Process Evaluation Report:

Adoption of Chronic Disease Self-Management Programs as Paid Benefits by Oregon’s Public Employee Benefits Boards

Oregon Diabetes Prevention & Control Program

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The Oregon Diabetes Prevention and Control Program thanks the following people for their contributions to this report:

- Joan Kapowich - Administrator, Oregon Public Employees’ Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
- Kathy Loretz, Deputy Administrator, PEBB
- Margaret Smith-Isa - Program Development Coordinator, PEBB
- Danna Drum - Chronic Disease Programs Manager, Health Promotion & Chronic Disease Prevention, Oregon Public Health Division
- Sabrina Freewynn - Colorectal Cancer Program Coordinator/Community Programs Liaison, Health Promotion and Chronic Disease Prevention, Oregon Public Health Division; Health Engagement Model Union representative
- Shaun Parkman, Evaluation Lead, Health Promotion and Chronic Disease Prevention, Oregon Public Health Division; Health Engagement Model Union representative

Prepared by:

- Laura Chisholm, MPH, MCHES, Self-Management Technical Lead
- Andrew Epstein, MPH, CHES, Diabetes Coordinator
- Cara Biddlecom, MPH, Health Systems Coordinator
- Rodney Garland-Forshee, MS, Epidemiologist
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For more information about Living Well, visit http://public.health.oregon.gov/PHD/ODPE/HPCDP/LivingWell/

For more information about the Public Employees’ Benefit Board, visit http://www.oregon.gov/DAS/PEBB

For more information about the Oregon Educators Benefit Board, visit http://www.oregon.gov/DAS/OEBB
# Table of Contents

- Executive Summary ........................................................................................................ 1
  - Purpose .......................................................................................................................... 1
  - Results ........................................................................................................................... 1
  - Conclusions .................................................................................................................... 2

- Introduction .................................................................................................................... 3
  - Background ...................................................................................................................... 3
    - Living Well (Stanford Chronic Disease Self-Management Program) ......................... 3
    - The National Diabetes Prevention Program .............................................................. 5
    - The PEBB/OEBB Partnership ..................................................................................... 6
  - Evaluation Questions ..................................................................................................... 7

- Methods ........................................................................................................................... 8
  - Overview of the Policy Adoption Process ..................................................................... 10
    - The Medicaid Process ............................................................................................... 10
    - The Oregon Health Services Commission Policy Process ........................................ 10
  - A Policy Setback ........................................................................................................... 12
  - The PEBB/OEBB Process ............................................................................................. 13
    - A Long-Standing Partnership .................................................................................... 13
    - Progress with Self-Management Program Coverage ................................................. 14
    - The 2014 Benefit Policy ............................................................................................ 16

- Conclusions .................................................................................................................... 16
  - Accomplishments and Outcomes ................................................................................. 16
  - Significant Factors Enabling Reimbursement Policy Implementation ........................ 17
  - Barriers to Reimbursement Policy Implementation and Outcomes Tracking .............. 19
  - Additional Lessons Learned ......................................................................................... 20

- Next Steps ....................................................................................................................... 21

- Appendix A: Key Informants .......................................................................................... 25

- Appendix B: PEBB Key Informant Interview Questions .................................................. 26
Executive Summary

Purpose
Establishment of evidence-based chronic disease self-management programs as covered, paid employee benefits is a strategy recognized by the US Centers for Disease Control, National Council on Aging and the US Administration on Aging for creating financial sustainability to ensure the long-term viability of these important community resources. Following several years of collaboration between the Oregon Diabetes Prevention and Control Program (DPCP) and Oregon’s public employees’ benefit boards, two such programs – the Stanford Chronic Disease Self-Management Program (CDSMP) and the National Diabetes Prevention Program (NDPP) – will be benefits available at no cost for Oregon state employees beginning in 2014. This report documents the process leading up to implementation of this self-management coverage policy, and provides insight on how significant milestones were achieved. It is anticipated that the key enabling factors and barriers to the program policy adoption process described here will help to inform similar efforts in other states. The next steps identified in this report will also assist planning for future activities of the Oregon Diabetes Prevention and Control Program.

Results
Following several years of collaboration on worksite wellness activities with the Oregon public employees’ benefit boards and quality improvement projects with the Oregon Medicaid program, in 2011 the DPCP advised the Oregon Health Services Commission as it considered adding self-management programs as a covered benefit for Medicaid members with specific diagnoses. Although this initiative did not result in a policy change due to cost concerns, it did help to educate key decision makers about the efficacy of the programs in terms of improved chronic disease outcomes and potential cost avoidance. Following this attempted policy change, the administrator of the Public Employees Benefit Board and Oregon Educators Benefit Board championed a gradual process of adopting self-management programs as paid public employee benefits. In 2013, the Stanford Chronic Disease Self-Management Program was promoted to early retirees, and then to the general PEBB and OEBB populations. In 2013,
CDSMP was promoted further as an approved activity under PEBB’s Health Engagement Model, and then was adopted, along with the National Diabetes Prevention Program, as a covered benefit for 2014.

Conclusions

This report identifies factors enabling coverage policy implementation: long-term partnership development, a gradual and stepwise implementation process, sufficient statewide program delivery infrastructure, support from influential champions, an established evidence base, and documentation of the chronic disease burden in the population of interest. Key barriers to implementation of a policy to cover self-management programs as paid benefits in Oregon included lack of a statewide program contracting structure for program purchasers, time constraints, and inability to measure policy impact. Next steps will include establishment of a centralized, statewide self-management program delivery and payment infrastructure and continued evaluation of policy implementation process and impact.
**Introduction**

In May 2013, the Oregon Public Employees’ Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) adopted the Stanford Chronic Disease Self-Management Program and the National Diabetes Prevention Program as covered benefits for 300,000 public employees and dependents in Oregon, beginning in 2014. This policy change is anticipated to significantly enhance reach and sustainability for evidence-based self-management programs that serve people with diabetes and other chronic conditions.

Based on key informant interviews and document review, this case study report describes major milestones in the self-management program insurance coverage policy development process, and provides insight on how these milestones were achieved. It also documents the development of partnerships over several years between the Oregon Diabetes Prevention and Control Program (DPCP), the state Medicaid program and state employee health benefits purchasers to achieve this policy change. Additionally, this report describes key enabling factors and barriers to the PEBB/OEBB self-management program policy adoption process, accomplishments and outcomes to date, and next steps.

**Background**

*Living Well (Stanford Chronic Disease Self-Management Program)*

The Living Well with Chronic Conditions program, Oregon’s brand for the Chronic Disease Self-management Program (CDSMP) developed at the Stanford University Patient Education Research Center, teaches people with one or more chronic conditions skills for living a full, healthy life. The Spanish language/Latino cultural version of Living Well is called Tomando Control de su Salud. From this point forward, references to Living Well encompass both versions of the Stanford Chronic Disease Self-Management Program.

Living Well is delivered over a six-week period in two-and-one-half hour weekly sessions. Workshops are held primarily in community settings such as senior centers, churches,
and libraries and may also be held in health care settings such as primary care clinics and hospital education centers. People with a variety of chronic health conditions attend the workshop series. Support people (e.g., family members, caregivers) are also invited to attend jointly. Workshops are facilitated by two trained leaders who follow a scripted agenda and curriculum developed at Stanford. One or both of the leaders are non-health professional peers with a chronic disease.

Better Choices, Better Health (BCBH) is an online self-management program with similar outcomes and design to Living Well. Based on the CDSMP and also developed at the Stanford University Patient Education Research Center, BCBH was provided free of charge until summer 2011. During the time BCBH was available for free, the DPCP worked through program delivery partners, as well as PEBB and OEBB, to promote the program. It is currently licensed via the National Council on Aging and available via contract.

State-level support and coordination for Living Well has been provided since 2001 through a partnership between the Oregon Health Authority, Public Health Division (OHA/PHD) Health Promotion and Chronic Disease Prevention Program (HPCDP) and the Oregon Department of Human Services, Division of Aging and People with Disabilities, State Unit on Aging. Initial HPCDP funding for these efforts from the Centers for Disease Control and Prevention (CDC) Division of Diabetes Translation supported leader training and program delivery in four counties. In 2005, HPCDP began to support Living Well through the DPCP, as well as the Arthritis, Heart Disease and Stroke Prevention and Asthma programs, and shifted its emphasis from grants to support program delivery to statewide leader training, partnership development, data collection and reporting, and provision of technical assistance to local Stanford-licensed organizations. Grants provided to consortia of health systems and local public health departments helped develop key program delivery infrastructure from 2006-2008. With funding from the Administration on Aging Evidence-Based Disease and Disability Prevention Program to the State Unit on Aging, Living Well and other evidence-based healthy aging efforts were further expanded.
From May 2008 through April 2011, HPCDP received funding from the National Council on Aging (NCOA) to build a sustainable statewide delivery system for Living Well. During that time, Oregon also participated in a pilot of BCBH that allowed participants to access the online program free of charge. Today, direct funding support for Living Well comes from a three-year Administration on Aging Chronic Disease Self-Management Education cooperative agreement and Oregon’s CDC-funded Arthritis, Asthma, Diabetes, and Heart Disease and Stroke Prevention programs. In local communities, support for Living Well is provided by the HPCDP-funded Healthy Communities and Tobacco Prevention and Education Programs. HPCDP supports local Living Well/Tomando Control delivery with a website, a toll-free workshop information number, a Living Well email address, and a variety of resources for leader training, technical assistance, data collection and reporting, partnership development, and program promotion. HPCDP’s long-term goal for Living Well is to provide access to programs for all Oregonians by implementing a sustainable system for statewide program delivery and financing, guided by the Living Well Business Plan developed in 2012.¹

Program reach has grown steadily since 2006. Between 2006 and 2012, a total of 9,300 Oregonians have participated in a Living Well or Tomando Control program. Approximately 2,000 participated in 2012, roughly 30 percent of whom reported a diagnosis of diabetes. In 2012, programs were held in 25 of Oregon’s 36 counties; just under one-third of participants were from rural or frontier counties. Since 2006, programs have been held in 33 of Oregon’s 36 counties.²

**The National Diabetes Prevention Program**

The National Diabetes Prevention Program (NDPP) is a one-year, community-based lifestyle change program that significantly decreases the risk of people at high risk for type 2 diabetes.

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¹ Oregon Health Authority. Living Well Business Plan, 2012. See Appendix 1 for a schematic of the proposed self-management program delivery and financing system.

diabetes developing the disease. To date in Oregon, the NDPP is less widely available than Living Well programs. In addition to YMCA-led programs in Salem, Eugene and Roseburg, NDPP programs with current or pending CDC recognition include the Harold Schnitzer Diabetes Health Center at Oregon Health & Science University (OHSU) in Portland, Samaritan Health Plans in the Corvallis/Lebanon area, and the Center for Family Development in Eugene. Four community-based organizations serving racial and ethnic minorities (Latinos, Asian Americans, and African Americans) had lifestyle coaches trained in May 2013 and are preparing to offer programs and attain CDC recognition.

Because program delivery capacity was not well developed statewide, the Oregon DPCP did not actively promote establishment of the NDPP as a covered benefit for statewide purchasers such as PEBB and OEBB alongside Living Well. Instead, the DPCP partnered with OHSU in the 2012-2013 funding year to identify organizations currently providing the program and those interested in developing it as a resource, and to develop recommendations for planning a possible future program delivery system. The DPCP also coordinated OHSU’s work with efforts by the Oregon Coalition of Health Care Purchasers to promote the program among employers and insurance companies as potentially sustainable funding sources.

**The PEBB/OEBB Partnership**

As part of its strategy for establishing financial sustainability for Living Well, the DPCP has nurtured a long-term partnership with PEBB and OEBB. These labor-management boards, with a combined membership of approximately 300,000 employees and dependents, share the mission of providing high-quality benefits at a cost affordable to employees and the state. Since 2010, the DPCP and PEBB/OEBB have become organizationally more connected due to a restructuring of state-level health purchasing and public health functions from disparate governmental entities to form the Oregon Health Authority. In addition to fielding the Behavioral Risk Factor Surveillance System Survey of Oregon state employees (BSSE, described in greater detail below), the DPCP has been working with PEBB and OEBB to begin offering Living Well to members through their health plans, initially under the auspices of PEBB’s Health Engagement Model (described in detail below) and with the eventual goal of
establishing Living Well as a covered benefit. Due to the large size of the PEBB/OEBB population, adoption of Living Well and the DPP by PEBB and OEBB as paid benefits is anticipated to greatly expand the number of Oregonians participating in Living Well and the National Diabetes Prevention Program.

**Evaluation Questions**

The questions to be answered by this evaluation, and their associated data sources, are as follows:

**TABLE 1: EVALUATION QUESTIONS AND DATA SOURCES**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Question</th>
<th>Data Sources</th>
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| Policy development to adopt Living Well as a program promoted through the Health Engagement Model | What was the process for developing policy to include Living Well in the 2013 Health Engagement Model and the 2014 benefits structure? | • Health Services Commission documents  
  • PEBB board meeting documentation  
  • Key informant interview data |
| Barriers to coverage as a paid benefit                                  | What factors stood in the way of policy implementation?                                     | • PEBB/OEBB board meeting documentation  
  • Key informant interview data |
| Enabling factors                                                       | What factors enabled movement toward adoption of Living Well workshops as part of the Health Engagement Model and the 2014 benefits structure? | • PEBB/OEBB board meeting documentation  
  • Key informant interview data |
| Lessons learned                                                        | What lessons learned from this process could be integrated into future program planning to guide policy development initiatives? How may any remaining barriers to full implementation of LW as a paid benefit be potentially overcome? | • PEBB/OEBB board meeting documentation  
  • Key informant interview data |
Methods

This report uses a case study design to document and examine the process of policy development to date. Major milestones in the policy development process are outlined in Table 1. Data were gleaned from document review and key informant interviews. Key informants are listed in Appendix A.

HPCDP’s contractor, Nonprofit Impact, Inc., conducted initial interviews with PEBB/OEBB leadership and staff in January 2012 as part of an information collection process to inform the creation of the Living Well Business Plan. To provide greater perspective on the PEBB/OEBB policy development process during 2012, PEBB/OEBB leadership and staff were re-interviewed in December 2012, along with two HPCDP staff who served as labor representatives on the advisory committee for the Health Engagement Model that PEBB initiated in 2012 (see details below). HPCDP shared a summary of findings with interview participants for their feedback. HPCDP staff also reviewed Health Services Commission (HSC) documents and PEBB/OEBB Board meeting documentation to identify milestones in the policy adoption process. Using information from interviews and document review, HPCDP staff drafted a narrative about PEBB/OEBB’s adoption of Living Well. Stakeholders at PEBB/OEBB reviewed the narrative to ensure accuracy and completeness.
# Table 1: Key PEBB/OEBB Policy Change Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>Initial meeting with HPCDP and PEBB/OEBB staff to discuss self-management programs</td>
<td>March 2009</td>
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<tr>
<td>HPCDP staff continue check-ins with PEBB/OEBB staff about medical plan carrier contracting timelines</td>
<td>May and December 2009</td>
</tr>
<tr>
<td>Medicaid Disease Management Coordinator begins advocacy for coverage of self-management programs under the Oregon Health Plan (Medicaid)</td>
<td>July 2010</td>
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<tr>
<td>HPCDP staff meet with PEBB/OEBB administrator about promoting self-management programs to members; PEBB begins promoting programs to early retirees</td>
<td>December 2010</td>
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<tr>
<td>Oregon’s Health Improvement Plan(^3) is presented to the Oregon Health Policy Board. It includes establishing wide access and reimbursement for self-management interventions as a recommended action for 2011.</td>
<td>November 2010</td>
</tr>
<tr>
<td>Health Services Commission approves Oregon Health Plan coverage for self-management programs for enrollees with six specific diagnoses</td>
<td>January 2011</td>
</tr>
<tr>
<td>HPCDP staff present to PEBB and OEBB boards of directors on self-management programs</td>
<td>February 2011</td>
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<tr>
<td>PEBB begins promotion of Living Well, Tomando Control and online Better Choices, Better Health to general membership</td>
<td>February 2011</td>
</tr>
<tr>
<td>Health Services Commission rescinds approval for coverage due to budget concerns related to reimbursement rates for Federally Qualified Health Centers</td>
<td>March 2011</td>
</tr>
<tr>
<td>HPCDP staff facilitate a conference call between PEBB and NCOA regarding pricing for Better Choices, Better Health</td>
<td>April 2011</td>
</tr>
<tr>
<td>HPCDP provides technical assistance to PEBB about logistics for including Living Well in the future Health Engagement Model</td>
<td>Summer 2011</td>
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<tr>
<td>PEBB launches Health Engagement Model without Living Well as an approved wellness program option</td>
<td>January 2012</td>
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<tr>
<td>Joint labor/management Health Engagement Model advisory committee established, including Living Well advocates</td>
<td>January 2012</td>
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<tr>
<td>PEBB announces Living Well as an approved HEM wellness program option (not a paid benefit) for plan year 2013</td>
<td>July 2012</td>
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<tr>
<td>HPCDP completes the Living Well Business Plan</td>
<td>August 2012</td>
</tr>
<tr>
<td>PEBB/OEBB board approves Living Well and the National Diabetes Prevention Program as part of their 2014 benefit design</td>
<td>May 2013</td>
</tr>
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</table>

\(^3\) Oregon Health Authority, Oregon Health Policy Board (2010). Oregon Health Improvement Plan: Improving the health of all Oregonians where they live, work and play. http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Pages/index.aspx
Overview of the Policy Adoption Process

The Medicaid Process

A policy process undertaken by the Oregon Health Services Commission (HSC) in early 2011 laid important groundwork for the PEBB/OEBB policy process described in this report. This entity, which was renamed the Health Evidence Review Committee in 2011, is responsible for setting the Prioritized List of Health Services that determines what services are covered under the Oregon Health Plan, Oregon’s Medicaid program. After attending the American Reinvestment and Recovery Act/CDSMP grantee meeting in June 2010, the Division of Medical Assistance Programs (Oregon’s Medicaid program) disease management coordinator brought the issue of Living Well reimbursement to the attention of the Medicaid director and medical director, and the HSC administrator. Simultaneously, DPCP staff and the HPCDP Chronic Disease Programs Manager worked with the Oregon State Epidemiologist to increase the visibility of Living Well programs with the Medicaid director at regular leadership meetings.

The Oregon Health Services Commission Policy Process

In late November 2010, the HSC alerted DPCP staff that a discussion about adding evidence-based chronic disease self-management programs to the Prioritized List of Health Services was scheduled for a future meeting of the HSC Health Outcomes Committee. The Prioritized List determines the services covered by the Oregon Health Plan (Medicaid). In preparation, the HPCDP Health Systems and Self-Management Lead worked closely with the HSC medical director to provide supporting documentation for the commissioners. This included general Oregon program information, the Oregon Living Well Data Report, the Oregon Living Well Impact Report, an endorsement of CDSMP from the Surgeon General,  


self-management specific recommendations in the Oregon Health Improvement Plan\textsuperscript{7} and a preview abstract of the meta-analysis of CDSMP outcomes conducted by the CDC Arthritis Program.\textsuperscript{8} Because the HSC evidence standards called for meta-analysis level data and the full CDC Arthritis Program article\textsuperscript{9} was not yet available at that time, HPCDP also obtained letters of support from the CDC Asthma Program, the Hartford Foundation and the National Council on Aging to demonstrate national-level support for the program despite a lack of meta-analyses of CDSMP outcomes.

Based on this review, HSC staff made recommendations to the commission about what diagnoses for which CDSMP should be covered under the Oregon Health Plan. At the Health Services Commission Health Outcomes Subcommittee meeting on January 13, 2011, the State Epidemiologist presented evidence supporting the program and encouraged the commissioners to approve coverage of peer-led programs as well as those led by professionals. Discussion at that meeting centered on what billing codes would be appropriate, and whether over-use of the service was a potential issue. After a lengthy discussion, the commissioners unanimously approved addition of specific CPT codes (98960-98962) to the Prioritized List for Oregon Health Plan members with hypertension, coronary heart disease, congestive heart failure, major recurrent depression, type 2 diabetes, and asthma. The codes approved covered patient self-management education from a standardized curriculum, prescribed by a physician and delivered by a non-physician, licensed health care professional. This new benefit was to become effective April 1, 2011. Although the commissioners also expressed support for the concept of peer led self-management, they were not able to approve reimbursement for


\textsuperscript{8}Brady, TJ et al. The Effects of Stanford’s Chronic Disease Self-management Program (CDSMP) on Health Status, Health Behaviors, and Health Care Utilization: Results of a Meta-Analysis. Unpublished, March 2011.

programs with non-licensed (peer) leaders because CMS rules prohibited the use of Medicaid funds to pay for non-licensed providers.

A Policy Setback

On February 28, 2011 the HSC clinical services consultant notified DPCP staff that upon further research, DMAP had raised issues about the feasibility of implementing the newly approved billing codes. Chief among them was the cost of reimbursement for self-management education services provided to Medicaid beneficiaries through Federally Qualified Health Centers (FQHCs). DMAP had discovered that reimbursing for chronic disease self-management education would be more expensive to implement than previously anticipated because of the encounter billing rate required by federal rules set by the Centers for Medicare and Medicaid Services. DMAP estimated encounter rates under the approved codes as $150-$250 per attendee, per self-management workshop session. This would mean that the cost for a single Medicaid enrollee to attend six self-management workshop sessions would be an estimated $900-$1500. If more than one Medicaid beneficiary were to attend a session, the encounter rate would multiply accordingly. A DPCP survey of local CDSMP programs conducted in 2009 had identified a statewide average per-participant program delivery cost of $375 for the six week workshop series; the encounter billing rate far exceeded the actual program cost.

In preparation for HSC discussion of the FQHC encounter rate issue, DPCP staff contacted several partners to ask for assistance in finding possible solutions. These included the financial improvement manager at the Oregon Primary Care Association and project officers at the US Centers for Disease Control and Prevention, the National Council on Aging and Administration on Aging. Although subsequent conversations were helpful in clarifying the issue, no specific solution could be identified.

On March 10, 2011, the Oregon Health Services Commission reversed its earlier decision to approve billing codes that would allow inclusion of patient self-management education as an Oregon Health Plan (Medicaid) benefit for members with specific diagnoses. Commissioners reiterated their support for the concept of making participation in chronic
disease self-management programs a covered Medicaid service for members with certain diagnoses. However, it was deemed that such coverage would not be possible until a solution for the FQHC billing rate issue could be found.

Although this policy reversal was a setback for Medicaid Living Well reimbursement efforts, the HSC’s support for the concept of self-management raised awareness of Living Well among key decision makers, including the administrators and board members of PEBB and OEBB. Discussion of the program by a high-profile policy body established it as a viable evidence-based resource for improving quality of life and potentially improving health outcomes and reducing medical costs for people with chronic conditions. The end result of this process – adoption of the program as part of the PEBB/OEBB benefits structure – is discussed below.

The PEBB/OEBB Process

A Long-Standing Partnership

For at least a decade, HPCDP and PEBB/OEBB have partnered on employee wellness initiatives, including promotion of tobacco cessation services. Data from the Behavioral Risk Factor Surveillance System Survey of Oregon state and school employees (BSSE) were crucial to the development of this partnership. The BSSE is a survey that contains questions about health behaviors, risk factors, and chronic diseases as well as questions on worksite policies and environments that can influence health-related choices. The BSSE consists of two surveys: one for people who work for Oregon state agencies and the Oregon University System and are covered by the Public Employees’ Benefit Board (PEBB) and the other for people who work in education service districts, school districts, community colleges, and charter schools and are covered by the Oregon Educators Benefit Board (OEBB). Results from the BSSE identify opportunities for health improvements and areas in which state employees are doing well.

Early versions of the BSSE (conducted in 2005 and 2007) identified significantly elevated levels of chronic disease risk factors, including obesity and lack of physical activity, in
the PEBB population. These risk factors were elevated in the PEBB population when compared to the OEBB population, and also in comparison with the overall population of employed and insured adults in Oregon. In response, PEBB and OEBB increased their support for workplace wellness initiatives and added Weight Watchers to their benefits packages in 2009. The Weight Watchers benefit proved to be extremely popular, and demonstrated that well-promoted evidence-based wellness programs could make a significant impact on employee health risks. The 2011/2012 BSSE revealed several significant health improvements, including increased fruit and vegetable consumption, and an apparent decline in obesity. Several other health indicators appeared to be moving in the right direction, as the data also showed decreased diagnoses in high cholesterol, high blood pressure, and diabetes.

Progress with Self-Management Program Coverage

In mid-December 2010, the Self-management Technical Lead and Chronic Disease Programs Manager held a meeting with the PEBB administrator about self-management program availability in Oregon and the potential for establishing coverage through PEBB/OEBB’s carriers. Subsequently, PEBB/OEBB began promoting Living Well, Tomando Control and Better Choices, Better Health to early retirees. Although uptake of the program was not widespread, several members sent unsolicited positive feedback to the boards about the program. Following presentations by DPCP staff on Living Well to the boards of directors of both PEBB and OEPP in February 2011, the boards began to promote the programs broadly to their membership. In April 2011, DPCP staff facilitated a conference call between the PEBB/OEBB administrator and NCOA regarding pricing and access to the online Better Choices, Better Health program.10

As planning for the 2011 benefit year moved forward, an impending financial crisis caused the PEBB board to enact a membership audit, implement cost sharing measures (increased premiums and co-pays) and enact a Health Engagement Model. The Health Engagement Model was originally structured to require member participation in a health risk

10 See meeting minutes, April 5, 2010.
assessment and follow-up education for risk factor reduction or incur a financial penalty. Living Well was under consideration as a follow-up education option under the model. Further discussions took place regarding logistics for including Living Well in the Health Engagement Model; in July DPCP staff provided recommendations regarding potential pilot program location options for in-person Living Well programs. However, due to inconsistent program pricing and insufficient time to surmount the challenge of PEBB’s two carriers contracting with multiple licensed organizations to provide statewide access and track member participation, PEBB launched the Health Engagement Model in fall 2010 without Living Well as an educational resource option.

Concerns about the 2011 plan year Health Engagement Model implementation and plan design led to establishment of a joint labor/management committee to advise the design, implementation and evaluation of the 2012 Health Engagement Model. Aided by strong public health representation from both labor and management, including the HPCDP section manager and two HPCDP staff, the committee focused on incentives for prevention and wellness and recommended expansion of the available options for education and risk reduction resources. PEBB leadership proposed including Living Well as part of the non-funded wellness program options. For plan year 2013, members receive a financial incentive to complete a health assessment and at least two health improvement activities or programs prior to open enrollment in October 2014. Participation in Living Well was promoted during the October 2012 open enrollment period as a qualifying activity. Completion of the assessment is tracked by PEBB’s insurance carriers, but participation in qualifying activities is tracked only by members, who must attest to their completion when they enroll for 2014 benefits. Thus, neither PEBB nor its carriers will have a reliable source of data regarding 2013 Living Well participation by members to fulfill their Health Engagement Model requirements.

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11 HEM Example Framework, July 19, 2011
12 See HEM Documents: HEM Committee Members and Letters of Agreement
The 2014 Benefit Policy

In May 2013, the PEBB and OEBB boards approved Living Well as part of their 2014 benefit design. Although administrative details have yet to be worked out, it is likely that PEBB/OEBB and one or more of its three insurance carriers will develop pilot contracts with one or more self-management program delivery organizations that serve areas with a high density of PEBB/OEBB members (e.g., Salem, Portland metro, Medford, Eugene) and that also have high readiness to establish insurance billing agreements and scale up program delivery capacity to meet increased demand from PEBB/OEBB members. HPCDP will continue to provide technical assistance to PEBB/OEBB and its carriers as they design administrative structures to support this covered benefit. The implementation of the Living Well Business Plan, which outlines a centralized mechanism for statewide program contracting and billing, is anticipated to simplify administrative processes. PEBB/OEBB is one of the initial target markets for the business plan, and feedback from the PEBB/OEBB administrator was instrumental in developing the plan.

Conclusions

Accomplishments and Outcomes

- **Establishment of Living Well as a 2013 Health Engagement Model qualifying activity**: Making Living Well a qualifying activity under the HEM was an important step toward full coverage because it increased the visibility of self-management programs among PEBB members. A recommendation from the HEM committee and strong support from the PEBB administrator made this an obvious starting point for future establishment of Living Well as a covered benefit.

- **Establishment of Living Well within the 2014 benefits structure**: Although the long-term effects of this policy change have yet to be seen, the newly announced coverage
for programs is anticipated to open the door for eventual establishment of payment
systems to support local program delivery organizations. Because PEBB and OEBB
were identified in the Living Well Business Plan as key purchasers, this policy change is
also likely to speed implementation of the Oregon Self-Management centralized hub
(see Figure 1 on page 22). This entity will coordinate for billing, participant and program
data collection, and will provide a single point for accessing a statewide program
delivery network. PEBB and OEBB are among the largest purchasers of health benefits
in Oregon, and thus their coverage policy decisions are quite influential.

- **Establishment of the National Diabetes Prevention Program (NDPP) within the
  2014 benefits structure:** In response to the PEBB/OEBB boards’ commitment to
  approving health and wellness benefits that are accessible to members statewide, the
  DPCP’s policy change efforts had focused primarily on Stanford self-management
  programs (CDSMP/Living Well and Tomando Control). The NDPP is currently available
  in only a few major metropolitan areas in Oregon. However, the PEBB/OEBB boards
  included coverage for the NDPP in its policy change, anticipating rapid growth in
  program delivery capacity in coming years.

**Significant Factors Enabling Reimbursement Policy Implementation**

Key informant interviews and document review identified the following factors as likely
to have enabled development of policy making Living Well programs a covered benefit for
PEBB/OEBB members:

- **Sufficient (or growing) delivery infrastructure:** Being able to provide statewide
  program access for members is important to large statewide purchasers. Oregon has
developed sufficient delivery infrastructure since 2005 to provide Stanford self-
management programs in more than two-thirds of Oregon counties. PEBB/OEBB
leaders have expressed continued interest in the online Better Choices, Better Health
program; this option may hold promise as a means of ensuring statewide access.
Although delivery capacity for the NDPP is much less developed, there is widespread interest in this program among potential program delivery organizations and purchasers. Prior experience with the Living Well program indicates the potential to rapidly scale up program availability.

- **Champions**: Advocacy from program champions within the Medicaid program played an important role in getting Living Well on the agenda for discussion by policy makers. Support for the program from high-level policy makers likely kept discussion of self-management benefits on the agenda. It is probable that receiving information about Living Well from multiple sources, including the PEBB/OEBB administrator and HSC members, was particularly effective in this regard.

- **Evidence base**: The literature convincingly describes how Living Well improves quality of life and reduces hospital stays and emergency room visits among participants with specific diagnoses. Availability of meta-analysis data was particularly important within the evidence review process. Although the CDC Arthritis program’s meta-analysis had not yet been published, an advance copy of the abstract was made available to the Health Evidence Review Committee. Additionally, the impact report prepared by the DPCP\(^{14}\) helped to quantify potential increases in quality of life and possible reductions in hospitalizations and emergency room visits as a result of program participation.

- **Documented chronic disease burden in the PEBB/OEBB population and potential cost savings**: Because health care cost increases have generated interest in cost saving measures, the potential return on investment of self-management programs is appealing to policy makers. The BSSE effectively quantified the chronic disease burden within PEBB/OEBB’s population. It is likely that impending cost increases related to the prevalence of health risk factors and chronic diseases among PEBB and OEBB

employees shortened the timeline for adoption of self-management programs as covered benefits.

**Barriers to Reimbursement Policy Implementation and Outcomes Tracking**

Key informant interviews and document review identified the following as major barriers to inclusion of Living Well programs as a covered benefit for PEBB/OEBB members:

- **Program delivery contracting issues**: The complexity of contracting with multiple program delivery organizations to provide statewide access for PEBB/OEBB members made adoption of Living Well and the NDPP as a statewide covered benefit an administratively challenging prospect. Due to the lack of a centralized structure for program delivery and billing, PEBB/OEBB’s insurance carriers would need to contract with dozens of program delivery organizations individually to allow statewide access to programs for members. Additionally, many organizations licensed to provide Living Well programs lack the capacity to bill insurance. It is anticipated that these problems may be surmounted for the 2014 benefit year by establishing program delivery contracts with only a few organizations serving geographic areas where the majority of PEBB members reside, and which are able to bill insurance. In summer 2013, the DPCP will assist PEBB/OEBB and its carriers to identify organizations with readiness to scale up program delivery to include members and to undertake insurance billing. However, the PEBB/OEBB administrator views this limited program pilot as only a temporary solution because the board is committed to providing statewide access to benefits. Lack of consistent statewide program pricing will make this process even more complex.

- **Time constraints**: Due to the rapid process of Health Engagement Model development for the 2012 benefit year, PEBB staff had little time to problem-solve the issues described above. Thus, Living Well was added to the Health Engagement Model for 2013, but not as a paid benefit. Similarly, administrative processes to support the May
2013 policy change described in this report will need to be developed quickly. These constraints are likely to lead to incremental implementation of these new benefits via pilot contracts as described above, rather than a full-scale roll-out to all PEBB/OEBB members simultaneously.

- **Inability to measure policy impact:** Lack of administrative systems to track member participation in self-management programs will continue to complicate tracking of associated outcomes. Since there are no established billing codes, it will be challenging for carriers to establish fee-for-service payment arrangements with program delivery organizations. Additionally, detailed insurance information is not currently tracked as part of the standard demographic information collected on self-management program participants, and is outside the scope of public health data collection. Without the ability to identify individual participants and track their health care utilization and metrics, it will be difficult to quantify the impact of the policy change in terms of the predicted outcomes of increased quality of life, reduced hospitalizations and emergency room visits, and reduced rates of conversion from pre-diabetes to diabetes.

**Additional Lessons Learned**

One major lesson learned from this evaluation is about the policy process itself: passing policy takes time, and should be regarded as ongoing and stepwise. It takes time to develop trust between partner organizations and to promote knowledge and familiarity with the programs among decision makers. Given the complexity of establishing delivery and financing systems for statewide purchasers like PEBB and OEBB, it has become clear from Oregon’s experience that incremental change over time is more likely than an immediate large policy change.

Lack of a centralized, statewide delivery system has proven to be the major administrative barrier to establishing Living Well as a paid PEBB/OEBB benefit. Although Oregon’s Living Well delivery network is made of up organizations that are committed to providing programs as a means of fulfilling their organizational missions, most licensees lack billing infrastructure. While implementation of the Living Well Business Plan is anticipated to
mitigate this issue by establishing a common platform for data sharing and billing, it will take months or years to establish this new system. Developing a more systematic mechanism for delivering self-management programs and a more sustainable means of paying for them at the outset of the DPCP’s support for Living Well would have avoided the task of reorganizing Oregon’s Living Well delivery network. Because the NDPP delivery system in Oregon is much less developed, it may be possible to scale up delivery and financing for this program more quickly by applying the lessons learned in the Living Well process.

Local data are also important to decision makers when considering policy change. Although a strong evidence base exists for Living Well, policy makers have consistently requested examples of successful program implementation and resultant documentation of cost savings in Oregon populations. It will be important to work with Living Well and NDPP program delivery partners that have capacity for data collection and analysis, and with PEBB/OEBB, to evaluate and share outcomes as policy change is implemented elsewhere.

Next Steps

- **Establish a statewide program delivery contracting entity.** The most significant barrier to full implementation of Living Well as a paid benefit encountered during the early Health Engagement Model development process was lack of a contracting network and consistent pricing. The self-management hub model (Figure 1) describes a centralized system for statewide program delivery and financing, and its implementation is anticipated to effectively address the system challenge described above. This model is set forth in detail in the Living Well Business Plan, which was created in 2012 partially in response to the barriers encountered in PEBB/OEBB policy development.

- **Implement the Living Well Business Plan.** The process of implementing the Living Well Business Plan will take several years. Identifying personnel with sufficient business
acumen to effectively guide the project will be a key first step. After that, the new centralized hub will need to be established. Its data processing platform will need to be brought online and contracts put in place to assure the hub’s ability to assure statewide program delivery. Over time, the NDPP and other evidence-based programs will also be supported by the, providing a broad menu of options to appeal to diverse participant populations. Although PEBB and OEBB will likely be the first purchasers to join the centralized hub model, other organizations – including the newly formed Coordinated Care Organizations that replaced Oregon’s Medicaid managed care organizations in 2012 – will need to be convinced of the benefits of providing self-management programs on a large scale to their members, and signed on as purchasers.

**Continue this evaluation.** As the policy process moves forward, this evaluation will continue to track the effect of chronic disease self-management program promotions by means of three new questions added to the 2012 BSSE. These questions asked Oregon state employees covered by PEBB and OEBB if they ever heard of the Living Well program, if they have ever attended a workshop, and if they attended a workshop in the last 12 months. Although confidence intervals are wide due to the small overall sample size, 2012 baseline data indicate that initial promotion of Living Well programs may have already developed a degree of name recognition within PEBB and OEBB members prior to implementation of the Health Engagement Model. Per the 2012 BSSE, 24.7 percent of PEBB members had heard about Living Well with Chronic Conditions, 1.5 percent had participated in Living Well, and 1.2 percent had participated in 2011. Of OEBB members, 12.4 percent had heard of Living Well, but less than 0.5 percent indicated having ever participated. The DPCP will continue to analyze BSSE data to track program knowledge and participation by state employees – especially those with diabetes – and will consider adding future BSSE questions to identify NDPP knowledge and participation. A possible second evaluation report could present further case study history of the policy implementation process, as well as findings from the evaluation of the effects of program participation on PEBB’s and OEBB’s members.
Should necessary data become available, the DPCP hopes to augment this future report with an evaluation of the effect of the boards’ adoption of Living Well and the NDPP on program participation, health outcomes and chronic disease management costs for PEBB/OEBB members.
Figure 1. The Oregon Self-Management Central Hub: Future System for Delivery and Financing of Living Well Programs

**Oregon Self-Management Central Hub**
- Coordinates workshop scheduling & payments
- Tracks & reports data
- Monitors quality & fidelity
- Leader training
- Marketing

**Contractors**
- Provide workshops
- Receive payments

**Franchisees**
- Provide workshops for specific populations
- Access to scheduling/payment system

**Purchasers**

**OHA**
- Assures statewide reach & equity
Appendix A: Key Informants

- Sabrina Freewynn, Oregon Health Authority/Public Health Division/HPCDP, Community Program Liaison/Comprehensive Cancer Coordinator (union representative to Health Engagement Model Advisory Committee)
- Danna Drum, Oregon Health Authority/Public Health Division/HPCDP, Chronic Disease Programs Manager
- Joan Kapowich, Oregon Health Authority/PEBB/OEBB, Administrator
- Kathy Loretz, Oregon Health Authority/PEBB Deputy Administrator
- Shaun Parkman, Oregon Health Authority/Public Health Division/HPCDP, Evaluation Coordinator (union representative to Health Engagement Model Advisory Committee)
- Margaret Smith-Isa, Oregon Health Authority/PEBB Program Development Coordinator
Appendix B: PEBB Key Informant Interview Questions

1. Looking back, what initially drove your interest in chronic disease self-management and Living Well in particular?

2. What steps did you take to get to the point of presenting Living Well to your staff, boards, and other constituents?

3. What has been the greatest influence in your work related to Living Well?

4. What barriers have you faced and why?

5. What process will your organization need to include Living Well as a covered benefit for PEBB/OEBB beneficiaries?

6. What information, resources or other support would you need in order to begin offering Living Well as a covered benefit? What of this information, resources or other support is most important to making this change?

7. What challenges do you anticipate in this process?

8. What advice would you give to another organization, such as a private health plan or Medicaid, seeking to include Living Well as a covered benefit?

9. After coverage for Living Well is in place, what will need to happen to ensure successful implementation?

10. After coverage for Living Well is in place, what information would help your staff, board and other constituents understand how the benefit is working and whether it’s leading to the outcomes you intended?

11. What lessons have you learned about including community programs like Living Well as a PEBB/OEBB-covered benefit to date?
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