The Lewin Group
Taking Charge! Evidence-Based Self-Management Programs
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Karen Cheung: Hello everyone and welcome to the Resources for Integrated Care Webinar, Taking Charge! Evidence-Based Self-Management Programs.

My name is Karen Cheung. I am with the Lewin Group, and we are supporting the Medicare-Medicaid Coordination Office in the Centers for Medicare and Medicaid Services to ensure that beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs..

Before we get started, I want to go over a few pointers for using this webinar platform and help you troubleshoot any technical issues. First, for most of you, the audio portion of the presentation will automatically stream through your computer speakers. Make sure that the volume is turned up on your computer speakers to hear the presentation. If you're experiencing audio or technical difficulties, please use the Q&A pod on your screen or click on the Help button.

This is the fourth webinar in our 2017 Meaningful Member Engagement Series. Today's session will include a 60-minute presentation from experts, followed by a Q&A discussion between you and the presenters. This session is being recorded and a video replay and a slide presentation will be available on our website at https://resourcesforintegratedcare.com/.

Throughout the presentation, if you have a question, please go ahead and use the Q&A feature on the platform and submit your question at any time. Also, if you would like a copy of the slides from today's webinar, you can download them now under the resource list on this platform.

The Medicare-Medicaid Coordination Office or 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, please visit our website, https://resourcesforintegratedcare.com/. You can also follow us on Twitter for more details. Our Twitter handle is @integrate_care.

This webinar is presented in part by the Lewin Group and Community Catalyst's Center for Consumer Engagement in Health Innovation and supported through MMCO at CMS.

We have a full agenda for our wonderful speakers including someone who has participated in the chronic disease self-management program and is here to tell us more about her experience. I hope you'll take away some key learnings from each of our presenters including key components of evidence-based chronic disease self-management education; how CDSME programs can help plans and providers to support patients in taking charge of their health and their life; how plans can ensure person-centered care, improve health outcomes and control costs; how plans and providers can access CDSME programs in their states and communities.

We have outlined the topics for today's webinar here. Our speakers will provide an overview of the Chronic Disease Self-Management Program, and then the participant will share her experience. We will talk about the network of community-based organizations offering chronic disease self-management, which will help you get started, then we'll show how a state and health plans has partnered to offer CDSME to Medicare-Medicaid beneficiaries. We will have some time for questions and answers. We also would like for each of you to complete our survey and provide us feedback about this presentation.

At this time, I'd like to introduce our speakers. We are thrilled to have all of them here today. Dr. Kate Lorig serves as Director of the Stanford Patient Education Research Center and Professor of Medicine at the Stanford School of Medicine. She came to Stanford as a graduate student to develop and research an educational program that emphasizes self-help skills for people with arthritis. The program became the Arthritis Self-Help course and the prototype for the Chronic Disease Self-Management Program, the Diabetes Self-Management Program, the Positive Self-Management Program for HIV and Cancer: Thriving and Surviving Program, and Building Better Caregivers program and others. She has authored several books and articles about arthritis, chronic disease in general, health education, and behavioral science.

Then, Linda McGowan will share her experience as the CDSME participant. Linda lives in Richmond, Virginia, where she is active in the community and believes in bringing programs and interventions to where people are. We are so glad that you're here to provide your perspective, Linda.

Kristie Kulinski is a program officer for the Administration on Aging's Administration for Community Living (ACL) within the US Department of Health and Human Services. Kristie oversees ACL's chronic disease self-management education initiative. This initiative provides funding through competitive grants to organizations across the country to support the implementation and sustainability of chronic disease self-management intervention.

Lastly, April Holmes is the Coordinator of Prevention Programs at the Virginia Department of Aging and Rehabilitative Services. April manages chronic disease self-management education program delivered by area agencies on aging throughout Virginia. April has work for more than 20 years in disability and aging.

Dr. Lorig is our first presenter. So I will turn it over to you now, Dr. Lorig.

Kate Lorig: Thank you very much. I'm absolutely delighted to be here today.

The Chronic Disease Self-Management Program, and all the evidence-based programs that we developed at Stanford University over the last 30 or plus years, have recently moved to a new home, which is the Self-Management Resource Center. The basic mission is exactly the same as the one at Stanford, which is to get evidence-based programs to people throughout the nation. It includes the same programs, basically same people, new logo, new website, etc. So just to clarify, the Patient Education Research Center at Stanford is now closed, but the Self-Management Resource Center is now open.

So why is chronic disease self-management important? Most of the facts on the slide, you all know. One in four adults have multiple chronic conditions, and three in four adults over 65 have multiple chronic conditions. What we don't think about a lot is that people with chronic conditions live most of their time outside of the health care system. How they live during this time greatly determines their quality of life, their health, and also their utilization of the healthcare system.

Unfortunately, we have do not have a lot of standardized ways of helping people with chronic disease live their lives to the maximum benefit during this time, and the chronic disease self-management program was developed to do that. We looked at what people with chronic diseases need to know, and we found that across diseases, 80% to 90% of the strategies are the same. So it's those strategies which we teach within the context of the chronic disease self-management program.

So what is it? The program is six weeks, 2.5 hours a week. The program is provided in the community. This picture that you see is actually a course given in Georgia's garage in San Diego. Now, we don't have many courses given in garages, but I think it's a good indication of going to where people are and making it convenient for them. Our January course was given in senior centers, in libraries, in public schools, rooms, church basements, etc.

Programs are led by two peer leaders. That means that most of our leaders are actually patients themselves. We have a standardized program for training leaders. It's 24 hours given over four days. Leaders teach from a structured teaching protocol, so they're not left on their own to do whatever they want, but have a structure. In fact, many of our leaders will tell you it is too structured, but that's the way that we can know that the program that's given in Virginia or the American Virgin Islands or in Guam is the same program.

We have standardized materials. Generally, in a workshop, we will have 10 to 15 people with different chronic conditions, most of them with two or three chronic conditions.

One of the things that makes this program different is that we teach several different topics every session. The reason we do that is because people learn by getting little bites and then adding to them. When people will go to school, they don't have three months of reading and three months of writing. They have a little bit of reading and little bit of writing every day. We follow the same thing so, the same topic may be revisited four or five or six times.

What makes the program culturally appropriate is that it's self-tailoring. What do we mean by that? It means that we tell people general things about exercise, nutrition, sleep, pain, and then we help them figure out how to use this within the context of their own lives. So we never tell people what to do. We help them get started in doing things that are helpful for them.

Finally, almost all of our programs have been evaluated in randomized trials, and those that have not been evaluated in randomized trials have been evaluated in a pragmatic trial. These trials last as long as two years.

So what do we teach? We teach people how to deal with symptoms because what people are concerned about are symptoms. They are concerned about pain, shortness of breath, stress, depression, disabilities, sleep. So we actually teach about how to manage symptoms.

We also teach a bunch of self-management tools such as exercise, healthy eating, and medication management. We do not talk about specific medications, but we talk about medication management, communicating with family and friends, and communicating with health professionals.

Three key skills of self-management are action planning, which is actually doing something, not just learning about it. Second is problem-solving; in this case, we teach a formal problem solving process so that the next time a problem comes up, people have a way of dealing with it. Finally, there is decision making, and again, we teach a formal decision making process, because people with chronic diseases, have to make decisions every day, and when they make decisions, we want them to be able to make informed decisions.

Let me talk about a couple of studies now. I won't bore you with hundreds of these, but this was a study that was done a few years ago. It was done in 22 different sites across the United States. We had people participating in both English and Spanish. There were more than a thousand participants. The study was a yearlong. 40% of the participants were underserved minorities, and this is a study that focused on better care, better outcomes, and lower cost, the triple aims of healthcare.

So when you look at these triple aims, what was the better patient experience? Well, people had better medication adherence. They increased their minutes of exercise, and they improved their communication with physicians. Remember, this is thousand people over one year.

They also had improved symptoms. They had less depression, less fatigue, improved quality of life, fewer unhealthy physical days, fewer unhealthy mental health days, and for those with diabetes, they had lower hemoglobin A1C. By the way, these were all published studies. People can contact me or they can look on our website and find all the details. This is pretty high level.

There was also less healthcare utilization. Emergency rooms visits were reduced by 5%, hospitalizations were reduced and a cost of studies suggested that the potential net savings were about $350, $360 per participant for the people in this study. The national savings if 5% of the adults took this program would be over $3 billion.

Since that time, we've done a couple of more cost studies, and the cost studies generally come in just about the same range as the savings in healthcare utilization. So I'm fairly convinced that these figures are now real. We recently did a study with a major insurer and their data on cost came in right in the same range. They were using claims data as opposed to self-report data. So I feel positive about this data being valid.

One of the things that we are asked about, and I know a lot of you deal with, are people with severe mental health problems. While we were doing this larger study, people in Michigan called

me and said, can we do this looking at a group of people being served by mental health centers throughout the state? We said, sure we could do this.

These people we're not included in the data I just showed you. This was a little side study that was done at the same time. It was a six month study. You can see how these people break out as far as having major mental health issues, obviously this is more than a 100% because people had more than one condition.

This population is younger; you can see they had five conditions, but also there were a lot of people with both mental and physical health conditions and a very high percentage of both Medicare and Medicaid users.

Over six months, this group saw decreased fatigue, decreased depression, improved medication adherence, an improved amount and quality of sleep, and improved communication with providers. We are seeing, in a group of people with severe mental health problems, pretty much the same outcomes as we saw on the others.

This leads us to the thought that this program is for people with any sort of chronic illness, mental or physical. Around the country, generally these people have put in the programs together; sometimes they're separated, sometimes they're together. It seems to work pretty well across both mental and physical conditions.

The program is now available in 25 states, we have more than 2,000 active trainers and 10,000 leaders. The program is available in 14 languages, and it's also available in some other formats. There are no telehealth programs, but there is an internet program.

To find the program near you, there's a wonderful website from the Evidence-Based Leadership Council. There is an interactive map, and you can find not only the chronic disease self-management program, but all 19 or 20 of the evidence-based leadership council programs on that website.

If you want more information specifically about the programs given by the self-management resource center, take a look at our website or give us a call, and we will be happy to talk with you.

The other evidence-based programs are for arthritis, fall prevention, diabetes self-management, pain self-management, positive self-management to those folks with the HIV AIDS, Cancer: Thriving and Surviving and a soon to be released program, Building Better Caregivers. You will see there's a whole wide range of evidence-based programs that at least we think that you all might want to consider.

All right, Linda, you can now tell people the real truth. Thank you so much.

Linda McGowan: Hi.

April Holmes: Thank you for coming here to talk about your experiences as a CDSME participant. So Linda attended a workshop, I think it was this spring of this year, correct?

Linda McGowan: That's correct.

April Holmes: In Richmond. So what was it that made you decide to attend the workshop?

Linda McGowan: Well, I have two chronic conditions, diabetes and hypertension. I decided I wanted some more current information about the disease itself, but also I wanted to learn how to be more self-empowered, more active in my management of my disease, which was a big thing when I first started attending the workshop.

April Holmes: Really? So you were interested in managing your condition better?

Linda McGowan: I knew there had to be a way because that was something I needed to do.

April Holmes: Okay. So what are some things that you learned or thought was valuable about attending the workshop?

Linda McGowan: Well, the biggest thing, which was a surprise to me, was how valuable the support group in and of itself was, even though it was comprised of different people with different diseases. I took control. I wasn't depressed or once I got active, I started feeling better about myself. I've realized I have been overlooking that part of the issue. The other part was being active managers, learning how to be active, how to be proactive in the whole process of decision-making.

April Holmes: Great. Do you remember anything about the action planning and how that worked for you?

Linda McGowan: Well, I learned how to problem solve, how it overflows in other areas in my life too. I began to identify problems and maybe list and pick out options and see if things work. Then, if that didn't work out, we'll try something else, and that to me was the active management basis for me. That broke the resistance in my head about doing something about the disease.

April Holmes: So a practical approach in dealing with the problem.

Linda McGowan: A practical approach. Yes.

April Holmes: Okay. So how has it affected you to have attended the workshop?

Linda McGowan: Well, I think there's no rubber stamp in regards to how individuals can manage their own diseases and the disease is itself. You have a responsibility to take control of what you need to do in management. As I just began to understand, I learned how to be positive. I had depression with the diabetes, and I'm just still working and getting in control of that and doing some things to help put me in control of that. I'm a positive person, and I'm an active person. For me, that's proactive.

April Holmes: Yeah, and then you tell me something about exercise?

Linda McGowan: Oh, yes. That's a big thing. I hated going to the gym. That was part of my action plan, go to the gym, and it took me two or three gyms to find one that was non-judgmental. You work at your own pace, there was nobody there making you feel bad about yourself, and I've been at it for about three to four months.

April Holmes: Oh, that's great. Congratulations.

Linda McGowan: Thank you very much.

April Holmes: So considering the audience, we've got a lot administrators on or some people in healthcare or health insurance. Do you have any comments you want to make for them about this?

Linda McGowan: I think the comments have been said. We need to get out there where the people are. We need to go the recreational and park centers for the children, the schools for the children, senior centers, and reach out to doctors and nurses and help them understand the value of promoting chronic disease self-management for the individuals, the patients, empowering the patients.

April Holmes: Great. Thank you, Linda. Now, Kristie Kulinski will take over and talk about it from the perspective of the Administration for Community Living.

Kristie Kulinski: Thank you, April and Linda. Linda, you really just hammered home why we invest in these programs at the federal level. Thank you so much. So throughout the course of my presentation, I will to demonstrate how the Administration for Community Living, or ACL, has made major investments on these programs. I'd like to highlight the breadth of availability of these programs and then also just increase awareness about the availability of experienced community-based providers that you all can partner with if you aren't already to offer this program.

So I'd like to begin today by giving you a brief introduction to the Administration for Community Living to those of you who aren't familiar. Our mission is to maximize the independence, the well-being, and the health of older adults, people with disabilities across their lifespan, as well as their families and caregivers. We have one fundamental principle and that's that 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.

So in direct alignment with our mission to maximize independence, well-being, and health, ACL has supported Chronic Disease Self-Management Education, or CDSME, and other evidence-based programs for more than a decade. The powerful evidence behind the CDSME program, which Kate highlighted earlier, is what fuels this investment. Federal resources for the program have significantly declined over the past five years as the budgets have gotten smaller and tighter, so supporting programs with proven outcomes is really critical. We want to be sure that

we're investing our limited resources in programs that we know work and have a benefit for participants.

We currently support 20 organizations including five tribes to expand access to and develop a sustainable infrastructure for evidence-based CDSME and self-management support programs, and the programs that were developed at Stanford are now housed at the Self-Management Resource Center offered by all of our grantees.

Because of the significant investment by ACL as well as other federal CDC investments in these programs, state and local partners, there's delivery capacity in communities across the country. Later in my presentation, I'll once again highlight the program locator that's available on the Evidence-Based Leadership Council website, and that will allow you to identify licensed organizations in your area.

I know Kate highlighted the CDSMP national study, but I think it's important to emphasize the study for two reasons. First, the study demonstrated the value of the program with respect to impact on locations, such as with the improved health, improved depression symptoms, quality of life, etc., as well the impact on healthcare providers and payers. We saw better care through improved communication, medication compliance as well as decreased cost. The participant outcomes, which is what really impact the healthcare system, are, of course, very important.

Additionally, this study evaluated the effectiveness of the intervention in community sites across the country. This was a real world study in a non-research setting and saw results that were consistent with the original research. This tells us that community-based organizations are delivering high quality programs, and we can be confident that participants are indeed benefiting. That gets back to the information that Kate shared earlier about it being a highly scripted program with rigorous training. We can be sure that participants, regardless if the program is in Richmond or in Georgia's garage in San Diego, are getting the same intervention.

As I've mentioned earlier, CDSME programs have significant value for both participants and healthcare providers. With respect to participant's CDSME, CDSMP, it's patient-centered. It builds primary role for patients in understanding and managing their own health conditions. I think that Linda said she wanted to be more active in taking charge of her health, and that really speaks to that patient-centered aspect.

It also facilitates active engagement with healthcare providers, so patients are coached in becoming a full member of their healthcare team with enhanced partnership with providers. The interventions also build mutual support through an interactive environment to increase confidence and the ability to manage health and maintain a fulfilling life. That's where the self-efficacy component comes in. People have the tools, the skills, and the confidence to actually carry that out.

CDSME results in measurable and positive effects on physical and emotional outcomes and health-related quality of life, both Kate and I have covered that. The participants also become more physically active and maintain this activity over time, despite any condition related

barriers. Linda spoke to that as well about not enjoying exercise very much but being more activate and taking that on as a result of the program.

Finally and I think this is a really key point to emphasize, when workshops are provided by a community-based organization, it can be a gateway to additional supportive services. There's considerable opportunity here to impact social determinants of health, and these are the types of programs and services that in addition to self-management programs that community-based organizations either directly provide or can provide linkages to.

For providers and payers, in addition to the participant outcomes that have already been discussed, there's also a significant value with respect to improved health status, which translates to better scoring on quality and performance outcome. When we look at HEDIS, Medicare Star, CAHPS, is there an ability to link that with member participation in these programs.

Activated patients who are effective self-managers are also likely to report higher satisfaction with their provider or insurer. This can lead to improved patient or member retention, and also referring to and/or paying for these programs can help attract new members and distinguish a provider or a payer from others in their market. We have seen this play out in some states where a particular plan begins offering self-management and other evidence-based programs, and suddenly there's interest from other payers because they too want to be able to offer that additional benefit for their members.

As I noted earlier, ACL has invested millions of dollars in developing a national delivery infrastructure for CDSME programs. While you can certainly choose to build it internally versus buying it from a community-based organization, there is inherent value that comes with partnering with community-based organizations. These organizations have experienced delivering the intervention, offering a health promotion program is not new to them. Area agencies on aging, for example, senior centers, deliver disease prevention and health promotion programs on a regular basis.

They have processes in place to assure quality. They often are doing fidelity checks. They're collecting data, and they're analyzing that data or reviewing that data to ensure quality. They also have the ability to leverage efficiencies with respect to training, ordering materials, deploying leaders, etc. They also have the capacity, often times, to train new leaders to account for either expansion of a program or potentially attrition of leaders if there's turnover.

As I mentioned before, community-based organizations are a trusted community resource. Beyond CDSME programs, these organizations are well known and valued in their communities. Many also provide or can help individuals access long-term services and support that directly impact various social determinants of health. If we look at food security, transportation, housing, etc., these are all areas that community-based organizations are experts in.

I wanted to provide an example of a community-based organization who's partnering with a dual plan. The Healthy Living Center of Excellence is in Massachusetts is a 90-plus member provider network of community-based organizations delivering CDSME as well as other evidence-based programs, and they're partnering with Senior Whole Health, which is a dual eligible health plan.

Senior Whole Health pays the Healthy Living Center of Excellence for any member who attends CDSME as well as other evidence-based programs that are under the umbrella of the Healthy Living Center of Excellence. I should say that the Healthier Living Center of Excellence is under the umbrella of Elder Services of the Merrimack Valley, which is an Area Agency on Aging.

Senior Whole Health members find their way to workshops through a variety of mechanisms. Sometimes they self-refer, and they collect data to learn who an individual's insurer is so that way they can report back to Senior Whole Health if they engage one of their members in a workshop. They're also referred by Senior Whole Health providers and case managers, and they also use internal registries and Healthy Living Center of Excellence conducts the outreach to these registries to engage members in workshops.

I want to draw your attention to the CDSME program locator. I know Kate mentioned this during her presentation. I've listed the web links there as well and a screengrab, and you can see that I simply put in my home zip code in Fairfax County, Virginia, and then we've got the pins that pops up. I believe I did a 20-mile radius, either a 10 or a 20 mile radius of my home, so a really convenient way to access licensed organizations by program in your area.

To learn more, you know, Kate of course told you about the Self-Management Resource Center. They have an excellent website. The Administration for Community Living funds a CDMSE National Resource Center. They have a number of tools and resources and information on the program, and the Evidence-Based Leadership Council is also another great resource. I also wanted to call attention to a recently released ACL issue brief on CDSME that you may want to review. That's available at https://www.acl.gov/ under the Aging and Disability in America tab.

In summary, we've had significant federal investments in CDSME programs. We know that programs have proven participant outcomes as well as considerable value for providers and payers. Finally, there are experienced licensed organizations throughout the country, and I encourage you to partner with them to impact the health of the individuals who you serve. Thank you very much, and now I will turn it over to April Holmes.

April Holmes: Well, thank you for this opportunity to talk about CDSME for Medicaid beneficiaries participating in Commonwealth Coordinated Care Plus through Virginia Premier Health Plan. This presentation will demonstrate how CDSME is being offered by health plans serving dual eligibles by partnering with a state agency, that's us, and using our mechanisms to facilitate referral and billing. We're fortunate to be an ACL grantee, so we're very familiar with what Kristie just talked about.

First, a little bit about our agency. The Department for Aging and Rehabilitative Services, or DARS, is a Virginia state agency that provides and advocates resources and services for all Virginians and adult with disabilities. One of the many things that we do is administer Live Well Virginia, our state CDSME program. The CDSME programs are coordinated for DARS at the Virginia Division for the Aging.

CDSME was first brought to Virginia in 2005 by the State Health Department and thanks to generous grants and support from the Administration for Community Living, DARS has been

able to offer CDSME to increasing areas throughout Virginia since 2010. This slide shows the timeframe of the grants. We're currently in year two of 2016 Prevention and Public Health Fund grant, and I'm pleased to announce that DARS has just been notified that we were awarded a 2017 follow up prevention grant as well.

CDSME is delivered at the regional level by Area Agencies on Aging or AAAs. These local programs handle all aspects of program delivery from leader recruitment, to marketing, to building local partnerships for sustaining the program. Under DARS coordination and with supported ACL funding, CDSME is now offered directly in 19 Area Agencies on Aging, which are listed in black. Those listed in green are called satellites of other programs, which means that the neighboring AAA operates the program by providing leader training, fidelity monitoring, mentoring and other support.

We offer CDSMP or Chronic Disease Self-Management Programs, Diabetes Self-Management Programs and at limited areas also offer Cancer: Thriving and Surviving and the Chronic Pain Self-Management Programs. Workshops are provided in wider area settings including clinics and health systems, community and state-based organizations, homeless shelters, behavioral health and substance abuse, recovery programs and prisons and detention centers, and with the current grant, we're especially reaching out to people with early stage dementia and their caregivers.

Since our agency first started with CDSME, there has been 1,066 workshops with 13,499 people enrolled and 10,326 of those completing, that is attending at least four of the six sessions. Over time, Virginia's completed rate has averaged 76%. This picture shows a typical workshop scene with participants contributing ideas and leaders writing them on an easel pad. As Kate explained, there's a lot of that in the workshop.

This graph was drawn from a database maintained by the National Council on Aging that tracks attendance and participant demographics. It's showing the type of chronic conditions reported by workshop participants. In Virginia, the most commonly reported individual condition is hypertension, with arthritis and diabetes second and third most common. The most striking statistic is that 57% of participants reported having two or more chronic health conditions. We are definitely reaching individuals challenged by multiple chronic diseases.

DARS is partnering with Virginia Premier Health Plan to provide CDMSE to its members and Commonwealth Coordinated Care Plus or CCC Plus. Virginia Premier is a non-profit health plan headquartered in Richmond, Virginia. Previously, Virginia Premier served dually eligible beneficiaries in the Commonwealth Coordinated Care Program which is part of CMS's financial alignment initiative. Currently, Virginia Premier is one of six MCOs offering coverage under Commonwealth Coordinated Care Plus into which the Commonwealth Coordinated Care was absorbed. CCC Plus is a state-wide Medicaid-managed long-term services and supports program to serve individuals with complex care needs. 114,000 of the individuals to be enrolled in CCCC Plus are also dually eligible.

We first started talking in 2015 to health insurance companies when DARS made presentations to the health plan about the benefits of chronic disease self-management for its members. Things really took off when the state Medicaid agency, the Department of Medical Assistance Services,

or DMAS, included CDSME in its request for proposals to health plans proposing to offer benefits to CCC Plus members. In fact, DMAS strongly encouraged health plans to partner with us to offer CDSME as an enhanced member benefit. Virginia Premier took them up on that suggestion and will be the first CCC Plus plan in the state that offers CDSME.

So DARS and VPHP, or Virginia Premier, just signed a contract and are poised to embark on this new venture. Key to the process is Virginia's No Wrong Door System. No Wrong Door is a virtual system and state-wide network to help individuals access services and supports.

This is how a referral will work. Virginia Premier will use software tools on their No Wrong Door System to refer individuals to AAAs. This may also include referrals for a range of services provided through AAAs such as home-delivered meals, as well as the CDSME. Now, Kristie mentioned some other services that are available through community-based organizations and this system can help people access that.

When a referral goes to the CDSME program, a local coordinator accepts the referral and contacts the individual to enroll him or her in a workshop. Once the person attends, the local coordinator tracks the attendance using the No Wrong Door tools. Those tools generate monthly reports that are used for DARS to bill Virginia Premier and in turn pay the AAAs.

I was very excited about this partnership that will yield advantages for both Virginia Premier and DARS. For Virginia Premier, the advantages include having one hub that starts in the No Wrong Door system by connecting to CDSME programs throughout Virginia. The improved health outcomes for participants and described by Kate, savings in hospitalization cost for members and access through No Wrong Door to a wide range of potential services and support for its members. For DARS, it's an opportunity to reach a high priority population, Medicaid and dual eligible beneficiaries of long-term care needs. Also, payment from Virginia Premier supports our goal to sustain the program long term. Through Virginia Premier utilization data, we hope to learn more about health outcomes and costs for our participating members.

This will be a win-win-win situation for Virginia Premier, DARS, and most importantly the beneficiaries with chronic health conditions. We offer the following takeaways for consideration. CDSME is a valuable resource for your members and often has a pre-made product available. As Kristie described, many states had an existing infrastructure for delivering the program and long experience with CDSME. There's no need to reinvent the wheel. CDSME can make a significant difference for your member's capacity to manage their health, and as a result, improve their health status. Finally, an investment in CDSME for your members can result in significant healthcare cost savings.

I would like to conclude by reading some comments offered by our partner. We pursue this program for our members to help improve their outcomes by empowering them to live healthy on a daily basis. The CDSME program is promising as it is evidence-based so we are looking forward to positive results for participating members. In addition, the idea of having someone who's living with a chronic condition to mentor and share their experience with our members appeals to Virginia Premier. By empowering our members to better manage their own condition, this program will help members make good choices and hopefully become better healthcare

consumers as a result. We will use HEDIS rates and ER and hospitalization data to measure improved outcomes. Additionally, patient satisfaction will be gauged by continuing attendance in the program.

That's the end of my part of the presentation, and thank you for your attention.

Karen Cheung: Fantastic. Great. Thank you so much to all our speakers, Dr. Lorig, Linda, Kristie and April for your presentations. We learned about CDSMP, and we received a lot of resources related to it. We heard from Linda who experienced the program firsthand and can attest to its value in self-empowerment. We also learned about how to partner with community-based organizations to offer CDSME and how this can begin addressing social determinants of health.

Then, April gave a really nice example of health plans and providers partnered to offer CDSME as an enhanced benefit for members. We now have some time for questions. Go ahead and type in your questions into the Q&A pod, and we will get through as many as we can during the session.

I will start with the question for Dr. Lorig. Dr. Lorig, how does one get training or certification in chronic disease self-management program?

Kate Lorig: There are several ways of doing this. If you want to train leaders, you contact the local organizations in your area, which you can find by looking on the Evidence-Based Leadership Council website. You can always call us at Self-Management Resource Center or send us an email. We also do training of master trainers so leaders teach participants, master trainers train leaders. There are about 30 master trainings given in the United States each year, and we can help you find one. Maybe we can help you find one near you. We also do about five of them a year here in California. There's a lot of different doors, and I think the best thing to do is just send me an email at kate@selfmanagmentresource.com. Then, depending on what you want, we can help direct you to where you want to be.

Karen Cheung: Great. Thank you. I have a question for Linda here. Linda, have you been able to use the strategies you learned in the program to teach and empower others?

Linda McGowan: Yes, I helped family members, and I've also used it in my own personal life, dealing with other big issues that I had not taken charge of, had not been active in. The whole decision-making process is the concept of this type of workshop I've been sharing with people as I come in contact with them.

Karen Cheung: Great. That's nice to hear, and I have two specific questions that are related to Kristie and April's examples. Are participants, with or without the Senior Whole Health insurance, going to class together, and if so, are those without Senior Whole Health insurance billed a seat to participate?

Then relatedly, does Virginia charge non-health plan members to attend the CDSMP classes? Both questions are related to billing.

Kristie Kulinski: For the example of Senior Whole Health in Massachusetts, I'm speaking as a program officer for their grant. Clearly, I'm not on the ground in Massachusetts, but it's my understanding that yes, there's a mixed class of individuals. You have both Senior Whole Health as their insurer as well as other members of the community.

I do know that in Massachusetts, Elder Services of the Merrimack Valley, their Healthy Living Center of Excellence, uses braided and blended sources of funding to support their workshop. They have a couple of contracts. If a participant happens to fall under one of their contracts, they would get billed that way. They also have grant funds from the Administration for Community Living that supports workshops. I think also some state-based funding as well.

I don't know that participants are billed or paying a nominal fee or anything like that if they aren't covered under a contract. I do think other sources of funding likely pick it up.

April Holmes: I'll just answer that from Virginia, because we have grants and we have other sources of funding. We do not have to charge participants. When those sources dissipate, we will have to be charging for participation in the workshop.

Karen Cheung: Okay, thank you. Another question that is pretty specific to the program. How and by what method are participating members reporting back to their primary care physicians for continuity of care? I don't know if anyone has the sense of that.

Kate Lorig: After the fifth session of every workshop, we ask participants to write letters or send emails to their physicians, it is more emails these days, telling them about the workshop and what they've gained or what they haven't gained if that's the case. So we do have a small formal feedback loop to do that.

Kristie Kulinski: Kate mentioned that feedback loop, and that's so important. I know at least one example where, with participant consent, participant action plans can be shared with the provider and documented in the electronic health record, so that there's that continuity of care following the six-week duration of the workshop. I know for our community-based organizations, particularly those who have contracts with healthcare providers or payers, they're at a minimum documenting participation and completion in the workshop.

April Holmes: We use a little of what Kate was talking about in the fifth session. Sometimes people bring those back and leave them and share with the group. Some of those AAAs have initiated additional steps for participants to provide feedback to their provider, such as a form letter that they can add their information and what they've learned and gained from it. So we go a little beyond in some areas.

Karen Cheung: How do we get physicians and providers to understand the importance of encouraging their patients to attend the CDSMP workshops?

Kate Lorig: I think physicians actually understand the importance. I also know that they're incredibly short on time, and that the second they start talking about a workshop, it costs them

three to five minutes. They don't have that much time. What we've done is have the physicians tell people about the programs through the patient portal in the electronic medical record. We did an exam at Stanford last year where everybody with a chronic disease in a clinic was sent an invitation to attend the workshop in various different modes. In fact, we had a third of the entire clinic population respond.

I think the issue is not how we get them to know that it's important. They do know it's important. The real issue is how we get to patients in the healthcare setting without infringing on physician time. I think that there are various ways of doing that, and that's the challenge.

Kristie Kulinski: There is a geriatrician in Massachusetts who's been a long time champion of this program, and he has said recently that when he is presenting to healthcare providers or payers on behalf of the program, either Massachusetts or nationally, he won't do it unless there's a participant champion with him. So it takes me back to Linda, we need more Lindas. For community-based organizations, we need to find our Linda and bring them with us when we're presenting these programs.

A couple of the other strategies I know is to continually be in front of providers. It's not a one and done, I've dropped a brochure, I handed you a flyer and now you'll refer. We need multiple touch points, as well as looking at other staff. Oftentimes, I know in my own experience, I spend more time with the medical assistant than I do with my healthcare provider. So it is important to look at other key contacts within the practice, beyond just the provider, who may have more time or who also have that trusted relationship with the patient.

April Holmes: This is April, and I would second what Kristie was saying. That's been an issue. We have regular conference calls with our local programs and at the state level. We have special conference calls about particular topics that were identified by the programs. The first priority is recruiting enough participants. The second priority is getting practices to refer. On our next conference call, we will be talking about some of the works with our quality improvement network who works with practices and has a lot of good ideas to share.

Individual AAAs have had varying degrees of success. Some of them have a great relationship with the practices, and practices that have taken the ball and run with it. I would agree that sometimes it's another person besides the busy doctor, like the practice manager, that you want to talk to or maybe a nurse.

Karen Cheung: Great. On a related note, do you have suggestions for recruiting and retaining volunteer leaders for this program when participation in the organization and leader turnover is a huge issue for organizations?

April Holmes: What we found, and I think it's borne out by national results too that personal contact is the most effective, including just talking to other people. The local coordinator going to meet with a group at a senior housing residence or a senior center doing a session zero, which is sort of a sample of the workshop so people can see what it's about. I think that helps too.

Kate Lorig: For recruiting leaders, we did loads of public presentations. Every time, we'd say, "you can come to the workshop, and, by the way, if you'd like to teach it, put a star by your name." Then we call the people up and talk to them.

You need to be careful because you end up choosing people like you or choosing people you like. Sometimes some of the best leaders are not like you and are not people that you particularly like, but they serve their own communities exceedingly well. Sometimes you have to suspend judgment. You obviously keep your judgment about whether they can keep fidelity and whether they're going to show up, but some of the other things you need to suspend judgment a little bit about. The way you find leaders is you go to the community and say, "who wants to do this?" You talk to them.

If there's a huge leader turnover, I would actually look at the volunteer coordination because maybe you're asking people to do too much.

April Holmes: I would say too that it's a nice way to connect sometimes with a practice. If they can sell the idea of the CDSME with their patients, you might actually get some people that work at the practice to lead the workshop.

Kate Lorig: Yeah. We have several medical assistants that lead the workshop, for example.

Karen Cheung: Has there been much use of CDSMP in federally qualified health centers?

April Holmes: Yes.

Kristie Kulinski: Yes.

Karen Cheung: Do you all know if those centers are seeing similar results to some of these national studies in terms of the evidence, some of the outcomes?

Kate Lorig: I believe a couple of the sites in the study I showed you with a thousand people were federally qualified health centers. We did not see much difference between sites.

Karen Cheung: Does California or other states have an equivalent organization to No Wrong Door in Virginia?

I don't know if anyone knows that because other folks on the phone were interested in learning whether there's a No Wrong Door equivalent in Texas, in California and a couple of other states.

April Holmes: Yes, there are other states that have No Wrong Doors. Actually that is the global term for the system of the different states, not just Virginia. What varies is what kind of tools are used, the software that's used for the system.

Karen Cheung: Right. April, do you know how folks can go about finding out more about that global program?

April Holmes: I think it depends on each state.

Kristie Kulinski: It's actually ACL with managers that program at a federal level and coordination with CMS and Veteran Health Administration. There's a website. It's NWD, for No Wrong Door, https://nwd.acl.gov/, and you can learn more there.

Karen Cheung: What are the differences between health coaching and CDSME?

Kate Lorig: CDSME is a very set program. It's exactly the same, every place it's given. Health coaching is basically when the health coach finds out something about you, and based on that, they make recommendations that work for you.

It is one-on-one as opposed to a group, but is also more tailored. It is more focused on tailoring as opposed to helping the person do what they want to do. That's probably cutting too fine but there are distinct differences.

The other difference with health coaching is that because it's one-on-one, you do not have the benefit of modeling from everybody else in the group nor do you have the benefits of the peer pressure when everybody else is doing something. There are a lot of differences, and we could talk all day about it. Those are some basic ones.

Karen Cheung: Dr. Lorig, the CDSMP website, referring to the Stanford Education program, someone was wondering if there is a new website to new information in education programs.

Kate Lorig: Absolutely, it is called, https://www.selfmanagementresource.com/.

Karen Cheung: Great. Someone was also wondering if the programs are widespread around the United States? I know there was a map with a locator that we presented. This person is interested in finding a program near him as he or she is a crisis case manager for a mental health crisis team.

Kate Lorig: Yes. I can't promise you that they're absolutely everywhere, but I believe that we have programs in every state at this point. Obviously, some areas are better served than others, but go to the locator and you should probably be able to find an organization near you.

Karen Cheung: If an organization is offering a program that's not listed on the locator, how should the organization go about making sure that it is updated in the locator?

Kate Lorig: The only programs in the locator are programs of members of the Evidence-Based Leadership Council. The way you do that is become a member of the Evidence-Based Leadership Council, and at that point, it would go in the locator.

Karen Cheung: Great. Can you clarify the cost, if any, to the participants, in the program given the state level of support for CDSME in Virginia; are they included in the state budget for DARs or Area Agencies on Aging?

April Holmes: The cost in general, we found is, you know, averages around $350 or so per participant. We do not charge, again, right now. Individual programs, sometimes, they ask for contributions, and they can charge. We have tried to get it into the state budget and the governor has supported that, but that hasn't gotten through.

Kristie Kulinski: To add to what April said, I think it's important to be clear that these programs aren't free of charge, and in many states, they may be subsidized by a federal grant or underwritten by a contract, but that there is certainly a monetary cost and value to these programs.

Typically, though, we haven't seen the full cost passed down to participants. Sometimes, it's just a nominal fee but I'm not aware of any circumstances where the participants themselves have paid $300 or $350. That's typically either underwritten by a grant or is included in a contracted rate.

Karen Cheung: Can anyone speak to the background of leaders conducting these workshops? What are the core skills that might be needed for an effective leader?

Kate Lorig: A leader needs to be somebody that's comfortable speaking before a group. They don't have to be an expert, but they can't be terrified to be speaking before the group. Preferably, they have a chronic illness of their own. They get on with life without making the illness the center of their life, because we do not really want to hear about everybody's aches and pains every instant.

They have the time to do two and a half hours a week for six weeks, preferably twice a year. They are able to follow the fidelity of the manual, without kind of adding great amounts of their own stuff. Finally, they represent the community that they're teaching. I think those, for me, are the biggest characteristics. Other people may have some other ones.

Karen Cheung: Great. Thank you. If folks have additional questions or comments, feel free to email them to RIC@lewin.com, and we will add it to our list of questions that we will post on the website. Slides for today's presentation, a recording and a transcript will be available on our Resources for Integrated Care website shortly.

A huge thank you to all of our speakers, and thank you to everyone for attending and participating. At the end of this webinar, a survey will appear on the window behind the presentation. Your feedback is incredibly important to us, so please submit your survey. We'll take your feedback into consideration as we plan for future webinars.

Thank you, everyone, for your questions. Thank you to our speakers, and have a good rest of your day.