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ATLANTA AREA DIABETES COLLABORATIVE

DIABETES PILOT: INTERIM REPORT

August 2020

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EXECUTIVE SUMMARY

Health systems in Atlanta have made great strides in improving their patient's ability to self-manage chronic diseases like diabetes. Hospitals and clinics have robust disease management programs that have good success with the patients who are able to access these programs. However, there are many patients who are unable to access these programs due to low health literacy, lack of transportation, and comorbidities that impact single disease management.

In 2017, several health systems in metro Atlanta completed their community health needs assessment and identified diabetes as a pressing issue for their community. Those health systems—Grady Health System, St. Joseph's Mercy Care, Wellstar, Piedmont Hospital, and Kaiser Permanente—wanted to find new ways to collaborate around diabetes and determine if a joint effort to impact diabetes at a population health level was feasible. The Atlanta Area Diabetes Collaborate was borne of this effort and the pilot was launched in 2018. The pilot was funded by the organizations within the collaborative using a pooled funding model.

Patients for this pilot were recruited from three health systems—Grady, Wellstar, and Mercy Care—and were offered either one or two alternative Diabetes Self-Management Education (DSME) programs. The first was an online DSME program designed for patients with an A1C of 7 or greater. The online program was self-paced and included clinical and nonclinical information about diabetes management. Additionally, patients had the opportunity to interact online with a certified health coach. The second program was a four-month telephonic coaching program designed for patients with an A1c of 9 or higher. As part of this program, patients had access to a certified health coach who worked with patients across the program. The coaching relationship involved building trust and being available to help with any questions or situations that came up for patients concerning their diabetes. The coaching program focused on improving patient ability to manage diabetes while addressing the social needs that were impacting their ability to manage their health.

Relying on self-report for the online DSME program and a clinical chart review for the telephonic coaching program, the data shows that both interventions were effective in helping patients manage their disease. Patients in the online program reported higher levels of knowledge about diabetes management and reported high levels of satisfaction with the course. Patients in the telephonic coaching program also reported high levels of satisfaction with the program. Additionally, they reported better clinical outcomes at three months after graduation from the program, with most patients having lowered A1c scores, blood pressure, and weight.

Additionally, a process evaluation completed on the collaborative showed strong trust across the partners as well as a shared desire to invest in innovation to increase diabetes self-management at the population level. The process evaluation also highlighted the importance of shared decision-making and meeting collaborative members where they are. Results identified a number of barriers to collaboration, including the need for increased communication and the difficulty of getting buy-in for innovative interventions that may benefit noncovered populations.

There is still a lot of work to be done with respect to collaboration across health systems to target population health, but these results are promising. Identifying and removing the nonclinical barriers to health can contribute to improved health outcomes for patients who need it most. Patients reported high levels of satisfaction with the interventions offered in the pilot, which in turn resulted in better health outcomes.

OVERVIEW OF THE DIABETES COLLABORATIVE PILOT

The Atlanta Area Diabetes Collaborative is a joint effort between Grady Health System, St. Joseph's Mercy Care, Wellstar, and Kaiser Permanente of Georgia to increase patient access to Diabetes Self-Management Education (DSME) and provide additional social supports (coaching and referrals to supportive services). Diabetes remains a pressing clinical issue across Metro Atlanta health systems, and this pilot was designed to highlight and support the unmet clinical needs of patients with uncontrolled diabetes. This pilot offered patients the opportunity to enroll across two interventions that were designed to supplement clinical care by offering additional educational resources and social support.

Patients were recruited through Grady Health System's Diabetes Clinic, Mercy Care City of Refuge, and Wellstar's Sheffield Clinic. Grady and Mercy Care participated in both intervention arms; Wellstar participated in the telephonic coaching arm only. Patients with an A1C ≥ 7 were given the opportunity to participate in online DSME courses that they could access by computer or smartphone. These courses were designed by and supported through the Rimidi platform. Course material for the online DSME course was developed by Rimidi in collaboration with Diabetes-What To Know, and focused on general education about diabetes management, including glucose monitoring, nutrition, exercise, and medications for diabetes.

Patients with uncontrolled diabetes (A1C >9 and one hospital admission OR two emergency department visits OR a physician referral), were given the opportunity to enroll in a four-month intensive telephonic coaching program offered through the Aging and Disability Resource Connection at the Atlanta Regional Commission (ARC). The coaching program included set touch-points throughout the four months and focused on individual goal-setting, identifying nonmedical social needs, and referrals to supportive services to meet those needs. Patients over age 60 years were potentially eligible for assistive technology help, such as portion control plates and talking glucometers, through supplemental funding outside of the pilot.

The collaborative began enrolling in November 2018 at Grady Health System's Diabetes Clinic. Mercy Care began enrolling in February 2019 and Wellstar began enrollment in April 2019. The last date for enrollment in the pilot was March 31, 2020.

The pilot was funded by Grady Health System, Piedmont Health System, Kaiser Permanente, Wellstar, and the Georgia Department of Public Health. Individual contributions ranged from \$20,000 to \$75,000. A detailed budget, including individual contributions and expenditures to-date, is in Appendix 1.

Target Population

In order to be enrolled in the pilot study, individuals had to meet certain criteria.

Patients who met the following criteria were referred to the online DSME course provided by Rimidi:

- A patient at one of the participating study sites

- 18 years or older
- Uncontrolled diabetes (A1C \geq 7)
- Verbal fluency in English or Spanish

Patients who met the additional following criteria were also referred to telephonic coaching through ARC:

- A1C \geq 9
- Two emergency department visits OR one inpatient hospital stay in the previous six months OR physician referral

The original aim of the pilot was to enroll 1,000 patients into the online DSME course and 130 into the telephonic coaching arm.

Recruitment

Patients were recruited to participate in the study in a number of ways.

Online DSME:

For the online DSME intervention, information about enrollment was given out during clinic visits and patients were given the opportunity to enroll on-site before leaving the clinic. If they did not enroll on-site, patients were given 5x7 recruitment cards with an overview of the course and enrollment information. Additionally, Rimidi staff attended in-person DSME courses once a week or were stationed in the clinic waiting room to encourage enrollment into the online program and assist with enrollment if patients were interested. Patients enrolled themselves into the online course using the Rimidi platform and completed the course at their own pace.

Rimidi also offered a number of incentives throughout the program that were designed to increase enrollment numbers, including:

- Staff gift cards awarded monthly to staff who encouraged the most patients to enroll
- Staff gift cards awarded monthly to staff who encouraged the most patients to complete the online DSME course
- Headphones given to patients who signed up for the online DSME course on-site
- Patient gift cards awarded for completion of the online DSME course

Telephonic Coaching:

For the telephonic coaching intervention, patients from Mercy Care and Grady were initially recruited by diabetes educators who completed a chart review to identify possible study candidates based on the inclusion criteria outlined above. Once identified, those patients were contacted by phone and told about the coaching program or were introduced to the program during their next clinic visit. Patients who were interested in participating were

referred to the ARC's Division of Aging and Independent Studies, where they were matched with a certified diabetes health coach.

To facilitate the data exchange process between the health system and ARC, Grady, and Mercy Care sent secure, password-protected spreadsheets to ARC with patient name and telephone number so that the ARC health coach could reach out and enroll patients in the coaching program. Patients were able to decline the program at any time during the referral, enrollment, and coaching process. As patients moved through the coaching program, the ARC counselor would add data to the spreadsheet, including dates of contact, social support needs identified, referrals made, and any information on uptake of referrals.

Due to a delayed institutional review board approval process at Wellstar, patients from the Sheffield Clinic needed to self-enroll in the program. Eligible patients were given contact information for the ARC counselor and patients contacted the counselor directly for enrollment.

Study Design

Online DSME:

Enrolled patients were able to complete the course at their own pace and were able to review modules as needed. The course consisted of eight lessons:

- Introduction to Diabetes
- All About Testing
- Food
- Exercise
- Medications
- Reducing Risks
- Healthy Coping
- Problem Solving

Patients were also able to ask questions and exchange emails with a certified health educator through the online platform. The health educator responded to all questions and comments within 24 hours, and would refer anyone reporting clinical issues back to their referring health system. Additionally, the health educator would reach out to patients with incomplete modules and encourage them to complete the course.

Telephonic Coaching:

For patients enrolled in the telephonic coaching arm, a diabetes health coach made initial telephone contact with the client within two business days of receiving the referral. During the initial phone call, the health coach gave patients an overview of the coaching program, conducted an initial needs assessment to identify unmet needs, determined eligibility for enrollment in public or private home and community supports, and scheduled a time for a follow-up call.

Follow-up contacts were then conducted at the following intervals:

- Two weeks after initial contact and enrollment
- 30 days after enrollment
- Six weeks after enrollment
- 60 days after enrollment
- 90 days after enrollment
- 120 days after enrollment

Counselors were also available for ad hoc conversations and were responsive to all nonscheduled calls and emails. Contacts were tracked on the referral spreadsheet.

Data Collected

A summary of the data collected across the project is below.

Online DSME:

Rimidi collected a number of data points, including ethnicity, gender, age, educational attainment, diabetes diagnosis, length of time with diabetes, and reported diabetes control.

Telephonic Coaching:

As noted above, ARC tracked contact information on the referral spreadsheet along with identified social support needs, referrals made, referral follow-up (if known), and notes of anything that came up during conversations that might be helpful to clinical staff. Once a patient completed the coaching program, ARC conducted a close-out survey that asked about what they had learned, recommendations for future programming, and how the coaching program had impacted their ability to manage their diabetes.

Additionally, the referring hospital system conducted a chart review for patients who completed the coaching program to document:

- Basic demographics (age, gender, race, ethnicity, ZIP code of residence)
- Weight (at enrollment, graduation from the coaching program, and three months post-graduation)
- A1C (at enrollment, graduation from the coaching program, and three months post-graduation)
- Blood pressure (at enrollment, graduation from the coaching program, and three months post-graduation)
- Insulin prescribed (yes/no)
- Mental health diagnosis
- Endocrine and metabolic diagnosis
- Cardiovascular diagnosis

- Insurance (primary and secondary)

Collaborative Work:

In addition to measuring the effectiveness of the interventions, the collaborative also looked at the process of collaboration across health systems. The collaborative conducted a separate process evaluation of the collaborative work, with the high-level results included at the end of the results section.

RESULTS

Enrollment and Completion Status

Total enrollment and completion status by intervention and health system is listed in Table 1.

Table 1: Enrollment and Completion Status by Intervention and Health System				
	Grady	Mercy Care	Wellstar	Total
Online DSME				
Patients–Completed the Online Course	85	42		127
Patients–Did Not Complete the Online Course	368	118		486
Total Enrollment	453	160		613
Telephonic Coaching				
Total Referrals	72	29	1	102
Patients Who Never Enrolled	17	4	0	21
Patients Currently Enrolled*	4	9	0	13
Patients Discharged But Incomplete	18	11	0	29
Patients Discharged and Complete	33	7	1	41
Total Completes and Incompletes	51	18	1	70

**Patients who started the coaching program in March 2020 are still enrolled in the telephonic coaching program at the time of this report. It is anticipated that they will complete the program by Sept. 30, 2020.*

Online DSME Results

The basic demographics of online DSME users is listed below in Table 2. In summary, more Black/African American patients enrolled in the online DSME course than any other group. Females were more likely to sign up and most users fell in the 45 to 64 age bracket. Additionally, most users had lower educational attainment, with the majority having either a high school degree or some college, but no degree.

Table 2: Demographics of Online DSME Users	
Ethnicity	Percentage
Black/African American	81%
White	8%
Hispanic or Latino	6%
Asian	2%
Multiple Ethnicities Listed	2%
Other	1%
Gender	Percentage
Female	69%
Male	31%
Age	Percentage
18-44	29%
45-64	62%
65+	9%
Education	Percentage
Some High School (HS)	9%
HS Graduate/GED	37%
Some College/No Degree	28%
Associate Degree	9%
Bachelor's Degree	11%
Graduate School	6%

The online DSME course included pre-course and post-course quizzes for participants. On average, patients reported a higher score on the post-course quiz than on the pre-course quiz. The average pre-course quiz score was 93%, while the average post-course quiz score was 95%. This is indicative that patients understood the material and retained knowledge.

Since patients were able to complete the course at their own speed, Rimidi also looked at days to course completion. The minimum length of time was one day (meaning that a patient completed all eight modules in one day) and the maximum length of time was 251 days. The average completion time was 39.5 days.

Lastly, upon completion of the course, Rimidi asked patients about their satisfaction with the course. Most respondents (97%) reported being very satisfied or satisfied with the course, with 3% reporting a neutral response. Additionally, 98% of respondents said that the course material was helpful and relevant to their diabetes management, while 2% said that the course material was only moderately relevant.

Telephonic Coaching Results

Since there are still patients engaged in the telephonic coaching program at the time of this report, the results here only reflect patients who have completed the telephonic coaching program. Table 3 shows the basic demographics of patients who completed the coaching program.

Table 3: Demographics of Patients Enrolled in Telephonic Coaching	
Ethnicity	Percentage
Black/African American	100%
White	0%
Hispanic or Latino	0%
Asian	0%
Other	0%
Gender	Percentage
Female	63%
Male	37%
Age	Percentage
18-29	2%
30-49	29%
50-64	52%
65+	10%
Missing	7%

A large part of the telephonic coaching was working with a patient to identify personal health goals and identify the steps necessary to meet those goals. Over the course of the coaching program, the ARC coach helped patients to set up smaller goals that would allow them meet larger health goals. Table 4 outlines personal health goals identified and achieved by patients in the coaching program.

Table 4: Identified Personal Health Goals Achieved (Self-Report)	
Health Goal Identified	Percentage of Patients Who Met Goal
Improved Eating Habits	76%
Lower A1C	73%
Added Exercise Routine	56%
Weight Loss	32%
Improved Medication Management	27%
Check Blood Sugar More Consistently	27%
Increased Knowledge About Healthy Food Choices	22%
Reduced Number or Dose of Medications	12%

Another important component of the coaching program was the identification of social support or social determinants of health (SDOH) needs. ARC counselors worked with patients to identify the SDOH needs of each patient and provide referrals to meet those needs. Once a need was identified, ARC counselors would provide referrals to service providers that could assist patients with those needs. A sample of primary referral sources are listed below.

Table 5: Primary Referral Sources by Identified SDOH

SDOH Need	Referral
Legal	Atlanta Legal Aid, Atlanta Bar Association
Housing	GA Housing Search Link, Dekalb/Fulton County Housing Authority, Hosea Williams Homeless Prevention Services, available supportive/transitional housing providers, emergency housing shelters
Transportation	MARTA mobility, nonemergency medical transportation
Nutrition	Fresh for Less program, food pantries, SNAP, home and community-based food services
Financial Assistance	Furniture Bank of Metro Atlanta, Decatur Cooperative Ministry, Partnership for Community Action, Salvation Army
Health	Elderly and Disabled Waiver Program, Diabetes Association of Atlanta (prescriptions assistance/emergency testing supplies), Friends of Disabled Adults and Children (medical equipment/assistive technology), Tools for Life (assistive technology), prescription assistance programs, senior centers, home and community-based services
Behavioral Health	Agencies that provide in-home behavioral health therapy and sliding scale behavioral health therapy

Patients enrolled in the telephonic coaching program demonstrated a wide variety of SDOH needs, often overlapping. While 27% of patients reported no need for any SDOH support, 24% reported needing support in one area, 24% reported needing support in two areas, 15% reported needing support in three areas, and 10% reported needing support in four areas.

Table 6 outlines identified needs for social supports among those with SDOH needs identified.

Table 6: Social Determinants of Health Needs Identified

SDOH Need Identified by ARC Counselor	Percentage
Emergency Financial Assistance (utilities, etc.)	59%
Housing Resources (includes waitlists)	37%
Nutritional Counseling	32%
Transportation	24%
Insurance or Grady Financial Aid	24%
Mental Health Services	17%
Food Stamps Assistance	12%

Through nonpilot funding, ARC was also able to provide assistive technology products to patients enrolled in the program. Table 7 outlines the assistive technology resources that were provided for coaching patients.

Table 7: Assistive Technology Provided for Coaching Patients	
Device	Percentage of Total Coaching Patients
Durable Medical Equipment (bedside toilet, shower chair, walker, etc.)	15%
Pedometer	12%
Portion Control Plate	10%
Talking Glucometer	2%

The coaching program is time-intensive. ARC counselors reported spending four to six hours per less complex patient and six to eight hours per more complex patient. Counselors also reported an average of 15 calls per patient, but also reported as high as 20 for some patients. They also reported a minimum of seven contacts per client over the four-month coaching program.

Once a patient completed the telephonic coaching program, health system staff conducted a chart review of A1C, weight, and blood pressure. Improvements in these measures were observed for a majority of patients. The results of the chart review for Grady and Mercy Care are listed below.

Table 8: Chart Review Results on A1C, Weight, and Blood Pressure Post-Program			
	Grady Health System	Mercy Care	Total
A1C			
Decrease	69%	50%	67%
Increase	25%	50%	27%
No Change	6%	0	6%
Weight			
Decrease	57%	100%	61%
Increase	38%	0	35%
No Change	5%	0	4%
Blood Pressure			
Decrease	67%	50%	65%
Increase	24%	50%	26%
No Change	9%	0	9%

The pilot also tracked comorbidities in diabetic patients enrolled in the telephonic coaching program. Table 9 outlines the most common comorbidities based on documentation in the electronic medical record.

Hypertension	82%
Dyslipidemia	55%
Obesity/Overweight	50%
Depression	36%
Congestive Heart Failure	18%
Number of Comorbidities	
1 comorbidity	5%
2 comorbidities	18%
3+ comorbidities	73%

A review of the qualitative data gathered through the close-out survey supports the appropriateness and effectiveness of this intervention. Patients report increased confidence in asking family to be supportive of changes needed to better manage diabetes. They report learning that they do not have to make major changes to have an impact on their disease management and that they appreciated having someone to discuss their health and personal concerns and goals with. They also report feeling encouraged and motivated.

Overall, 94% of patients felt more empowered to manage their diabetes and 94% reported making a lifestyle change to improve their diabetes management, while 89% wished the program was longer. All respondents (100%) reported that their counselor helped them better understand the role and impact of diabetes on their life and feel supported in reaching their personal health goals.

A few example quotes from the survey are below.

Patient 1	"I was using some of my medicines at certain times of the day or not using them at all because I wasn't home. She (the ARC counselor) taught me tricks about taking my meds with me so I would have them at the right time."
Patient 2	"She [the ARC counselor] gave me kids of stuff I hadn't thought about or even knew about. She was very knowledgeable about things that would help me, and she did a very good job...she stayed on it."
Patient 3	"Prior to working with [the ARC counselor], my exercise is only walking from home to the grocery store. But now I go 2 miles beyond the grocery store and turn back. She let me know that exercise helps with diabetes."
Patient 4	"I'm going to the diabetic clinic more and going to the podiatrist, but only due to the resources she gave. I'm very, very thankful."
Patient 5	"She explained the benefits of exercise and eating properly. That was the most important thing to me."
Patient 6	"Her being there for me. Answering questions that I didn't understand about my diabetes and its effects on my body. I love her. I wish I could be back talking to her."
Patient 7	"I told myself I could stick myself for the rest of my life or change. The only thing I knew about diabetes was the cutting off the toes. I told myself I'm going to beat this. Doctors can't believe the changes I've made."

Collaboration (Process Evaluation) Results

As mentioned previously, the collaborative completed a process evaluation to better understand the collaborative environment and to identify essential factors in collaboration as well as barriers. The evaluation was comprised of seven semi-structured stakeholder interviews and followed a set interview guide.

The process evaluation identified a number of essential motivating factors in building the collaboration and keeping the work moving forward. Those essential factors included trust among the partner organizations, the common identification of diabetes as a health issue, having a neutral convener, and the ability to work with health systems where they are to build the pilot. The evaluation also uncovered a number of barriers to the shared work, including identifying money that can be used for pooled resources, retention of information among collaborative members across the project planning and implementation period, occasional communication challenges within the collaborative, leadership/legal/clinical staff buy-in within systems, and staff changes across the collaborative over the pilot period.

The process evaluation also found that the collaborative process required unique planning and implementation techniques that included communal decision-making and frequent communication points.

PILOT SUCCESSES

This pilot had a number of successes, which are outlined below.

Online DSME

This intervention showed that online courses can be an effective method of disseminating health information, particularly for patients in the 45 to 64 year age range. It also showed that patients are able to navigate online disease management courses and engage with them in meaningful and productive ways. Patients who were able to enroll and complete the course found it beneficial.

Telephonic Coaching

This intervention demonstrated that a person-centered coaching program focused on addressing nonclinical needs of patients is highly effective in improving clinical outcomes. Patients reported a high-level of satisfaction with the coaching program, and the intervention translated into improved clinical outcomes for the majority of patients. It also highlighted the complex nature of patients being seen at safety-net hospitals and Federally Qualified Health Centers (FQHCs), with 73% of patients identifying at least one social support need and almost half (49%) identifying two or more social support needs.

PILOT BARRIERS

The evaluation also highlighted a number of barriers.

Online DSME

The pilot did not incorporate online DSME completion status into the electronic medical record so track the impact of completion against clinical outcomes was not possible. As a result, the collaborative had to use a change in pre-course and post-course quiz scores as a proxy for improved disease management and patient satisfaction surveys as validation of course content. Additionally, the course was not well-received by the majority of enrolled patients, as there was a high noncompletion rate.

Telephonic Coaching

Recruitment got off to a slow start, which impacted the timeline and recruitment totals. The pilot was not able to reach the recruitment target for either intervention, only enrolling 613 (127 completions) into the online DSME program and 72 (41 completions) into the coaching program. Additionally, because of the complexity in data sharing between health systems, ARC, and ARCHI, real-time data analysis was difficult. Because ARCHI was not allowed to see the patient data being shared between the health systems and ARC, staff had to rely on both entities to de-identify data, which is not a quick process, and share outcomes.

Additionally, contracting between ARCHI, ARC, and the health systems was a barrier to streamlined implementation for this intervention. There were several points during the pilot where the collaborative had to stop services in order to complete memorandum of understanding (MOU) and contracts. The contracting issues, combined with the slow start and low recruitment numbers, had an impact on the timeline and budget.

LESSONS LEARNED

Online DSME

Based on the outcomes from this pilot, the collaborative has identified a number of lessons around the online DSME intervention:

- Staff and patient incentives are big drivers in promotion of a non-health system affiliated online resource
- Staff involvement in recruitment and enrollment is crucial to success
- In order to ramp up to critical mass, the incentive structure needs to be determined early on and given time to ramp up
- Even in low-resource clinic settings, many patients have access to smartphones

Telephonic Coaching:

This pilot outlined a number of lessons around the telephonic coaching program as well:

- The social service needs of patients are diverse and often very complex
- Addressing the SDOH needs of patients requires a person-centered approach and extensive collaboration with partner agencies
- Building trust with patients takes time but is imperative in building a solid foundation in a coaching model
- Accessing some public services takes more time and patients very often need assistance and advocacy through that process
- Mental health diagnoses such as depression often require more intensive follow-up with patients
- Contracting issues need to be outlined clearly from the outset. As much as possible, contract and MOU term dates need to take into account recruitment delays and allow for additional time so that contracting issues do not disrupt the work

CONCLUSIONS

Program

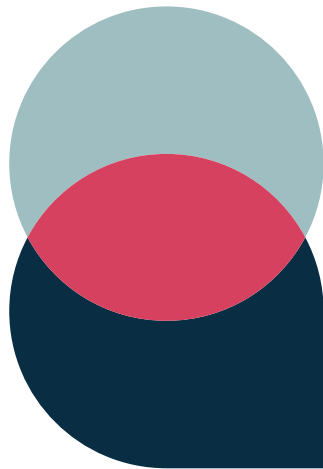
This was the first time that major health systems in Atlanta have joined together and pooled funds to create a pilot designed to address social support needs and impact community health outcomes. Our work together highlighted a number of logistical issues that will need to be addressed differently in our work going forward. The pilot highlighted that a large percentage of patients at safety-net and FQHCs need additional social support and assistance navigating the myriad of social support agencies. This pilot also demonstrated that a person-centered approach help with engagement in a telephonic coaching program. This was true even with an outside provider that was contracted for the telephonic coaching program. Lastly, this pilot showed that a telephonic coaching program that helps address social support needs can have an impact on clinical outcomes.

Collaboration Across Health Systems

Collaboration across health systems is possible but does require some unique considerations. Trust among collaborating organizations emerged as the largest contributor of success, as did having a neutral convener that assumed project management responsibilities. Communication also emerged as an important consideration, as ensuring that all collaborative members had the same information became a challenge at times. Lastly, having a shared focus on diabetes across health systems was helpful in moving the work forward.

APPENDIX 1: DIABETES PILOT PROJECT BUDGET AND EXPENDITURES

Diabetes Pilot Project Budget Update, August 2020			
expenses projected through August 2020			
<u>Item</u>	<u>Budget January to December 2019</u>	<u>Spent to Date January 2019 to August 2020</u>	<u>General Notes</u>
Project Management	\$73,305	\$102,626	The Georgia Health Policy Center will serve as administrative home .Original budget: ARCHI 0.5 FTE January to December 2019; Extended January to August 2020 at 0.3 FTE to include final evaluation
RIMIDI Technology (@ 501 - 1000 patients)	\$50,000	\$50,000	Includes training and project coordination budgeted: 1,000 patients complete program Total enrolled: 486 Total completed first module: 256 Completed program: 127
Diabetes Educator	\$16,450	\$6,361	Coaching and assistance to individuals enrolled in Rimidi technology; (\$35/hour, not to exceed 10 hours/week)
Nonclinical Supports counseling	\$75,000	\$34,325	Telephonic coaching/referral support; home visit if needed budgeted: 130 patients complete Total referred: 78 Total complete: 36 Total incomplete: 37
Transportation Support	\$15,000	\$9,500	Funding MARTA cards
TOTAL	<u>\$229,755</u>	<u>\$202,812</u>	
Revenue			
Grady	\$45,000		
<i>Piedmont</i>	<i>\$13,800</i>		
KP	\$75,000		
Wellstar	\$30,000		
DPH	\$40,000		
TOTAL	<u>\$203,800</u>		
Difference	-\$25,955	\$988	



**BOTTOM LINE.
BALANCED HEALTH.
BETTER BEINGS.**