are having problems WITH ANY OF these and would like us to call you back, please press 1. If not, press 2

- patient actively requests to hear health education in story form
 - To hear about Mrs. Perez who had diabetes for 7 years and felt she was too sick and too old to exercise, press 1.
 - To hear about Mr. Tan who never seemed to have time to exercise, press 2.
 - To hear about Mr. Louis who lived by himself and always felt too tired and depressed to exercise, press 3.
 - If you do not want to hear these options, press 4.

The Nurse Care Manager receives daily reports of any out of range responses for patients enrolled in the ATDM program and attempts to engage patients on telephone regarding their responses. There is emphasis on supporting and educating patients in disease management and guiding them toward self-generated action plans to improve health behaviors. For diabetes patients, self-care that occurs in day-to-day life is critical to optimizing health status; the ATDM system offers greater support for these patients in between office visits.

The goal is to enhance primary care. The Nurse Care Manager can collaborate with primary care providers in medication regimen changes, reinforce target goals for a particular patient, and help navigate patients through a complex health care system. Patients have reported a sense of greater access and an expanded care team. In turn, the automated portion of the ATDM system serves as triage, identifying those patients who respond beyond a particular predetermined threshold.

At present, the research project is winding down and we have received funding to integrate the system into a few existing clinics in the Community Health Network of San Francisco. Along with this task comes rethinking queries, thresholds and call frequency to make the ATDM as useful and efficient as possible in the clinical setting. We will refine protocols and train clinic RNs to staff the ATDM nurse calls. We hope to facilitate and promote a team approach to chronic disease management by supporting communication and engaging and empowering patients in their own care.