Coaching and supporting people to reduce the risk of diabetes through dynamic digital engagement.

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MOUNT FOREST FAMILY HEALTH TEAM
"Growing into a healthy, rural community."

TAKE ACTION Practice Efficiency by IMBA Medical
healthy @ HOME

ONCE UPON A TIME THE PCDPP HAD GOOD OUTCOMES AND WAS READY TO GROW

In 2011 - 2015, the MFFHT participated in the **Primary Care Diabetes Prevention Pilot Project**. The PCDPP used the evidenced based Group Lifestyle Balance Program (GLB). Based on evidence from this pilot, it was concluded that scaling up of the program would produce a NNT (number-needed to treat) of approx. 36 and avert 6401 cases of diabetes in 5 years. So we continue to offer the GLB program in Mount Forest.

From 2015 - 2017 the MFFHT certified 2 lifestyle coaches as GLB Master Trainers, and our team worked collaboratively with Nutrition Connections and OPHEA to create the **PCDPP Implementation Manual**. We also offered GLB Lifestyle Coaches Training across the province, to improve access to the PCDPP.

THEN WE HIT SOME STUMBLING BLOCKS AND NEEDED TO THINK HARDER...

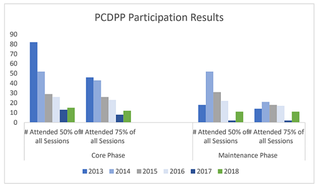
1) Recruitment started to get more challenging. Had we reached saturation in our community? We were doing great at reaching the population of people 50+ years and older (74% of participants were 50+), but we found we were missing the people that could not make it to us - parents of young children, people who commute or travel for work, people who have unreliable transportation, people who feel uncomfortable in groups, etc... How could we engage this group?

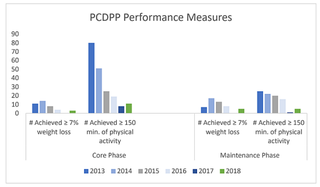
2) Dropping Retention Rates in Maintenance: Retention @ week 12 was 75%, and @ the 1 year mark, the program was only 20%. We thought, "How can we keep people engaged without demanding more provider time?"

CORE							
Start Date MM/DD/YY	# Enrolled	# of Sessions	Date of Last Session MM/DD/YY	# who attended 50% of all sessions	# who attended 75% of all sessions	# who achieved at least 7% weight loss*	# who achieved at least 150 min of moderate physical activity per week

MAINTENANCE						
Start Date MM/DD/YY	# Enrolled	# of Sessions	Date of Last Session MM/DD/YY	# who attended 50% of all sessions	# who attended 75% of all sessions	

PROGRAM END	
# who achieved at least 7% weight loss*	# who achieved at least 150 min of moderate physical activity per week





3) Gathering outcome data in real world community programs was a challenge. We also found that collecting physical activity records was a challenge to get from participants. In addition, there was a high risk of weight stigma with frequent monitoring of weight changes and tracking nutrition changes was time consuming for providers.

4) Other Primary Care teams were finding it difficult to carve out time and resources for a 1 year program for their patients, despite the evidence that long term programs provide better behaviour change maintenance.

CAN WE IMPROVE?

To have the impact we knew PCDPP could have, we needed:

1. A way to reach participants in their world instead of bringing them to us.
2. To listen to our participants to find out what parts of the program were beneficial to them.
3. To find a way to support more people without increasing resources - ex. health care provider time.

WE WENT TO THE DRAWING BOARD

Could we deliver program content to participants in a new way?

- podcasts
- videos
- home calls
- emails etc.

But we knew there are some limitations to these models:

- Missing coach and/or peer support connections
- Increased provider time to make individual calls/emails connections

What if we focused on the STAGES OF CHANGE and supported progress from (a-b-c-d)?

MEET LINDA

A 60 yr old female, living life with HTN and Pre-DM. She worked for years towards a lifestyle change in the community with TOPS and then was connected with the Group Lifestyle Balance program at the MFFHT.

LINDA'S STORY

Linda started the PCDPP program on two different occasions. The first time she made it only to session 4 of 22, the second attempt she made it to session 5 of 22. **She identified barriers** to her completing the program and they included: caregiver responsibilities at home, multiple community commitments, and dealing with stress and mental health challenges. Linda would miss a couple of group sessions and then feel uncomfortable coming back. She met with a RD and other AHCPs for support in between, but found it challenging to make changes in her life to support her health goals.

UNTIL FINALLY, A SOLUTION TO TRY

The Take Action Platform. A cloud based platform that supports coaching done by clinicians in a low-impact (time), high efficiency (low cost) manner.

Based on Micro Learning and Nudge Theories, workflows instead of classes, were created to break weekly sessions into short **education modules** that are sent directly to participants. Take Action also uses **daily progress reports** as an opportunity to nudge participants to move towards behaviour change.

Could this be it? Could this have all of the resources we wanted with push of a button? Can they do it? Can we do it?

In 2018, we started translating the GLB curriculum and structured it into **Healthy @ Home**
This was structured in a way so that each session is broken down into a 5-10 step workflows. These workflows walk participants through videos, emails, links to related resources, information and handouts to enhance learning. There are also Daily nudges to help encourage daily practice of new skills and knowledge. Along with the nudges, we continue to offer weekly live sessions for coaching and/or peer support opportunities.

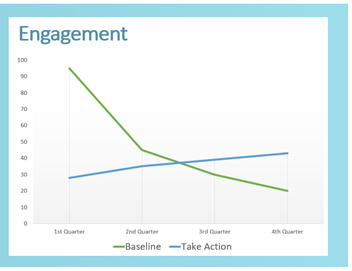
"Make It Bad Make It Better", we followed our own advice, progress not perfection and got started! We continued to develop the program as we used the platform taking cues and advice from our participants. This allowed us to remain patient centred as we built the program with them.

With their help, we determined that the nudge system (no consequence, no reward) was going to work best vs the nag system (carrot and stick).

THE STORY LINE STARTS TO CHANGE!

When we moved to the Take Action platform, we noticed:

- **Increased capacity - over 384 individual participants in 18 months, an increase of 600%, with no increase in staff or resource allocations year-over-year**.
- 18-27% participants reported they achieved the 150 min Physical Activity goal
- 45% of participants were self reporting following Balanced Plate
- **Engagement (open, and/or click) through Take Action Platform was 43%**
  - With an increase of 50% from the first 10 weeks to the last 10 weeks. The complete opposite trend from in-person traditional model.
- Success (as measured by 1 click per week on progress review) was achieved for 41% of participants



LINDA RETURNS...

Linda came back for a third try, this time with in-person classes and online Take Action support. She made it through the first 12 weeks.
Linda found that using the Take Action platform helped to keep her engaged when she couldn't make it to in person sessions.

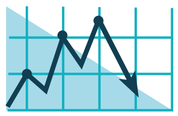
MEET STUART

A male in his 60's living life with high blood pressure and preDM.

STUART'S JOURNEY BEGINS

Stuart identified he was at high risk and sought out ways to protect his health.
He was using all the usual ways: going to the gym, consulting with his healthcare providers (i.e. Doctor, Dietitian, Personal Trainers, etc)

BUT...



After implementing changes to his lifestyle - he had increased his activity and was implementing new nutrition goals. But then, Stuart like many, started to slip, and was at a loss on how to improve his momentum again.

AND THEN

In January 2021, Healthy @ Home partnered with The Co-Operators.

Stuart received his offer to join this program and figured it couldn't hurt and it could be exactly the help he needed. **Stuart actively viewed emails, videos and stayed engaged with daily nudges.** He connected regularly to weekly coaching calls. And found also great value in connecting with other participants to share, celebrate and problem-solve together.

STUART CELEBRATES HIS OWN OUTCOMES

Stuart's main take-aways from the program are:
1. Understanding and listening to your body and its true hunger needs
2. Learning what makes a proper meal and snack
3. Learning about all the various means of fitness at home using apps and websites
4. Importance of personal social support during the program
5. Strategies for dealing with the lack of supportive behaviours from friends and family
6. Task management and planning for various situations including setbacks that may arise

"The program operates as a non-judgmental and supportive program allowing participants to feel open to learn and discuss the material presented."
- Stuart, 2021 Healthy @ Home Co-Operators Participant

WHERE IS LINDA NOW?

Linda stayed engaged and for the first time, completed the full 1 year program. She was also able to say that she reached her lifestyle goals.

2 years later, she is still connected with the coaches and reaches out for support as needed to help maintain her goals.

THE SUSAN EFFECT: A FRESH START.

Susan, a Healthy @ Home participant, started in Feb. 2021. She had received emails and program information. She read the emails, but was not ready for change when she received them. In April 2021, Susan reached out asking if she could start over.

Our daily nudges had helped her move from Contemplation when she signed up, to Planning and eventually Action!

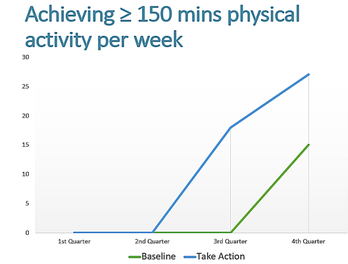
MOVING TO ACTION

Susan follows the pattern of building engagement over time to increase participant success and reduce the 'drop-out' rate. **Building connection with our participants through non-consequence nudges builds trust and can help them shift from Contemplation to Planning and then finally to Action.**

THANKS TO LINDA, STUART AND SUSAN, WHAT HAVE WE LEARNED?

Linda, Stuart and Susan all tell the story that the no risk/no reward nudge system works. Online programs, including Take Action are designed, is to be more forgiving. Take Action provides the participant ability to get back on track, with no longer feeling the need to justify themselves for needing to start over or change their pace. Take Action/Healthy @ Home has demonstrated that participants can achieve similar outcomes, while also reversing the pattern of reducing attendance over time. **Instead we see increasing engagement over time and based on behaviour change research, this means we can help support more participants to maintenance of lifestyle goals.** Delivering diabetes prevention support online increases access, so participants can take part in the program at home and on their schedule in a more convenient way.

With these stories, we see promise in being able to capture data we have never been able to measure. This data paints a story of how participants move through the stages of change. It can help us adapt our programs to meet their needs, and find alternative ways to measure health outcomes related to lifestyle modification.



THE NEXT CHAPTER

- **New!** Partnering with **CALB** (Canadian Association for Lifestyle Balance) supporting access to diabetes prevention programs across Canada
- GLB - Lifestyle Coaches Training: online, in person and self directed options
- **New!** Canadian GLB community of practice to enhance coaching skills and maintain program integrity
- Development of a Peer to Peer support program
- Continuing to reach future diabetes prevention Participants in their environments that are increasingly convenient and accessible for them so that they can consistently participate in their own wellness journey over time.
- Partnered with Diabetes Canada, The Co-operators, Danby Appliances to promote spread to large employers and groups across the country

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