Moving From Clinic to Community

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Partners in Care Foundation

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Bringing medicine, patients and community-based services together.

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Building Infrastructures for Health

- Physician offices need to connect to community resources to build health
- Creation of widespread community-based programs to address lifestyle change are needed – especially to manage risks like diabetes progressing, heart disease and falls
- Pro-active care is emerging – the whole person
- Evidence-based programs are essential

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Health Reform: Moving From Volume to Value

- Infrastructures and reimbursement are transforming
- The roles of hospitals, physicians and payers are blurring and social skills are more recognized
- Major consolidation – unpredictable future
- Growing role for community and agencies
- New broader partnerships are essential within medicine, within social services and between

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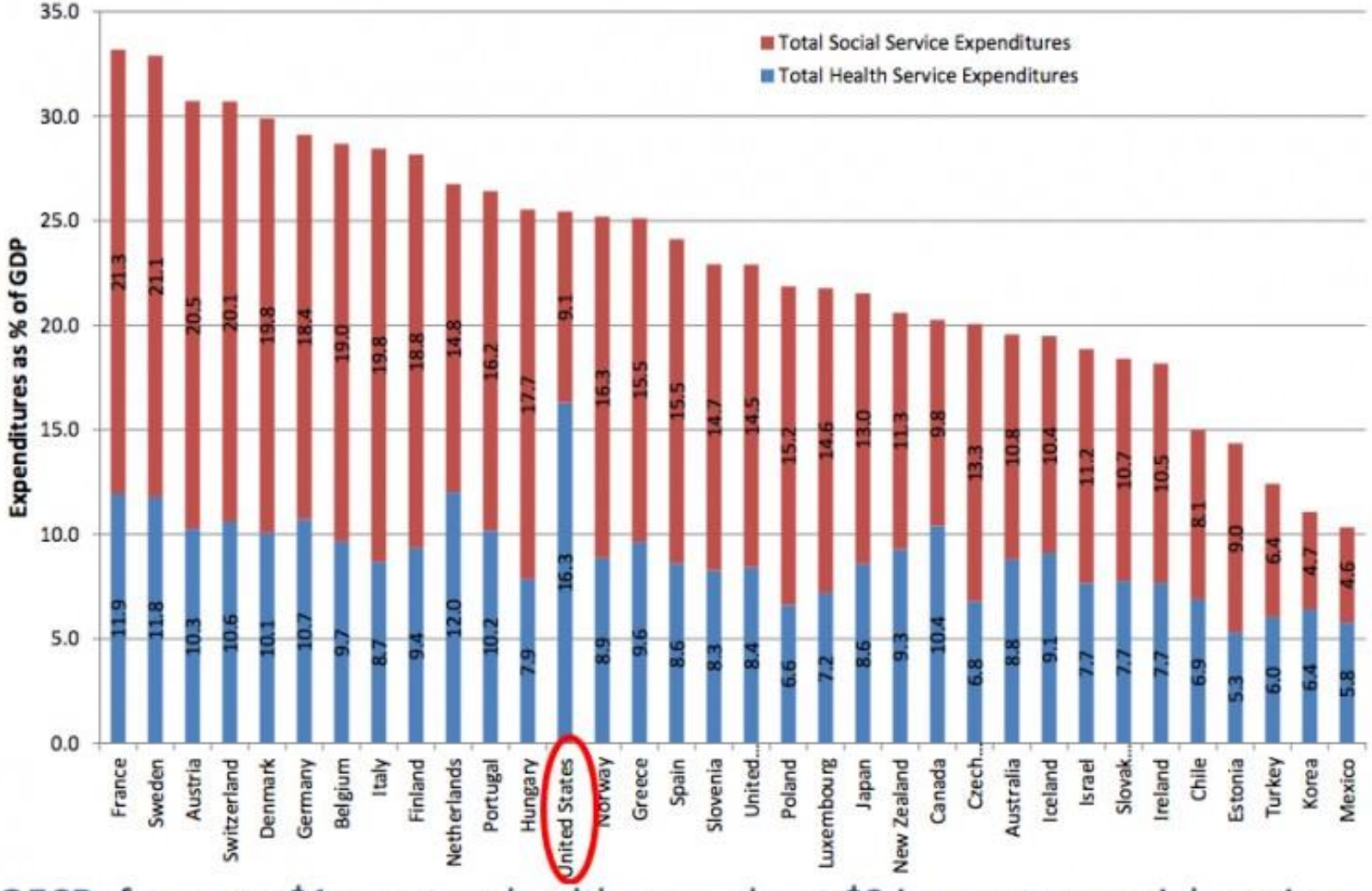
Total health care investment in US is *less*



In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services

Social Determinants of Health:

Time to do something about them – community partnerships must seize the day!

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Massive Change Calls for Strategic Focus & Collaboration

- Times of Transformation – disruptive levels of change
- Even *positive* change is disruptive at this level of intensity and scale
- Moving everyone's cheese at once!
- But the positive impact is so delightful
- Worth the pressures and extra work!

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Transforming Health Care

- **Goal is individual and organizational investment in self empowerment in avoiding/managing chronic health conditions**
- **Mainstreaming access to health promotion tools**
- **Building a platform to disseminate programs that transform health and quality of life**

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More than new infrastructure

- Need "pathways to health"
  - methods to identify those who will benefit
  - brief methods to open the door to change
  - skills and tools to enhance class completion
  - alternatives available for continuing involvement in healthy lifestyle

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Community-wide Partnerships = Better Health, Lower Costs

- Address social determinants of health
  - Personal choices in everyday life
  - Isolation, Family structure/issues, caregiver needs
  - Environment – home safety, neighborhood
  - Economics – affordability, access

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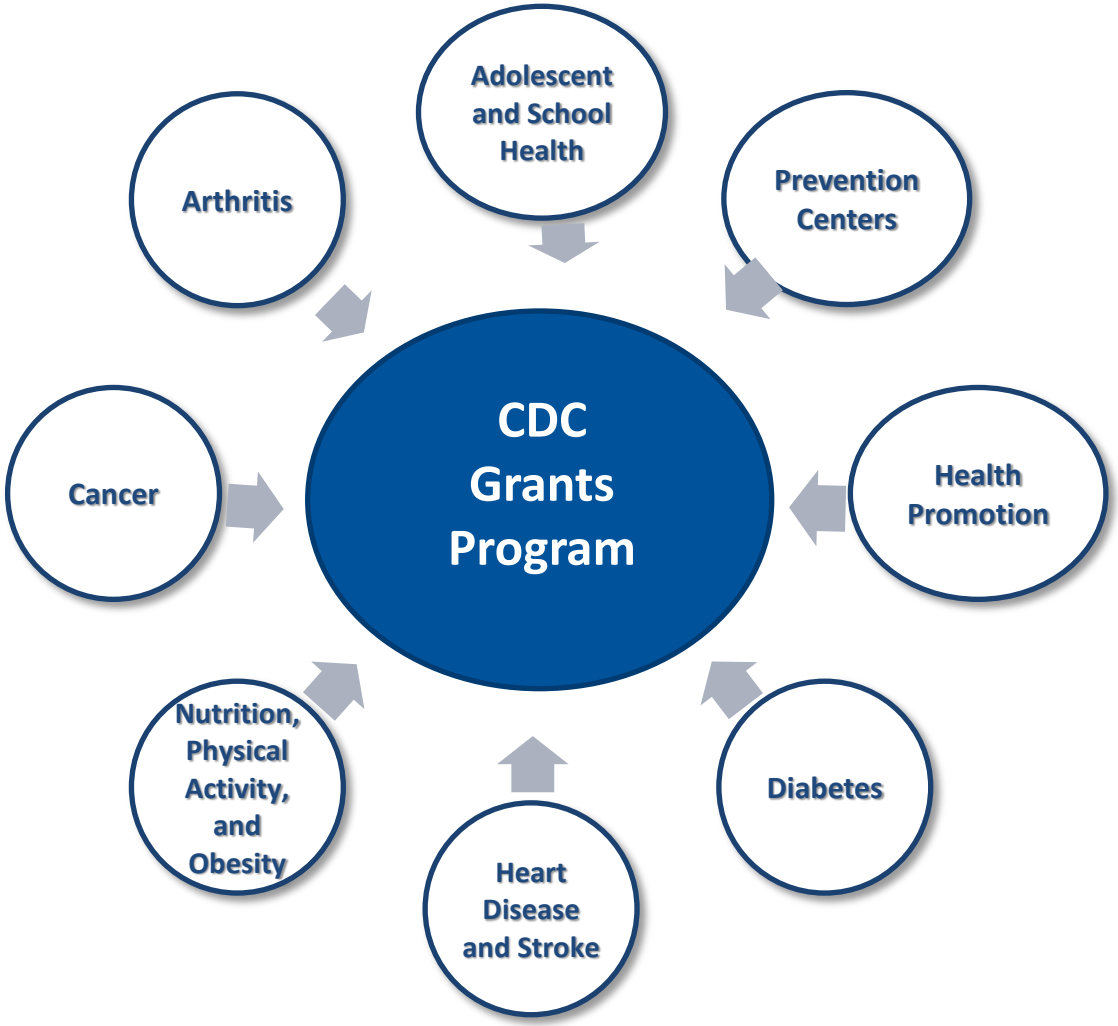
President's Proposal



Consolidated Chronic Disease Program

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Cross-sector Collaboration & Adoption

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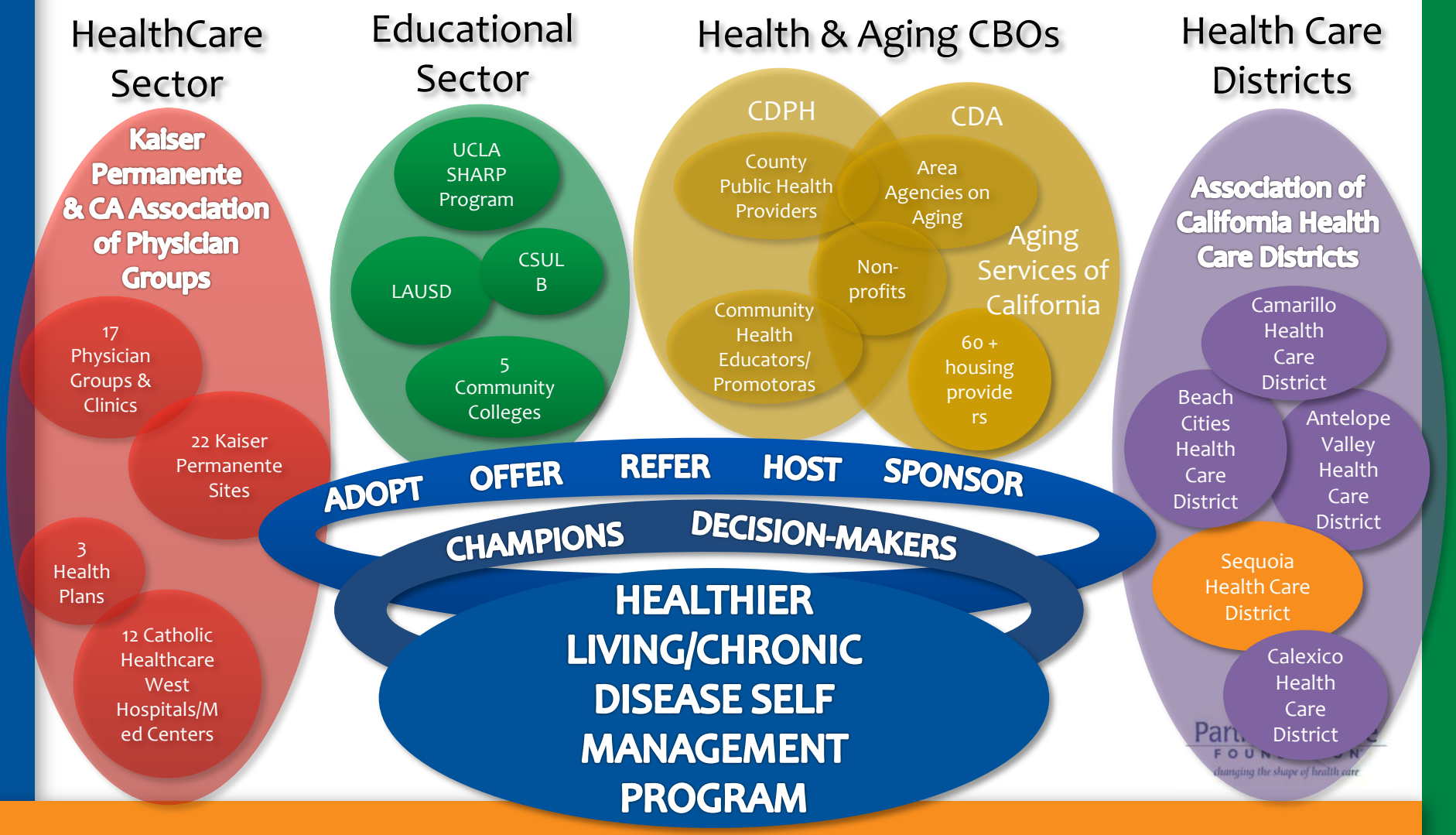
Dissemination Strategy



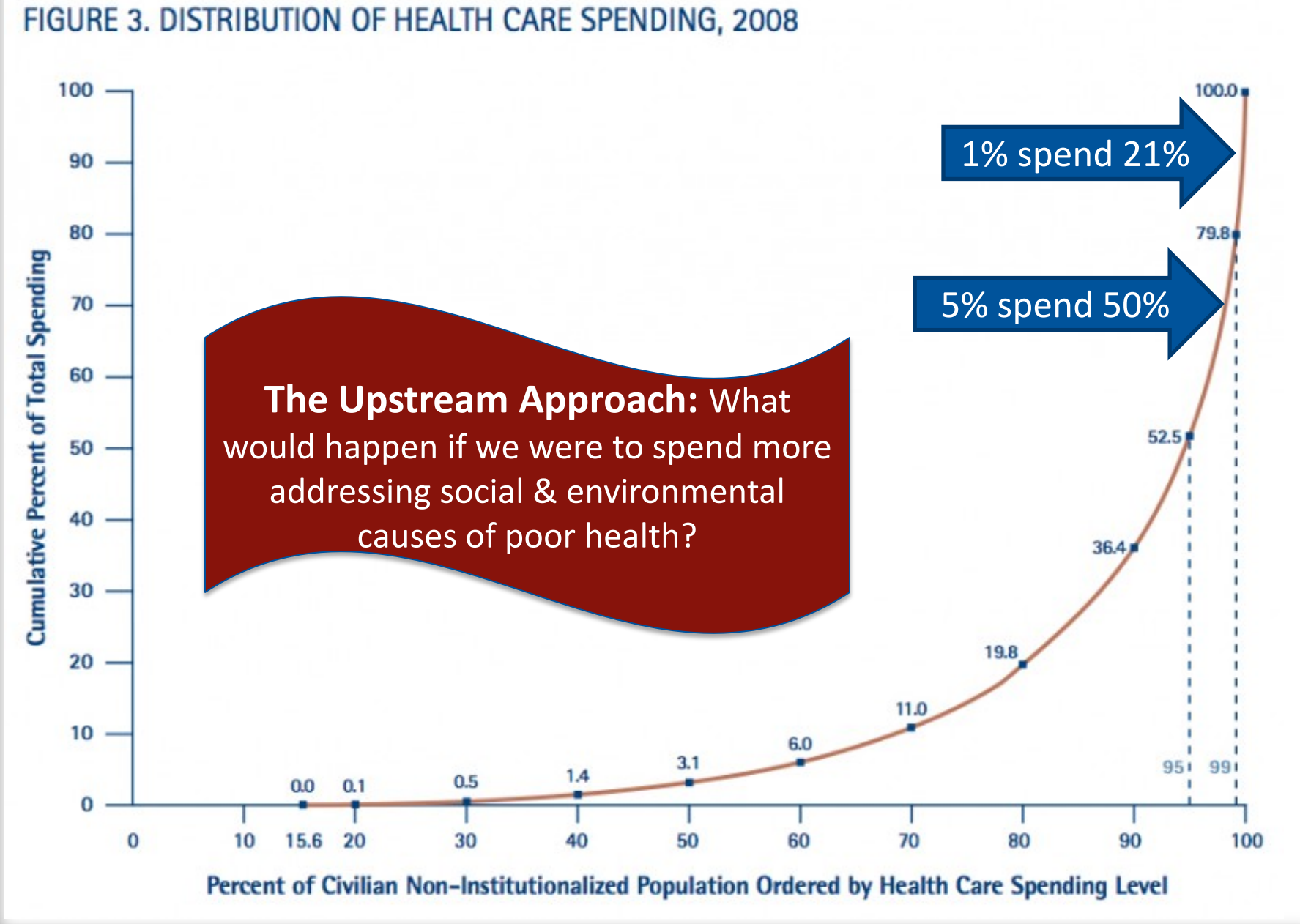
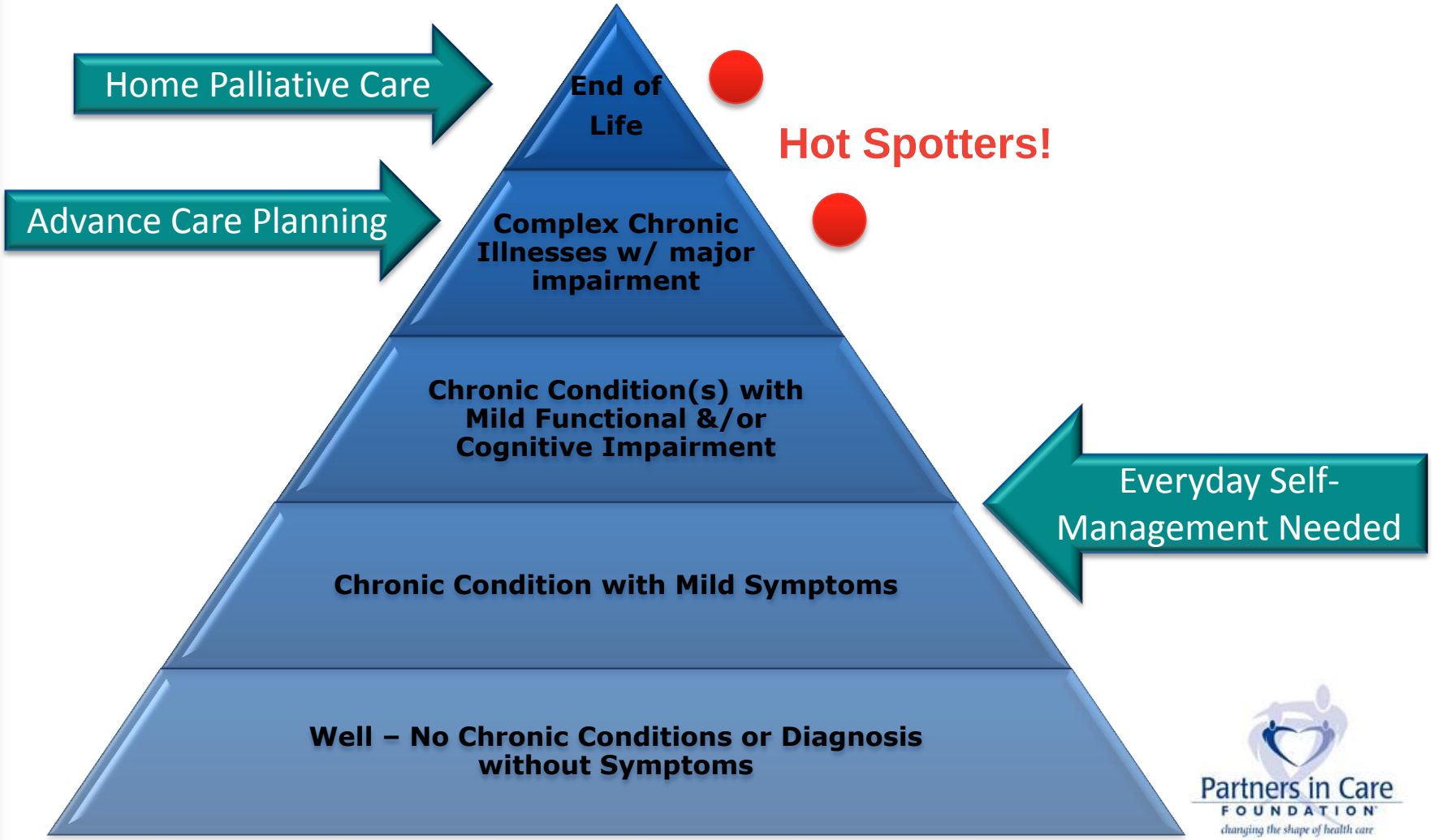


FIGURE 3. DISTRIBUTION OF HEALTH CARE SPENDING, 2008
Cumulative Percent of Total Spending
100
90
80
70
60
50
40
30
20
10
0
0.0
0.1
0.5
1.4
3.1
6.0
11.0
19.8
36.4
52.5
79.8
100.0
95
99
0
10
15.6
20
30
40
50
60
70
80
90
100
Percent of Civilian Non-Institutionalized Population Ordered by Health Care Spending Level
1% spend 21%
5% spend 50%
The Upstream Approach: What would happen if we were to spend more addressing social & environmental causes of poor health?

Targeted Patient Population Management



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Framework for Implementing Evidence-Based Health Promotion Programs

*Materials adapted from National Council on Aging (2012)

Background

Scope of the Problem

- 1.7 million Americans die of a chronic disease each year
- Chronic diseases affect the quality of life for 90 million Americans
- 87% of persons aged 65 and over have at least 1 chronic condition; 67% have 2 or more
- 99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition

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Projected “Boomers” Health in 2030:

- More than 6 of every 10 will be managing more than one chronic condition
- 14 million (1 out of 4) will be living with diabetes
- >21 million (1 out of 3) will be considered obese
  - Their health care will cost Medicare 34% more than others
- 26 million (1 out of 2) will have arthritis
  - Knee replacement surgeries will increase 800% by 2030

From:“ When I’m 64: How Boomers Will Change Health Care ”, American Hospital Association, May 2007

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Background

National Centers for Disease Control & Prevention (CDC)

- CDC invested in research aimed at identifying best practices in treating chronic health conditions
- Best practices grew to become “evidence-based” models of care
- Today, numerous evidence-based interventions are being implemented around the country with promising outcomes

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What is Evidence-Based Programming?

- Tested models or interventions that directly address the health risks of the target population
- Advantages:
  - Provides tangible scientific evidence that program works
  - Increases likelihood of successful outcomes
  - Increases effective use of resources

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What is Self-Management?

The actions that individuals living with chronic conditions must do in order to live a healthy life.

Physical Activity

Medications

Planning

Manage Fatigue

Working with Health Professionals

Problem-Solving

Family Support

Managing Pain

Communication

Understanding Emotions

Healthy Eating

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CDSMP: The "Gold Standard"

- Improves health and quality of life
  - Benefits people at all SES and education levels
- Reduces health care costs
- Improvements and cost savings are sustained over time
- Findings documented over 20 years of research in a variety of settings
- Offered in many countries and in over 20 languages

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Stanford Healthier Living (CDSMP): Participant Health Outcomes

Randomized, controlled trial of 1,000 participants

Increase in

Exercise

Energy

Psychological well-being

Decrease in

Pain and fatigue

Depression

Shortness of Breath

Limitations on Social and role activities

Overall Improved health status & quality of life

Greater self-efficacy and empowerment

Enhanced partnerships with physicians

Sources: Lorig, KR et al. (1999). *Med Care*, 37:5-14; Lorig, KR et al. (2001). *Eff Clin Pract,* 4: 256-52; Lorig, KR et al. (2001). *Med Care,* 39: 1217-23.

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CDSMP Healthcare Utilization Effects

- Results showed more appropriate utilization of health care resources through **decreased**:
  - Outpatient visits
  - Emergency room visits
  - Hospitalizations
  - Days in hospital

Ultimate Result: **Reduction in health care expenditures**

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Key Requirements

- Targeted chronic disease programs
  - Heart Disease, Cancer, Diabetes, Stroke, Arthritis
- Associated risk factors
  - Obesity, Physical Activity, Nutrition, Tobacco
- Support development or enhancement of state chronic disease:
  - Leadership, Coordination, Expertise, Directions
- Foster collaboration, increase efficiency, expand the use of evidence-based policy, system, and environmental change strategies to increase the impact of categorical chronic disease programs
- Risk factor programs with direct impact on reducing the burden of top five chronic diseases

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Some Evidence-Based Programs

SELF-MANAGEMENT
- Chronic Disease Self-Management
- Tomando Control de su Salud
- Chronic Pain Self-Management
- Diabetes Self-Management Program

PHYSICAL ACTIVITY
- Enhanced Fitness & Enhanced Wellness
- Healthy Moves
- Fit & Strong
- Arthritis Foundation Exercise Program
- Arthritis Foundation Walk With Ease Program
- Active Start
- Active Living Every Day

MEDICATION MANAGEMENT
- HomeMeds

FALL RISK REDUCTION
- Stepping On
- Tai Chi Moving for Better Balance
- Matter of Balance

DEPRESSION MANAGEMENT
- Healthy Ideas
- PEARLS

CAREGIVER PROGRAMS
- Powerful Tools for Caregivers
- Savvy Caregiver

NUTRITION
- Healthy Eating

DRUG AND ALCOHOL
- Prevention & Management of Alcohol Problems

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Community-Wide Collaboratives for Health

- Your community is on the cutting edge
- Your vision is the vision of the future
- Los Angeles County has similar dreams – County Public Health, universities, community organizations – all are working together to craft an initiative for Aging Well (starting at 50) – community wide and multi-sector
- And measured, so will produce evidence-based approaches that are proven and enhance learning

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BLUE ZONES PROJECT™
by HEALTHWAYS

BCHD
A Public Agency
Beach Cities Health District

Mission & Vision

"A healthy beach community"

Blue Zones Project™ Goals

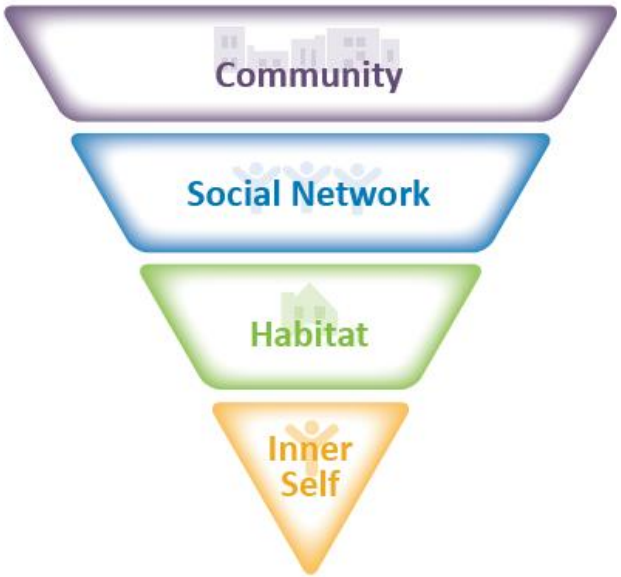
- Increase positive health behaviors and measurably improve the health and well-being of beach cities residents
- Increase knowledge and awareness
- Engage residents and create action
- Create positive, memorable encounters
- Support the beach cities in achieving Blue Zones Project Community Certification™.

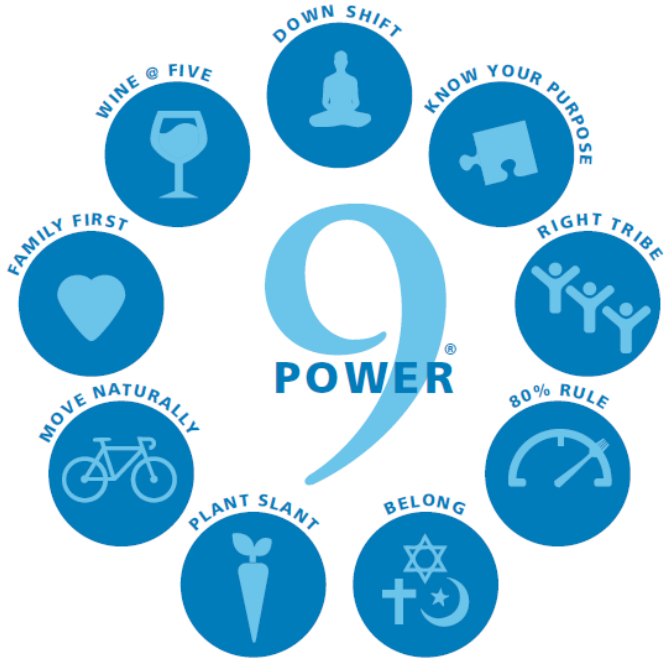
Blue Zones Strategies

1. **Engage Communities**

2. **Change where people live, work and play**

3. **Make healthy choices easy**





Blue Zones Project™ Community Certificaton

CITIZENS	20% sign up and complete one pledge action
EMPLOYERS	50% of top 20 employers designated Blue Zones Worksites™
RESTAURANTS	25% of locally owned restaurants designated Blue Zones Restaurants™
GROCERY	25% of grocery stores designated Blue Zones Grocery Stores™
SCHOOLS	25% of schools designated Blue Zones Schools™
POLICY	Adopt recommended policies and complete recommended projects

Blue Zones Pilot

Why the Beach Cities?

I EAT WISELY at Blue Zones Restaurants™ bluezonesproject.com

LIVE LONGER BETTER bluezonesproject.com — Proud to support BLUE ZONES PROJECT™ Beach Cities

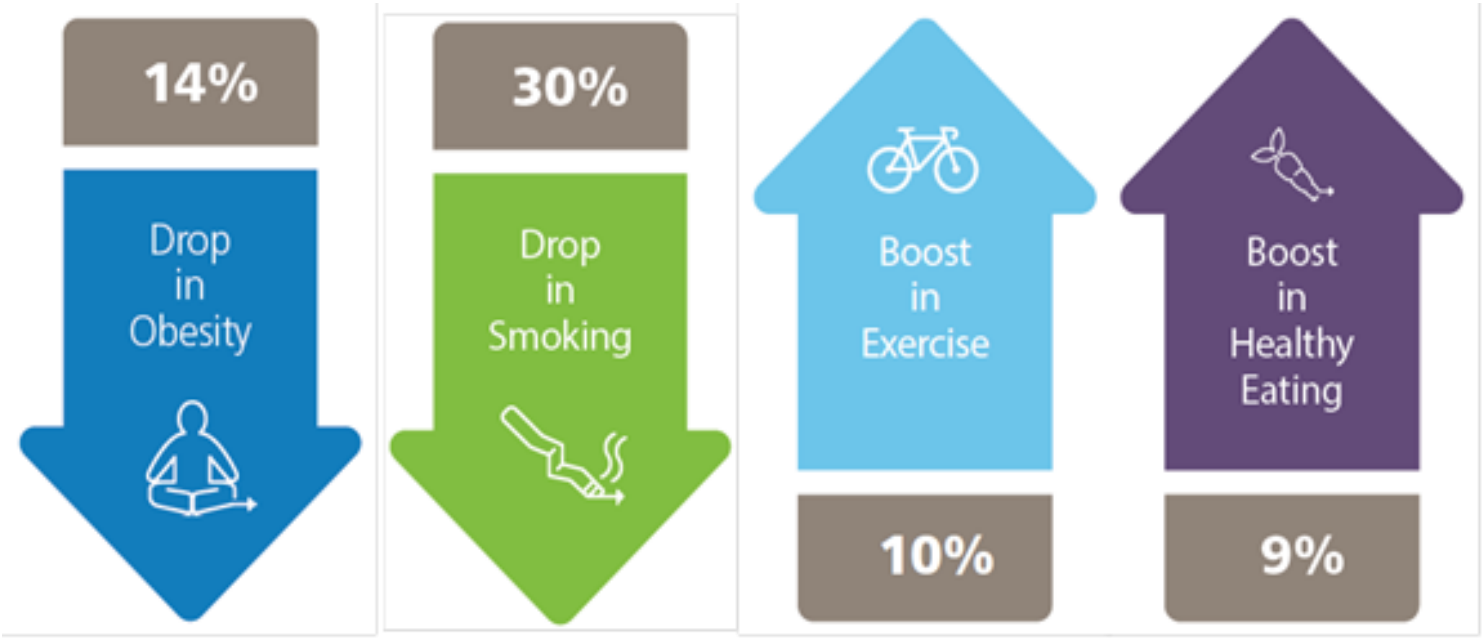
Key Selection Factors:

- Readiness, motivation and leadership
- Strong partner for innovation with the Beach Cities Health District (BCHD)
- A diverse and aging population (Silver Tsunami)
- Opportunities to improve walkability, bikability and emotional health
- High profile media near Los Angeles

MOVE Naturally bluezonesproject.com

The Results (2010 -2012)

Gallup · Healthways Well-Being Index™



What it means?
$2.35 Million in annual health care savings

What it means?
$6.97 Million in annual health care savings

Blue Zones Project™ by Healthways

BCHD Beach Cities Health District

2 Engage Clients, Leadership & Champions

Citizen Control

Partnership & Collaboration

Consultation

Informing

Nonparticipation

Getting Started on an Exciting Journey!