

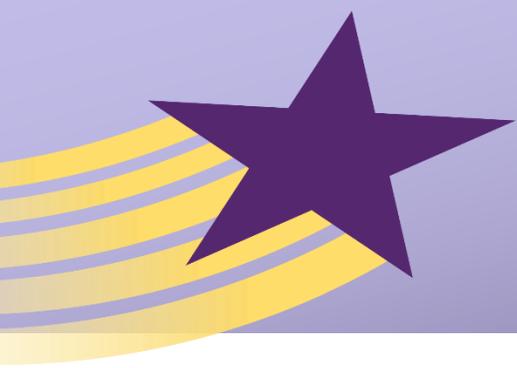


Laying the Groundwork for Success of Evidence-Based Self-Management Programs

Building Success of Evidence-Based Community Programs

College Park, Maryland

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Presentation Objectives

- Understand the importance of evidence-based community programs for communities
- Analyze various strategies that contribute to the success of evidence-based community programs
- Select factors that contribute to program sustainability



Context and Community

Why Evidence-based Interventions Fit



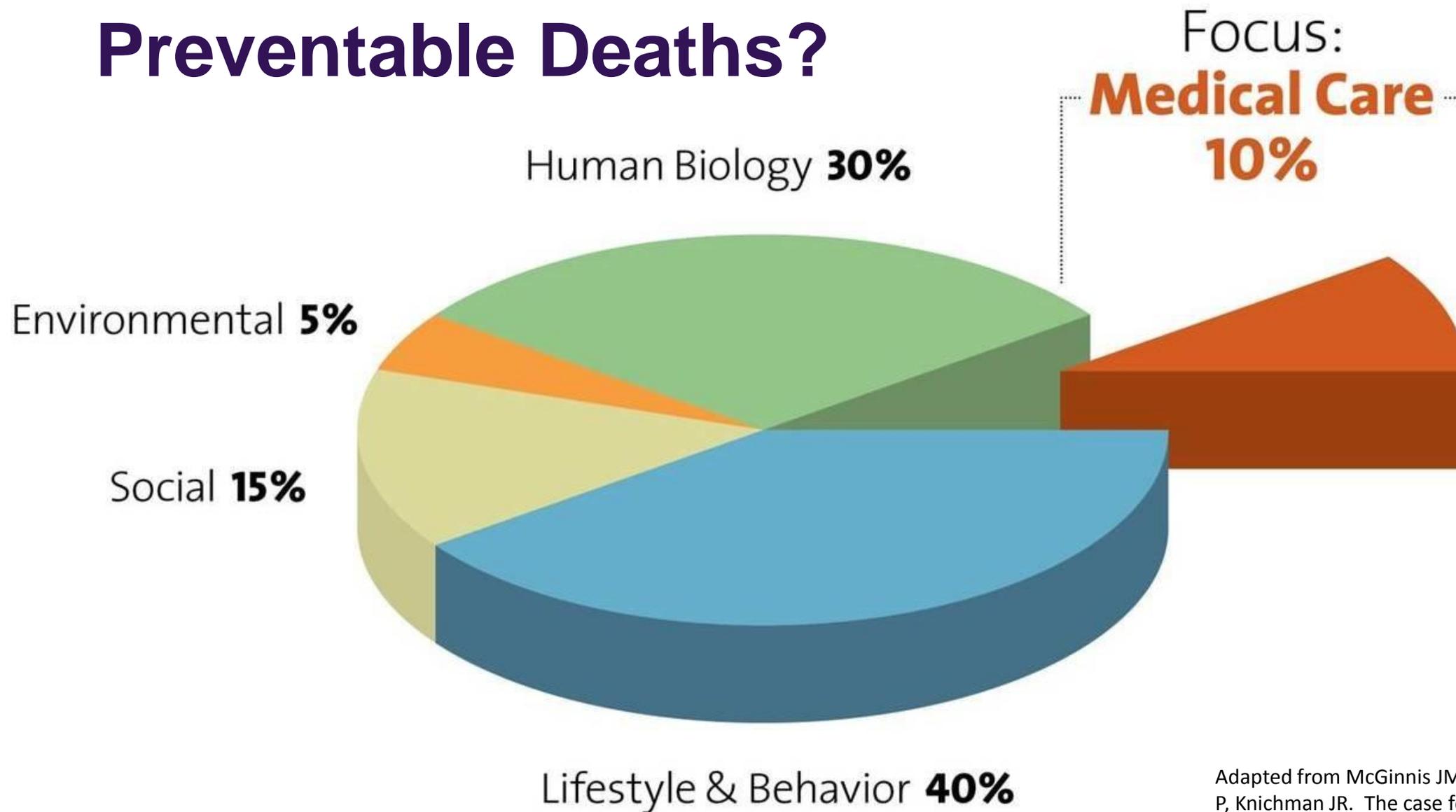
Why Engage Communities?

- Cornerstone of public health practice
- Builds skills and capacity within the community context
- Essential to identify long-term solution to address health disparities
- Crucial in recruitment/retention of diverse populations
- Critical to dissemination and implementation of EBIs
- Domain of greatest impact of EBIs

Person in Environment

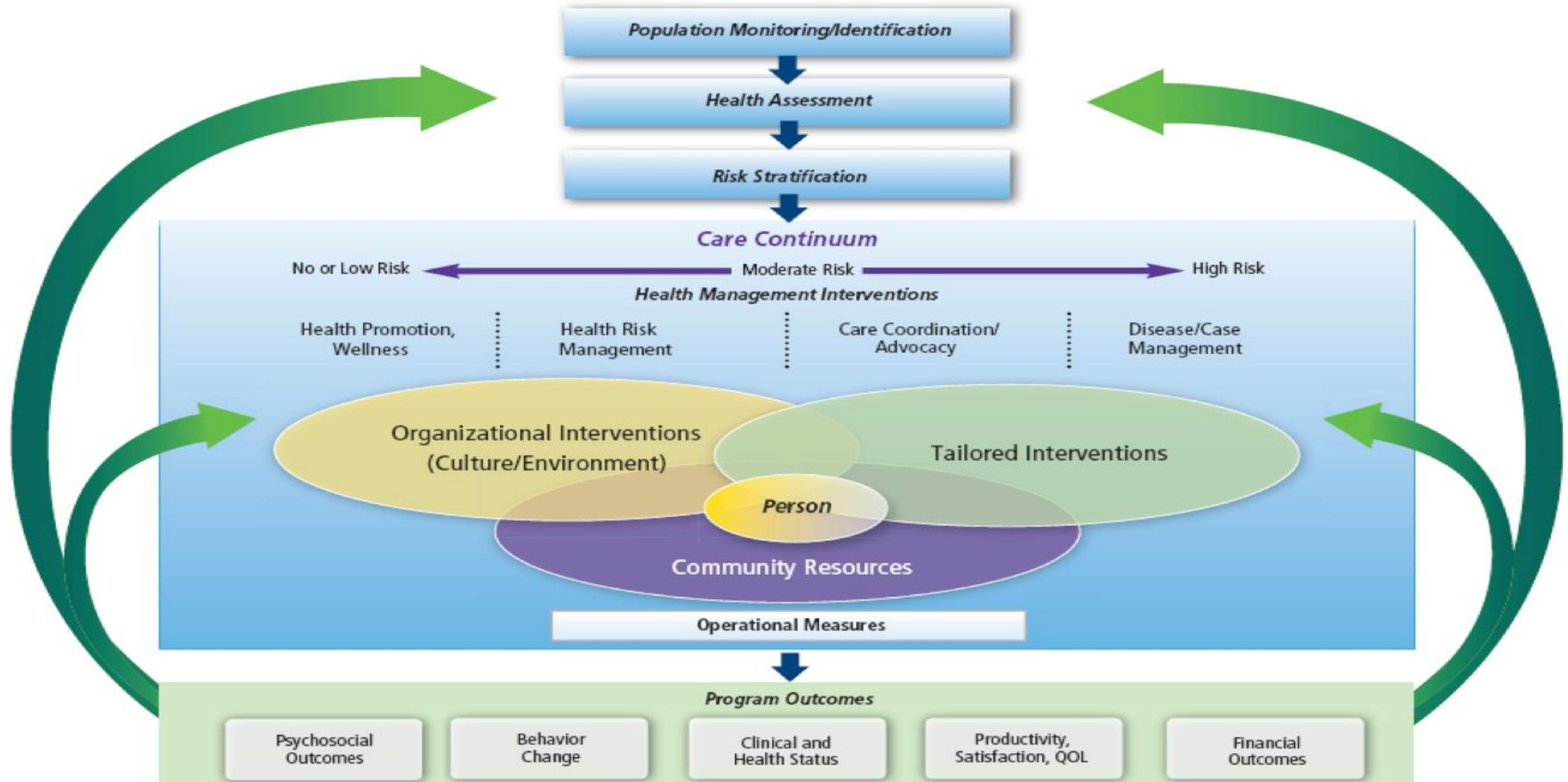


What Accounts for Preventable Deaths?

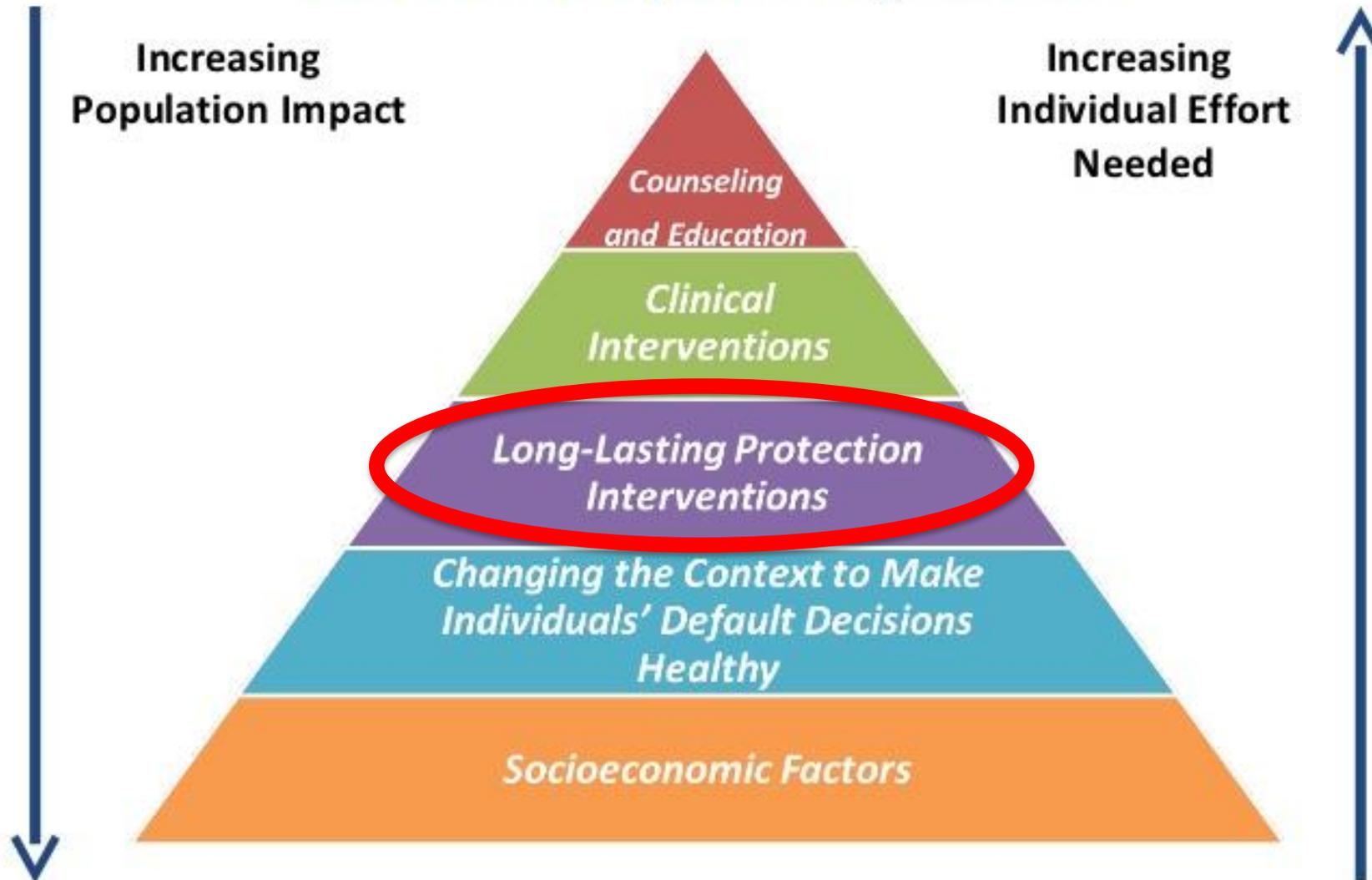


Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)* 2002;21(2):78-93.

Conceptual PHM Framework



Health Impact Pyramid





Community

Resources & Policies
Self-Management Support

Health Provider

ORGANIZATION OF HEALTH CARE

Delivery System Change
Decision Support
Clinical Information System

Informed,
Activated
Patient



PRODUCTIVE
INTERACTIONS



Prepared,
Proactive
Practice
Team

Improved Outcomes

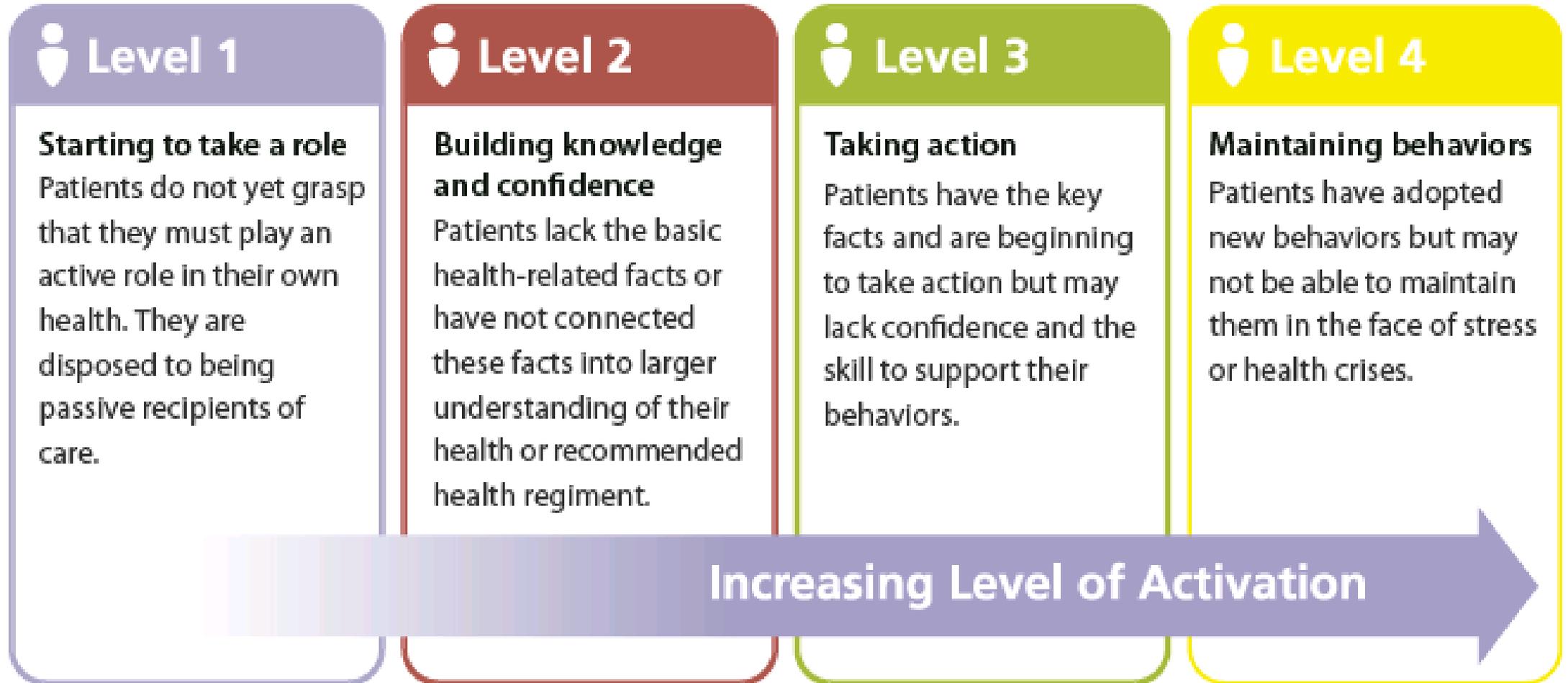




Self-Management Support

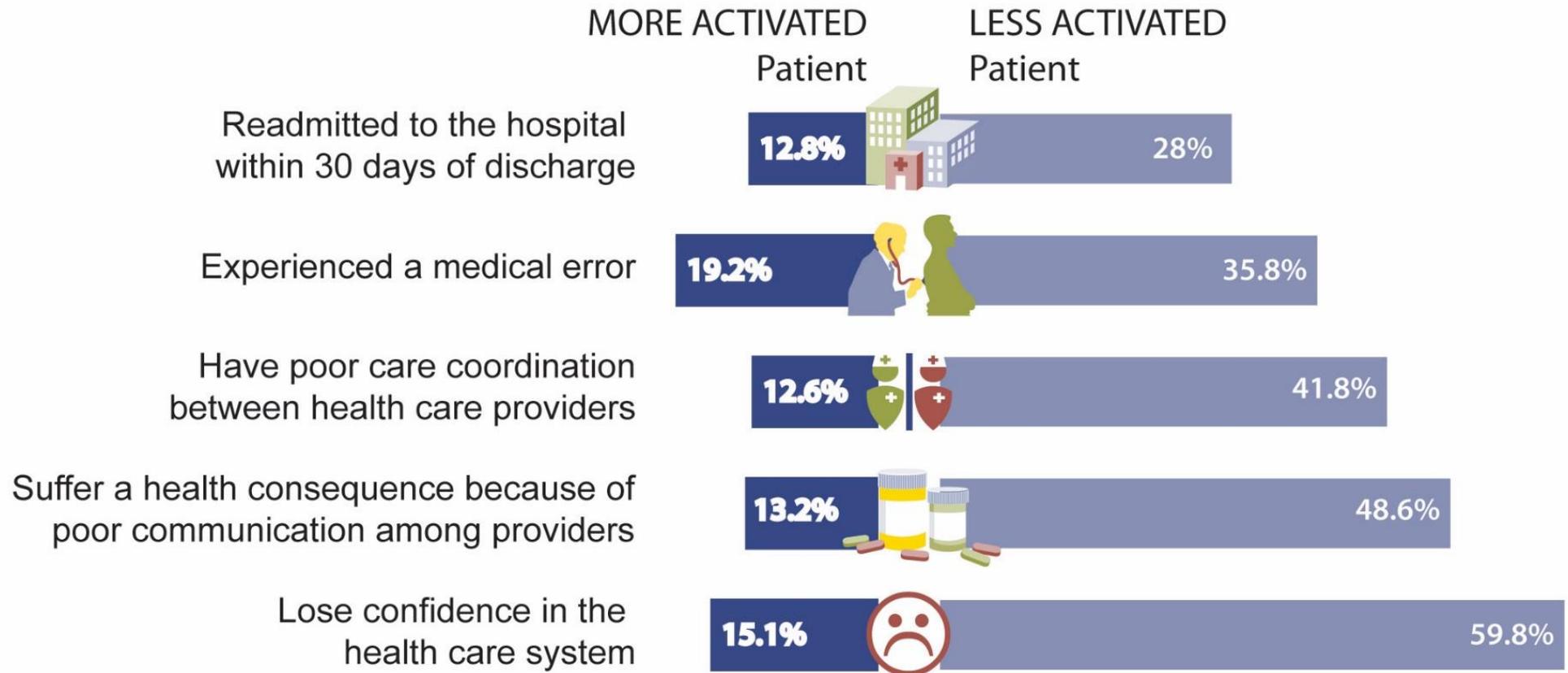
- Emphasize the patient's central role.
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up.
- Organize resources to provide support.

Activation is developmental

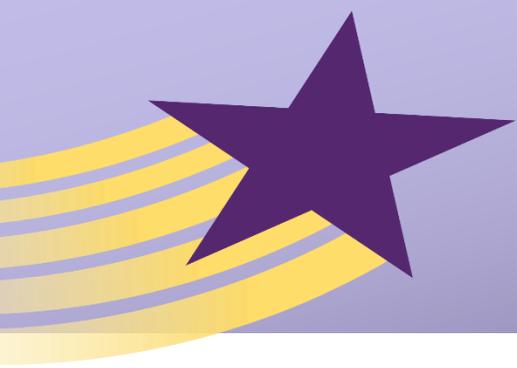


Low activation signals problems (and opportunities)

The **MORE ACTIVATED** you are in your own health care,
the **BETTER HEALTH CARE** you get...



Source: Adapted from AARP & You, "Beyond 50.09" Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2



Capacity and Community

How to Build Successful EBIs in Your Community

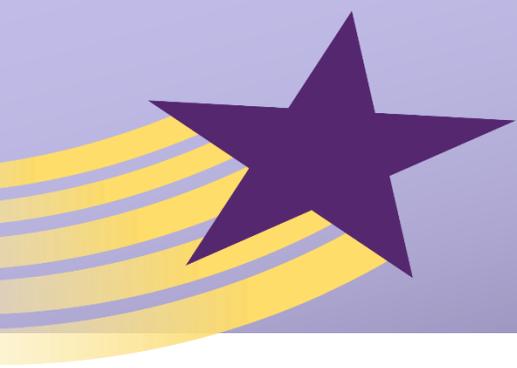


Elements of a Sustainable Delivery Infrastructure



1. Workforce Development

- Consider capacity to meet program needs
- Workforce includes multiple roles
 - Coordination, delivery, data collection/management, etc.
- Training is only the beginning
- Workforce must be held accountable to program quality standards



2. Referral Networks and Marketing

- Important for sustainability
- Include multiple sources/or limit sources as needed
- Consider marketing needs and marketing venues
- Develop a market niche
- Articulate your value proposition
- Link with or establish a coalition



3. Delivery Sites/Systems

- Delivery site – where you hold your programs
 - Sites should be accessible and inclusive
- Delivery system – supports the delivery site and generally provides:
 - Resources for delivery
 - Workforce support
 - Access to a specific population of interest



4. QA/QI

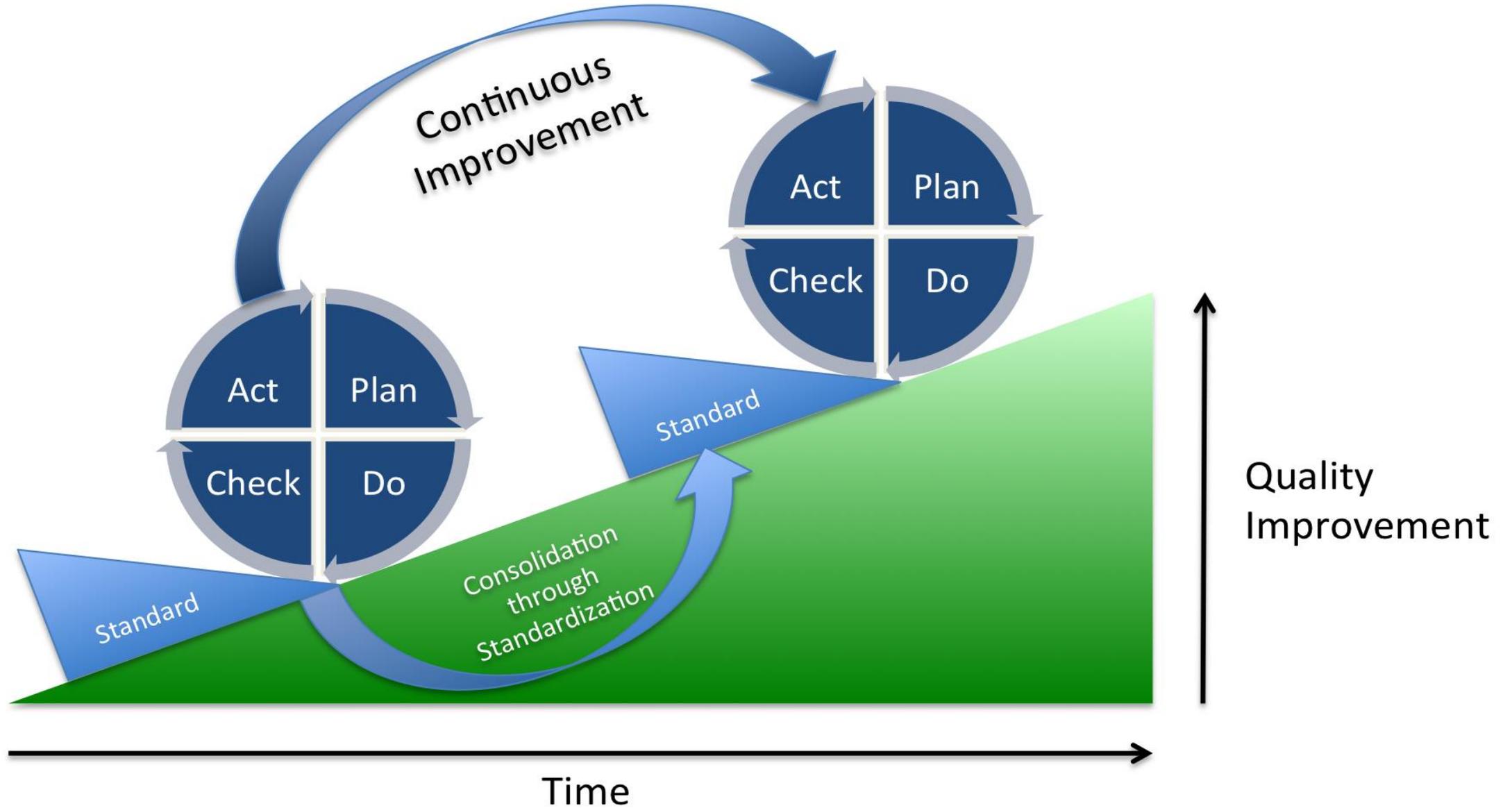
Quality assurance - assuring that activities that require good quality in delivery are being performed effectively.

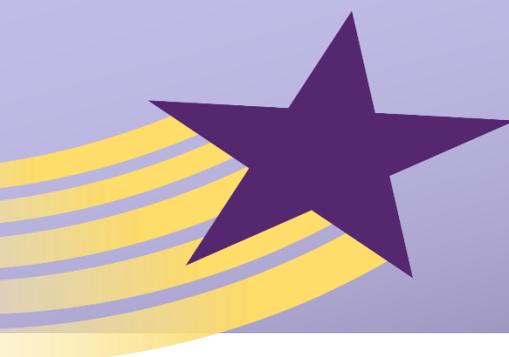
“Good quality” is established through comparison with an external standard.

Quality Improvement - raising the quality of program delivery.

“Improvement” is established primarily by comparing current performance with past performance with a goal of better attaining the “Quality Assurance” set standard.

The CQI Cycle





5. Evaluation: Measures and Methods for Quality and Fidelity

- Checklists/Rating scales to objectively quantify accuracy in delivery
- Manuals, training, supervision & observation protocols to standardize QA/QI activities
- Consultation to determine
 - 1) core “non-negotiable” elements and
 - 2) appropriateness of local adaptations



5. Evaluation: Short-Term Performance Measures

- Number and type of EBIs offered
- Number of participants at EBIs offered
- Percent of adults with one or more chronic diseases who have attended a self-management program
- Number of referrals to EBIs from health care professionals
- Number and percent of adults among population(s) of focus (e.g., communities of color, persons with disabilities, low income neighborhoods) who have attended EBIs



5. Evaluation: Long-Term Performance Measures

- Percentage of adults who are overweight or obese
- Age-adjusted hospital discharge rate for diabetes per 10,000 population
- Percentage of health plan members with hypertension who have controlled their blood pressure
- Age-adjusted rate for heart attack
- Others



6. Financing & Resources

- **Who pays for what and why?**
 - Specific participant groups
 - Why is cost reasonable?
 - Volume
 - Initial cost - Ramp up rate
- **Cost Structure**
 - Delivery costs
 - Marketing Costs
 - Support Costs



Successful Delivery Models for EBIs



Centralized

- Centralized Models
 - Single coordinating organization
 - Manage key delivery activities for multiple partners
 - Utilize multiple funding sources to achieve capacity goals for all
 - Generally most successful way to serve targeted populations



Centralized Models: Advantages/Challenges

- Advantages
 - Streamline access for implementation sites, leaders, participants and evaluation data processes
 - Simplify cost structures for payment/reimbursement
 - Less complex structures needed to manage quality protocols
- Challenges
 - Limited by outreach territory
 - May present reach concerns for partners



De-Centralized

- De-centralized Models
 - Multiple partners are key stakeholders
 - Each partner manages specific key delivery activities
 - Program resources shared across programs



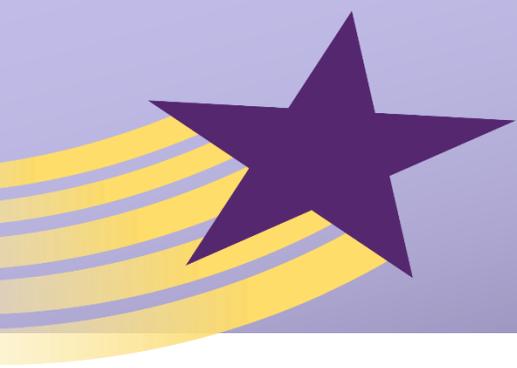
De-Centralized Models: Advantages/Challenges

- Advantages
 - Workload shared across organizational partners
 - Resources shared across organizational partners
 - Reach potential possibly increased
- Challenges
 - More complex structures needed to manage quality protocols (who will do what, when and for whom?)
 - Access possibly more complex for partners, leaders, participants
 - More complex cost structures



Hybrid Models

- May include some elements of Centralized and De-Centralized
- Generally organizations or groups coalesce around a particular target population/outcome goal or both
- Likely “back of the house” functions are coordinated and partners compete for resources based on performance

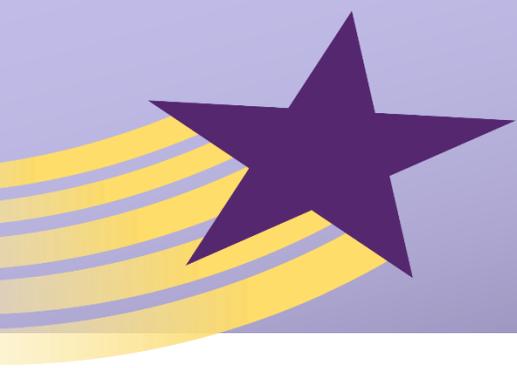


Cohesion and Community

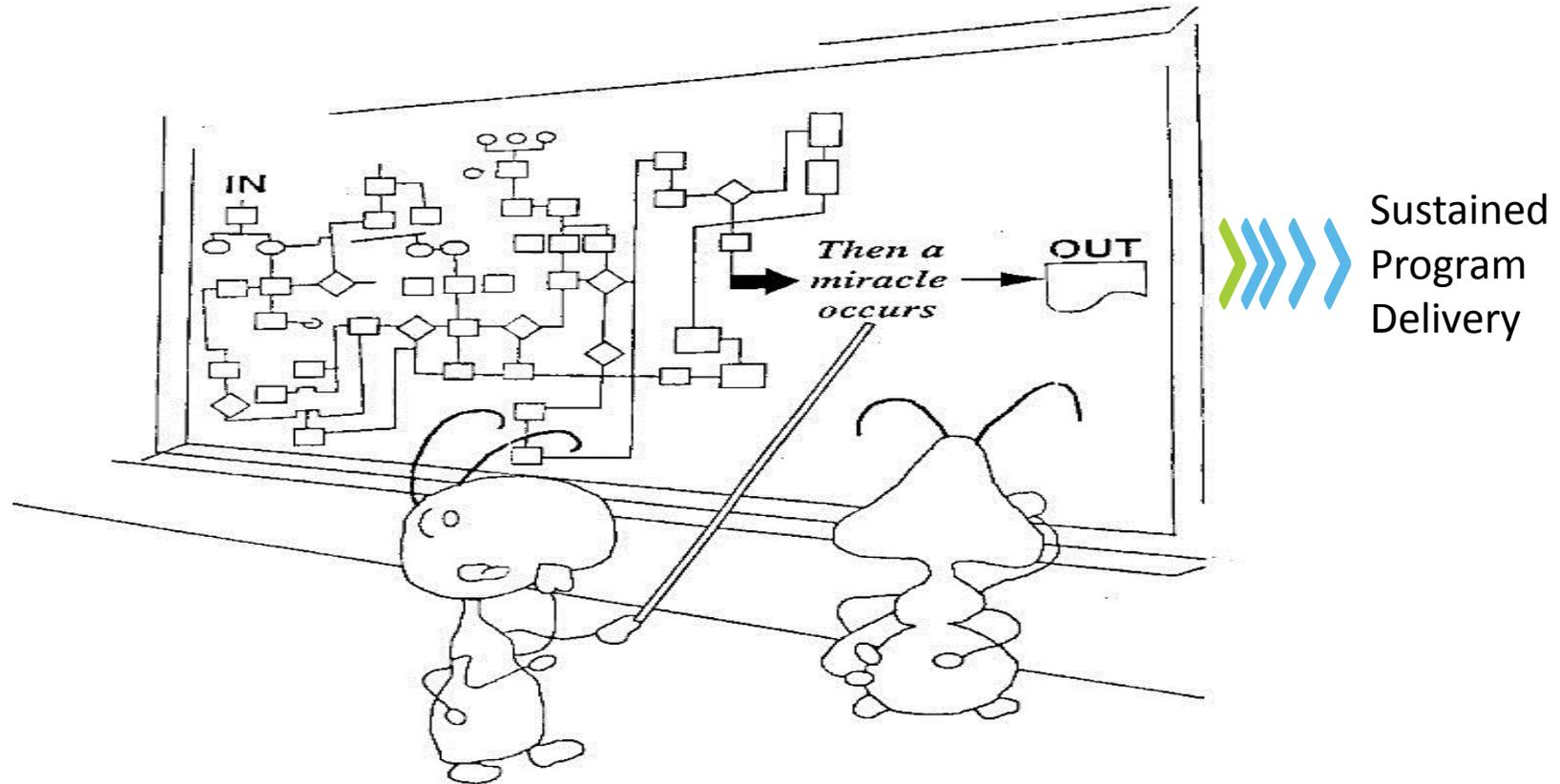
Sustaining Community Interventions



Sustainability Opportunities



Building Sustainability

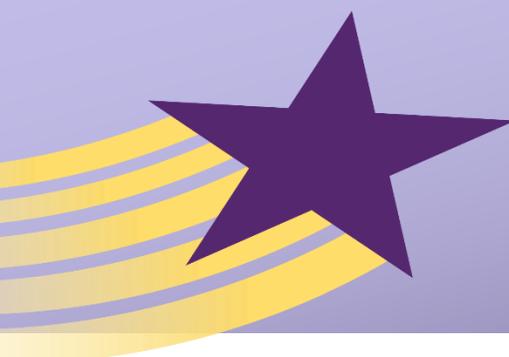


"Good work but I think we need just a little more detail right here"



Right sizing and leverage

- Building a level of delivery that is possible and sustainable
- Building a level of delivery sufficiently robust to leverage referrals and resources



Finding Funds/Resources

- What are foundations looking for in projects?
- What other grant funding sources are possible?
- What is the fit for State funding?
- What new funding streams are out there: Healthy Aging/Health Communities, ACOs, Medicare, Medicaid, PCMH, HCRA, reducing re-admissions....



CDSME & Meeting PCMH needs – NCQA expectations

- Referral tracking and follow-up (standard 5)
- Care plans (standard 4)
- Self-management goals (standard 4)
- Continuous Quality Improvement (standard 6)
- Linkage to EHR/EMR



Accountable Care Organizations (ACO)

- The association of hospitals, providers and insurers together assume accountability for the quality of patient care and make decisions about how monies are spent.
 - ACOs eligible for percentage of savings they create if they meet quality and cost containment goals
- Will the quality of the delivery of your programs be such that participation in your programs will be demonstrated to increase the likelihood of desired health outcomes and reduced costs in ways that can be objectively measured.**



CDSME & Hospital Performance Penalties

- **Readmissions – 3%**
 - Will participation in your programs help reduce potential for 30 day readmissions
- **Hospital Acquired Conditions – 1%**
 - Will participation in your programs help reduce admissions of an at risk population (multiple chronic conditions) and therefore risk of hospital acquired conditions
- **Value based Purchasing – 1.5%**
 - Will participation in your programs increase the quality of care in a hospital

Table 1. 2012 Medicare Advantage plan measures

| Measure | Weighting |
|---|-----------|
| Breast cancer screening | 1 |
| Colorectal cancer screening | 1 |
| Cardiovascular care – cholesterol screening | 1 |
| Glaucoma testing | 1 |
| Annual flu vaccine | 1 |
| Pneumonia vaccine | 1 |
| Improving or maintaining physical health | 3 |
| Improving or maintaining mental health | 3 |
| Monitoring physical ability | 1 |
| Access to primary care doctor visits | 1.5 |
| Adult body mass index assessment | 1 |
| Care for older adults – medication review | 1 |
| Care for older adults – functional status assessment | 1 |
| Care for older adults – pain screening | 1 |
| Osteoporosis management in women who had a fracture | 1 |
| Diabetes care – eye exam | 1 |
| Diabetes care – kidney disease monitoring | 1 |
| Diabetes care – blood sugar controlled | 3 |
| Diabetes care – cholesterol controlled | 3 |
| Controlling blood pressure | 3 |
| Rheumatoid arthritis management | 1 |
| Improving bladder control | 1 |
| Reducing the risk of falling | 1 |
| Plan all-cause readmissions | 1 |
| Getting needed care | 1.5 |
| Getting appointments and care quickly | 1.5 |
| Customer service | 1.5 |
| Overall rating of health care quality | 1.5 |
| Overall rating of plan | 1.5 |
| Complaints about the health plan | 1.5 |
| Beneficiary access and performance problems | 1.5 |
| Members choosing to leave the plan | 1.5 |
| Plan makes timely decision about appeals | 1.5 |
| Reviewing appeals decisions | 1.5 |
| Call center – foreign language interpreter and TTY/TDD availability | 1.5 |

Medicare Advantage Plans CDSME & Meeting Star Rating Top 10

Quality delivery of these programs will improve ratings in the areas of:

1. Improving or maintaining physical health
2. Diabetes care
3. Controlling blood pressure
4. Plan all-cause readmissions
5. Getting needed care
6. Getting appointments and care quickly
7. Overall rating of health care quality
8. Overall rating of plan
9. Complaints about the health plan
10. Members choosing to leave the plan



Sustainability

- Grants don't last forever
- What is your value proposition and who are you making it to?
- Is your goal to deliver good programs or to have your good programs be integrated into critical systems of care in communities?
- What combination of volunteer effort, existing staffing and resources and reimbursement are needed to be viable over long term?
- What leverage exists with others to embed referral process, manage scheduling and staff classes?
- How can you “prove” the value of your programs?



For More Information

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