BLEND

Better Living through Education and Nutrition for persons with Diabetes

The University of North Carolina at Asheville

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Table of Contents

Background and Purpose 3
Partners and Project Staff 5
Funding and Sustainability 6
Recruitment 7
Tools 9
Project Timeline 10
Frequently Asked Questions 12
Advice for Replication 14
Appendix List 15
References 16

Background and Purpose

A. Goal:

The goal of this project is to facilitate healthcare investments in Older Americans Act (OAA) services by linking cost-effective modernized OAA Title III-C and OAA Title III-D diabetes services to improved health outcomes.

B. Objectives:

1) Identify cost-effective methods to provide palatable, carb-controlled Home-Delivered (HD) and Congregate Nutrition (CN) meals

2) Improve health outcomes among participants receiving meals and/or completing programs

3) Increase enrollment of older adults with pre-diabetes and diabetes in evidence-based prevention and self-management programs

C. Overview of Project:

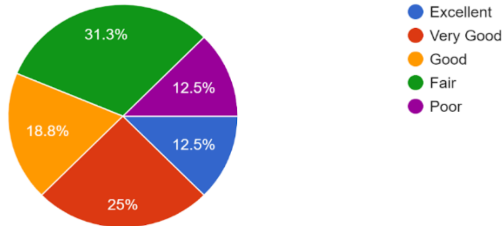
The Better Living through Education and Nutrition for persons with Diabetes (BLEND) pilot project works to facilitate healthcare investments in OAA services through a Food is Medicine intervention,[1] linking Title III-C home-delivered meal services and Title III-D diabetes services to improve health outcomes in several counties in central North Carolina. Working with a regional Area Agency on Aging (AAA), this project connected older adults with diabetes to medically tailored meals and Diabetes Self-Management Education and Support (DSMES) through a referral pathway that consists of regional healthcare providers, community health workers, meal providers and senior centers. This project demonstrated the potential that a collaborative approach connecting foundational nutrition and health promotion services for older adults can effectively support social determinants of health and build a case for healthcare investments in these services.

D. Project Results:

- Total referrals: 68
- Total enrolled: 36
- Total that completed a pre and post survey: 16
- Meals provided: 480
- Those that rated their current knowledge about Diabetes as “Good”, “Very Good”, or “Excellent” increased from 56.3% in the intake survey to 100% in the final survey, a 77% improvement.
- Those that rated their confidence in managing their Diabetes “Good”, “Very Good, or “Excellent” increased from 62.5% to 100% in the final survey. The largest improvement came in the “Very Good” category, from 12.5% in the initial survey to 43.8% in the post survey, a 71% improvement.
- Slight decrease in average diabetes distress scale from 3.275 to 3.212

Background and Purpose *Continued*

How do you rate your current knowledge about Diabetes?
16 responses



How do you rate your current knowledge about Diabetes?
16 responses

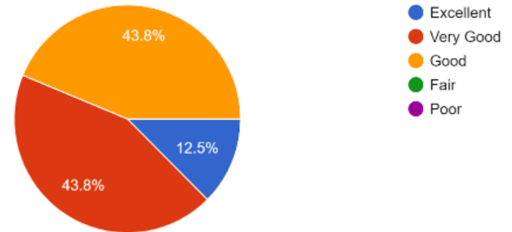
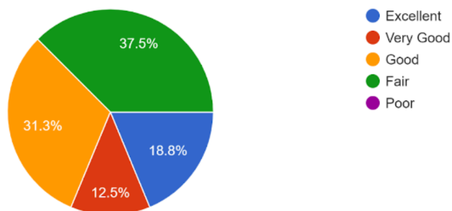


Figure A. Demonstrates the increase in current knowledge about diabetes among the 16 program participants who completed the pre(left) and post(right) evaluations.

How do you rate your confidence in being able to manage your Diabetes?
16 responses



How do you rate your confidence in being able to manage your Diabetes?
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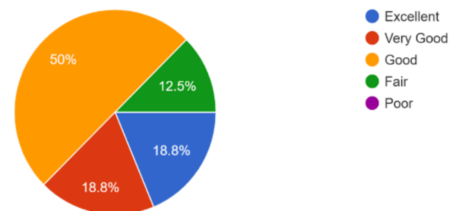


Figure B. Demonstrates the increase in confidence ratings in diabetes management among the 16 program participants who completed the pre(left) and post(right) evaluations.

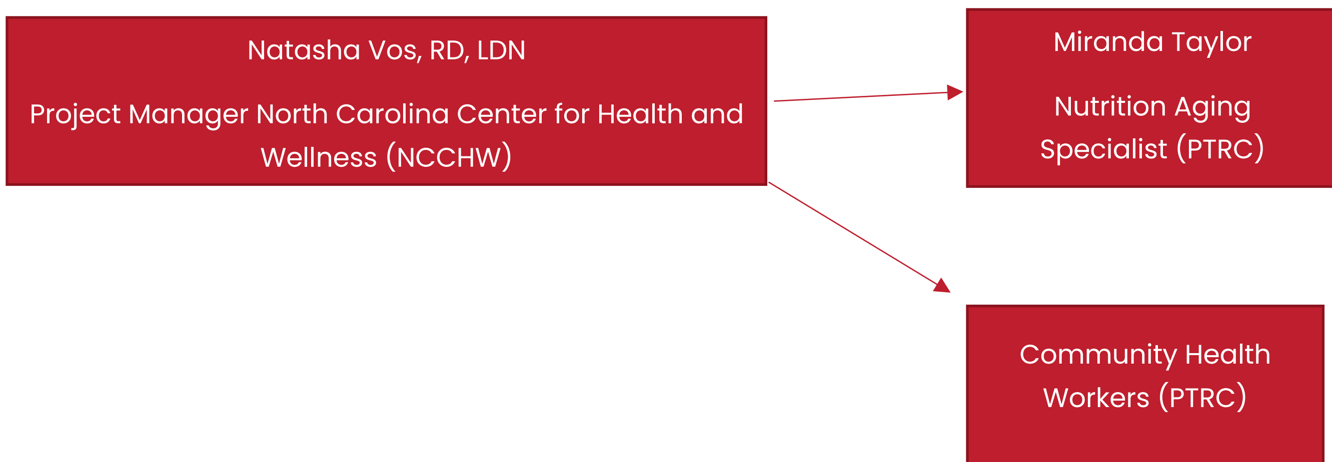
Partners and Project Staff

A. Partners:

- Piedmont Triad Regional Council (PTRC) Area Agency on Aging- a regional AAA covering 12 counties in central North Carolina and serving as the main provider on the BLEND project through their DSMES programming and community health workers.[2]
- Providence Catering and Culinary Training- "meal program of the Second Harvest Food Bank of Northwest North Carolina" that is working to expand their medically tailored meals offerings through the BLEND project and participation in the Food Is Medicine accelerator program.[3]
- CHESS Value Accountable Care Organization- "a physician-led health care services company empowering clinicians and health systems to make the transition to value-based medicine" through "negotiation of value-based payer contracts and risk-based agreements to reward providers financially for focusing on cost and quality."[4]

B. Project Staff Roles:

a. FTEs: 2
b. Staff titles and general responsibilities
   - Project Manager: Oversight of the entire project including development and monitoring of contracts, fiscal management, monthly/quarterly contact with project partners, communication with Nutrition and Aging Resource Center/ACL monthly as required, maintenance of Institutional Review Board (IRB) approval and content development.
   - Nutrition Aging Specialist (NAS): Managed recruitment of participants, administered surveys, provide group education classes, content development.
   - Community Health Workers (CHW): Managed referral list of participants from CHESS, administered surveys, connected participants with technology when appropriate.



Funding and Sustainability

A. Initial Funding:

- 2020 Administration for Community Living Nutrition Innovations Grant
- In Kind Match including:
  - Piedmont Triad Regional Council staff time
  - Community collaborators staff time
  - Cone Health staff time
- Leveraged other NCCHW grants for overlapping work
  - CDC Arthritis Grant (health coaching)
  - CDSME 2019 (Mon Ami platform)
  - Falls Prevention 2020 (Mon Ami platform and Community Care Hub development)

B. Continued Funding:

- DSMES reimbursement from Medicare Part B (Diabetes Self-Management Training and Medical Nutrition Therapy benefits)[5]
- Pending contract with CHESS Value Accountable Care Organization

C. Sustainability:

- Leveraging NCCARE360 Platform: Utilization of NCCARE360 platform for healthcare provider referrals to community-based resources addressing SDOH needs.
- Alignment of BLEND workflow into existing PTRC infrastructure for evidence-based programming, including DSMES.
- Establishment of a network of Health Coaches available for older adults in NC and connection with the Healthie platform for continuing Health Coaching programming.
- Continued efforts to provide a value proposition to CHESS beyond the BLEND project for continued referrals.
- Maintenance of the relationship between PTRC and Providence Catering for congregate nutrition contracts.

Recruitment

A. Participants

a. Requirements

- Older adults age 60+ or eligible to be served by Area Agency on Aging
- Diagnosis of diabetes
- Residents of Rockingham, Caswell, Forsyth or Guilford counties

b. What recruitment methods were used?

<u>Successful:</u>

- Word of mouth: In the beginning of the project while working in rural communities, especially with older adults, it was helpful to recruit from already existing groups such as attendees of Senior Centers and church groups.
- Nurse Navigators: working with the nurse navigators at CHESS enabled better identification of potential participants as well having an initial conversation with potential participants about the BLEND program.
- Recruitment letter: a letter was drafted that was sent out to all eligible participants on the roster from CHESS. The letter explained the program and was sent from CHESS, which helped avoid cold calling participants and increased the likelihood they would enroll in the program.
- Rolling recruitment: allowed for continuous recruitment. Participants were not deterred to enter the program due to wait time.
- Phone calls: Following up with weekly phone calls to participants who had enrolled but not attended a session.

<u>Not successful:</u>

- Defined cohorts: If participants had too long to wait between initial contact and initiation of the next cohort, they tended not to respond to the communication regarding cohort start.
- Independent clinics: Many clinics, while expressing enthusiasm for the program, did not have the capacity to send many referrals. This was due to a combination of staff changes, existing programs that supported diabetes education and the challenges of having an extra step for a referral (as opposed to being incorporated into the electronic health record).

B. Marketing Tips

Successful:

- Brochures: Creating brochures with a photo of the Nutrition Aging Specialist and her contact information. This gave the program a face and made introductions easier for following up after the initial interest was expressed.
- Local interview: a local station interviewed the director of PTRC, who briefly described the BLEND program leading to an increase in phone calls from interested community members. Unfortunately, this did not yield many participants, but it served to increase the visibility of the program.
- Registered Dietitian: Advertising one-on-one time with a dietitian was one of the largest draws for potential participants.

Not successful:

- Brochures at clinics: Despite leaving brochures at several area clinics, it did not translate to increased referrals.
- Congregate sites: In the initial design of the project the recruitment was heavily held at congregate nutrition sites. However, many congregate sites remained closed well into the second year of the project, so no recruitment could be done in-person at these sites.
- Written description of the program: When collaborating with the nurse navigators, initially a program description was provided for education, however the program was not being advertised accurately to participants based on conversations in follow-up phone calls. A presentation was prepared and delivered in a meeting to the nurse navigators including time for questions that enabled the team and the navigators to be in alignment with messaging.
- Meals: Surprisingly, leading with the inclusion of the meals was not successful. Many participants were concerned they were "taking food away from someone else" and that they did not "qualify for the meals" which is a common concern among older adults. Some participants opted out of the meals despite clarification that the meals were provided for by funding through the grant and not other food assistance.

Tools

A. Technology

- Claris Companion Tablets: The Claris Companion Console is an intuitive online dashboard that ensures an older adult can easily stay connected.[6] The console includes the ability to remotely configure each tablet-including reminders and adding new functions and more. The tablet was pre-loaded with Zoom and the Healthie platform that allowed virtual programming, either DSMES or Health Coaching. Reminders were pre-set to let participants know when sessions were starting.
- Hot spots: In addition to the tablets, hot spots were provided if broadband connectivity was an issue.
- Healthie Platform: Healthie is a HIPAA compliant platform that allows for protected exchange of health information and virtual sessions.[7] This platform was used primarily for the health coach sessions. Healthie also contains the ability to bill through the platform, but that was not used as a part of the BLEND project.
- Mon Ami Platform: Mon Ami is "an operating system designed specifically for Aging & Disability agencies to make everything from case management to telephone reassurance easier through automation, integrations, and thoughtful design."[8] The Events Management module is designed specifically to increase efficiency and capacity for evidence-based programs with tools for attendees and administrators.

B. Resources

- ADCES (https://www.adces.org/): A one-stop-shop source for information related to DSMES services
- NCDHHS DSMES (https://diabetesmanagementnc.com/): Resource for DSMES providers in North Carolina
- Food Is Medicine Coalition (https://fimcoalition.org/): Resource for Food Is Medicine interventions. FIMC has quarterly meetings that anyone can attend.
- Results Based Accountability (https://clearimpact.com/results-based-accountability/): "RBA uses a data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking action to solve problems."
- National Council on Aging (https://www.ncoa.org/): A national agency that provides "the resources, tools, best practices, and advocacy our nation needs to ensure that every person can age with health and financial security." NCOA has a robust database of articles and webinars to assist any agency working with adults for everything from recruitment to reimbursement.
- Nutrition and Aging Resource Center (https://acl.gov/senior-nutrition): NRCNA provides resources including webinars, articles and learning modules to assist agencies working in the older adult nutrition system.

Project Timeline

2020

Spring 2020

- Wrote grant proposal for 2020 ACL Innovations in Nutrition Grant
- Obtained Letters of Commitment from project partners

Fall 2020

- Received ACL Innovations in Nutrition Grant
- Hired Project Manager

2021

Spring 2021

- Hired and onboarded Nutrition Aging Specialist (NAS) at PTRC.
- Conducted environmental scan of organizations in Rockingham County engaged in diabetes work and/or meal providers of home-delivered or congregate meals
- Convened collaborators in an initial meeting (met quarterly after) to discuss desired results for collaborative work and relationship building

Fall 2021

- Second Project Manager was onboarded after initial Project Manager left
- Conducted a review of medically tailored meals organizations to develop a shared understanding of terms and development of the project
- Initial IRB review was submitted and approved as an expedited review
- Applied and was awarded supplementary funding for year 2
- Purchased 15 Claris Companion tablets to be used for virtual programming

2022

Spring 2022

- NAS started recruitment of the BLEND program through home-delivered meal routes and follow-up with intake surveys
- Health Coach connected the BLEND project to the Healthie platform for virtual health coaching
- NCCHW staff worked to ensure that all listing of programs supported (including DSMES) were correctly listed on NCCARE360 platform

Summer 2022

- First DSMES class was held virtually with participants from Rockingham County
- Finalized contract with Providence Catering for Medically Tailored Meals

Fall 2022

- First in-person class was held in Caswell County
- First round of Medically Tailored Meals delivered to participants upon completion of workshop
- Changes made, with support from evaluation team, to intake forms to reflect desired data collection between CHESS and PTRC
- IRB amendment submitted with changes to surveys
- Community Health Workers began working with BLEND for processing of referrals

2023

Spring 2023

- IRB amendment approved
- Business Services and Data Sharing Agreement signed between CHESS ACO and PTRC
- First round of patients from CHESS roster sent to PTRC for enrollment
- Mon Ami platform was purchased for AAA use in North Carolina

Summer 2023

- Two in-person DSMES workshops were held in Forsyth and Guilford Counties
- Second round of patients from CHESS roster sent to PTRC for enrollment
- CHESS roster virtual class was held

Fall 2023

- Meal deliveries were completed for the three workshops held in the summer
- Conducted post-survey follow ups of participants
- No Cost Extension September-December 2023

Frequently Asked Questions

Q: Can a person who does not have diabetes participate in the program?
A: No. DSMES is a reimbursement Medicare benefit that requires a diagnosis by a healthcare provider. Exceptions were made for individuals who did not have diabetes but were interested in Health Coaching.

Q: The intake form contains some sensitive health information; can a participant opt out of completing it?
A: The intake form is a requirement of the program to collect data and must be completed to be able to receive services.

Q: Can a person opt-out of medically tailored meals?
A: A participant can opt-out of medically tailored meals at any point in the program.

Q: Can a person opt-out of the Diabetes Self-Management Education and Support program and still receive meals?
A: A participant can opt-out of the DSMES program if they elect to participate in Health Coaching. The intervention is made up of education and meals, so participants must choose one form of education to be eligible for the meals.

Q: What if a participant did not have technology or broadband access for virtual programming?
A: If an individual lacked access to technology or broadband, a Claris companion tablet was loaned to them along with a hot spot for connectivity. The Nutrition Aging Specialist or Community Health Workers would deliver the pre-programmed tablets to the participant and spend time setting them up and demonstrating how to use them. Tablets could also be remotely accessed by Claris tech support if there were additional issues.

Q: Is Diabetes Self-Management Education and Support an accredited program?
A: Yes, DSMES is a program accredited through Association of Diabetes Care and Education Specialists (ADCES) or the American Diabetes Association (ADA). DSMES programs can be built upon existing diabetes education curriculum, such as Diabetes Self-Management Program, an evidence-based program eligible for Title III-D funding, that is a part of the Chronic Disease Self-Management Education suite of programs from the Self-Management Resource Center. In order to become accredited, programs must demonstrate adherence to the criteria set forth by ADCES or ADA.

Q: How are meals determined to be "medically tailored?"
A: "Medically tailored meals are designed for individuals living with severe, complex and chronic illness through a referral from a medical professional or healthcare plan. Meals are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower costs of care and increase patient satisfaction."[1]

Q: When is the Registered Dietitian involved?
A: An RDN is involved for two aspects of the BLEND program. The first part is during the DSMES program for medical nutrition therapy, both individually and in a group. The RDN meets with each participant individually for an initial conversation and then again after the program as a follow-up. The second part is calculation of needs for the medically tailored meals using the information gathered during the initial conversation.

Q: If there is no RDN on staff, how does an agency work with one?
A: If no RDN is on staff, then one must be contracted within the community. For the BLEND project, the project manager served as the RDN for meal calculation and occasionally assisting with group medical nutrition therapy. An outside RDN was contracted with otherwise and reimbursed for their time.

Q: What kinds of data were helpful to collect to demonstrate the value of the program?
A: While clinical quantitative data such as a1c is usually collected for diabetes-related metrics, due to the length of the intervention and focus on self-efficacy, the BLEND project collected non-clinical quantitative and qualitative data to demonstrate programmatic value. This included the diabetes distress scale, perceived diabetes-related knowledge, and confidence in management of diabetes and its symptoms.

Advice for Replication

1) **Communication and partnerships**- Achievement lies in continual communication and collaboration, starting from the planning phase and extending beyond implementation, with a continuous evaluation and enhancement process. Leverage existing relationships and available technology.
2) **Pilot**- Start with a distinct program and initiate on a small scale to address potential problems in new systems and procedures.
3) **Roster management**- Automate tasks for optimal efficiency and effectiveness, particularly to accommodate higher volume. When the referral volume was relatively low, the Nutrition Aging Specialist was able to manage intake and follow-up, but once the team started to receive the CHESS referrals, it became necessary to involve other staff members at PTRC due to the increase.
4) **Sustainability**- Examine the feasibility of engaging in and collectively receiving compensation for aiding Chronic Care Management services by utilizing Community Health Worker services.
5) **Recruitment and retention**- Alignment in messaging across partner agencies is crucial. When the first round of participants from the CHESS roster were contacted, they did not have a good understanding of the BLEND program and what was available. As a result, the team had to connect with the nurse navigators to align messaging for more effective enrollment. Additionally, having dedicated persons completing follow-up will serve to maximize enrollment instead of part-time of several team members. Work with participants to identify barriers to participation.

Appendix List

A. Initial Intake Survey: form to gather basic medical information, assess diabetes diagnosis/risk, and evaluate diabetes-related knowledge and self-efficacy to determine which program was the best fit for participants.
B. Post-Survey: form that gathers much of the same information as the intake form around diabetes-related knowledge and self-efficacy, but without the demographic and medical information.
C. Brochure/Flyers: to advertise the services of the BLEND project that participants received, including DSMES and medically tailored meals. A separate brochure was made to explain the DSMES program and services included.
D. Introduction Letter: letter from ACO to patients introducing BLEND program.
E. Medically Tailored Meals Spreadsheet: Spreadsheet used by the dietitian to calculate needs for medically tailored meals.
F. Results-Based Accountability[9] Meeting Agenda: Template to structure meetings with partners following the Results-Based Accountability framework.
G. Diabetes Resources: A list of diabetes-related apps for participants.

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