ncoa Center for Healthy Aging

Value Proposition Tips and Sample Statement

The Affordable Care Act contains provisions that support implementation of the Patient Centered Medical Home (PCMH) model to help achieve the Triple Aim of better health care quality, lower costs, and improved health outcomes. The PCMH model focuses on coordinated, team-based, whole-person care centered on the patient's needs. The model aims to improve access to and overall quality of care, while reducing costs. Providing education and support to help patients improve self-management and self-care skills are key components of the PCMH model.[1]

To encourage use of the PCMH by more health care providers, the Affordable Care Act provides payment incentives to those who serve high-risk populations as recognized PCMHs under the standards of designated accrediting bodies. FQHCs are designed to serve those populations in greatest need and receive funding incentives by HRSA to become recognized as PCMHs.[2]

Partnerships with community-based organizations (CBOs) can assist FQHCs in reaching the target populations, by providing access to older adults, especially those who are frail or vulnerable. CBOs provide valuable services, such as chronic disease self-management education (CDSME) and a variety of community resources that can activate patients to become more involved in their care and lead to improved health outcomes, while helping the FQHC contain their costs. Research studies of the Stanford's CDSME programs have demonstrated positive results in a number of health-related measures, including self-efficacy, healthy lifestyle behaviors, quality of life, health status, and mental health.[3]

As a CBO, you offer two important benefits to FQHCs: 1) provide direct access to their target audience of older adults, and 2) offer them a program that is proven to improve patient outcomes and support their goals. These two benefits should be the cornerstone of your value proposition.

The tips and sample value proposition talking points below can help you write a strong value proposition that persuades FQHCs to partner with you to deliver CDSME to older adults.

Tips for Writing your Value Proposition

- Highlight the health outcomes, lowered costs, and additional people, specifically older adults and adults with disabilities (Medicare consumers) that CDSME programs can attract to the health center
- Describe the role CDSME plays in activating patients to self-manage their chronic disease symptoms

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[1] The National Conference of State Legislatures. *The Medical Home Model of Care*. http://www.ncsl.org/research/health/the-medical-home-model-of-care.aspx. Accessed July 15, 2016.

[2] Abrams, M., Nuzum, R., Zezza, M., Ryan, J., Kiszla, J., and Guterman, S. (2015). *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years*. The Commonwealth Fund, (12), 1-16.

[3] Stanford University Patient Education Research Center. *Selected Publications*. http://patienteducation.stanford.edu/bibliog.html. Accessed July 15, 2016.

- Highlight the benefits to the practice, including the connection between CDSME, practice transformation work, and PCMH recognition
- Individualize the benefits that you highlight, based on the role and interests of the person you are talking with (e.g., provider, educator, administrator, quality improvement person)

Sample Value Proposition with Talking Points

- **CDSME is a way to Activate more Medicare Beneficiaries in Self-Management and Self-Care**
  CDSME is a proven to activate older adults and people with disabilities who are living with one or more chronic health conditions to self-manage their symptoms and achieve better health. Partnering with a CBO to provide CDSME to Medicare-eligible and dual-eligible participants can increase the number of high-risk older adults that your health center serves. Individuals with chronic diseases who attend CDSME workshops require additional medical services that can be obtained at your FQHC. Therefore, by providing CDSME programs, you can expand the number of unique users that receive services from your center for this key demographic.

  Your potential alignment with the CDSME program will provide an opportunity to introduce the full range of your FQHC services to a target population of Medicare beneficiaries, while providing them an intervention that has been proven to improve their health and health care experience. Increased utilization of your services by Medicare-eligible consumers can improve your Uniform Data Set (UDS) report by increasing the number of unique users from an older demographic and improving your reported payer mix.

- **CDSME Improves Clinical Outcomes and Saves on Health Care Expenditures**

  CDSME is a low-cost, evidence-based intervention to help those with chronic diseases manage their conditions, improve their health status, and reduce their need for more costly medical care. The Stanford programs consist of a series of workshop sessions that are conducted once a week for two and a half hours over a six-week period in community settings or online. The programs help participants gain the knowledge and develop the skills needed to manage their symptoms through action planning, problem-solving, interactive learning, behavior modeling, decision-making, and social support for change.[4]

  A key feature of CDSME is the strength of evidence about its effectiveness. Based on a review of major published studies, CDSME results in significant, measurable improvements in health and quality of life for people with chronic conditions. These include considerable improvements in health status, self-efficacy, and psychological well-being; increased physical activity; fewer social role limitations and reduced fatigue; and improved communication with their health care providers. Cost

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[4] Stanford University Patient Education Research Center. *Stanford Patient Education Research Center*. http://patienteducation.stanford.edu/. Accessed July 15, 2016.

savings research has shown that CDSME can result in $714 per person savings in reduced emergency room visits and hospital utilization.[5]

- **CDSME can Support Your Health Center's Transformation to the PCMH Model**

  The PCMH model requires use of team-based care approaches that support patients, along with their families and caregivers, in self-management education, self-efficacy, and behavior change. CDSME has been proven to enhance patient-provider communication, increase patient confidence, and build the skills that patients need to take control of their health. Participants in CDSME develop self-management goals and access social support and educational resources that reinforce healthy lifestyle choices and lead to positive health outcomes. This makes CDSME a nice fit for a PCMH that is built upon principles of self-management, health education, and peer support.

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[5] Ory, M. G., Ahn, S., Jiang L., Smith, M. L., Ritter, P., Whitelaw, N., & Lorig, K. (2013). Successes of a National Study of the Chronic Disease Self-Management Program: Meeting the Triple Aim of Health Care Reform. Medical Care, 51(11), 992-998.