VA CENTER FOR CLINICAL MANAGEMENT RESEARCH

RESEARCH BRIEF
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VA CCMR

Getting Better with a Little Help from My Friends

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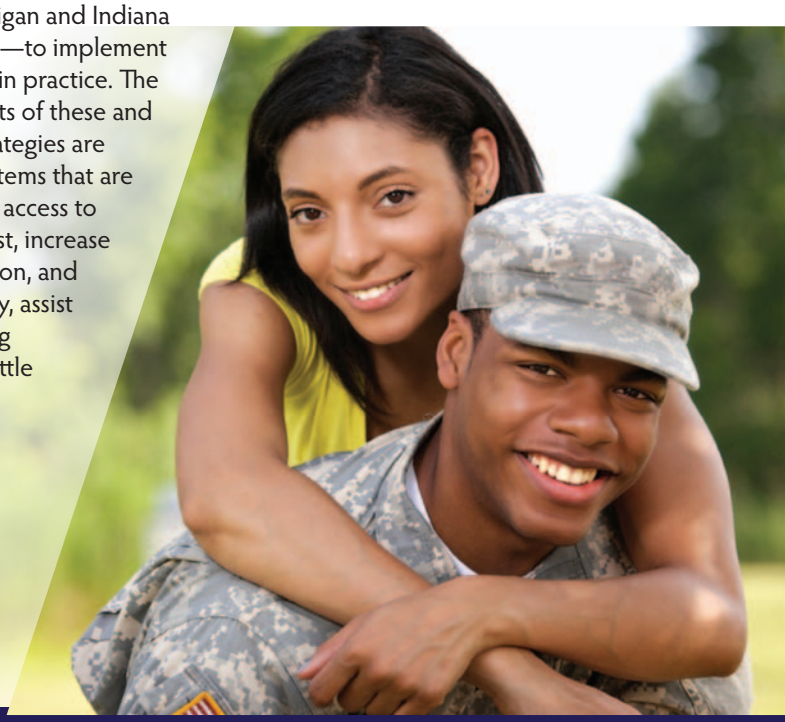
Many chronically ill patients need frequent help managing their illnesses between visits with their physicians, but resource constraints make it difficult for health systems to provide the help patients need outside of the formal care system.

Patients' family and friends are often willing to do more to support them—and could help to fill the gaps in traditional systems of care—but these caregivers often lack the support they need to be effective.

In cooperation with the Veterans Affairs/University of Michigan supported program for research on Quality Improvement for Complex Chronic Conditions (QUICCC), the VA **Center for Clinical Management Research (CCMR)** is testing a number of innovative strategies for helping patients manage their conditions between clinic visits. These strategies connect patients with peers, family, or friends, and provide a supportive structure that offers education and assistance. This research brief presents results from a recent study and a demonstration project, and describes a promising new project, which use patients' families and friends to help augment traditional systems of care to efficiently improve Veterans' health outcomes.

CCMR is working with Veterans Affairs (VA) and community partners—including the VA's Veterans Integrated Service Network (VISN) 11 and Office of Rural Health, as well as the Michigan and Indiana National Guards—to implement these programs in practice. The potential benefits of these and other similar strategies are great: health systems that are able to improve access to care at lower cost, increase patient satisfaction, and most importantly, assist people in getting better—with a little help from their friends.



HSR&D INNOVATIVE

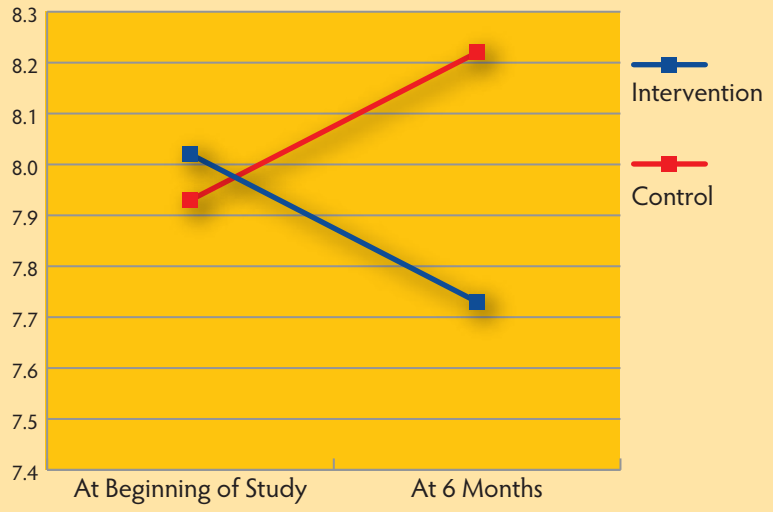
Diabetes patients in ***Peer to Peer*** program achieve significant improvements

The CCMR Peer to Peer (P2P) program uses group visits in conjunction with an interactive voice response (IVR) exchange system to promote more effective care management as well as peer to peer communication among diabetes patients working on similar diabetes care goals. Using the IVR system, participants can talk by phone with a peer facing the same self-management challenges, but without divulging their home phone number, incurring the cost of long distance calls, or being solely responsible for ensuring that the peer contacts occur regularly. The intervention also supports "asynchronous" communication between peers using voicemail, as well as between participants and their care manager. A six-month study of the P2P program showed that patients enrolled in the program were able to achieve markedly improved results over a control group receiving traditional nurse case management.

The study (a randomized, controlled trial led by Principal Investigator Dr. Michele Heisler) was conducted in two VA health care facilities in 2010 and enrolled diabetes patients with high hemoglobin A1c levels. Each pair of patients in the P2P group received an initial brief training in peer communications skills and was asked to communicate by telephone at least once a week about their mutual efforts to improve diabetes control. Program participants also were offered periodic nurse-facilitated group sessions to exchange experiences with fellow patients.

Figure 1 shows changes in hemoglobin A1c levels from baseline to six month follow-up. (Hemoglobin A1c, or "HbA1c", is a laboratory test that represents the level of diabetes control—lower levels are better.) Mean HbA1c levels for patients in the P2P group dropped 0.29 percent, from 8.02 to 7.73 percent. For patients in the nurse care management group, mean HbA1c levels increased 0.29 percent, from 7.93 to 8.22 percent. The difference between the two groups was -0.58 percent. These results are statistically and clinically significant.[1]

Figure 1:
Change in HbA1c levels over six months



For patients with baseline HbA1c levels greater than eight percent, the gap was even wider: a mean decrease of 0.88 percent for the P2P group vs. a decrease of 0.07 percent for the nurse care management group. The difference between the two groups in this analysis was 0.81 percent—the equivalent to the benefit that can be expected by starting an oral anti-hyperglycemic medication—showing that results of social supports can compare to those achievable through medication.

> *"It's nice to be able to get together with a group of guys who understand what it's like to have diabetes and be in the same branch of the service. We are a brotherhood."*
>
> —Patient

[1] Heisler M, Vijan S, Makki F, Piette JD. Diabetes control with reciprocal peer support versus nurse care management: a randomized trial. Ann Intern Med. 2010 Oct 19; 153(8):507-15.

HIGHLIGHTS

Peer to Peer program participants experienced a significantly greater decline in HbA1c levels than patients in the nurse care management group.

Results of the Peer to Peer program compare favorably to those achievable through medication.

Peer to Peer interventions are less resource-intensive than many diabetes management programs.

These findings reinforce evidence from observational and nonrandomized studies that suggest significant health benefits can be obtained from both receiving and giving social support. Because this trial was conducted with nurse care managers who provided care as part of their normal duties, results are more likely to be replicable in other real-life clinical settings. The Center for Clinical Management Research is working with VISN 11 to implement a peer to peer program for both diabetes and depression as part of the Patient Aligned Care Teams (PACT) Program.

"Being with the program made me think more seriously about my diabetes. It made me want to prove to the group that I can do this."

—Patient

"I don't snack anymore and I read food labels before I buy something."

—Patient

"I think everyone who has diabetes should go through this program."

—Patient

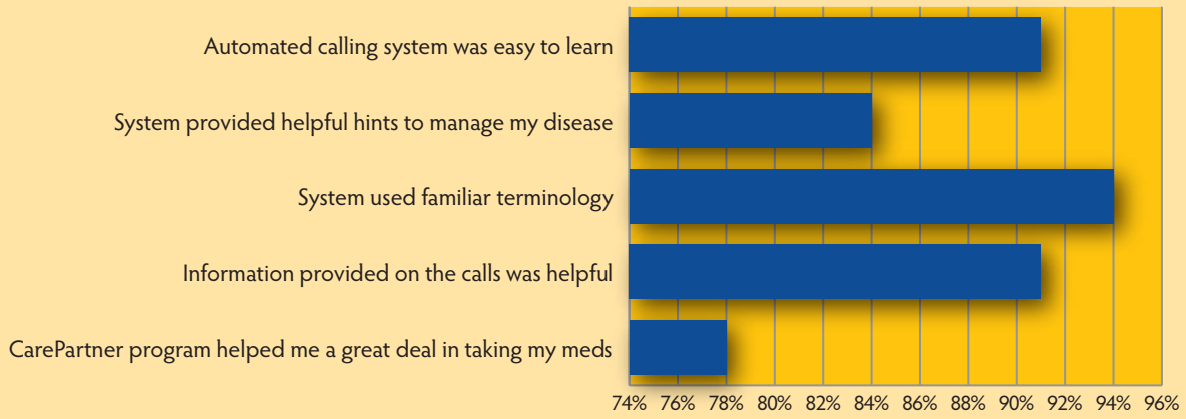
Patients and informal caregivers report positive outcomes in ***CarePartners*** approach

Dr. John Piette, with support from CCMR and QUICCC, developed the CarePartners program to improve the effectiveness of patient self-care. The program works by linking chronically ill patients with informal caregivers—family members or friends outside the home—and providing them with information and tools they need to manage their conditions. The system enables adult friends or family members to support patients' efforts at self-care and managing symptoms between visits to the doctor.

In 2009 CCMR investigators launched several versions of the CarePartners Program. Each of these new programs was developed with medical specialists and primary care providers, and all of the programs are being evaluated in randomized trials or implementation studies. One such CarePartners program, funded as a demonstration project by VA's Office of Rural Health, is specifically focused on providing care for rural VA patients with chronic diseases such as diabetes, heart failure, and depression. Investigators are working with community-based outpatient clinics in Michigan, Indiana, Illinois, and Ohio to connect Veterans with care partners and health care facilities.

Patients who use the service receive regular health and behavioral monitoring via automated telephone calls, which also provide targeted feedback on reported problems. The patient's informal caregiver, or CarePartner, receives reports via e-mail based on the patient's weekly assessments. CarePartners also have access to a comprehensive website with more detailed information about the patient's illness and how they can help. Urgent health problems are reported to the patient's health care team via e-mail and fax, and care managers can enroll Veterans and review their status using a website.

FIGURE 2:
Percent agreeing to the following statements about the CarePartners program
(diabetes, depression, and heart failure patients combined)



"[My dad] is more encouraged to do the proper [diabetes] testing on a regular basis. Now that I am aware that he had not been checking either his blood sugar or blood pressure regularly, I am more apt to bring it up each day."
—CARE PARTNER

"I think everything is very well done. I think this is wonderful. The program really gives you a lot of help and gives you advice for how to address things that people don't want to talk about."
—CARE PARTNER

"I feel this is a wonderful way to learn more about my dad's condition."
—CARE PARTNER

Results to date show the system has functioned well technically, is well-liked by both patients and their care partners, and has resulted in meaningful improvements in disease management and outcomes. Three months after enrollment, patients in the program report they are watching their health behaviors more closely and their care partners tell us they feel more confident in helping their patient partners, as evidenced by the survey responses summarized in **Figure 2** and by quotes from participants.

These preliminary findings show that structured, automated telemonitoring with feedback to informal caregivers (for routine support) and health care teams (for urgent/complex problems) may be a feasible and effective strategy to increase patients' access to self-management support. Program evaluation of these and other CarePartners programs is ongoing, including randomized controlled trials of the CarePartners approach for patients with heart failure, cancer chemotherapy, and depression.

HIGHLIGHTS

Automated telephone calls can be used to help patients manage chronic conditions.

The CarePartner model incorporates informal caregivers, including family and friends, into the weekly management of chronic illnesses.

Patients are reporting positive health outcomes as a result of the CarePartner program.

"I feel I was helping a great friend and it made us closer. I would do it again, anytime."
—Care Partner

"I'm keeping more aware of what it's all about and keeping track of everything better. I know more about the side effects now and what could happen if I don't take my meds. It's a good reminder."
—Patient

"I'm watching my sugar closer and paying more attention to taking my medications on time. I used to think that checking my blood pressure wasn't important and only checked it when I felt like it, but after listening to the advice on the calls, I check it every day."
—Patient

Buddy to Buddy: A citizen soldier peer support program for the National Guard

Up to 40 percent of the approximately two million troops that have been deployed to military conflicts in Afghanistan and Iraq have been members of America's National Guard or military reserve units. These "citizen soldiers" experience traumas and stresses comparable to those encountered by active duty soldiers, and they are more likely to experience subsequent symptoms of post-traumatic stress disorder, depression, and substance abuse.

Unfortunately, approximately half of National Guard soldiers with mental health needs do not seek evaluation or services. In a survey completed by 926 returning Michigan Army National Guard, just 47 percent with high levels of mental health symptoms had sought any help. Stigma was one of the most important barriers to seeking care. In response to this identified need, a collaborative group involving the Michigan Army National Guard, VA, University of Michigan, Michigan State University, and Veteran advocates developed the "Buddy to Buddy" (B2B) peer outreach program.

Buddy to Buddy uses military culture, which emphasizes looking out for your buddy, to change military culture, which often stigmatizes seeking outside help for one's problems. In the B2B program, each returning National Guard soldier is assigned a trained, first-tier Buddy from the same demobilized unit ("Buddy One"). Buddy Ones make regular contacts (through phone calls, texts, or visits) with these soldiers in their unit to see how they're doing and to identify those who may need help. Volunteer Veterans outside of the Guard, "Buddy Twos," are also available to returning National Guard Soldiers during monthly drill weekends at National Guard armories. The Veterans have the advantage of being outside the unit, in case a soldier is too concerned about stigma to share his problems with another soldier. These volunteer Veterans are trained in communication techniques and become well-versed in VA and other local mental health resources. They are supported by professional staff with weekly teleconference meetings. Consistent with military traditions, "buddies, families, and resiliency" are constant messages, accompanied by the messages of "you are not alone, treatment has helped many of your buddies, and pursuing help is a sign of strength."

Evidence to date indicates that this approach may help many overcome prevailing stigma. Among participants surveyed, 9 of 10 understood the intent of the program, approximately two-thirds were receiving regular calls from their Buddy and felt comfortable talking with them, and more than half reported using resources or services suggested by their Buddy. More than 20 percent had been referred by their Buddy to formal treatment, reflecting previously unmet clinical needs. A VA grant (led by principal investigator Dr. Marcia A. Valenstein) has been awarded to conduct a formal evaluation of the B2B program in use by the National Guard in Michigan and Indiana, to determine whether the program increases use of mental health and substance abuse treatment and improves soldiers' mental health outcomes.

> *"As a Vietnam era Veteran, this program allows me an opportunity to provide support to our men and women in uniform."* —Program Volunteer

> *"After having spent almost a year as a Buddy to Buddy volunteer, there is no doubt in my mind that we are making a very significant contribution to helping many of these soldiers successfully make that transition."*
>
> —Program Volunteer

HIGHLIGHTS

National Guard soldiers are not pursuing mental health services because of the stigma associated with seeking outside help.

The Buddy to Buddy program carries the message that "pursuing help is a sign of strength."

More soldiers are receiving help for depression, PTSD, and substance abuse through this program.

"Very few things that I've done in my lifetime have been as rewarding as working with these young Veterans."

—Program Volunteer

"The Buddy to Buddy Program provides an avenue to support those who are serving in the armed forces with resources that will provide them a good transition into civilian life."

—Program Volunteer

Conclusion

Many patients need more help than clinicians can ever realistically provide during standard encounters. Models that increase the quality and frequency of help for patients between office visits show great promise in efficiently improving self-management for common chronic conditions while effectively involving caregivers and peers.

The models for providing patients with support between medical visits discussed in this research brief share common features:

- They access the under-utilized potential of caregivers outside the structure of standard clinical encounters—be they fellow patients, friends, or family members—to support patient self-care.
- They are less resource intensive than traditional clinical encounters.
- They provide structures and evidence-based guidelines for those involved in supporting patient self-care.

The Center for Clinical Management Research's successful partnership with the National Guard, VA's Office of Rural Health, and VISN 11 medical centers can guide other efforts to support patient self-care and behavior changes in these and other conditions that require high levels of self-management.

Health Research that Improves Lives

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