

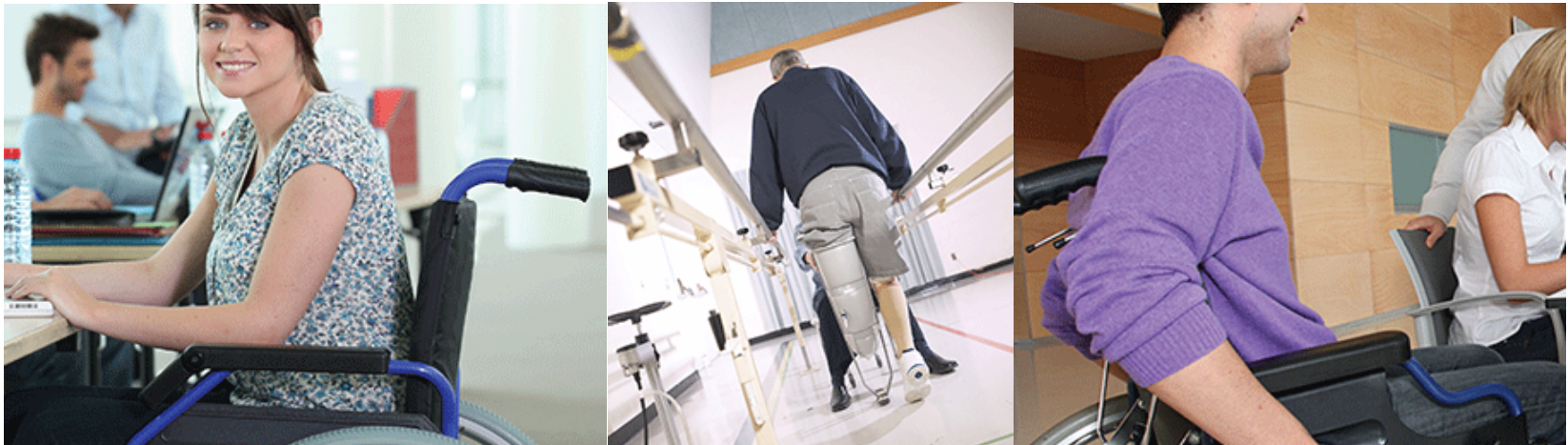
Taking Charge! Evidence-Based Self-Management Programs

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September 13, 2017

Member Engagement Webinar Series Taking Charge! Evidence-Based Self-Management Programs



Overview

- This is the fourth session of the “2017 Member Engagement Webinar Series”
- Each session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussion
- Video replay and slide presentation are available after each session at:
<https://www.resourcesforintegratedcare.com>

Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO is developing technical assistance and actionable tools based on successful innovations and care models, such as this webinar.
- To learn more about current efforts and resources, visit Resources for Integrated Care at:
<https://www.resourcesforintegratedcare.com>

Taking Charge!

Evidence-Based Self-Management Programs

- **Developed by:**
 - The Lewin Group
 - Community Catalyst's Center for Consumer Engagement in Health Innovation
- **Hosted by:**
 - The Medicare-Medicaid Coordination Office (MMCO)
Resources for Integrated Care

Learning Objectives

This webinar will emphasize:

- Key components of evidence-based chronic disease self-management education (CDSME)
- How CDSME programs can help plans and providers to:
 - support patients in taking charge of their health and their life
 - ensure person-centered care, improve health outcomes and control costs
- How plans and providers can access CDSME programs in their states and communities

Webinar Outline/Agenda

- Polls
- Overview of the Chronic Disease Self-Management Program
- A Participant's Experience
- Building the Network of Community-Based Organizations Offering CDSME
- State-Health Plan Partnership to Offer CDSME to Medicare-Medicaid Beneficiaries
- Q&A
- Evaluation

Taking Charge! Evidence-Based Programs

POLL 1

What is your primary role?

- Administrator/Director/Manager
- Clinician
- Educator
- Researcher
- Consumer Advocate
- Care Coordinator
- Family Caregiver
- Other

Taking Charge! Evidence-Based Programs

POLL 2

In which setting do you work?

- Managed Care Organization
- Medicare Advantage Plans
- Long-term Services and Support (MLTSS) Plans Care Facility
- Home Care Agency
- Community Based Organization
- PACE organizations
- Dual Eligible Special Needs Plans (D-SNPs)
- Medicare-Medicaid Plans
- Other

Presenters



Kate Lorig, DrPH

Stanford Patient Education Research Center and Professor of Medicine at the Stanford School of Medicine



Linda McGowan

Chronic Disease Self-Management Education Participant



Kristie Kulinski, MSW

Program Officer
Administration on Aging Administration for Community Living
U.S. Department of Health and Human Services



April Holmes, MEd

Coordinator of Prevention Programs
Virginia Department for Aging and Rehabilitative Services

Overview of the Chronic Disease Self-Management Program



Kate Lorig, DrPH

Stanford Patient Education Research Center and
Professor of Medicine at the Stanford School of
Medicine

Self-Management Resource Center

- The Self-Management Resource Center is the culmination of 38 years of research and program development all focused on the goal of helping people better manage their chronic health conditions
- The evidence-based self-management programs were previously offered by the Stanford Patient Education Research Center
- 30 years of published research on our evidence-based programs



Why a Chronic Disease Self-Management Program (CDSMP)?

- One in four adults have multiple chronic conditions.
- Three in four adults over 65 have multiple chronic conditions.
- People with chronic conditions live primarily outside of the health care system, and what they do during this time (when they are not seeing doctors or in the hospital) largely determines their symptoms, quality of life, and health care use.
- Eighty to ninety percent of self-management strategies are common across chronic diseases.
- CDSMP teaches people how to live with multiple chronic conditions. It fills the space between provider visits.

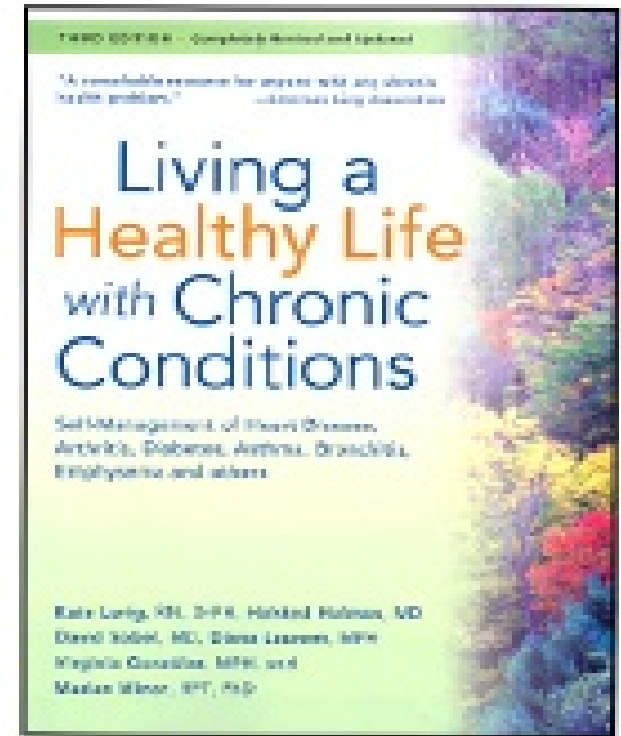
Chronic Disease Self-Management Program

- Six weeks for 2.5 hours per week
- Based in the community
- Led by two peer leaders
- Standardized leader training
- Structured teaching protocol
- Standardized materials
- 10-15 persons with different diseases
- Several topics each session
- Self-tailoring
- Has been evaluated in randomized trials



What is Taught?

- How to care for symptoms – pain, shortness of breath, stress, depression, sleep
- Exercise
- Healthy eating
- Medication management
- Communication with health professionals
- **Action-planning**
- **Problem-solving**
- **Decision-making**



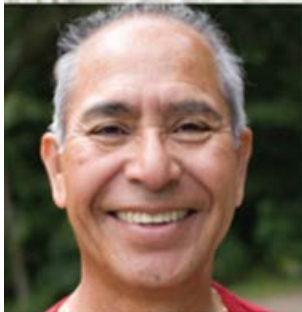
CDSMP: A National Translation Study

- 22 sites in the U.S. delivered program (*English and Spanish*)
- More than 1,000 participants
- 40% underserved minorities
- Focused on better care, better outcomes, and lower cost

Triple Aim: Better Patient Experience of Care

- Improved medication adherence
- Increased minutes of exercise
- Improved communication with physicians

Triple Aim: Better Health Outcomes



- Improved symptoms of depression
- Less fatigue/improved sleep
- Improved quality of life
- Fewer unhealthy physical days
- Fewer unhealthy mental health days
- Improved self-assessed health
- Lower A1C (*people with diabetes*)

Triple Aim: Lower Costs

- Reduced ER visits (5%) at 6 and 12 months
- Reduced hospitalizations (3%) at 6 months
- Potential net savings of \$364/participant and national savings of \$3.3 billion if 5% of adults with chronic conditions are reached

Ahn, SangNam: (2013): *BMC Public Health* 13.1 1141

Case Study: Michigan Mental Health Services

N=139

Depression	55%
Bipolar	45%
Schizophrenia	17%
Schizoaffective disorder	15%
Substance abuse	26%
Other mental health	64%

Lorig, Kate et al: *Community Mental Health J* 50.1 96-103 2014

Case Study: Population Demographics

Average Age	48.2
Male	27%
African American	24%
Number of conditions	5.9
Medicare	55%
Medicaid	63%

Case Study: Behavioral Health Outcomes

Significant Improvements after Six Months:

- Decreased fatigue
- Decreased depression
- Improved medication adherence
- Increased amount and quality of sleep
- Improved communication with providers

CDSMP Reach

- Available in most states and 25 countries
- More than 2,000 active trainers and 10,000 leaders
- Available in 14 languages
- Other formats: Spanish CDSMP, mailed programs and online program
- To find a program near you:
Evidence-Based Leadership Council
<http://www.eblcprograms.org/evidence-based/map-of-programs>
- More Information:
Self-Management Resource Center
<http://www.selfmanagementresource.com/>

Other Evidence-Based, Self-Management Programs

- Arthritis, including Spanish version and mailed programs
- Falls Prevention
- Diabetes Self-Management, including Spanish Diabetes/DSMP
- Pain Self-Management
- Positive Self-Management
- Cancer: Thriving and Surviving
- Building Better Caregivers

A Participant's Experience



Linda McGowan
Chronic Disease Self-Management Education
Participant

The Role of ACL in Chronic Disease Self-Management



Kristie Kulinski, MSW

Program Officer

Administration on Aging Administration for
Community Living

U.S. Department of Health and Human Services

About the Administration for Community Living (ACL)

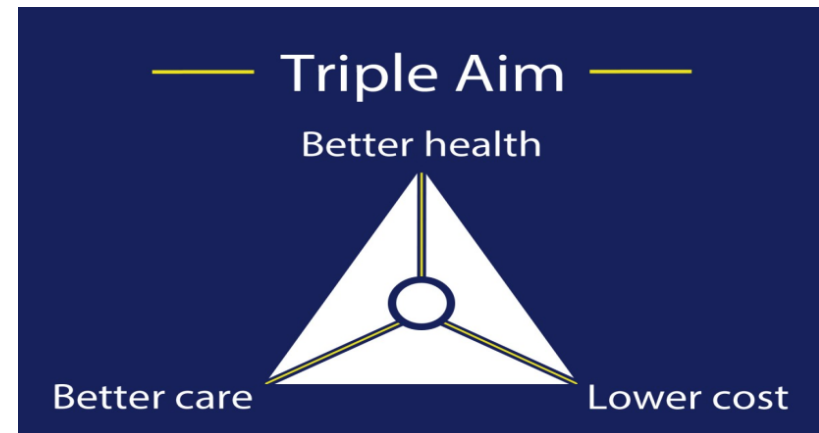
- **Mission:** Maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan and their families and caregivers
- Commitment to one **fundamental principle:** People with disabilities and older adults should be able to live where they choose, with the people they choose and participate fully in their communities

CDSME Funding

- Within ACL, the Administration on Aging supports Chronic Disease Self-Management Education (CDSME) via discretionary grants
- Nearly \$28 million was invested since 2012 supporting 42 grantees across four cohorts
- Approximately 320,000 participants reached

CDSMP National Study

- **Better Care**
 - Communication with health care team
 - Medication compliance
 - Health literacy
- **Better Health**
 - Self-assessed health
 - Depression
 - Quality of life
 - Unhealthy physical/mental days
- **Lower Costs**
 - ER visits
 - Hospitalizations



Value of CDSME for Participants

- Patient-centered
- Active engagement
- Group support
- Quality of life
- Active lives
- Gateway to additional supportive services

Value of CDSME for Providers and Payers

- Improved patient/member outcomes
- Improved quality/performance outcomes
 - HEDIS, Medicare STARS, CAHPS
- Improved patient/member retention
 - Higher satisfaction with provider/insurer
- Positive publicity
 - Attract new members
 - Distinguish provider/payer in their market

Partnering with Community-Based Organizations (CBOs) to Offer CDSME

- CBOs provide value with respect to:
 - Intervention delivery
 - Quality and efficiency
 - Training capacity
 - Trusted community resource
 - More than just CDSME, but also ability to impact other social determinants of health (housing, transportation, etc.)

Example: Partnering with a CBO to Improve Patient Health

- Healthy Living Center of Excellence (HLCE) and Senior Whole Health (SWH) in Massachusetts
- SWH pays for any plan member who attends a CDSME workshop (other evidence-based programs are included in contract as well)
- Multiple referral streams
 - Self-referral, referral by SWH providers and case managers, internal registries (HLCE handles registry outreach)

CDSME Program Locator

To find a licensed organization near you, visit:
<http://www.eblcprograms.org/evidence-based/map-of-programs/>

www.eblcprograms.org/evidence-based/map-of-programs

Enter ZIP/City/State or Find a program by State
22039

Distance
20 miles

Not finding anything? Try increasing your search radius!

Select Programs Search

We found several programs.

Fairfax County Public Health Department
Programs offered: 703 246-6017
 • **Chronic Disease Self-Management Program** patricia.garcia@fairfaxcounty.gov
 10777 Main Street #320
 Fairfax, 22030 USA

Not listed?
Updated information?
If your organization is licensed by the program developers to offer a program and is not listed, or if you need to update information, please send us an email.
Changes to the Locator will require approval by the program administrators prior to being reflected on this website.
Reminder: We DO NOT currently list individual workshop/program locations. If you operate under another organization's license, please check to see if that organization is listed.

Learn More

Self-Management Resource Center

<https://www.selfmanagementresource.com/>

CDSME National Resource Center

<https://www.ncoa.org/center-for-healthy-aging/>

Evidence-Based Leadership Council

<http://www.eblcprograms.org/>

In Summary...

- Significant federal investment in CDSME programs
- Programs have proven participant outcomes as well as considerable value for providers/payers
- Experienced, licensed organizations exist throughout the country – partner with them!

Chronic Disease Self-Management Education in the State of Virginia



April Holmes
Coordinator of Prevention Programs
Virginia Department for Aging and
Rehabilitative Services

About the Department for Aging and Rehabilitative Services (DARS)

The Virginia Department for Aging and Rehabilitative Services, in collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

Timeline: CDSME in Virginia

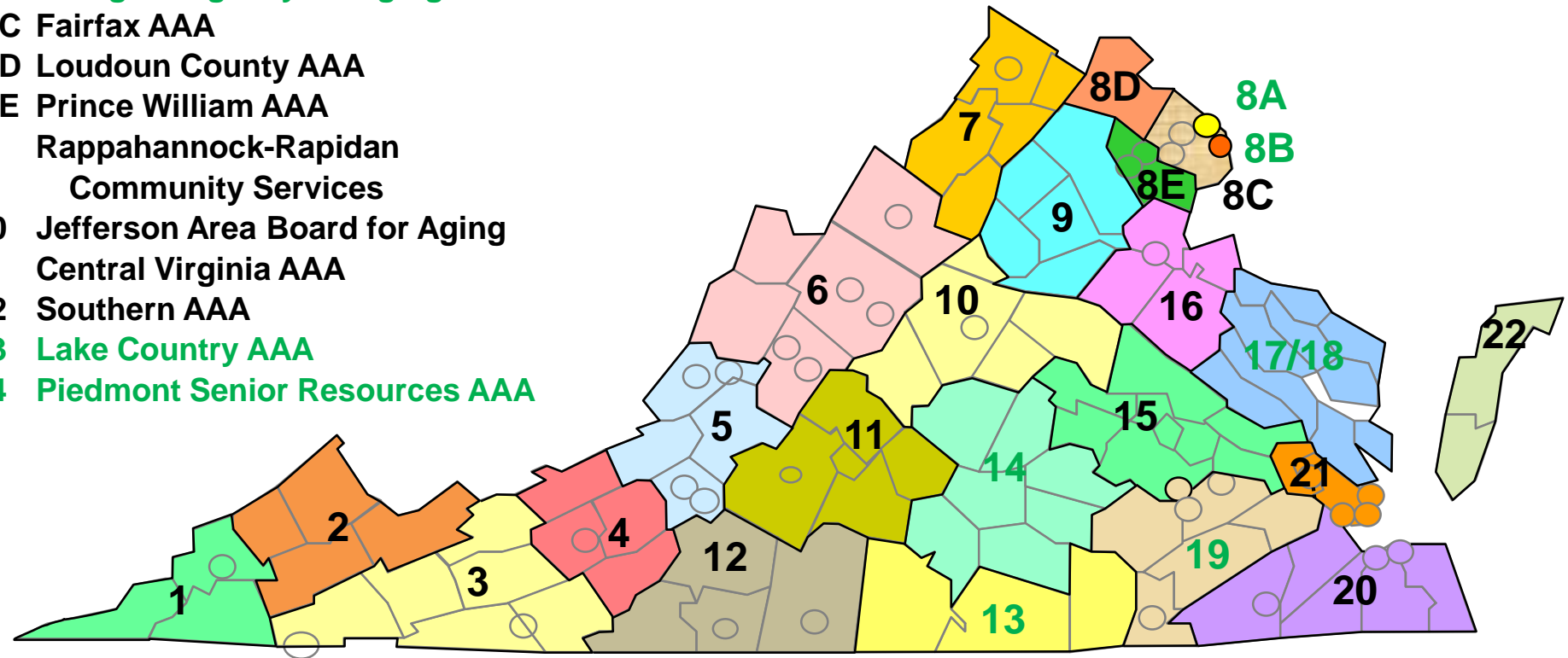
- 2005: Introduced by Virginia Department of Health
- March 2010: Two-year grants to states from US
- Administration on Aging to disseminate CDSM to older adults
 - Virginia receives \$1,040,000, one of the highest awards
- September 2012: Virginia one of 22 states awarded a three year grant under the Prevention and Public Health Funds (PPHF-2012) Affordable Care Act
- August 2016: Virginia is one of eight states awarded a two year grant under the PPHF-2016

Virginia's 25 Area Agencies on Aging

- | | |
|--|--|
| 1 Mountain Empire Older Citizens | 15 Senior Connections, The Capital AAA |
| 2 Appalachian Agency for Senior Citizens | 16 Rappahannock AAA |
| 3 District Three Senior Services | 17/18 Bay Aging |
| 4 New River Valley Agency on Aging | 19 Crater District AA |
| 5 LOA Area Agency on Aging | 20 Senior Services of Southeastern Virginia |
| 6 Valley Program for Aging Services | 21 Peninsula Agency on Aging |
| 7 Shenandoah AAA | 22 Eastern Shore AAA - Community Action Agency |

- 8A Alexandria Division of Aging and Adult Services
- 8B Arlington Agency on Aging
- 8C Fairfax AAA
- 8D Loudoun County AAA
- 8E Prince William AAA
- 9 Rappahannock-Rapidan Community Services
- 10 Jefferson Area Board for Aging
- 11 Central Virginia AAA
- 12 Southern AAA
- 13 Lake Country AAA
- 14 Piedmont Senior Resources AAA

Green font: Referrals and coordination handled by another AAA

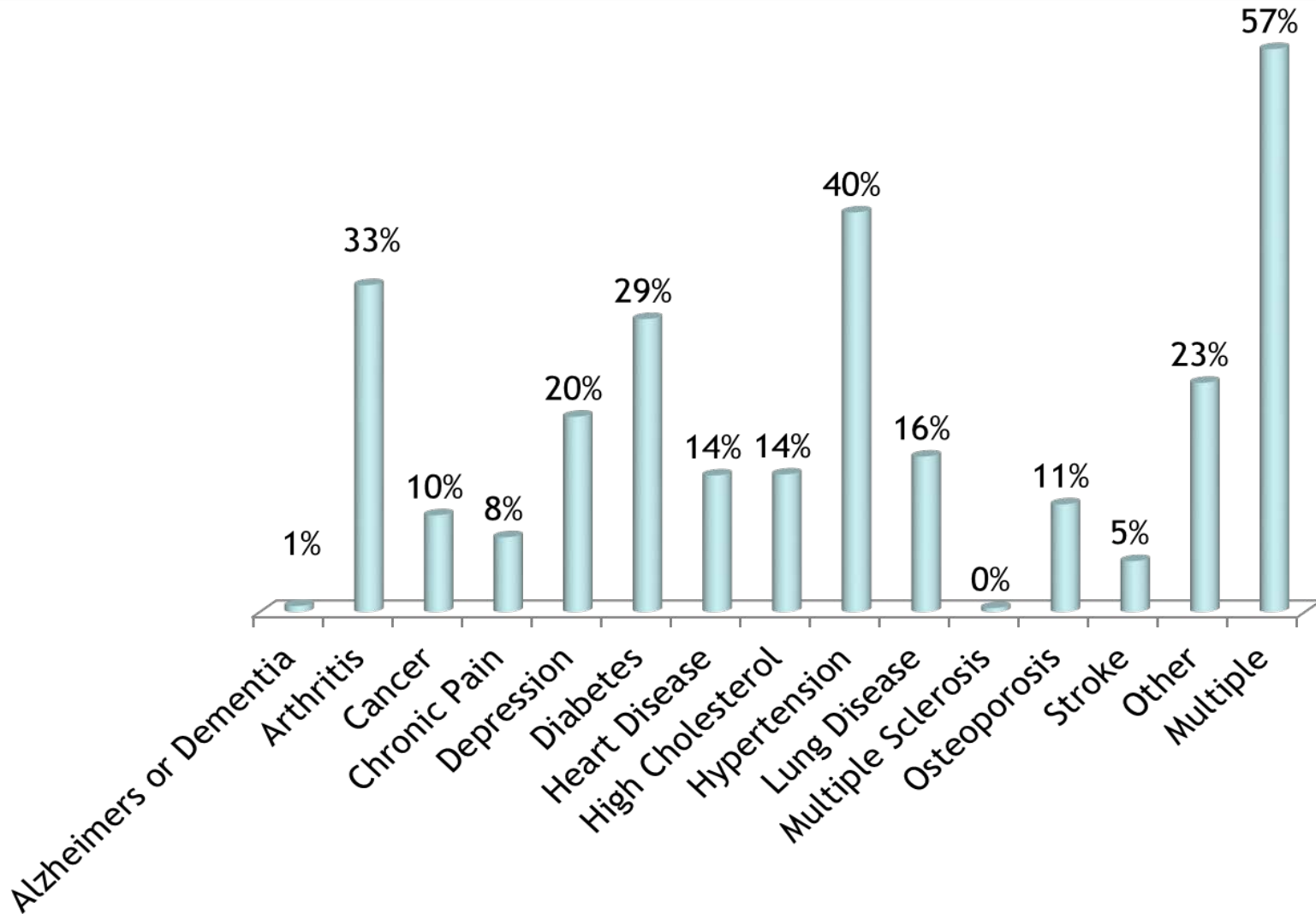


Participation in CDSME Workshops April 1, 2010 – August 28, 2017

- 1,066 workshops
- 13,499 enrollees
- 10,326 completers
- 76% completion rate



Chronic Conditions Among CDSME Participants



About Virginia Premier Health Plan (VPHP)

- Non-profit health plan
- Formed to coordinate health care for low-income persons
- Headquartered in Richmond, Virginia with offices in Bristol, Wise, Richlands, Winchester, Roanoke and Tidewater
- Served Medicare-Medicaid beneficiaries enrolled in Commonwealth Coordinated Care, part of the CMS Financial Alignment Initiative
- Serving Medicaid beneficiaries with long-term services and supports needs enrolled in Commonwealth Coordinated Care Plus

Partnership with Virginia Premier

- Discussions began in 2015
- CDSME included in Department for Medical Assistance Services (DMAS) Managed Long-Term Services and Supports RFP to health plans
- DMAS *strongly encouraged* health plans to partner with DARS to offer CDSME to its members as an enhanced benefit
- Virginia Premier is the first health plan to include CDSME as an enhanced benefit
- DMAS awarded contracts to six health plans, including Virginia Premier

Referral and Billing Process



No Wrong Door Virginia is a virtual system and statewide network of shared resources, designed to streamline access to long term services and supports – connecting individuals, providers and communities across the Commonwealth.

- Referrals from VPHP go directly to Area Agencies on Aging (AAAs)
- Local CDSME Coordinator uses No Wrong Door tools to track attendance
- No Wrong Door tools generate monthly reports used for DARS to bill VPHP
- DARS contracts with and pays AAAs based on workshop attendance

VPHP-DARS Partnership

Advantages to VPHP:

- One hub for connecting to CDSME programs throughout Virginia
- Improved health outcomes for members
- Savings in health care costs
- Access through *No Wrong Door* to a wide range of community-based services and supports

Advantages to DARS:

- Opportunity to reach high-priority populations
- Supports long-range program sustainability
- Potential access to health outcome and cost data

Takeaways

- No need to reinvent the wheel. Many states have extensive infrastructure and experience in delivering CDSME
- CDSME can make a significant difference for your members:
 - Capacity to effectively manage chronic health conditions
 - Overall health and wellbeing
- An investment in CDSME for your members can result in healthcare cost savings

Questions



Thank You!

Evaluation Form

Thank you for joining our webinar.
Please take a moment to complete a brief
evaluation on the quality of the webinar.