



Scaling and Sustaining Self-Management Programs: Sustainable Financing for the Future

BACKGROUND

Self-management (SM) programs are considered vital tools in enabling individuals with multiple chronic conditions (MCC) to learn how to manage their overall health, symptoms, and risk factors. While the format and methods of these programs may vary, they generally encompass self-management skills and confidence-building to handle health problems. Programs typically include goal setting, decision-making, problem solving, and self-monitoring. Given the prevalence of MCC—which afflicts two-thirds of Medicare beneficiaries—and the direct relationship between the number of chronic conditions and health care costs and health outcomes, more attention is being given to the issue of how to better manage and improve SM among individuals with MCC.

The U.S. Department of Health and Human Services (HHS) and its partners/stakeholders are actively planning how to scale and sustain effective, evidence-based SM programming.

Goal 2 of the MCC Strategic Framework focuses specifically on improving SM: “Maximize the use of proven self-care management and other services by individuals with MCC.”

An MCC Expert Panel meeting was held at HHS on March 27, 2012, to identify and prioritize strategies outlined in the MCC Strategic Framework that merit more intensive activity. This panel of experts identified improving and bringing to scale evidence-based self-care management activities and programs, and enhancing their sustainability (Goal 2, Objective A, Strategies 1 and 2 of the MCC Strategic Framework), as a priority topic to address in order to maximize care of, and improve health and quality of life for, individuals with MCC.

Many SM programs are currently offered in community-based organizations (CBOs) such as the Aging Services Network or through public health departments. The provision of these programs in community settings has had some demonstrable advantages. Among these are the “non-medicalization” of SM services, delivery through organizations that have a deep understanding of the needs of their client base, and low-cost delivery through existing networks. Another advantage, for some programs (e.g., CDSMP), is a reduction in cost, which is achieved by maximizing the use of trained “lay leaders” who themselves

Examples of Evidence-Based Self-Management Programs

- ✓ *Stanford’s Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (Spanish version), and other self-management programs (e.g., for arthritis, diabetes, and HIV/AIDS)*
- ✓ *A Matter of Balance (MOB)*
- ✓ *Care Transitions programs*
- ✓ *EnhanceWellness and EnhanceFitness*
- ✓ *Fit and Strong!*
- ✓ *Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)*
- ✓ *Healthy Moves for Aging Well*
- ✓ *HomeMeds (medication management)*
- ✓ *PEARLS (Program to Encourage Active, Rewarding Lives for Seniors and those with Epilepsy)*

often have MCC, rather than credentialed health care personnel (who are scarce and relatively well-compensated). Therefore, this meeting centered on the question of how to develop necessary relationships and establish partnerships between community and health care systems, and then build capacity through infrastructure and funding that can support the delivery of SM programs.

PURPOSE OF THE MEETING

On July 24th, HHS hosted a 1-day meeting of public- and private-sector stakeholders on the topic of scaling and sustaining SM programs. The purpose was to start a dialogue on the issues that need to be addressed to finance, scale, and sustain SM programs. Panelists provided brief presentations of how their respective organizations have scaled and are currently sustaining SM models, followed by in-depth discussions among participants (e.g., public and private payers, health providers, health policy experts, foundations, aging organizations, and others) on how to expand, finance, and sustain SM programs.

Meeting Objectives

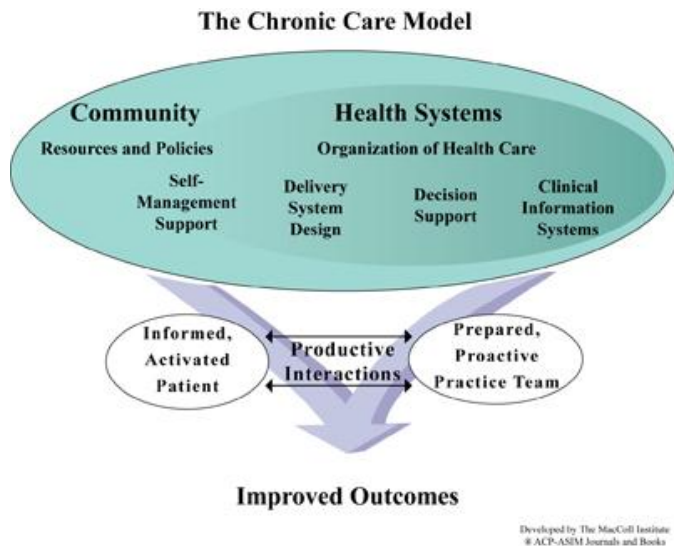
1. Learn how organizations have incorporated evidence-based SM programs into models of care for patients with MCC and how they finance and sustain them
2. Learn about successful models that bridge community-based SM approaches with medical care
3. Identify the key requirements and barriers in scaling and sustaining SM programs
4. Identify potential opportunities to leverage in scaling and sustaining SM implementation

EXPERT PANEL DISCUSSION – KEY THEMES

What Will It Take to Scale and Sustain SM Programs?

1. Putting Self-Management in Context

Overall, there was much support for SM programming and the need to incorporate it to better manage the health of individuals with MCC. A number of participants spoke about the need to think about SM in the context of the larger model of care. Numerous references were made to Ed Wagner’s Chronic Care Model (CCM). The CCM summarizes the basic elements for improving care for individuals with chronic conditions in health systems on multiple levels. SM support and partnerships with community organizations are key elements of the model, but successfully implementing change that improves outcomes and reduces costs requires embracing the entire model.



- *It is hard to view self-management support in isolation. It needs to be considered within a broader context, such as the CCM. We should also be thinking about end-of-life and palliative care.*
- *What Dr. Wagner and his team did years ago with the CCM was to show that it is the sum of the whole that has an impact.*

2. Need for a Clear Definition of What SM Is

Participants commented on the need for a clear definition of SM and what it entails. A definition for SM support was provided by the National Council on Aging (NCOA) and representatives of the Self-Management Alliance (SMA).

- *Self-Management Support (SMS) is the systematic provision of education and supportive interventions by health care or other providers to strengthen patients’ skills and confidence in managing their health problems.*

Additional discussion centered on the need to include caregivers in a definition of who SM programs target—given that in many instances, SM is facilitated by family members or caregivers of individuals with MCC.

3. Identification of Who Benefits From SM

There was general agreement on the need to develop a targeting strategy to identify who benefits from these types of programs, which also takes into consideration the cost of the SM intervention. Additionally, it was noted that some of the issues related to costs and demonstrating a cost savings, may be critically linked to targeting the most appropriate intervention at those who can benefit.

- *It is really important to determine who benefits and how.*

4. Standards for SM

Participants identified the need for standards/guidelines that foster the delivery of more comprehensive SM support activities, and noted that standards should stress that these programs are often best delivered in the community.

- *Payment reform and standards of care are motivating for primary care providers.*

5. Technology That Supports SM

Systematic processes to track and document the delivery of or referral to SM were also identified as a need for supporting sustainability. Currently, electronic medical records (EMRs) are not equipped to document activities related to self-management. Care providers are not yet able to track and document that they are providing or that they even need to provide these types of services. These systems might also support supplying reminders to providers about the need to recommend SM services to patients, much like they are able to support the provision of reminders for other activities based on recommendations from clinical practice guidelines.

6. Training on SM

Other participants commented on the need to incorporate SM concepts into medical and other health care professions’ training and education. Additional discussion centered on establishing learning networks to share experiences, knowledge, and resources.

7. Making the Business Case for SM

Participants discussed the need to establish a value proposition and business case to payers. It was noted that these services have traditionally been available at little or no cost to patients, providers, or payers through grants from the Federal Government.

Discussion centered on requirements for making a business case.

A. Show the Value of SM Programs to Potential Payers

- *SM programs have demonstrated effectiveness, and many are relatively inexpensive to deliver (e.g., CDSMP).*
- *The third leg of the triple aim is about improving patient experience. Health care systems can build loyalty through patient experience.*
- *Payers could see the marketing value of these services because it could give them some competitive advantage in their community.*

Additional value for these services was also noted in relation to health providers who are trying to meet the National Committee for Quality Assurance (NCQA) requirements for becoming a patient-centered medical home (PCMH). A number of the models discussed during the meeting used SM supports delivered through CBOs as part of their strategies for meeting the NCQA's requirements.

B. Develop the Capability and Sophistication of CBOs to Deliver SM

There was discussion among participants about the need for CBOs to demonstrate credibility with health care systems, and to do this it was noted that they need to have good data, know how much their programs cost, and have a good business plan.

- *We need support systems (e.g., collaboratives, consortia, etc.) within the States to help providers and CBOs make their own business cases (such as the State support provided in Vermont and the CDSMP Collaborative that exists in Colorado).*
- *We need to create blueprints for specific approaches (e.g., working with a national payer, a local health maintenance organization [HMO], or an employer group, etc.). Secondly, the blueprints shouldn't be built for a single program. They should support a larger set of activities and programs (e.g., care coordination services, care transitions, etc.).*
- *We need a much more sophisticated segmentation of the payer market, and we have to help organizations understand each of the payer segments' needs. Then we have to identify the anchor client for each one. That is essential to the success of these CBO entities.*

C. Multi-Stakeholder Collaborations and Shared Responsibility

There was much discussion about the infrastructure aspects related to delivering SM and the costs of establishing the infrastructure that assures quality, access, and fidelity. Some suggestions centered on the need for partners to share the costs, not only in the provision of SM services, but for the ongoing infrastructure requirements.

- *Philanthropic organizations, government entities, foundations, and others need to participate in helping to create and maintain the infrastructure.*
- *We need to be thinking more collaboratively... this could be done by pooling resources to create an infrastructure for the things that we think are important to provide.*

Partnership was also emphasized in discussions related to creating referral sources. Provider organizations are important partners for CBOs, due to their ability to support referrals to SM programs.

D. Marketing

Marketing was considered both in terms of presenting the value proposition to payers, but also in terms of persuasively making the case to providers. The topic of patients' wants and needs for managing their conditions was also identified as important for establishing the business case. The increased focus on value-based purchasing offers opportunities to market SM as a way of improving care and reducing costs for individuals with complex conditions.

8. Exploring Alternative Financing Models

Participants talked about current financing models that rely on short-term grant funding and the need to move to more secure funding models.

- *If the goal is to bring self-management to scale and make it an integral component of health, there has to be a shift from grant funding as the primary method for supporting the delivery of these programs to mainstream health care payments.*

There was much discussion among panelists about the need for payment reforms that provide incentives and align the priorities of payers, providers, and patients to promote health and quality care at a lower cost.

- *An important reality is that until we get our payment systems aligned, funding for these types of programs is going to be challenging.*

Several individuals discussed the changing health care environment and the need to consider partnerships with provider organizations. With emerging integrated care models and the role of accountable care organizations (ACOs), provider organizations will be more receptive to non-medical models for maintaining and improving the health of their patients.

- *The focus seems to be on bringing existing payers on board, but the world is changing and with the change to at-risk providers, providers need to be brought to the table as well.*
- *From an ACO's perspective, there is a real appetite for these types of programs because provider organizations bear the financial risk, and SM programs may help providers manage that risk.*

Others also suggested that consideration should be given to incorporating SM programs into benefit packages, much like a gym benefit.

9. Data/Evaluation

There was strong agreement regarding the need for data on the cost-effectiveness of SM.

- *We need data to power our decisions and our reimbursement strategies.*
- *Another important data need is consistency and quality delivery of service, and a sophisticated and streamlined process for data sharing and performance reporting.*

There was strong agreement among the participants that the findings/results of the current Centers for Medicare & Medicaid Services (CMS) evaluation authorized under Section 4202(b) of the Affordable Care Act (ACA) should be shared publicly, as early as possible, to help decision-makers and health care organizations make more informed decisions about their efforts to scale and sustain SM.

10. Uptake and Implementation of Programs

It was noted that even with a financial pathway for sustainability, implementation and uptake are not guaranteed. For example, the Stanford Diabetes Self-Management Program (DSMP) is now a covered benefit for Medicare patients, but the uptake has been very poor. Some problems with uptake were related to the challenges of becoming accredited to provide and bill for the services through CMS, as well as the complexity and processes required to actually be reimbursed.

Participants noted that there have to be multiple incentives to ensure uptake and participation in SM programs. There has to be a shared goal among payers, providers, and CBOs to keep their clients well and to provide the tools and programs to enable effective SM. Experience has shown that when CBOs promote chronic disease self-management programs, the market responds—as evidenced by the more than 140,000 individuals who have participated in Stanford SM programs over the past 18 months. Further scaling will require effective partnerships, information, tools, community engagement, and sharing of knowledge, in addition to financial support.

For more information about the HHS Initiative on MCC visit <http://www.hhs.gov/ash/initiatives/mcc/index.html>.

To view the HHS MCC Strategic Framework visit http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf.

To receive periodic updates about activities related to the HHS Initiative on MCC, subscribe to the MCC Newsletter by sending your request to mcc@hhs.gov.

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