Activating Communities and Leveraging Technology to Advance the Complex Health Needs of People Living with Cardiometabolic and Cardiovascular Diseases

Moderator – **Tracy Wang**, MD, FAHA

**Cindy Lamendola**, NP, MSN, FAHA

**Kate Kirley**, MD, MS

**Patrick Wayte**, SVP
Educating and Mobilizing Provider Communities to Improve Multidisciplinary Team Communication and Increase Clinical Best Practices Across the Spectrum of Care

Cindy Lamendola, NP, MSN, FAHA

Stanford University
Preventive Cardiovascular Nurses Association
PCNA
Barriers to Health Changes For Patients

- Low income and poverty, disparities in care
- Cultural sensitivity, Literacy levels
- No social support
- Pill burden – number of medications and costs
- No access to regular care or difficulty getting to appointments
- No access to settings for lifestyle changes sidewalks, grocery stores
- Multiple jobs or high stress positions, family responsibilities
There are 3 million nurses across the United States and are the most trusted profession.

Nurses work in all disciplines with opportunities to educate patients with prediabetes, diabetes and metabolic syndrome as well as families.

Nurses educate other nurses – local lecture series, webinars, annual symposiums, online education, mini behavioral certificates.

Nurses can reach out to the community educate lay people, students, employees and employers.
The Preventive Cardiovascular Nurses Association:
Linking Diabetes and Cardiovascular Disease

PCNA Mission: PCNA is the leading nursing organization dedicated to preventing cardiovascular disease (CVD) through assessing risk, facilitating lifestyle changes, and guiding individuals to achieve treatment goals. Our mission is to promote nurses as leaders in cardiovascular risk reduction and disease management across the lifespan.

Reach: PCNA represents over 16,000 health care professionals who promote comprehensive CVD risk reduction for individuals, families and diverse populations. PCNA members work in hospitals, clinics and universities and see over 2 million patients each year.

The Power of Partnerships
PCNA recognizes the importance of partnering with other organizations to expand our reach and advance the role of nurses as part of the cardiometabolics team. We partner with dozens of organizations, including:

- American College of Cardiology
- American Diabetes Association
- American Heart Association
- Mended Hearts
- The National Forum
- Women Heart

PCNA actively participates in guidelines development and review, including the most recent hypertension guidelines update.

Patient Education (English/Spanish)
- Diabetes and CVD (available 2018)
- Hypertension booklet & fact sheet
- Cholesterol booklet & fact sheet
- Triglycerides fact sheet
- Heart-healthy toolkit fact sheets on weight management & lifestyle

Professional Education
- In-person meetings (national, international and regional)
- Live and recorded webinars
- Publications - monographs and journal articles

CE topics include:
- CVD Risk Management in Patients with Diabetes
- Engaging Patients in Health Behavior Change
- Management of Hypertension
- Obesity and Health Behaviors
- Physical Activity
- Race and Ethnicity: Impact on Heart Disease
- Lipid Management in High Risk Patients
- Heart Failure
PCNA Members Work

- Cardiology
- Preventive Cardiology
- Cardiac Rehab
- Heart Failure
- Family Practice
- Primary Care
- Internal Medicine
- Public Health
- Women’s Health
- Universities
- We Have International reach
Professional Barriers to Implementation

- Limited resources for counseling and sustained follow up support and dietitian services
- Time restraints or lack of financial incentives or reimbursement for health promotion
- Insufficient information on most effective strategies, lack of skills/lack of confidence to provide counseling to use preventive strategies for long term behavior change

Resources: William Polonsky, William Miller and Stephen Rollnick
http://www.motivationalinterview.org/training/trainers.html
Artinian, N Circ 2010; 122;406-441
PCNA Behavior Change Mini-Certificate

- Develop skills and knowledge to effectively partner with patients to develop and implement lifestyle changes to minimize risk in primordial and primary prevention of cardiovascular disease and to develop and implement realistic plans of care to manage their risk factors as secondary prevention.
Behavior Change Objectives

- Perform cardiovascular risk assessments using the most effective individualized tool and communicate the results effectively to patients.
- Utilize risk communication strategies based on individualized patient characteristics.
- Develop beginning knowledge and skill in using motivational Interviewing and coaching to move patients toward behavior change.
- Select and implement a variety of behavior change strategies for an individual and work collaboratively to develop goals, a plan for changing behavior, and mechanisms to evaluate goal completion.
Summary

- These patients represent a challenging population with an increased risk of CVD, multiple CV risk factors, comorbid conditions, and multiple medications.
- HCPs need to be knowledgeable about scientific evidence and national guidelines for CVD and T2DM risk reduction.
- All HCPs need to be involved in:
  - Identifying and assessing CVD risk factors
  - Implementing treatment for CVD risk factors
  - Incorporating both lifestyle interventions and pharmacotherapy to decrease CVD risk.
Community-Based Programs

Kate Kirley, MD, MS

American Medical Association
Community-Based Programs

Program Examples

**National Diabetes Prevention Program**
- One year
- Group sessions
- Lay or licensed coach
- CDC recognition

**Diabetes Self-Management Program (Stanford)**
- Six weeks
- Group session
- 2 leaders – at least one is lay individual, both with type 2 diabetes

**Chronic Disease Self-Management Program (Stanford)**
- Six weeks
- Group sessions
- 2 leaders – at least one is lay individual, both with a chronic disease

Program Providers

- Community-based orgs
- Employers
- Health departments
- Health/wellness vendors
- Schools, universities
- Healthcare systems
AMA’s clients increasingly recognize the value of community-clinical linkages

- Allows physicians to offer our patients services – like intensive lifestyle change counseling – that they need, but that we don’t have the time/capacity to do
- Aligns to value based care trends
  - Included as Improvement Activities under QPP (MIPS)
  - Aligns with PCMH standards
- Increased frequency of insurance coverage or other methods to offset patient out-of-pocket costs for these programs
- Achieves the IHI Triple (Quadruple) Aim
  - Better care: Adheres to evidence-based guidelines for diabetes prevention
  - Better outcomes: Lowers incidence of diabetes by 58 percent
  - Lower cost: Medicare estimated savings at $2,650 per beneficiary
  - Improving Care Giver Experiences: Reduce
Likewise, community-based organizations increasingly recognize the value of partnering with healthcare delivery organizations.

Medicare DPP is a major step towards the “medicalization” of these programs.

Data collection, storage, and sharing challenges.

Reporting to receive certification/ recognition.

Billing/ claims submission.

Quality measures?
Facilitators and Barriers of Community-Clinical Linkages

**Barriers**
- Clinician lack of awareness
- Clinician skepticism and comfort-level
- Healthcare “speak”
- Technology infrastructure
- Program capacity
- Patient engagement and follow-through
- Inconsistent insurance coverage/patient out-of-pocket cost

**Facilitators**
- Outreach efforts to clinicians by CBOs
- Increasing recognition from healthcare leadership
- Strong evidence-base and support in clinical guidelines
- Shift towards team-based care
- Emerging technological solutions
- Evolving payment environment
Your MISSION is Our MISSION
The Role of Health-Tech in Cardiometabolic Health

Patrick Wayte, SVP

Center for Health Technology & Innovation
American Heart Association
The Health Experience

- Too much information
- Too many choices
- Everything is difficult
- I feel all alone
- Who can I trust?
- What do I do next?
Widespread Adoption

- When to use apps and wearables
- Choosing the right product
- Trusting the device, process
- How to interpret and apply

Patients

- Defining use case
- Understanding pts, provider needs
- Incorporating into clinical care

Digital Device & App Companies

Clinicians Insurers Health Systems & Pharma

- Inertia/sharing control
- Need the evidence!
- Incorporating into workflows
- IT implementation
- Reimbursement issues
Industry Innovators

Platforms & Enabling Solutions

- Welltok
- SOLERA
- Samsung
- fitbit

Health Management
Diabetes/Cardiometabolic

- Livongo
- fruit street
- Omada
- Newtopia
- Zipongo
- Noom

Remote Monitoring
and Telehealth

- TupeloLife
- Teladoc
- MDLIVE
- Amwell
- Dr. Doctor on Demand
Learn More about CHTI

- The AHA Center for Health Technology & Innovation
- At www.ahahealthtech.org
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- What are the 3 short-term solutions that could have the largest impact?

- What are the 3 long-term solutions that could come out of the summit?