Improving Outcomes for Patients with Chronic Diseases
Community-based and digital self-management support

May 17, 2018
Presented to:

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Agenda

- Self-management support
- Stanford’s CDSMP model
  - Community-based
  - Digital delivery
- Partners In Care
- Evidence-based self-management programs
- Blue Shield of California
- Bringing self-management support to members
- Discussion
Four Approaches to Value-Based Care

- Clinical Management
- Delivery System
- Insurance Design
Four Approaches to Value-Based Care

Self-Management Support is The Missing Piece
Which is better?

I’ll never get better
I’m useless
Why do I hurt?

I can heal myself
I’m organized
I’m in control
Goal

Equipped to manage:
- Medical
- Roles
- Emotions

Passive → Active
Living Better With Self-Management

My condition
My terms
My life
Improves:
- Therapy adherence
- Self-efficacy
- Relationships / communications
- Healthy diet and exercise
- Severity of symptoms
- Coping with feelings/depression

People with chronic diseases who are confident and practice self-management experience improved **health status and use fewer health resources**

- Impacts outcomes for self-managed chronic conditions
- Reduces utilization and costs
Focus on Self-Management Brings Value

- Consumer choice
- Consumer satisfaction
- Consumer engagement
- Social determinants of health
- Cost saving
- Quality of care / HEDIS scores
- Value based care
- Customer expectations (e.g., employer, government)
- Network management/provider support
- Competitive positioning / innovation leader
- Brand awareness
Chronic Disease Self-Management Program

- Developed by Stanford’s Patient Education Research Center, now with Self-Management Resource Center
- Peer-to-peer, group-based, six-week - in-person and virtual
- Proven effective with hundreds of thousands of adults living with chronic conditions
- Helps individuals manage their lives, emotions and relationships AND medical care.
- Improves participants’ depression, self-efficacy, medication adherence, health behaviors
- Improves long-term medical outcomes and saves money
Engage through story-telling: Outreach to outcomes

Outreach
- Prioritize, segment, develop personas, stories re changing life, getting motivated

Educate Activate
- Stories re: chronic diseases, worsening trajectories, prevention possible

Sign-up Show-up
- Stories re: intervention success, overcoming inertia, optimizing future

Participate
- Stories re: others who overcame barriers, solved problems, provided and received support

Succeed
- Authentic stories re: long-term behavior change with positive outcomes;
Better Choices Better Health
Three Decades of Stanford University Research

Originally developed by the Stanford Patient Education Research Center.

WEEKLY TOPICS

- Guided Lessons
- Action Planning
- Peer Coaching
- Moderated Discussions (Weeks 2-6)

Repeats for 6 weeks
Program Impact all Chronic Conditions

For adults living with one or more chronic condition which require daily self-management

Workshop Topics

Foundational
- Self-Management Principles
- Goal Setting / Action Planning
- Relaxation
- Pain Management
- Problem Solving

Supporting
- Difficult Emotions
- Physical Activity
- Weight Management
- Fatigue Management
- Sleeping Well
- Communication
- Medications
- Evaluating Treatment Plans
- Working with Healthcare Team
- Depression

- Cancer
- Joint
- Diabetes
- Musculoskeletal
- Multiple Sclerosis
- Sleep Apnea
- Asthma
- Heart
- COPD
- Arthritis
- Depression
- Hyperlipidemia
- Hypertension
- Fatigue
- Depression
- Hypertension
- Hyperlipidemia
- Fatigue

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The program works at scale

- **8 Major Studies – 20+ peer-reviewed articles**
  - Diverse populations: Pre-diabetes, Arthritis, Diabetes, Depression, rarer conditions, multiple

- **2014-2016 Anthem-Stanford study**
  - Decreased A1C 0.45% at 12 months
  - Decreased A1C 1.27% at 12 months (Initial A1C > 9%)
  - Reduced incidence of Depression 27%
  - Improved Medication Adherence by 16%
  - Increased Exercise 43 minutes Per Week
  - Significant cost-savings; pending publication

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A Diabetes Self-Management Program: 12-Month Outcome Sustainability From a Nonreinforced Pragmatic Trial - Lorig, KL; J Med Internet Res 2016 | vol. 18 | iss. 12 | e322
How Digital Works – Live Demo at Health 2.0

Click Here to Watch Video
Dual Venue | Community-based or Digital: Same Service-Different Approach

### In-Person
- 6-Week peer-to-peer workshops
- Facilitated by 2 trained peer leaders
- Group dynamic and support
- Validated protocol and curriculum

#### Weekly/same day & time
- 2.5 hours per week
- 10-15 people in group
- Choice of items to discuss
- People develop “safe space”

### Digital
- Login 24/7/365
- 1.5-2 hours per week
- 20-30 people in group
- Self-tailored experience
- Anonymous
Dual Venue Creates Value

- Increase number of individuals served
- Offer choice of delivery method
- Partner with purchasers to sustain and scale
- Reach vulnerable/underserved populations
- Create margin to further mission
- Support governmental entities
Dual Venue Models

- Regional coalitions/organizations
- State and local governmental agencies
- Healthcare delivery systems
Community and Governmental Partners
Thank you

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Patient Engagement: A Tri-Venue Approach

Los Angeles University of Best Practices
Dianne Davis, MPH

May 17, 2018
Partners in Care Foundation

*Changing the Shape of Healthcare*

- Partners is a **think-tank** and a **proving ground**
- Partners changes the shape of health care by **creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities**
- Partners’ direct services **test, measure, refine and replicate innovative programs and services**, and bring needed care to diverse populations
Our Service Lines: Overview

Health Self-Management

Long-Term Services & Supports

Short-Term In-Home Services
Why a network?

- Health plans have large service areas
- Typically prefer not to have multiple contracts for the same service
- Competition is large (for-profit) companies
- Need to offer variety of skills, ethnicities, languages
- We want to raise all boats
- Shared accreditation, IT, sales, billing, contract negotiation, compliance, quality
  - Members focus on service provision
Theory behind the Network

• IF CBOs join together to present a unified contracting entity to healthcare organizations

• AND they can meet the quality, volume, confidentiality, geographic coverage and information needs of healthcare

• AND they can demonstrate their value in terms of the Triple Aim

• AND they are competitively priced

• THEN they will win contracts with healthcare entities and perform well
Maintaining the Network

• Ambitious work
• Value proposition
  • (in marketing) an innovation, service, or feature intended to make a company or product attractive to customers
    • WIIF-Them
• The work doesn’t end after the contract is signed:
  • Value needs to be continuously proven
  • Need to keep network partners’ leadership & operations engaged
  • Create a network culture that members feel connected to
  • Transparency and communications are key
Integration with Clinical Systems #1

• **Blue Shield of California**
  – Funded by **Disease Management budget**
    • Asthma, Diabetes, COPD, CHF, CAD
  – Outreach and engagement by Contact Center across the state of California offering three modalities of **CDSMP**
    • In-person
    • On-line
    • Tool kit

• **Culture Change**
  – IT savvy
    • Reporting abilities
  – Quality Assurance
    • Measurement, improvement, best practices and systems across the network
  – Sufficient Volume within various regions
Outreach & Engagement for Population Health

- **Contact Center: New outreach & engagement strategy**
  - 117,000 referrals received in 24 months
    - Choice of three modalities (in-person, online, toolkit)
    - Initial 24 months 2.7% enrollment rate
    - Year 3 enrollment rate, 3.4%; Currently closer to 5%
      - Industry average 1% – 2%; initial contract goal 2% enrollment

- **Significant IT investment required**
  - Customer Relationship Management (CRM) platform
    - Data reporting requirements are huge!
  - Interactive Voice Response (IVR) system
  - Auto-dialer
  - Motivational Interviewing script development & training
Integration with Clinical Systems #2

- **Care1st – Medicaid Managed Care Plan**
  - Funded by **marketing budget**
  - Sponsoring workshops and health education talks in senior housing sites
    - English & Spanish Workshops
      - CDSMP / DSMP
      - Arthritis Exercise
      - A Matter of Balance
      - UCLA Memory Program

- **Culture Change (for both entities)**
  - Very slow to start . . . Have to hold hands and be persistent
    - Sometimes you need to call in the “big guns”
  - Provided significant dollars for collateral (t-shirts, bags, etc.)
  - Once the kinks are worked out . . . This can be a good way of beginning to work with a plan
Wellness Club

- Free t-shirt and loyalty card upon sign-up
- Colored button for every workshop completed
- Free reusable grocery bag when a three workshop series is completed
Integration with Clinical Systems #3

- Cedars Sinai / AARP
  - Funded by grant dollars
- Direct Referrals from Geriatric practice into programs
  - CDSMP
  - Enhance Fitness / Arthritis Exercise
  - Tai Chi for Arthritis
- Hired a Navigator to connect patients to programs in the community
- Culture Change
  - Jump How high?
    - Make sure to set expectations early on
  - Large health systems don’t work at the same pace as a small community based organization – be patient
    - Contracting, finance, etc.
- IRB – outcomes research on social isolation and falls prevention
Testimonials

• “Because I have been afflicted with Parkinson’s for over 20 years, I have suffered a great deal of depression. The skills you’ve taught me in maintaining positive thinking and combating depression have really helped to improve my condition.” - John, age 69

• “I found the interaction with the other students in the class to be most enlightening. I realized that although I have a chronic illness I am not alone. Thank you for all the lessons in helping me to deal with this.” - Suzanne, age 57

• “The workshop put me back in charge of my life, and I feel great. I only wish I had done this sooner.” - Robert, age 68
Blue Shield of California
Evidence-Based
Self-Management
Programs
Paula Lunde, MPH, CDE
Sr. Program Manager
Why Evidence-Based Self-Management (EBSMP)?

• Diversify program engagement modalities
  • Engage members when and where they need it
• Enhance traditional disease management programs
• Utilize widely tested evidence-based strategies
• Connect members to their communities
Blue Shield EBSMP Program History

• Began pilot in 2015 and fully integrated into Disease Management program offering in 2017
  • Three EBSMP modalities offered
    • In-person workshops
    • Online workshops
    • Self-Help mailed toolkits
• Blue Shield contracts with two community-based organization to provide EBSMP services
• Data driven identification-Members who are identified and enrolled in Disease Management
• Available for eligible members with asthma, coronary artery disease, COPD, diabetes and heart failure
• Nearly 65,000 referrals to EBSMP each year
• 3% enrollment rate across all three modalities
Program Challenges

• Community-based organization infrastructure
• Technology and IT security requirements
• Program engagement and attendance
Future State

• Additional types of EBSMP workshops available to members
  • Pain management
  • Worksite version

• Potential expansion of in-person workshop network beyond California for national accounts

• Ability to process direct referrals from
  • Members
  • Providers