GRANT MAKERS IN HEALTH

Scaling Evidence-Based Programs to Address Chronic Illness

July 20, 2017 1:00 p.m. Eastern

Cosponsored with Grantmakers In Aging

Kathy Cameron, National Council on Aging

Jim Firman, National Council on Aging

Lourdes Rodriguez, The University of Texas at Austin

Scaling and Sustaining Evidence-Based Community Health Programs for Older Adults

James Firman
Lourdes Rodriguez
Kathleen Cameron

July 20, 2017

Today's Agenda

- **Setting the Stage –** Jim Firman
- **NCOA's Center for Healthy Aging Experiences –** Kathleen Cameron
- **NYS Health Foundation Experiences –** Lourdes Rodriguez
- **Lessons Learned from the Aging Mastery Program® –** Jim Firman
- **Discussion**

Setting the Stage: Six Key Challenges in Scaling and Sustaining Evidence-Based Community Health Programs.

Jim Firman, MBA/Ed.D
NCOA President & CEO

About NCOA

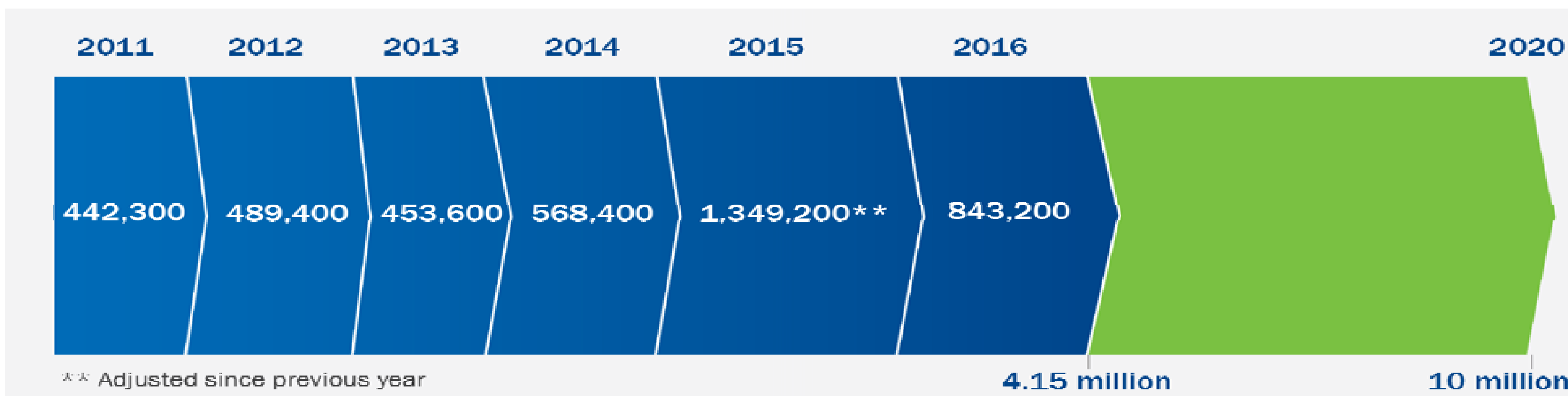
Our Mission:

Improve the lives of millions of older adults, especially those who are struggling

Our Social Impact Goal:

Improve the health and economic security of 10 million older adults by 2020

NCOA's Social Impact



Source: NCOA's 2016 Social Impact Report:
https://www.ncoa.org/resources/ncoa-2016-impact-report

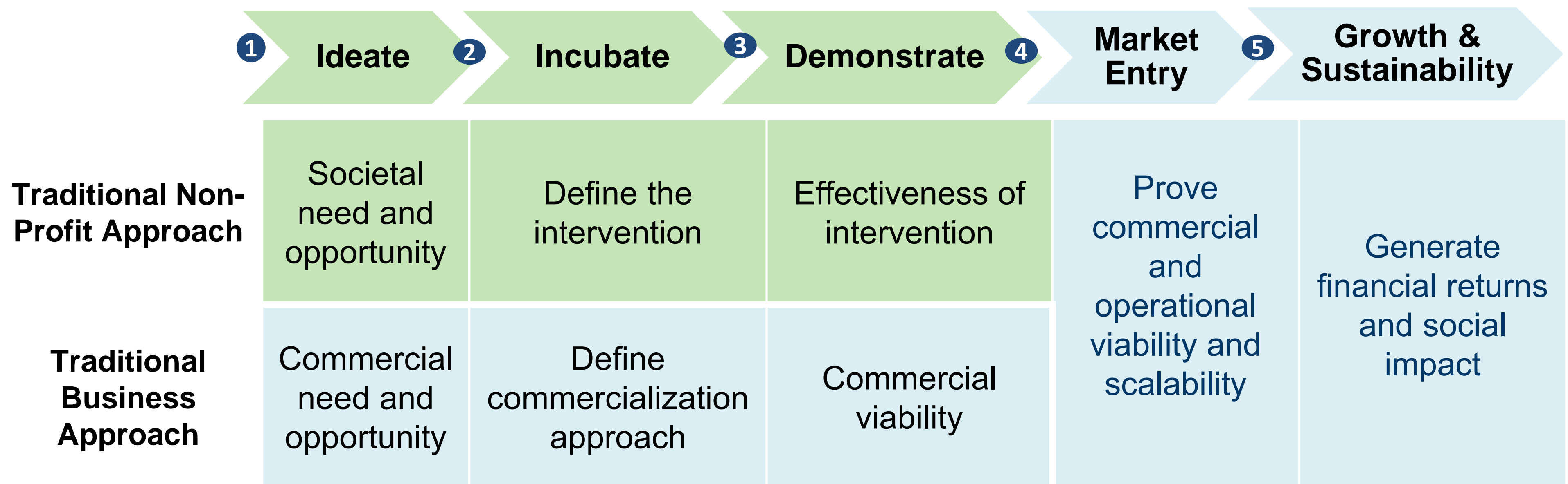
Behavior Change is Key to Preventing and Managing Chronic Conditions and Falls

- Multiple chronic conditions are the primary driver of health challenges and health care costs for older adults.

- Behavior change is important to:
  - Prevent other chronic conditions and worsening of existing conditions
  - Improve health outcomes and quality measures
  - Reduce health care costs
  - Improve quality of life

- Evidence-based self-management and engagement programs are effective for behavior change, patient activation and improving healthy behaviors

Challenge: Many Interventions were Designed for Impact, not Scale



Framework adapted from [United Capital Funding]

Challenge: Success requires adoption by multiple stakeholders

Stakeholders	Actions Required	Roger's Characteristics of Innovations Influencing Adoption				
		Relative Advantage	Compatible	Simple to Use	Testable	Observable Benefits
Participants	**Show up**	?	?	?	?	?
Community Organizations	**Implement / Recruit participants**	?	?	?	?	?
Health Professionals & Organizations	**Refer/recruit participants**	?	?	?	?	?
Payers	**Provide funding**	?	?	?	?	?

Challenge: Recruiting Participants Can be Very Difficult

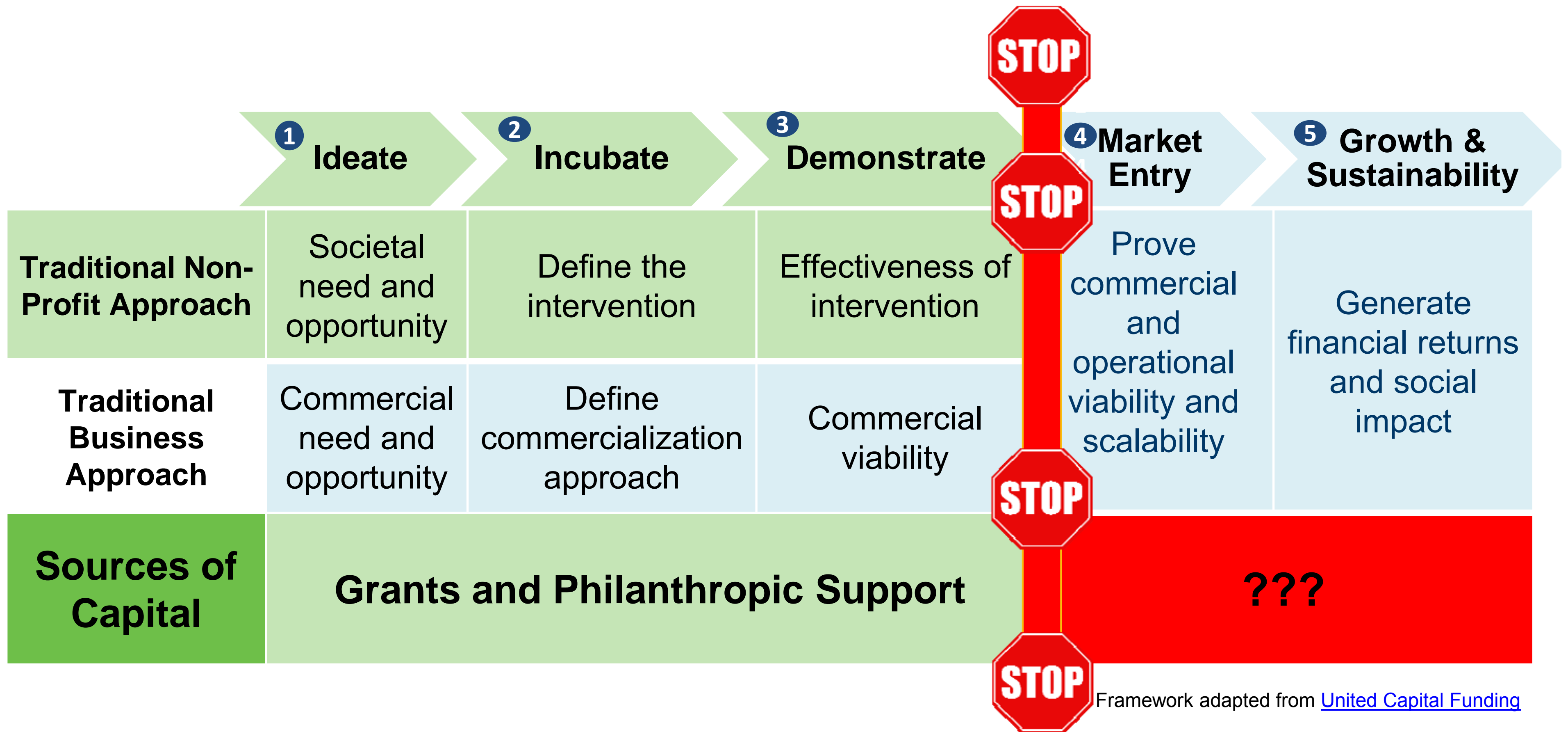
Challenge: It is Very Difficult to Have Population-Level Impact with Just Community-Based Interventions

Challenge: Cost Savings Value Proposition Leads to Targeting

Tackling the High Cost of Chronic Disease: Health Care's Costliest 1%

Caring for the chronically ill consumes 75 percent of the nation's health care resources. A growing number of hospitals and communities are targeting those individuals to reduce costs and improve overall health.

Challenge: Very Difficult for Non-Profits to Get Capital to Scale



Six Key Challenges for Scaling Evidence-based Health Promotion and Disease Prevention Programs for People with Chronic Illnesses

1. Most interventions programs were designed for impact, not scale
2. Success requires adoption by multiple stakeholders
3. Getting people to participate can be surprisingly difficult
4. Can’t scale just through community-based interventions
5. Value proposition of cost-savings is often antithetical to scale
6. Very difficult for non-profits to get capital to scale

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Scaling Evidence-Based Self-Management and Falls Prevention Programs/Lessons Learned

Kathleen Cameron, MPH

NCOA Senior Director

Center for Healthy Aging

NCOA Center for Healthy Aging

Overarching Goal

- Increase the quality and years of healthy life

Two National Resource Centers funded by Administration for Community Living, DHHS

- Chronic Disease Self-Management Education (CDSME) Programs
- Falls Prevention

Partner Areas of Focus

- Behavioral Health
- Oral Health
- Physical Activity
- Flu Prevention

Chronic Disease Self-Management Education Programs (CDSME) Overview

- Developed at Stanford University
- 6 workshop sessions held once a week
- Each session 2.5 hours, highly interactive
- Co-facilitated by 2 trained leaders, one of whom has a chronic condition
- Core content related to behavior change:
  - Symptom management/social role function
  - Exercises to build self-efficacy
  - Goal setting and action plans
  - Problem solving to overcome challenges

Why CDSME is Important to Integrated Health Care

- **Patients** gain the knowledge, skills, and necessary support to take control of their health and make healthy lifestyle changes
- **Community-based organizations** successfully address the impact of chronic diseases on the lives of older adults and to improve their quality of life
- **Health care providers** have activated patients to participate in their medical plan of care to achieve better health
- **The national health care system** will be more effective and efficient – CDSME can help achieve the Triple Aim

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CDSME Program Benefits – Triple Aim Study

Better Health

- Better self-assessed health and quality of life
- Fewer sick days
- More active
- Less depression
- Improved symptom management

Better Care

- Improved communication with physicians
- Improved medication compliance
- Increased health literacy

Lower Costs

- Decreased ER visits and hospitalizations ($364 net savings per person)

Source: https://www.ncoa.org/resources/national-study-of-the-chronic-disease-self-management-program-a-brief-overview/

CDSME Program Participants Demographics

Participant Characteristics	% or n
Average Age	65.3 years
Race/Ethnicity	
White	68.5%
Hispanic	16.3%
African-American	22.9%
Asian-American	3.9%
Hypertension/Diabetes/Arthritis	41%/37%/32%
More than one chronic condition	55.2%
Limiting condition	46.6%
Caregiver	27.5%
# of sessions attended	4.3 sessions

Data collected from March 1, 2010 to June 16, 2017
N = 315,895

Online CDSME – Better Choices, Better Health (BCBH)

- Developed by Stanford University Patient Education Research Center

- Offered by Canary Health, exclusive provider of online CDSME

- Used by more than 14,000 individuals over 10+ years

- Proven effective to help people living with chronic conditions

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BCBH Significantly Impacts Diabetes Outcomes

- 1,299 person study (1,000 online) conducted with Anthem
- Two peer-reviewed articles published reporting on results at 6 and 12 months
- Results
  - Decreased AIC by 0.93% at 6 months and 1.27% at 12 months (for those with AIC >9% at study start)
  - Decreased frequent hypoglycemic symptoms
  - Improved depressive symptoms
  - Improved medication adherence
  - Increased exercise 43 minutes per week
  - Savings of **$816** per person in hospital and ED costs in the first year following the intervention

Sources: Lorig KL, et al. Benefits of Diabetes Self-Management for health plan members: A 6-month translation study. J Med Internet Res 2016; 18)6):e164.

Lorig KL, et al. A Diabetes Self-Management Program: 12 month outcome sustainability for a non-reinforced pragmatic trial. J Med Internet Research 2016; 18(12):e322.

Benefits of Falls Prevention Programs

Falls Prevention Program	Effectiveness	Net Benefits and ROI
Tai Ji Quan: Moving for Better Balance	Fall rate among participants was reduced by **55%**	Net benefit = $530 ROI = 509%
Stepping On	Fall rate among participants was reduced by **30%**	Net benefit = $134 ROI = 64%
Otago Exercise Program (adults 80+)	Reduction of **35%** in adults over age 80	Net benefit = $429 ROI = 127%
A Matter of Balance	Significant increase in falls efficacy, falls management, and falls control	Total cost savings per Medicare beneficiary = $938

Sources: Report to Congress in November 2013: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act.
Stevens JA, Sogolow, ED. Preventing Falls: What Works A CDC Compendium of Effective Community-based Interventions from Around the World; Atlanta, GA: CDC, 2009.
Carande-Kulis , VG, Stevens, JA, Beattie, BL & Arias, LA cost-benefit analysis of three older adult fall prevention interventions, Journal of Safety Research, 2015

ACL Fall Prevention Grantee Program Reach

Since September 2014, 40,000+ older adults and adults with disabilities have enrolled in ACL/AoA grantee-supported falls prevention programs

Participant Profile	% Reporting Relevant Data
Living Alone	48%
Average Age	76 years
At least one fall in last three months	30%
One or more chronic conditions	89%
Multiple chronic conditions	56%
Disability	39%
Feared falling “somewhat” or “a lot”	50%

Reported Program Outcomes

Since September 2014, program participants have reported:

- 89% **reduced** their fear of falling
- 63% **made changes** in home to reduce their risk of falling/made their home safer
- 90% **exercised** at home
- 31% had **medications reviewed**
- 32% had **vision checked**
- 99% **would recommend** the program to a friend or relative

Lessons Learned

- Creative outreach is a must
  - Just because a program is offered, doesn't meant they will come
- More EBPs are needed to need diverse and cultural needs of growing older adult population
- CBOs must clearly articulate value proposition of programs
- Partnerships and health care integration are key to sustainability, examples:
  - Medicare Advantage
  - Medicaid – dual eligible plans
  - Hospital systems, trauma centers
  - Value based, shared risk – ACOs, PCMH
- Business acumen skills are lacking for negotiating and developing contracts
  - Learning Collaboratives
  - n4a Aging and Disability Business Institute
- Health care partners want centralized evidence-based program network hubs

Tale of Two Programs:

Scaling up the National Diabetes Prevention Program

Building the Evidence for the Aging Mastery Program

Lourdes Rodriguez, DrPH

Director, Center for Place-based Initiatives

Dell Medical School, University of Texas at Austin

Formerly, Program Officer, New York State Health Foundation

Tale of Two Programs: Scaling up the NDPP

Program Area: Diabetes Prevention and Management

What we set out to do:

- Raise Awareness
  - Targeted communication (Faith Fights Diabetes, Half-the Care)
  - Bridges to Excellence & NCQA
- Scale Evidence-Based Programs
  - Seed program grants (Faith-based Defy Diabetes, Y-DPP)
  - Strategic plan by Bridgespan

Tale of Two Programs: Scaling up the NDPP

What we ended up doing

- Changing our approach to grantmaking
  - Shift to 3D grantmaking (i.e. funding units of program delivery not enough)
    - Work regionally
    - Build demand
    - Establish referral pipelines
    - Identify pathways for sustainability
      - Reimbursement
      - Redefined Scope of Work
      - Incorporate into organizational structure

Tale of Two Programs: Scaling up the NDPP

- **Lessons for funders**
  - Fund the program in (and its) context
  - Be an ally, use your reputational capital
  - Go for the long run
- **Lessons for researchers and practitioners**
  - Build the evidence with the field in mind
  - Think sustainability: Reimbursement? New protocol? Value?

Tale of Two Programs: Building the Evidence for the Aging Mastery Program

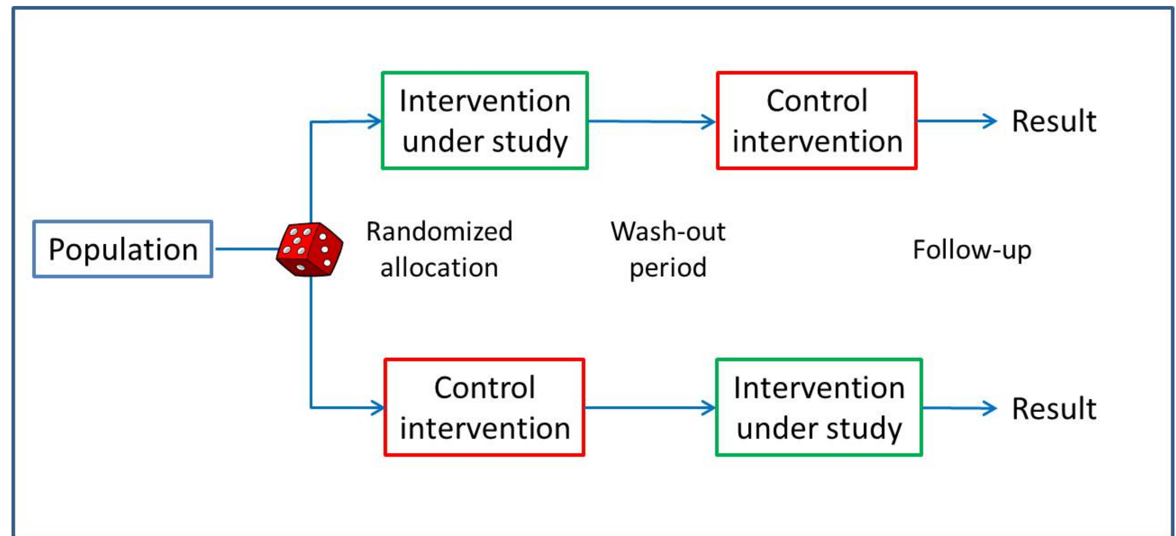
- **New approach for Evidence-Based Program funding**
  - Betting on the AMP promise: fun, engaging, in vivo learning
  - Capitalizing on context: joining other NYC-based funders on initial pilots
  - Using our reputational capital: inviting others to come along as partners

- **New approach for Evidence-Building and Sustainability**
  - Layering on with existing investments in our Healthy Neighborhoods Initiative
  - Not only funding units of program delivered, but also quasi-experiment to develop evidence
  - Clear pathway for sustainability: Title III-D of Older Americans Act.

Tale of Two Programs: Building the Evidence for the Aging Mastery Program

Measuring Impact:
Quasi–Experimental
Design Study

Phil McCallion, Lisa
Ferretti
SUNY Albany



Intervention and Control Groups Matched and Randomized at site level:

NYC: 2 mostly White sites + 2 mostly African-American/Black sites

NYS: 4 mostly White sites + 2 mostly African-American/Black sites

Tale of Two Programs: Building the Evidence for the Aging Mastery Program

- Intervention vs Control group, T1 to T2 and T3:
  - Significant differences (p=.04) in days walking, minutes walking, and care planning actions (all were p=.04) as compared to the control group; sustained approximately three months later.

Note: *Second quasi-experiment underway in Los Angeles exploring impact of AMP on mental health, quality of life and patient activation.*

Tale of Two Programs Building the Evidence for the Aging Mastery Program

- Will publish results of quasi-experimental study in peer-review journal
- Publication will qualify AMP for funding under Title III-D (Health Promotion) of Older Americans Act (Funding levels is $19.6M nationally and $1.28M in New York State)
- AMP for Caregivers **qualifies now** for funding under Title III-E of the OAA. (Funding levels is $149 M nationally and $8.9M in New York State)
- Rapid statewide expansion underway: 9 Area Agencies on Aging throughout NYS recently purchased licenses and will be offering AMP in Q3 2017
- NCOA reports strong interest in AMP from major health plans

Scaling and Sustaining the Aging Mastery Program®: Lessons Learned

Jim Firman, MBA/Ed.D

NCOA President & CEO

Aging Mastery Program® Addresses Key Challenges Associated with Longer Lifespans

Chronic conditions Behavior change difficult	Insufficient savings Not optimizing assets	Inadequate preparation for inevitable transitions	Lack of institutions to help people navigate longer lives

Aging Mastery®: Navigating and Optimizing Longer Lives

- Comprehensive and fun community engagement program
- Education, goal-setting, daily practices, and peer support.
- Produces meaningful, measureable and enduring changes in the areas of health, finances, life enrichment and advanced planning
- Gateway program that encourages continued participation in other community offerings

The AMP class offering was actually profound for me. I am 70 years old and if I'm 'lucky' I may have 10 more 'good' years—if I'm lucky. The classes offered ways to make the years happier, healthier, and more worry free. - Recent AMP Participant

Aging Mastery Program® (Today)

Core Curriculum

Specialty Curricula (Caregiver, Faith-based, and Health-focused)

Elective Classes & Alumni Clubs

Core Curriculum

- Navigating Longer Lives
- Exercise and You
- Sleep
- Healthy Eating and Hydration
- Medication Management
- Financial Fitness
- Advance Planning
- Healthy Relationships
- Falls Prevention
- Community Engagement

Elective Classes (9)

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AMP is Designed to Address Key Wants and Motivators as well as Needs of Older Adults

Primary Wants:

- Have more fun
- Be healthy
- Be financially secure
- Have meaning and purpose

Primary Needs:

- Education, guidance and help to navigate longer lives!

Primary Motivators:

AMP By the Numbers: 2013 – July 2017

Descriptor	Results
# of AMP Participants	6,979
# of AMP Sites	210
Graduation Rate	80%
Average Age (Range)	72 (31-101)
Gender	80% Female, 20% Male
Provided long-term care in the past year	29% Yes, 71% No

*National roll-up data as of July, 2017

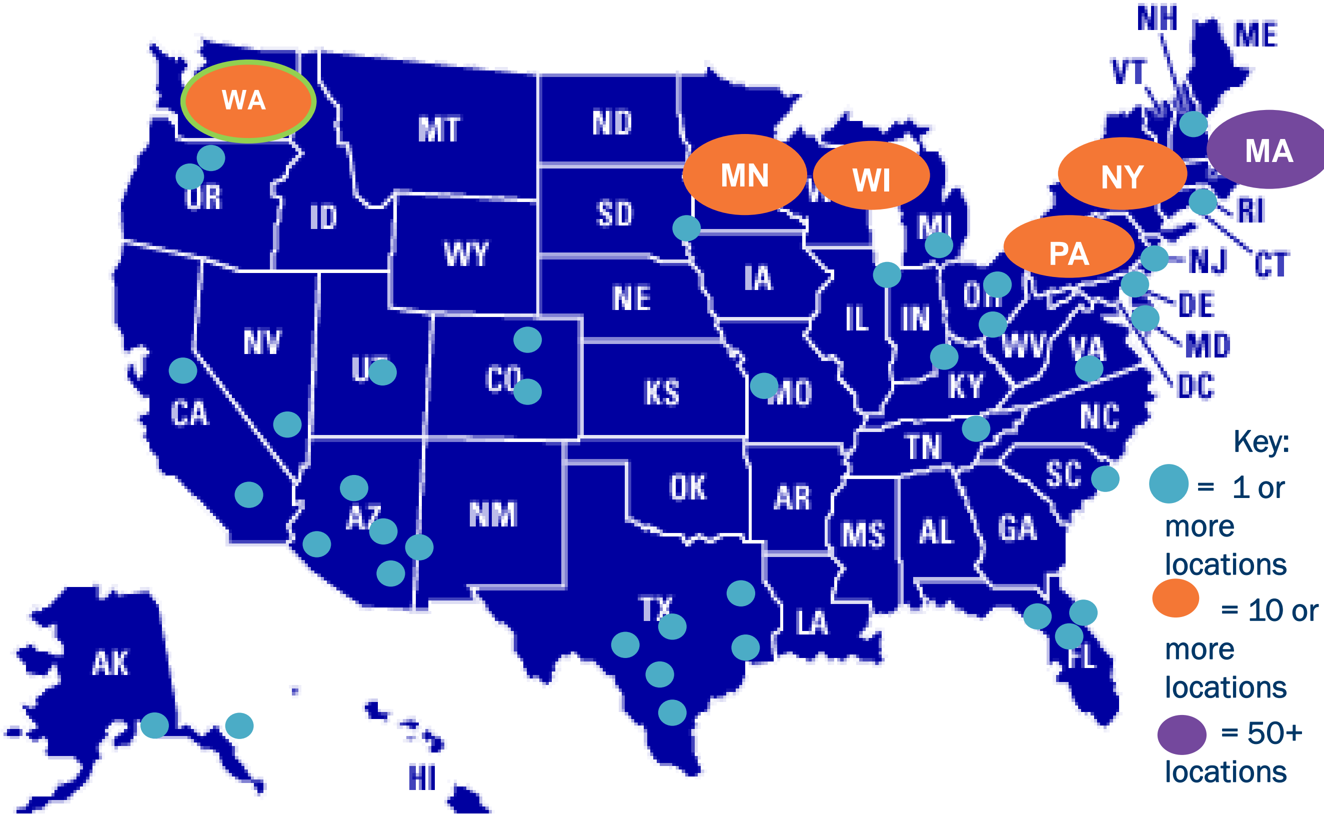
Impact: Ongoing Participant Satisfaction & Engagement (n=2,884)

	A lot of fun	Somewhat fun	Not much fun	Not fun at all
How much fun was AMP?	75%	23%	2%	0%
	Excellent	Good	Fair	Poor
How would you rate the quality of the program?	69%	29%	2%	0%
	Yes, definitely	Yes, I think so	No, not really	No, definitely not
Did you get the kind of education that you wanted?	54%	43%	3%	0%
Are you interested in taking additional AMP courses?	48%	39%	12%	1%
Would you recommend AMP to a friend?	77%	21%	2%	0%

Impact: Ongoing Participant Satisfaction & Engagement (n=2,884)

	Yes, it helped a great deal	Yes, it helped	No, it didn't really help	No, it seems to make things worse
Has AMP helped you deal more effectively with your health?	38%	55%	7%	0%
Has AMP helped you deal more effectively with your personal finances?	25%	52%	23%	0%
Has AMP improved the quality of your life in other ways?	40%	55%	5%	0%
	Yes, definitely	Yes, I think so	No, I don't think so	No, definitely not
People who know me would say this program has made a positive change in me.	24%	54%	22%	1%

Status: AMP is in 210+ communities (as of July 2017)



AMP Philanthropy Network: Fueling Innovation and Program Growth

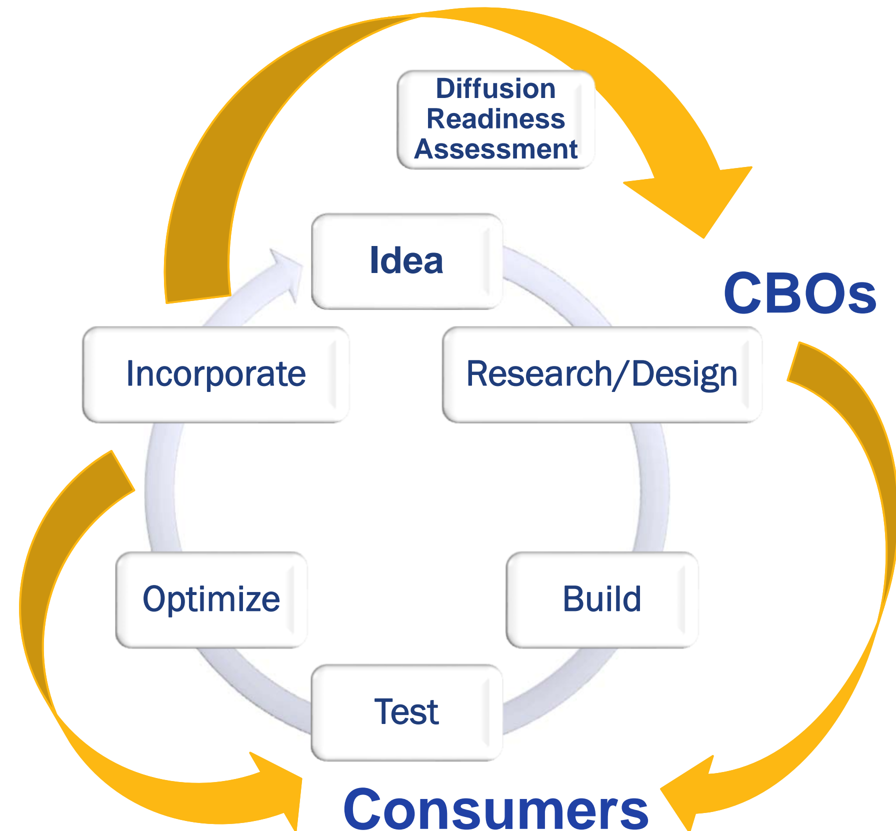
Place-based, Private Foundations	National Foundations, State Agencies, and Individuals
▪ Battle Creek Community Foundation (MI) ▪ Cleveland Foundation (OH) ▪ Florence V. Burden Foundation (NY) ▪ Margaret A. Cargill Foundation (WA, WI, MN) ▪ May and Stanley Smith Charitable Trust ▪ Michigan Health Endowment Fund (MI) ▪ New York Community Trust (NYC) • New York State Health Foundation • Plough Foundation (TN) ▪ Silverman Charitable Group (NYC) ▪ Tufts Health Plan Foundation (MA ,NH) ▪ WellMed Charitable Foundation (TX)	**National Foundations** ▪ Foundation for Financial Planning ▪ MetLife Foundation ▪ Patterson Foundation ▪ Verizon Foundation ▪ Wells Fargo Housing Foundation **State Government Agencies** ▪ Mass. Dept. on Aging ▪ NYS Office on Aging ▪ Pennsylvania Dept. on Aging **Individuals** ▪ Jim Firman ▪ Ken Dychtwald

Multi-Community, Rapid-Cycle Innovation Drives Program Development

Innovation Priorities

- Faith-based Curricula
- Ongoing Engagement
- New CBO Venues
- Health Partnerships
- In-home Program
- Sustainability Strategies
- Digital Platform

CBOs =
Senior centers, retirement communities, religious organizations, hospitals, adult education programs



Aging Mastery Program® for Caregivers

An AMP wraparound program that educates caregivers about the impacts of caregiving and also provides them with the tools to stay healthier in the caregiving journey.

Caregiver Perspectives: Assessing our Needs

10-Class AMP Core Curriculum

Caregiver Playbook: Planning, Connecting, and Doing

AMP In-Home Starter Kit

Distills the core themes of the Aging Mastery Program® - playbook, activity cards, games, notepad for marking progress, DVDs and materials designed to reinforce positive action steps.

- **Education** - the science and art of aging well
- **Inspiration** - bite-sized actions that help create positive change
- **Mastery** - guided playbook and goal-setting activities for optimizing health, finances, and well-being
- **Purpose** - improved connection to others and to communities

Promising Potential Sources of Sustainable Funding for AMP

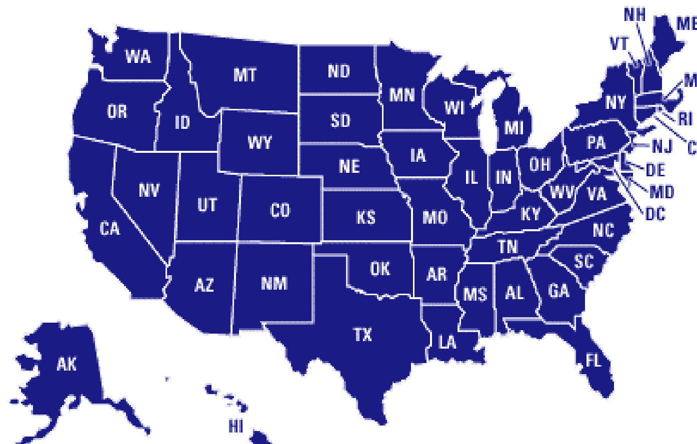
- **Title III-D of Older Americans Act (Health Promotion)** –
  - **AMP** is expected to qualify by August/September 2017.
  - ($19.7M in 2017)
- **Title III-E of the OAA – AMP for Caregivers** qualifies now
  - ($149M in 2017)
- **Consumer Pay** – Moderately successful in some communities
- **Hospitals** –Community benefits funds or Membership models
- **Philanthropy** – Seed funding; pilots, scholarships for low-income seniors.

Next Step: Health plans (Medicare Advantage, Medicare Supplements and Dual-Eligible Plans)

- Significant interest from several large health insurers
- Opportunities: Medicare Advantage, Medicaid, Employer-sponsored retirement plans, Medigap Plan F (Innovative Benefits Plan)
- Keys to success:
  - Value Proposition: 1) Revenue enhancement, 2) Cost savings
  - Price Points - Need lower cost options
  - Scalable Product Offerings:
    - Offered throughout the plans service area
    - More than community classes
    - In-home and digital programs

Status and Timetable for Scaling AMP

Alpha (2013-14)	Beta (2015-17)	Scale (2018–2021)
▪ 5 site pilot ▪ 40 site expansion ▪ 1,200 participants	▪ 160+ sites (2016) ▪ 250+ sites (2017) ▪ 9,000+ participants	▪ 1500+ sites ▪ Network effect ▪ 500,000+ participants



Aging Mastery® 2.0 – Coming Soon!

Community-based classes and activities

In-home Program

Digital and TV Content and Apps

Attributes:

- Fun
- Engaging
- Educational
- Life-Changing
- Produces measureable results

Dimensions:

- Health
- Finances
- Quality of Live
- Advanced Planning

Next Stage Partnership and Innovation Opportunities

AMP Philanthropy Network Priorities:

- Expand AMP to new communities, leveraging local investments to tap into Older Americans Act (III-D and III-E) and consumer pay potential
- Multi-community rapid-cycle innovation for three-venue product development and deployment
- Partnerships with health plans – NCOA currently has interest from several major health plans

Lessons Learned / Strategies for Scaling and Sustaining Community-based Programs

1. Simultaneously design for impact and scale. (Don’t evaluate for impact prematurely)
2. Offer consumers what they want, not just what they need.
3. Develop multi-venue interventions (community-based, in-home and digital)
4. Look for revenue enhancement value propositions
5. Create multi-community, rapid-cycle innovation processes to harness place-based funding
6. To get capital for going to scale, seek/encourage engagement of strategic partners/investors
7. Consider sustainable public health strategies, not just individual intervention strategies

Discussion

Scaling and Sustaining Evidence-Based Community Health Programs for Older Adults

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- More webinars on this topic?
- New topics you want to tackle or learn more about?
- Innovative work that you want to share?
- A question you want to pose to your colleagues?

Contact us at aging@gih.org