April 24, 2020
Vermont Blueprint for Health

FINDINGS FROM PROVIDER & ADMINISTRATOR INTERVIEWS to inform SELF-MANAGEMENT PROGRAM REDESIGN

Methods

Interviews conducted

All interviews were conducted between March 9, 2020 and April 8, 2020. All were by phone.

Primary care providers

Primary care providers interview guide

1. DO practicing in primary care in Windham County
2. PA practicing in primary care in Chittenden County

Administrators

Administrators discussion guide

"Administrators" here is imperfect shorthand for folks ranging from the people administering Blueprint programs in communities to licensed professionals doing direct service. All are within the auspices of Blueprint programming, except for a person leading a Lifestyle Medicine department/program.

1. Bennington – Blueprint Program Manager
2. Brattleboro – Blueprint Program Manager, Self-Management Regional Coordinator
3. Springfield – Blueprint Community Health Team Leader, Diabetes Educator from the Community Health Team, Self-Management Regional Coordinator
4. Springfield – Lifestyle Medicine Program Manager who is also the RiseVT Program Manager for Windsor County
5. Informal phone "focus group" with nine Blueprint Community Health Team leaders

Note

Three providers who were interested in participating had to cancel or defer participation, due to emerging COVID-related responsibilities. The same was true for one Community Health Team/Marketing Department group interview. Any/all of these folks could be contacted again later.

Findings

Providers want their patients to eat better and move more.

- Providers tell us that weight loss could help slow or reverse disease progression, in their patients with type 2 diabetes or hypertension (and some other conditions that aren't the focus of this programming). They want their patients to eat better and move more, and to lose weight.
- Weight itself can be an uncomfortable topic for providers to discuss with patients. The stigma/shame factor is a primary deterrent.
- Some patients with overweight or obesity want to lose weight and struggle to do so. One provider says he also sees patients who tell him "I don't have a problem with my weight" even if he indicates it is a risk factor for chronic conditions. Some are living in families/communities where overweight and obesity is common.
- New Americans make up a large part of one provider's panel. She notes that she is seeing smaller weight gains in people from Nepal precipitating type 2 diabetes compared with white people. She also experiences different cultural perspectives on weight, for instance in working with some New Americans of African descent who associate weight loss with ill health.

Nutrition and exercise classes are on-offer and in demand

We asked administrators what else was being offered in their area in addition to the Blueprint's Self-Management program:

- Many Community Health Teams (and partners) offer cooking and nutrition education offerings. Patients are always asking "what should I eat?" This is a response.
- Many Community Health Teams (and partners) offer supported exercise programs. Some are targeted to support patients with specific health needs (e.g. cardiac "prehab" and cardiac rehab), others are more general.
- These offerings are all homegrown, indicating that local leaders in multiple areas of the state are independently identifying need for these types of programs and opportunity to support them.

Patients have limited knowledge of diabetes and hypertension

- Some providers are not diagnosing pre-diabetes – neither telling patients they have the condition nor putting it in their EMRs, despite tests showing blood sugar levels in the prediabetes range. Both a provider and an administrator mentioned this.
- Many patients do not immediately take the prediabetes diagnosis seriously. "[It's an understatement to say] there are a whole bunch of people who aren't phased by a prediabetes diagnosis."
- Patients also rarely understand why/how carrying excess weight puts them at risk for certain chronic conditions.
- A provider talked about the importance of not assuming any patient really knows what diabetes is, or what it does to a body, or why it is important to treat.
- A provider tells us these is "simultaneously a lack of information and excess exposure" – people may think they know more than they do, or think they know everything they need to know about a condition, or about what they should be doing to manage their health. "I don't need to

attend a year-long class to tell me what I already know" is the type of statement he hears about the Diabetes Prevention Program.

- A provider encouraged us not to "dumb down" education resources, to remember that many people with very little education are highly intelligent. The same provider asked for more evidence-based educational materials to support his conversations with patients about their conditions.
- Providers and administrators talked about the importance of customizing education to meet the needs of the individual patient.

Both prescribers talked about "overprescribing" being common and often a result of people not taking the first (or first few) medications they were prescribed as prescribed. Both talked about the importance of asking patients about whether and how they take their medication carefully, to elicit true information, and about working to understand why if they aren't taking it as prescribed.

- There may be a belief gap with hypertension – patients not feeling the disease process at work and therefore not truly believing in the risk or the need for medication.

The moment matters – engaging people when they are ready for change

- Some patients aren't currently equipped to learn about or actively manage a health condition. Some have awareness and knowledge but not motivation – or belief in their own capabilities. Some patients are fully, continuously ready and are experimenting with self-management approaches. Some will suddenly become ready to engage.
- Both providers and administrators work continuously to assess patient motivation and readiness for change, and to offer strategies and tools that "meet the person where they are at" (this phrase is used a lot).
- **It helps to hear from a doctor "you're ready for this." We heard this from an administrator and a provider independently. A provider told us about one of her patients with diabetes who made major improvements in his health. He told her he was motivated by "the fact that you told me <u>right now</u> is the important time to turn this around."**
- For many patients, being prescribed medication significantly shifts their perception of their health. **A prescription makes their diagnosis real, or serious. "It's alarming to be started on a medication – that kicks people into action."**
- Both providers talked about not taking medication/getting off medication as a motivator for patients. One uses this as a frame for encouraging weight loss – e.g. a 5% weight loss is likely to have about the same effect as this medication. "A lot of times getting off medicine is a carrot we can dangle."
- One provider asked for self-management offerings to be more like AA meetings, in that they are available "everywhere and all the time" to jump into, so you can "catch 'em while they're hot" and not lose "momentum"

Making risks – and the possibility of change – concrete

- Both a provider and CHT member talked about exercises that help patients with diabetes see how their actions impact their blood sugar – one asking patients to test blood sugar before and after taking a walk, another to test blood sugar before and after eating a big plate of pasta.

- (See above re: hypertension and medication, and the problem of belief in a condition you can't physically sense.)
- Administrators talked about the importance of building self-efficacy. Patients proving to themselves – even in small ways – that they can shift their habits and health builds momentum.

Classes and one-on-one support

Classes aren't for everyone, and they especially aren't for everyone right away. The one-on-one health education and health coaching sessions currently available in many Community Health Teams are more accessible to many patients. For some, this can be an entry point to other resources including classes.

- One-on-one support (by diabetes educators, nutritionists, and other health professionals – often in the Community Health Team) is easy for providers to refer to and for many patients to engage with. Providers appreciate when the professionals they refer to customize their work to meet each patient's unique needs for information and motivation.
- Administrators make significant effort to schedule existing self-management classes at times and in places that work for all potential participants. Still, committing to a series of classes is not feasible for everyone, whether because of competing commitments including work and caregiving, shifting work schedules, or lack of access to transportation.
- Social anxiety also came up frequently as a barrier to participation in classes. The term was used often and loosely, encompassing low self-confidence overall, feelings of vulnerability generally or in relation to health/disease, and concerns about exposure in small town settings. Taking a "class" can also provoke worry about being put on the spot, being judged, failing.
- **For some participants (including some who are initially anxious), classes are effective because they are a shared experience, where participants witness and support each other through change.**
- Successful classes are often supported by instructors or coordinators who make a significant commitment to supporting participants, including being available between classes. One regional coordinator calls class members between each session, just to touch base (clearly telling them this is not about checking on homework or otherwise assessing/judging). One instructor is a RD who is available for one-on-one consultation between classes.
- Some participants appreciate a program being led by a credentialed professional, like an RD. This can help instill confidence in the education and instruction they will receive.
- Successful instructors are often trusted members of their local community.

Change & identity

- The most successful Lifestyle Medicine Complete Health Improvement Program (CHIP) groups succeed in providing new elements of identity for participants, who become "CHIPers" who share a transformative experience with fellow participants. Over time they may encourage their family and friends to join the fold.
- For some people, their usual ways of participating in their communities (families, friend groups, neighborhoods) may be misaligned with their health goals. Lifestyle change may involve making choices that are different from the choices of people they care about, and this can be alienating and lonely.

When the providers talk about the new resources they would like, if anything were possible, those resources are people.

- One provider wished for a co-located Diabetes Educator. Somebody in the office, "who really gets it" and can customize information and support based on patient need.
- One provider wished for a person who really knows all the local resources and can connect a patient with the right offerings based on the provider's reason for referring and the patient's interest.

Patients are ready to engage online – or can get there fast with support

Most people have the necessary technology and connectivity to engage with health promotion apps and online classes or activities. While not everybody feels ready to jump in, most can get there quickly through some friendly "tech support." (Note, the text below uses "online" to indicate all offerings served remotely whether accessed on a computer or smartphone, and whether the offering is in real-time or asynchronous.)

- A provider questioned whether patients would engage with online offerings, but also said that patients of his sometimes come in having downloaded and tried health promotion apps. He would be interested in prescribing apps but doesn't know which are good.
- Another provider believes patients will engage in online offerings, but that it might be a different population of people than those who would engage offline.
- Some administrators have seen success with online offerings, others are hopeful about patient acceptance of an engagement with such offerings.
- The participant from Lifestyle Medicine spoke about research comparing two different online versions of Lifestyle Medicine courses – CHIP and Full Plate. CHIP was found to be more successful – she believes because of the group support and accountability vs. the more asynchronous, self-paced Full Plate offering.
- Provider and administrators both say that most patients have smartphones.
- Administrators say that prepping patients for how to use the offering or course technology ahead of time can help prepare them for a positive experience.

Incentives

No participants had experience of offering cash incentives to patients for self-management or health promotion behaviors. Many had experience with incentives related to program content, designed to promote activation:

- Examples include gym passes for people enrolled in certain programs, cooking classes that provide groceries to take home, and a program through a Lifestyle Medicine department that provides doctor-prescribed FitBits.
- All were appealing program elements, helping support engagement and ongoing participation. None were measured in ways that could isolate their relative value.
- One primary care provider signs attestation forms for patients seeking insurer-provided cash incentives, and reported that these patients are extremely motivated to secure these incentives.

Past programming

- Participants in this research were not concerned about cessation of support for self-management programs other than the Diabetes Prevention Program. Other self-management programs were said to be "stale" and a struggle to recruit for or maintain engagement with.
- The Diabetes Prevention Program is newer than the other programs and continues to be relevant and useful to patients in several communities.
- Workplace-based smoking cessation programming was an exception mentioned in one community. The workplace setting has been good for engagement with the program and for building relationships and support among participating co-workers.
- A provider mentioned one transformative patient experience with the Chronic Pain program. But for most people with chronic pain, these long, seated classes are a poor fit, according to several administrators.

Odds & ends (participant statements and ideas that don't fit into other categories)

- A provider talked about an experience where a wife of a married male patient had been an important partner in supporting change. Another provider independently talked about the importance of "the wives" in patient activation.
- A provider talked about being willing to refer to something that's newer, and less tested – and also to something shorter term, like a one-evening class that's a bridge to other offerings.
- An administrator with a PhD with special focus on rural health (and experience working in health promotion in a rural setting) talked about how people in rural communities define health, how it's often about the ability to participate in your community.
- One administrator's "wish list" items included offerings to support financial literacy, to help people access transportation (e.g. how to use the bus system), and to generally orient folks to all the various resources available to support them in the community.
- The provider interviewed in Windham County asked if we wanted his help asking patients about programs they might be interested in – offered to survey his patients.