Disclosure to Participants

Notice of Requirements For Successful Completion
Please refer to learning goals and objectives
Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours

Conflict of Interest (COI) and Financial Relationship Disclosures:
Presenter: Janice MacLeod, MA, RDN, LDN, CDE, Employee – WellDoc
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Diabetes Educators as the Leaders in Digital Health

Connecting the e-patient, the diabetes educator and the healthcare team to improve diabetes self-management and treatment optimization

Objectives

The participant will be able to:

• Discuss how educators can demonstrate their value in partnering with the e-patient
• Describe how technology can be leveraged to provide diabetes management services in evolving health care environments:
  – Primary Care/Population Health/IDN
  – Pharmacy/Medication Management Program
  – DSME/S program/Endo Clinic/Accountable Care Organization
• Demonstrate the leadership role the educator plays in value based care redesign

Agenda

• The transforming health care/diabetes education landscape
  – Janice MacLeod, MA, RDN, CDE
• The educator’s evolving role, the e-patient, & leveraging evidence based technology tools in:
  – Primary Care & Population Health Initiatives
  – Pharmacy/Medication Management Program
  – John Motsko, PharmD, CDE
  – Technology enhanced DSME/S programs in Endo Clinic
  – Diana O’Keefe, RN, CDE, CDTC
• Q/A – Panel

Diabetes Educators as the Leaders in Digital Health

Janice MacLeod, MA, RDN, CDE

THE TRANSFORMING HEALTH CARE ENVIRONMENT

The diabetes educator as the leader/mentor in value-based care redesign

Health Care Landscape

• Digital health technology has reached a tipping point
• The e-patient (educated, empowered, engaged) is here
• Value-based models of care are becoming established
• Increased demand for diabetes education services outside traditional programs
• Clinicians/practices need assistance in providing quality, evidence-based diabetes care/education to meet population needs
• Evidence-based digital health tools such as Mobile Prescription Therapy (MPT) can help fill the gap

Health Care Transformation

Diabetes & Chronic Care

Role Remodeling – Practice transformation
Leadership role of CDE

- Mentor
- Support
- Expert consultant
- Negotiate and drive ongoing care plan changes

Mobile Prescription Therapy

- Patient-centered, evidence-based technology platform empowering the educator and supporting practice transformation.

Integrating MPT Into Practice

- Configuration (Digital Care Plan)
- Treatment & Care Plan
- Monitoring & Adjustments
- Standards of Care
- Therapy guidelines

Mobile Prescription Therapy becomes part of the team does not in addition to.

Digital Real Time Feedback Messaging

- Educates patient to understand and take control of type II diabetes
- Helps patient and provider identify blood glucose and mood trends

MPT Data-Driven Practice Improvement

- Pharmacies
- ACO
- System
- Population Health Initiatives
- PCMH

Improve Outcomes

- Digital Diabetes Champion supports Digital Care Plan
- Health Coach
- Care Coordinator
- Diabetes Educators (Levels 1-3)
- Treatment & Care Plan
- Monitoring & Adjustments
- Standards of Care
- Therapy guidelines

Shelley Christian Taylor, RN, CDE

PRIMARY CARE POPULATION HEALTH
Practice Population

Meritus Healthcare is a large Integrated Delivery Network in Washington County, MD
- 8 Primary Care Practices
- Each practice has an RN care coordinator
- Population Health Management provided by 2 diabetes nurse educators
- One Endocrinology Practice with an ADA-recognized DSME/S program with RN/RD

Patient population
- 12.8% have diabetes (95% Type 2)
- 72.6% Washington County adults are overweight or obese
- AA with DM have increased ED visits
- Limited access to healthy, affordable foods
- Medicare/Medicaid/Commercial insurance/Uninsured

Optimize care: SMART Visit Report: A conversation with the patient

Critical to Success
- Leverage diabetes educator to maximum capacity of license (appropriate referral to program)
- Care Manager’s provide basic education and are mentored and supported by the diabetes educator
- Algorithms for medication management
- Bring all applicable therapies and tools to bear to provide ongoing support and optimize the care plan: Evidence-based technology tools such as MPT, Behavior Health, Med Assistance, Pastoral Care, etc.
- Communicate, communicate, communicate!!!

Challenges
- Patient Engagement
- Power
- Change

“Success is not final, failure is not fatal, it is the courage to continue that counts.”
- Churchill
Results to date

- Pre-intervention average A1c = 10.2% (over all practices)
  - 2.4% A1C reduction with patients using MPT along with CDE Intervention
  - 2.0% A1C reduction with CDE intervention

- Future Data:
  - ED Visits
  - Readmission rates
  - Patient & Provider Satisfaction
  - MPT vs. Usual Care

Age Range: 33 – 57 years old
(Mean Age: 45)

Services Provided

- Traditional education services, glucose meter data transfer, Medication Therapy Management
- Digital Self Management Tool (MPT) for local and rural patients-partnership with Care Coordinator as part of a health plan (CareFirst)
- Integrating MPT into DSME/S- supports patient self-involvement; a one stop shopping tool for resources and reports
- MPT SMART Visit Report serves as the communication vehicle

Patient/Pharmacist Partnership

MPT offered to all patients at assessment session or in group classes as a tool to facilitate partnership in diabetes management

- Patient role: Use tool according to digital self-management plan we agreed to; send report as agreed
- Pharmacist CDE role: Review reports as received and negotiates with the patient and other members of the health care team on diabetes care plan changes needed

Practice Population

- AADE accredited program in a large independent pharmacy serving a rural community. Two pharmacists CDEs, one with a specialty in medication therapy management
- Serving 200 new patients annually, 90% T2D; referrals from mostly PCP providers-2 endocrinologist in community of 120,000 individuals; diabetes rate in excess of 15%. 1 other diabetes program in area.
- 55% Medicare patients; 15% Medicaid; 30% Private Pay
- Recent partnership with largest private payer in area (BC/BS of MD)

Digital Health • PHARMACY • DSME/S

Self-management Support
- Digital patient education and guidance
- Clinical decision support
- Medication collaboration
- Care coordination
- Patient engagement
- Prevention of disease progression
How We Utilize MPT

- Assess engagement in self management
- Monthly report allows for more responsive coaching especially when hypoglycemia is an issue
- Medication Management Issues
  - Assess barriers: efficiency, side effects, cost
  - MPT automatically calculates bolus insulin dose at meals
  - Address appropriate BP and cholesterol therapy
  - Recommend medication changes to reach goals

Technology enhanced DSME/S

Our Journey with MPT

- How we enhanced our DSME/S program
- Referral form
- Technology in our assessment
- Our curriculum
- Documentation

Patient Population Profile

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% Male</th>
<th>% Female</th>
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<tr>
<td>29-40</td>
<td>67%</td>
<td>33%</td>
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<tr>
<td>41-50</td>
<td>45%</td>
<td>55%</td>
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<tr>
<td>51-60</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>61+</td>
<td>56%</td>
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Diabetes & Endocrine Institute of Morristown Medical Center

Our practice, in the Atlantic Health Care System is part of the Atlantic Accountable Care Organization.
Our office consists of 3 Endocrinologists, 2 Nurse practitioners. 6 RN CDE's, 2 RD CDE's.
We serve approximately 4600 patients, 65% type 2.
DSME with MPT Program

- PCP patient referral to DSME/S Program at the Diabetes Institute includes MPT
- Technology assessment is incorporated into initial DSME assessment
- Incorporate MPT into the DSME/S Curriculum
- DSME On-going Support includes MPT - (DSME Standard 8)
- SMART Visit Report

MOB Enhanced DSME Program:

- Informed decision-making
- Increased motivation/adherence
- Prevention of disease progression

MPT–DSME: Initial Visit

- All patients referred for DSME are evaluated for MPT at the initial assessment visit.
- Identify patients who meet MPT criteria:
  - Adult type 2 patients
  - Have smartphone, tablet, or home internet access; uses apps
  - Checks blood glucose

DSME Enhanced with Digital Tools & MPT

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<tr>
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Patient Engagement

- Empowers Educator
- Engages Patient
- Connects Team to Improve Outcomes

MPT-DSME/S Referral Form

- PCP signs referral form
- Patient enrolled in technology-enhanced DSME Program

MPT–DSME Program:

- Technology-assisted, life-long care for chronic disease
- Emphasizes goals and success
- MPT tool to support individuals in managing diabetes

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Informed decision-making

- Increased motivation/adherence
- Prevention of disease progression

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Ongoing education and support

- What's diabetes? (Resource articles and videos)
- Healthy Eating (Easy Carb Estimator, Restaurant Helper, Resource articles and videos)
- Being Active (Link to Fitbit, JAWBONE, MISFIT, S-Health for activity tracking)
- Monitoring (SMART Check, BG entries, notes, Real-Time Feedback, logbook, Send SMART Visit Report)
- Taking Medications (Listing, scheduling, setting reminders and logging meds)
- Problem Solving (Resource articles and videos)
- Healthy Coping (Real-Time Guidance, Motivational Messages, Resource articles and videos)
- Reducing Risks (Tracking Health Information, notifications when due)

MPT Engagement

- 80 patients enrolled in MPT
  - 70% male
  - 64% aged 40-60 years
  - 36% over age 60 years
  - 36% use insulin
- MPT Utilization
  - 79% remained active over 30 days
  - 66% remained active over 90 days

MPT/DSME: Documentation

- Complete Education Record

MPT/DSME: Documentation (Cont’d)

- Discharge from DSME Program
- SMART Visit Report

Self Management Engagement

- Percentage of patients making MPT entries
  - BG – 86%
  - Meds – 69%
  - Physical Activity – 11%
  - Food – 41%
  - Notes – 60%
- Smart Visit Report
  - 64% sent to health care team
  - 36% sent to themselves

QUESTION AND ANSWER PANEL
### Role of Health Care Team in MPT Implementation and Integration

| IDENTIFY patients who would benefit from MPT & PRESCRIBE as standard of care. |
| Engage patient in use of MPT CONFIGURED FOR THEIR TREATMENT PLAN. |
| Leverage the resulting PATIENT GENERATED DATA TO INFORM TIMELY TREATMENT AND CARE PLAN OPTIMIZATION. |
| Facilitate ONGOING PATIENT/TEAM ENGAGEMENT through use of MPT. |
| GOAL: Maximize capabilities of each health care team member to integrate MPT into diabetes clinical practice and education to optimize value for patient, health care team, and payer. |

Mobile Prescription Therapy becomes part of the team does not in addition to.

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