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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.

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Presenter Malinda Peeples, MS, RN, CDE – WellDoc employee

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Make the Primary Care Connection:
Health Coach, Care Coordinator, and Digital Health
Objectives

Program Objective 1
Increase perspective on the changing face of healthcare, healthcare systems, payment models and diabetes and communication technologies to deliver clinically- and cost-effective care to people at risk for and affected by diabetes

Objective 2
Establish novel and innovative programs and collaborations with a broad array of diabetes stakeholders to advance the role of diabetes educators and promote our involvement in chronic disease prevention and management in diverse populations

“Pillars” of the Medical Home

- The PCMH model includes:
  - Increased patient access (same day appointments, 24/7 connectivity, patient portals)
  - Team-based care, where each member works to the top of their license
  - Collaboration and bi-directional data sharing among providers in the medical neighborhood including specialists, hospitals and SARs
  - HIPAA-compliant technology solutions to collect, manage, and transmit patient data electronically
  - Participation in payer-incentive programs which help to defray transformation costs
  - On-site care coordination for the highest risk patients and TOC

Care Coordination Best Practices

- The Agency for Healthcare Research and Quality (AHRQ) defines Care Coordination as:
  “...the deliberate organization of patient care activities...to facilitate the appropriate delivery of health care services.”

- Care coordination in the PCMH setting focuses on population health management as it relates to 3 buckets of patients:
  - Transitions of Care (emergency room visit or hospital admission)
  - High Risk Patients (reducing utilization / preventing disease exacerbation)
  - Low and Rising Risk Patients (patient engagement in self management / improving quality)

- Supporting Patient Self Management
  - Identify and align with clinical goals (PCP plan of care)
  - Identify opportunities for health education (increase independence; decrease barriers to success)
  - Employ a variety of modalities suited to patient’s need / health literacy level

Population Health: Diabetes Management

- VMG has 50K patients across 5 sites; 21K in the Verona office
- In New Jersey, Approximately 22% of adults 65 or over have the diagnosis of diabetes, according to the NJ Department of Health 2011 statistics
- At the Verona site, 4819 patients or 18% have the diagnosis of diabetes
- Patients are seen Q3-4 months for fasting blood work (including A1c, microalbumin) and OV
Focus on Diabetes Interventions

- Concentrated outreach to high risk diabetes patients not at A1c goal:
  - Group or individual classes with on-site nutrition/diabetic educator
  - Diabetes Tool Kit w/ care coordinator
  - Proactive calls Q2-3 months for review of Action Plan; scheduling FBW and office visits; health coaching and disease education

- Practice seeking additional affordable modalities for outreach to rising risk diabetic population (+/- 1000 patients across all sites of VMG)
  - Traditional approaches: working with insurance resources; collaboration in medical neighborhood - diabetes clinic; peer coaching; and community health workers
  - Technology Solutions: portal messaging, practice eNewsletter, using eTools (BlueStar / MeVisit)

Health Care Landscape

- 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

Digital Health: Mobile Prescription Therapy

- Patient-centered, evidence-based technology platform empowering the educator and supporting practice transformation
- Real Time Feedback Messaging
- Educates patient to understand and take control of type 2 diabetes
- Helps patient and provider identify blood glucose and meal adherence trends
- Algorithms driven by the patient's treatment plan
- Delivery personalized guidance to the patient when they need it most
INTEGRATING DIGITAL HEALTH INTO PEER SUPPORT AND COLLABORATIVE CLINICAL CARE

MPT Features & Highlights
- Healthcare Provider Features:
  - Decision support tool:
    - Projected A1C
    - Detailed BG values
    - Medication treatment plan
    - Patient health v. ADA guidelines

  - Patient Features:

Patient Features: Integration with Activity Trackers
- Self-management Resources
  - Activity Tracker Integration
  - SMART Visit Report

Fundamental Role of Social Connections and Support
- Human beings are more effective and happier when they have someone
- they can talk to about personal matters
- who cares about them
- who can help them when they need help

The risk of death associated with social isolation is greater than the risk associated with cigarette smoking
  American Scientist 54: 244-272.

For Diabetes Self-Management Support: Strengths of Peer Supporters
- Not professionals
- They often have the health problem they are assisting with
  - e.g., people with diabetes helping others with diabetes
- Share perspectives, experience of those they help
- People believe them because they are “like me”
- Can teach how to implement basic self-management plans (e.g., healthy diet, physical activity, adherence to medications)
- Have time!!

Bright Shiny Objects
- Television
- Video
- Smartphones
- Apple Watches – 37% shortfall in sales
  (Fortune, 1/21/16)

Skepticism → Relationship is fundamental

Strategic Considerations
- Engaging “Hardly Reached”:
  Peer Support Reached Over 85% of
  - Low income, Latino adults with diabetes
  - Single mothers of children hospitalized for asthma
- Reaching Populations
  - 7 Compañeros reached 3,787
  - Improved blood sugar
- Integrating Behavioral Health and Peer Support
  - Reduced distress and likelihood of hospitalization in Hong Kong (Chao et al. JAMA Internal Med. 2014 174: 972-981)
Standardization & Adaptability
Four Key Functions of Peer Support

Design of Feasibility Test
- Single group, pre-post
- Continuous quality improvement framework
- Qualitative evaluation, coach contact notes, post survey, clinical data from Vanguard, app data from WellDoc
- Option to compare results with typical BlueStar users

Health Coach Training and Supervision
- Rapid 16-hour initial training
- Weekly conference calls to provide ongoing training, address protocol changes, troubleshoot clinical and study issues
- Clinical oversight from care coordinator
- Direct supervision from program manager

Patient Eligibility
- Adult patients at Vanguard
- Uncontrolled diabetes (HbA1c > 7.5, recruited starting with highest A1c)
- Has smartphone or internet-enabled home computer
- Able to read and write in English
Feasibility Protocol

- 1-2 days
- Initial Contact
  - N = 300
  - Refine screening criteria, enroll potential participants
- Ongoing patient recruitment
- Assignment of patients
  - Matching needs, preferences, goals
  - Assignment
- 1st Coaching Contact
  - Assess patient needs, discuss weight, diabetes self-management, provide resources, and referrals as needed
- 2nd Coaching Contact
  - Provide necessary information, support, and education
- 7-month implementation period

Quantitative Evaluation

- Pre-post measures: HbA1c, BP, cholesterol, BMI
- Health coach utilization
- # of successful contacts
- Duration of contacts
- Topics discussed
- Perceived support and satisfaction
- BlueStar utilization
- # of data entries
- Renewed prescriptions
- Unused/underused functions
- Perceived support and satisfaction

Timeline

- Health coaches trained
- Ongoing patient recruitment
- BlueStar data utilized by coaches
- Patient surveys and qualitative interviews
- 7-month implementation period
- Final coaching contact, ensuring continuity of care to clinic

Preliminary Results

- 43 patients enrolled / 89 contacted
  - Average HbA1c = 9.7, Age = 57, 53% men
- 30/43 patients sustained engagement, 70% retention rate

Preliminary Results

- 37/43 enrolled patients use BlueStar
- 76% smartphone, 24% computer
- Average 6.5 entries / patient / week
- Average 6.9 contacts with Coaches
- Varied patterns of engagement with coaching / BlueStar
- High program satisfaction, high willingness to participate in interviews

Qualitative Evaluation

- Structured telephone interviews
  - 15 patient interviews
  - 5 staff interviews
  - 2 health coach interviews
- Behavioral changes made
- Helpful features of coaching/BlueStar
- Quality of care improvements
Preliminary Results

Changes in HbA1c

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

# Contacts Associated with Reduced HbA1c

(p = 0.016)

changes in HbA1c

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

Preliminary Results

On Insulin

Not on Insulin

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

< 3 Contacts | 3 – 6 Contacts | > 6 Contacts

Engaging the patient.....can technology help?

The Challenge

• In US, 80-70% have not received self management training
• Reach and engagement more important than efficacy
• We don’t need a few “best practices”
• We need many “good practices”

RESOURCES

Global Evidence for Peer Support: Humanizing Health Care – Report from an International Conference

Peer Support in the Patient-Centred Medical Home: Primary Care
http://www.aade.org.au/Peer-Support

High Tech / Soft Touch Brief

Evidence-Based mHealth Chronic Disease Mobile App Intervention Design: Development of a Framework

Cluster-randomized trial of a mobile phone personalized behavioral intervention for blood glucose control

Is there an app to solve app overload?

OPPORTUNITY FOR EDUCATORS

AADE Technology-Enabled Framework

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