Business Plan Blueprint

Chronic Disease Self-Management Education

Office of Chronic Care, Wellbeing, and Performance Improvement
April 2018

NONPROFIT Impact
Your impact is our mission.

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NONPROFIT Impact

Your impact is our mission.

INTRODUCTION

Evidence-based Chronic Disease Self-Management Education (CDSME) programs have been offered across the state of Washington for over a decade. As health care reform has progressed, the outcomes generated by CDSME such as improved health outcomes and lower health care costs have become increasingly relevant. However, relevance and outcomes do not equal sustainability.

This business plan blueprint outlines how the Office of Chronic Care, Wellbeing, and Performance Improvement (the Office) will ensure ongoing, sustained access to CDSME and its outcomes for Washington's residents by acting as a program incubator. The purpose of the blueprint is to:

- Guide state actions to ensure sustained access to CDSME for Washington residents
- Define the type and amount of program management capacity needed at the regional level
- Define specific action steps to move towards sustainable and expanded access to CDSME

The blueprint is based on:

- 2014 sustainability and business planning work
- Review of current materials and program data
- Interviews with nine key informants
- Input from March 14, 2018, stakeholders meeting
- Experience and expertise of Nonprofit Impact and Office staff

Overview

The blueprint outlines

- A state-level strategic partnership focused on sustaining and expanding CDSME
- The scale, structure, and role of regional-level program delivery capacity
- Robust, sophisticated marketing and outreach to engage key gatekeepers and attract participants
- Scaling up program delivery to serve between 3-4x more individuals than presently served
- Revenue model and financial projections to ground truth the sustainability of the model

STRATEGIC FRAMEWORK

This section provides a high-level summary of the 'business' that is the focus of this blueprint document. Its format is similar to that of a strategic plan and it can be used as such.

Description

- The Office is a program incubator for CDSME

Purpose

- The Office's purpose is to ensure ongoing access to CDSME (and possibly other evidence-based programs) for a significant proportion of Washington residents with chronic conditions

Methods

- The Office pursues this purpose by:
  - Supporting the growth of strong regional centers to provide program management capacity
  - Partnering to align resources, policies, and systems that support sustainability
  - Using data to ensure equitable access to CDSME's outcomes for disparate populations

Values

- Data-driven decision making
- Providing access to disparate populations
- Person-centeredness and accessibility

Distinctive Competence

- Technical assistance
- Partnership development
- Market research
- Data analysis

Strategic Focus (Goals)

- Building regional program management capacity
- Taking program delivery to scale (right amount, right class, right leader, right place, right time)
- Building strong, effective partnerships
- Enacting necessary systems change (aligning resources, policies, and systems)
- Comprehensively aggregating and using data

Desired Impact

Informed by stakeholder input at March 14, 2018, meeting:

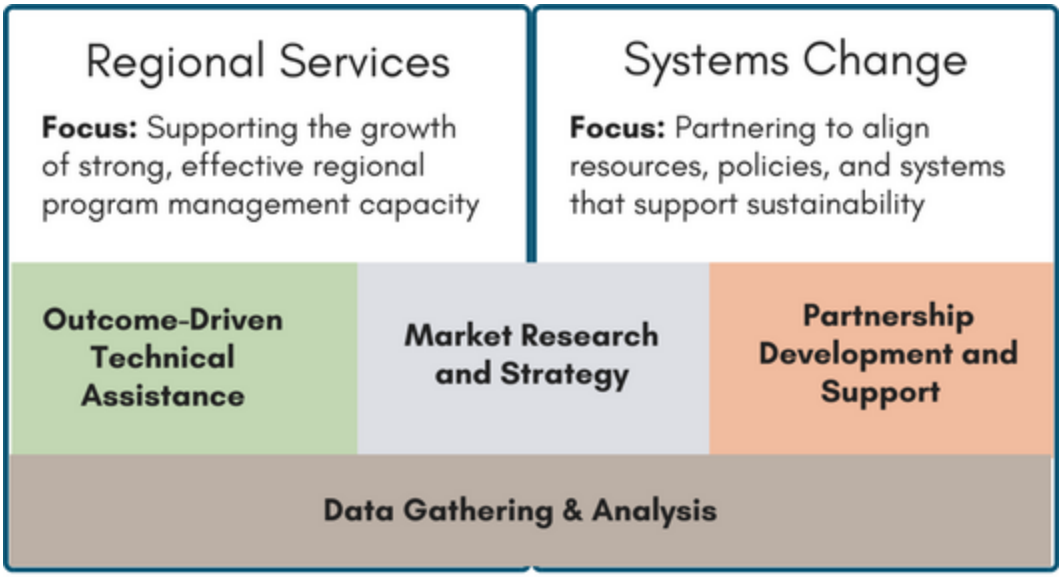
- People of all ages with chronic conditions – and especially those disparately impacted by such conditions – have access to CDSME and other evidence-based programs. These programs are attended and completed by a significant proporation of adults with chronic conditions each year
- Participants learn about CDSME programs from their health care provider, community health worker, community-based organization, or other trusted actor. Their participation is often part of an overall coordinated care plan
- Workshops are offered in their local community, in a variety of languages and settings (including online). CDSME programs are available in settings that are comfortable, culturally-relevant, and easily-accessible (transportation, mobility, sight, hearing, physical rigor, etc.)
- Program participants experience significant and sustained positive health outcomes and at a population level, CDSME programs make a demonstrable impact (reducing health care costs, ER usage, and hospital readmission rates; increases in patient activation, adherence, etc.)

PRODUCTS AND SERVICES

This section outlines what work the Office does to achieve its goals as the CDSME program incubator (its products and services).

Primary Products and Services

- The Office's primary products and services flow directly from the methods highlighted in the strategic framework:
  - Supporting the growth of strong regional centers to provide program management capacity
  - Partnering to align resources, policies, and systems that support sustainability
  - Using data to ensure equitable access to CDSME's outcomes for disparate populations
- These products and services fall into two broad categories: regional services and systems change
- The graphic below illustrates how products and services relate to these categories



Regional Support Products and Services

- The Office works to support and enable the growth of regional centers that manage the promotion, coordination, and delivery of CDSME programs at the regional level
- It does this by providing:
  - Outcome-driven technical assistance
  - Market research and strategy
  - Data gathering and analysis

Product/ Service	Description
Outcome-driven technical assistance	▲ Outcome-driven technical assistance is a systematic approach to TA that focuses on delivering specific, agreed-upon outcomes ▲ The Office's TA services provide customized training, information, tools, templates, processes and protocols to help regional centers: • Cultivate, structure, and launch regional centers • Define and implement appropriate business models • Navigate and build regional-level partnerships • Share best practices and lessons learned across regions
Market research and strategies	▲ The Office's market research and strategies services provide sophisticated, high-quality information and tools to help regional centers: • Reliably and effectively promote CDSME workshops to program participants • Build strong partnerships with regional health care actors ▲ Examples of products and services include: • Target market profiles • Overall marketing and outreach strategies and tactics and guidance in how to customize them for local markets • Customizable materials, templates, messaging, etc.
Data gathering and analysis	▲ The Office's data gathering and analysis services ensure consistent, high-quality activity and outcome data is available to help regional centers: • Make data-informed decisions • Strengthen funding proposals • Illustrate impact to partners and funders

Systems Change Products and Services

- ▲ The Office works with partners to align resources, policies, and systems that support sustainability of CDSME programs
- ▲ It does this by providing:
  - Partnership development and support
  - Market research and strategy
  - Data gathering and analysis

Product/ Service	Description
Partnership development and support	▲ The Office's partnership work focuses on the development and support of a strategic alliance – the Washington Evidence-Based Program Partnership (the Partnership) • For more information, see Strategic Partnership section

	▲ The Office's partnership development and support work will initially focus on helping to initiate the Partnership ▲ Future partnership development and support work be defined by the Partnership agreement (TBD)
Market research and strategies	▲ The Office's market research and strategies services provide sophisticated, high-quality information and tools to help the Partnership: • Understand state-level health care actors as a target market • Identify and develop effective outreach strategies and tools • Build strong partnerships and/or cases for support
Data gathering and analysis	▲ The Office's data gathering and analysis services ensure consistent, high-quality activity and outcome data is available to help the Partnership: • Quantify the impact of CDSME across a variety of indicators • Support its requests and proposals with data

Secondary Products and Services

- The Office provides secondary products and services to fill gaps and maximize resources

Central CDSME Infrastructure

- The Office develops and maintains those central CDSME infrastructures that are best provided at a statewide level to avoid duplication of effort and/or take advantage of economies of scale
- Current examples of these include:
  - Statewide CDSME website (https://livingwell.doh.wa.gov/)
  - Comprehensive program database (leaders, license holders, CDSME providers, etc.)
- Future examples might include:
  - Statewide volunteer management database
  - Statewide conference for leaders and/or CDSME program providers

Auxiliary Program Management

- In some cases, the Office directly manages the provision of CDSME programs. These include:
  - Better Choices, Better Health: the online version of CDSME
  - Targeted populations: CDSME programs targeted at a specific, underserved population
  - Pilot programs: New evidence-based programs, offered for limited periods of time to assess feasibility and impact

ORGANIZATIONAL DEVELOPMENT

This section defines the internal capacity the Office needs to be successful.

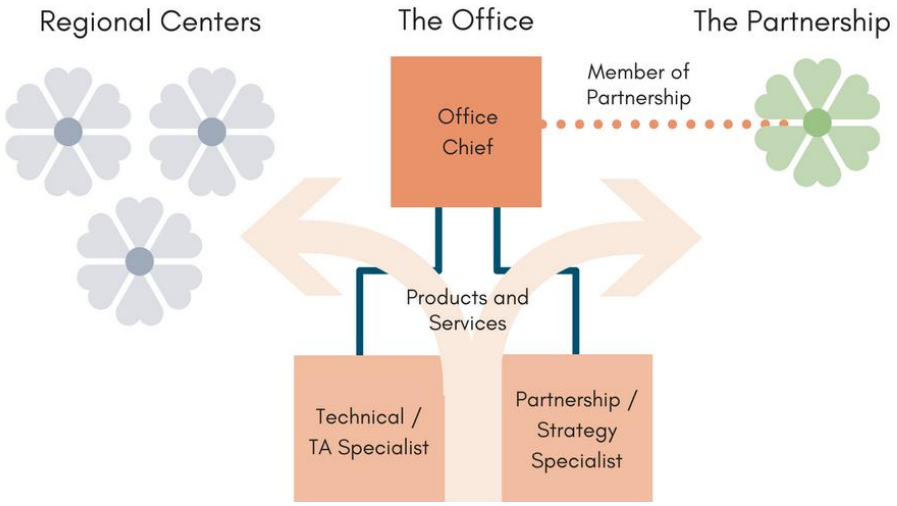
Leadership

- The organizational function of leadership includes setting a compelling vision, communicating that vision clearly and consistently to followers, and securing resources and removing obstacles so that the vision can be achieved
- In the effort to sustain CDSME, responsibility for providing leadership is shared:

Level	State	Regional
Leadership resides…	With the Washington Evidence-Based Program Partnership (the Partnership)	With the regional center
Responsibility for leadership is defined…	In the Partnership agreement	In the partnership agreement developed within the region
Office's role…	One among equals, sharing the state-level leadership responsibility	Supporting regional-level leadership through its products and services

Structure

- The Office Chief supervises the technical/TA specialist and the partnership/strategy specialist
  - The Office Chief is a member of the Partnership
  - Specialists provide products and services to the Partnership and Regional Centers



Management and Staffing

- The Office Chief is responsible for overall management towards results
- Specialists are high-level professionals, taking initiative, providing all products and services, and directly developing and managing relationships with Regional Center and Partnership leaders on behalf of the Office

Position	Role/ Responsibilities
Office Chief	▲ Set annual work goals and priorities with and supervise incubator staff ▲ Participate in the development and ongoing work of the Partnership ▲ Integrate work of incubator staff within overall Office goals and priorities
Partnership/strategy specialist	▲ Conduct market research and develop marketing strategies ▲ Research and make partnership development recommendations and making proposals to health care 'reformers' market (see Markets section) ▲ Quantify the connections between CDSME outcomes, the chronic care model, key health care indicators, etc. ▲ Support Regional Centers in customizing marketing and partnership development strategies
Technical/TA specialist	▲ Provide outcome-drive TA services to Regional Centers ▲ Gather and analyze CDSME program data ▲ Develop and maintain centralized CDSME infrastructure ▲ Capture and disseminate best practices, lessons learned, etc. ▲ Facilitate networking amongst regional centers and local providers ▲ Analyze program delivery, health equity, and public health data to identify high-priority populations

Systems and Processes

▲ The Office requires these core systems and processes to complete its work

Category	Systems & Processes
TA-Related	▲ Project management system to manage and track progress of individual TA projects and deliverables and maintain TA records and contact information ▲ Suite of tools and templates that address common requests and challenges (for example, process outline and meeting agendas to decide on regional model) ▲ Tools and systems to help efficiently deliver outcome-driven TA (intake form, TA engagement agreement, etc.) ▲ Communication vehicle to regularly share information and best practices
Marketing-Related	▲ CDSME website, workshop calendar, etc. with sufficient tech support to maintain ▲ Market research tools (e.g., access to research databases, journals, etc.) ▲ Shared drive where Regional Centers and local providers can access templates, logos, etc. ▲ System to measure effectiveness of marketing strategies ▲ Process to work with regions to customize marketing plans and materials
Data-Related	▲ Database to track license holders, providers, and leaders across the state ▲ User-friendly process to gather data from Regional Centers ▲ Tool to aggregate and analyze regional and local data ▲ Access to public health and other data sources to inform analyses

THE WASHINGTON EVIDENCE-BASED PROGRAM PARTNERSHIP

This section defines the strategic partnership of which the Office is one member. See Appendix: Potential Partnership Members for more information on other potential members.

Role and Responsibilities

- Responsibility for sustaining CDSME is owned at both the state and regional levels
  - At the state level, responsibility will be held by the Washington Evidence-Based Program Partnership (the Partnership), a new strategic partnership designed for the express purpose of sustaining and expanding CDSME
- The role of the Partnership is to create an environment where CDSME can flourish
- The Partnership's responsibilities include:
  - Defining and communicating a compelling vision for the impact that widely-available access to CDSME can have on the state of Washington
  - Actively making the case for CDSME to state-level health care and philanthropic organizations (explaining the benefits, presenting the evidence-base, connecting to dots between CDSME outcomes and the goals and priorities of others, etc.)
  - Aligning policies, regulations, and funding structures to support and/or incentivize the provision of CDSME programming (e.g., exploring Medicare Advantage coverage)
  - Monitoring CDSME outcome, public health, and other data to guide the growth and expansion of CDSME (e.g., to benefit underserved populations or geographies)
  - Brokering relationships between interested parties and regional coordinating organizations

Role of Convener

- The Partnership should be hosted by a nonprofit sector partner to enhance the agility and independence of the Partnership to pursue its work
- The host organization's role is that of convener, not leader, secretary, or gopher
  - Roles and responsibilities of all individual partners must be specifically delineated in a partnership agreement to ensure no undue burden falls on any one organization

Membership

- Membership includes organizations with missions or strategic goals that overlap with the Partnership's purpose of sustaining and expanding CDSME in Washington
- Such overlap exists between the Office and other state-level groups focused on evidence-based programs; in addition, organizations interested in health equity and disparities, active, educated health care consumers, and practice transformation are likely candidates

REGIONAL CENTERS

This section defines two different Regional Center models (structure, systems, and financial scenarios for both the Regional Centers and local CDSME providers).

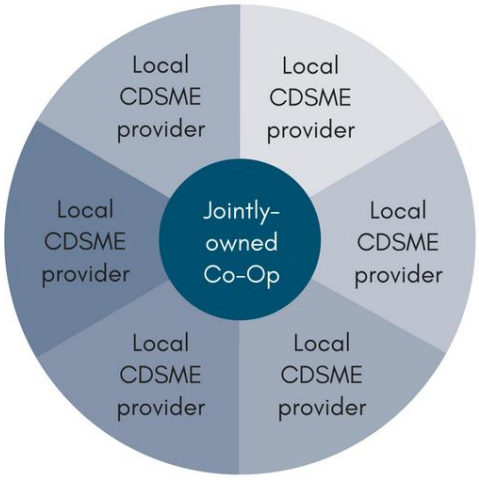
- In Washington, CDSME historically has been organized based on the state's Area Agency on Aging (AAA) regions; the state's ACHs and MCOs are also organized regionally
- Moving forward, CDSME will continue to be organized regionally, with Regional Centers as the primary means of managing and sustaining CDSME program delivery; however:
  - The map of those regions will vary from what currently exists (the most useful regional boundaries to be set on a case-by-case basis)

Purpose and Role of Regional Centers

- Organizing the delivery of CDSME programs at the regional level offers two key benefits:
  - Alignment between the scope and scale of CDSME programming and health care sector
  - Region-level economies of scale that lower per unit costs for local CDSME providers
- The purpose of the regional center is to manage the delivery of CDSME programming for the region, including:
  - Growing the demand for CDSME - business development, securing contracts to provide CDSME, etc.
  - Ensuring sufficient CDSME 'supply' to meet that demand– workshops, trainers, availability across the region
  - Gathering and aggregating data for the region (activity and outcome information, contact information (providers, lay leaders, health care customers, etc.)
  - Customizing and implementing marketing and outreach strategies to attract program participants
  - Building and maintain partner relationships and increasing the visibility and understanding of CDSME and its value among the regional 'reformers' market segment
  - Holding and maintaining the CDSME license for the region
- The two models for regional centers outlined here are:
  - Jointly-owned co-op model
  - Lead agency model

Model 1: Regional Center as Jointly-Owned Co-Op

- In this model, local CDSME providers/ partners develop and jointly-own the regional center
- As co-owners, all partners receive a share of the co-op's services and a share of its risk



Structure

- Uses a co-op business model
- "Co-operatives are people-centered enterprises owned and run by and for their members to realize their common dreams." (International Co-Operative Alliance)
- Operated by professional staff who provide member services and regional management functions outlined above
- Can be organized under the auspices of one of the co-op partners (i.e., via a fiscal agency agreement) or as a 501(c)(3) nonprofit organization
- Defined and governed by a co-operative agreement that outlines member services, decision making processes, accountability, and overall operations

Systems, Policies, and Procedures

- Volunteer / contact management system and database – including functionality to track the status of each volunteer trainer and provider, and recruit, train, and retain volunteers
- Regional workshop calendar/scheduling system
- Partnership development and management processes (esp. to organize the development of partnership with regional health care actors)
- Project management system (esp. to manage business development activities)
- Member services menu and systems (including regular member meetings and communications)
- Co-operative agreement and other organizing documents; for resources, see:
  - International Co-Operative Alliance (https://ica.coop/)
  - National Co-Operative Business Association (http://www.ncba.coop)
  - United States Federation of Worker Co-Operatives (https://usworker.coop)

Financial Scenario

- The following financial scenario for the Regional Center is based on the following assumptions:
  - Co-op employs 2 FTE (1 - Business Development, Partnerships; 1 - Program & Membership Assistant)
  - Co-op includes 18 members who provide 3-5 workshops/year (total of 80 workshops/year)
  - Co-Op is housed by one of the members, which also acts as fiscal agent

Regional Center: Co-Op Scenario

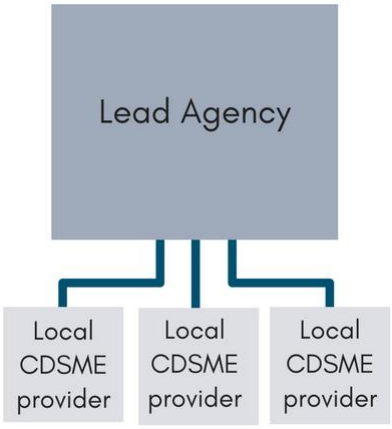
Line Item	Amount	Notes
Expenses		
Stanford License	2,667	$8000 umbrella license / 3 years
Salaries	115,000	2 FTE
Benefits	40,250	35% of salary
Mileage	2,000	
Leader Training	28,500	2 leader trainings/ year
Workshop Materials	8,960	See materials calculator in spreadsheet
Equipment	3,000	
Marketing & Advertising	6,500	
Supplies	1,000	
Meeting expenses	3,000	
Fiscal agent expense	5,000	Fiscal agent also exempt from membership fee
Total Annual Expenses	215,877	
Revenue		
Co-Op Membership Fees	8,500	17 members @ $500
BCBH Referrals to Office	10,000	100 referrals @ $100
Hospital/HC System Contracts	282,000	470 workshop seats @ $600
PEBB Pilot Project	120,000	200 workshop seats @ $600
Private Pay (individuals)	18,000	30 workshop seats @ $600
Employer-based workshops	60,000	10 workshops @ $6,000
Total Revenue	498,500	
Net Revenue	**282,623**	
Net Revenue/Workshop	3,533	

- The following financial scenario for co-op members is based on the following assumptions:
  - Members pay an annual membership fee which covers licensing costs, leader training for up to 2 trainers/year and workshop materials
  - Net revenue is split among members to cover their workshop expenses

CDSME Provider: Co-Op Member Scenario (5 workshops)

Line Item	Amount (2 staff leaders)	Amount (1 staff + 1 lay leader)	Notes
Expenses			
Co-Op Membership Fee	500	500	
Staff Expenses (leaders + coordination)	10,200	9,250	See provider calculator in spreadsheet
Space Rental	3,000	3,000	6 sessions x 5 workshops @ $100
Food	3,000	3,000	6 sessions x 5 workshops @ $100
Mileage	1,500	1,500	500 miles @ $.60/mile
Total Expenses	18,200	17,250	
Cost/Workshop	3,640	3,450	
Revenue			
Co-Op Payment	17,665	17,665	5 workshops @ $3,533
Net Revenue (Loss)	(535)	415	

Model 2: Lead Agency as Regional Center



- In this model, one organization or agency serves as the Regional Center; this is the lead agency
- CDSME is provided by either staff and volunteers of the lead agency, by local CDSME providers, or by a combination of the two

Structure

- Structure will vary depending upon the type of organization that serves as lead agency and how the Regional Center functions relate to the lead agency's overall mission and purpose (e.g., is serving as a regional center the lead agency's primary focus, or one program among many?)
- The lead agency and local CDSME providers have contractor-subcontractor relationships
  - The contract to provide CDSME programming defines and governs the relationship between the local provider and the lead agency

Systems, Policies, and Procedures

- Like the co-op model, this model also requires the volunteer / contact management, regional workshop calendar/ scheduling, partnership development and management, and project management systems and process
- In addition, the lead agency model requires:
  - Contract management tools and systems
  - Governing documents and other organizational systems aligned to reflect the Regional Center's responsibilities

Financial Scenario

- This first financial scenario for the Regional Center is based on the following assumptions:
  - Lead agency employs 1.5 FTE (1 - Business Development, Partnerships; .5 -Program Assistant)
  - Lead agency contracts with ~10 providers who provide ~5 workshops/year (total of 50)
  - Lead agency is organized as a program within an existing organization

Regional Center: Lead Agency Scenario 1

Line Item	Amount	Notes
Expenses		
Stanford License	2,667	$8000 umbrella license / 3 years
Salaries	100,000	1.5 FTE
Benefits	35,000	35% of salary
Mileage	1,000	
Leader Training	14,250	1 leader training/ year
Workshop Materials	5,600	See materials calculator in spreadsheet
Equipment	4,000	
Marketing & Advertising	7,500	
Supplies	1,000	
Meeting expenses	3,000	
CDSME provider contracts	175,000	Rate of $3,500/ workshop
Total Annual Expenses	349,017	
Revenue		
Contractor Share - Leader Training	13,000	Contractors cover materials and per diem
BCBH Referrals to Office	7500	75 referrals @ $100
Nonprofit Hospital Contracts	60,000	100 workshop seats @ $600
PEBB Pilot Project	120,000	200 workshop seats @ $600
Private Pay (individuals)	30,000	50 workshop seats @ $600

Employer-based workshops	30,000	50 workshop seats @ $600
Public pay pilot project	60,000	100 workshop seats @ $600
Total Revenue	320,500	
Net Revenue (Loss)	(28,517)	

- This second financial scenario for the Regional Center is based on the following assumptions:
  - Lead agency employs 2.5 FTE (2 - Business Development, Partnerships, Outreach; .5 - Program Assistant)
  - Lead agency contracts with 10-20 providers who provide 100 workshops/year in total
  - Lead agency is organized as a program within an existing organization

Regional Center: Lead Agency Scenario 2

Line Item	Amount	Notes
Expenses		
Stanford License	2,667	$8000 umbrella license / 3 years
Salaries	165,000	2.5 FTE
Benefits	57,750	35% of salary
Mileage	1,000	
Leader Training	28,500	2 leader trainings/ year
Workshop Materials	11,200	See materials calculator in spreadsheet
Equipment	4,000	
Marketing & Advertising	7,500	
Supplies	1,000	
Meeting expenses	3,000	
CDSME provider contracts	350,000	Rate of $3,500/ workshop
Total Annual Expenses	631,617	
Revenue		
Contractor Share - Leader Training	26,000	Contractors cover materials and per diem
BCBH Referrals to Office	125,000	125 referrals @ $100
Nonprofit Hospital Contracts	120,000	200 workshop seats @ $600
PEBB Pilot Project	240,000	400 workshop seats @ $600
Private Pay (individuals)	60,000	100 workshop seats @ $600
Employer-based workshops	60,000	100 workshop seats @ $600
Public pay pilot project	120,000	200 workshop seats @ $600
Total Revenue	751,000	
Net Revenue (Loss)	119,383	

- The following financial scenario for subcontractors is based on the following assumptions:
  - Subcontractors cover a portion of leader training expenses

CDSME Provider: Subcontractor to Lead Agency Scenario (5 workshops)

Line Item	Amount (2 staff leaders)	Amount (1 staff + 1 lay leader)	Notes
Expenses			
Leader Training Expenses	650	650	2 trainees @ $325
Staff Expenses (leaders + coordination)	10,200	9,250	See provider calculator in spreadsheet
Space Rental	3,000	3,000	6 sessions x 5 workshops @ $100
Food	3,000	3,000	6 sessions x 5 workshops @ $100
Mileage	1,500	1,500	500 miles @ $.60/mile
Total Expenses	18,350	17,400	
Cost/Workshop	3,670	3,480	
Revenue			
Co-Op Payment	17,500	17,500	5 workshops @ $3,500
Net Revenue (Loss)	(850)	415	

Implications and Considerations

- As the financial scenarios demonstrate, implementing the regional program delivery capacity needed to sustain CDSME requires significant increase in the number of workshops offered
- This fact further highlights the critical importance of:
  - High-quality, sophisticated, customizable marketing strategies, tactics, and materials to ensure full workshops
  - Demonstrating the value of CDSME to regional health care actors as a basis for long-term, durable partnerships
- Even so, financial scenarios are barely (and not always) break even for both Regional Centers and local CDSME providers; this indicates:
  - Higher likelihood of success by banding together (for example, with other evidence-based programs or other community social or support services) to:
    - Realize economies of scale and lower expenses
    - Provide additional value and hold a strong negotiating position with health care actors

Implications for Local CDSME Providers

- Both the Co-op and Lead Agency take some amount of control over how the program is managed away from local providers
- Given this loss, it is important to incentivize existing local providers to stay engaged, by:
  - Centralizing administrative tasks within Regional Centers while keeping other responsibilities within the control of local providers (for example, locating and using discounted or donated workshop space and/or lay leaders to lower direct expenses)
  - Respecting knowledge, connections, and affinity for local communities and target populations to the greatest extent possible (including, not stepping on already-established relationships and engaging local providers to ensure marketing materials are customized to best effect)
  - Convening local providers to deliberate and decide what model best serves their region
- In addition, stakeholders at the March 14, 2018, meeting recommended that Regional Centers:
  - Maintain existing relationships that connect individuals to CDSME while building new pipelines with the health care sector
  - Preserve and replicate bright spots within their region
  - Work with local providers to ensure that community-level relationships remain strong and the content expertise of local providers is maintained
  - Pay attention to details such as aligning the trainer with the community, addressing barriers to workshop access, and post-workshop support
- They also highlighted the following benefits and costs to local CDSME providers:

Benefits	Costs
Leaders can lead across regional partners (more experienced leaders, maintain certification)	Sharing of leaders with other CDSME providers; new demands on leaders
Participants have quicker access to programs	Participants may attend workshops offered by another provider
More consist, reliable, regional data	Risk of sharing data
Unified voice negotiating with health care, requesting funding, etc.	Competition (e.g., health care entities or funders who support CDSME regionally may not do so locally)
Off-loading administrative tasks (volunteer management, leader training, marketing, cost of licensing, responsibility for fidelity) to Regional Center	Less control (adhering to shared protocol, effect of differences in perspective in approach to management (for example, lens of social justice or specific population))

MARKETS

While it is beyond the scope of this project to complete all the needed market research and planning, this section outlines specific market segments and preliminary profiles target markets. See Appendix: Target Market Profiles and Appendix: Outreach Strategies for additional details.

Market Segment: Chronic Conditions Contemplators

- 38% of Washingtonians over the age of 18 have one or more chronic conditions
  - Total population (2016): 7,288,000
  - Population 18+: 5,655,488 (77.6%)
  - Estimated population 18+ with one or more chronic conditions: **2,149,085**
- While all 2+ million of these individuals can benefit from participating in CDSME, the transtheoretical model of behavior change helps focus on the target market most likely to take the desired action

Stage	Definition	% at Stage*	Mindset
Pre-Contemplation	Individual does not intend to act within the next 6 months; may be unaware of problematic behavior or negative consequences	40%	I won't; I can't
Contemplation	Individual does intend to act within the next 6 months; aware behavior may be problematic	40%	I might
Preparation	Individual is ready to act within the next 30 days; believe behavior change can lead to healthier life	20%	I will
Action	Individual has changed behavior within the last 6 months and intend to maintain the change		I am
Maintenance	Individual has sustained their behavior change for more than 6 months		I have

* "Basic research has generated a rule of thumb for at-risk populations: 40% in precontemplation, 40% in contemplation, and 20% in preparation." (https://www.ncbi.nlm.nih.gov/pubmed/10170434)

- Using this framework and the related rule of thumb as a guide, the size of the 'chronic disease contemplators' target market is estimated at **859,634 adults**
- The purpose of reaching this target market is to move them from the contemplating stage (I might) to the preparation stage (I will)
  - Success will be measured in terms of individuals beginning to act (e.g., signing up for a CDSME workshop and attending the first session)

- Individuals in the contemplation stage are aware that problematic behavior (i.e., not successfully managing their chronic condition) can lead to negative consequences
- Homing in on the source of this awareness helps define this market segment into three specific target markets:
  - New & overwhelmed
  - Transitioners
  - Connected & informed

Market Segments: Health Care Reformers

- In Washington, health care reform is tightly focused on the accountable communities of health (ACHs), which exist to:
  - Promote health equity throughout the state
  - Create, support, and collaborate on local health improvement plans
  - Support local and statewide initiatives such as the Medicaid Transformation, practice transformation, and value-based purchasing
  - Align resources and activities that improve whole-person health and wellness
- While the ACHs are the primary organizing framework at play, the larger health care sector includes a wide variety of actors: payers, providers, and policy makers just to name a few
- CDSMP desires these various actors to take a variety of actions, including:
  - Referring individuals with chronic conditions to CDSME programs
  - Reimbursing providers of CDSME
  - Enacting policies and regulations that incentivize use of CDSME
  - Setting priorities and precedents for contracting with CDSME providers at the regional level
- Therefore, the reformers market segment is divided into target markets by health care actor:
  - Private and public payers
  - Health care system (including hospitals)
  - ACHs and MCOs
  - Health care providers (individuals and networks)
  - Policy makers

OFFICE FINANCIALS

Annual Expenses

Line Item	Amount	Notes/ Assumptions
Partnership/strategy specialist	72,000	
Technical/TA specialist	72,000	
Fringe benefits	50,696	based on CDSME grant narrative
Travel	12,500	
Equipment	2,000	
Meeting expenses	5,000	primarily TA-related
Stanford license	1,500	variable; dependent on program management workload
Promotional materials	2,500	
Contractors	10,000	variable; design, evaluation, etc.
Systems (website, data, etc.)	12,000	
Indirect costs	201,720	$8450/FTE/month
Total	**441,916**	

Revenue Sources

- As the program manager for Better Choices, Better Health, the Office will be the recipient of contract or reimbursement revenue secured for this program (likely shared with Regional Centers that recruit on-line participants)
- Revenue from documented cost savings attributable to access to CDSME (likely to public payers – Medicaid, Medicare, PEBB) is an additional revenue source for the Office
  - Again, some level of revenue-sharing with Regional Centers is likely appropriate to ensure regional revenue models are not undercut

APPENDIX: POTENTIAL PARTNERSHIP MEMBERS

- Potential partners include leaders from the following offices and organizations

Partner	Mission
Governor's Interagency Council on Health Disparities	Responsible for identifying priorities and creating recommendations for the Governor and Legislature to eliminate health disparities by race /ethnicity and gender in Washington
Consumer Education Committee of Washington Health Alliance	To develop strategies to empower individuals to more actively manage their health and health care through consumer education initiatives
Healthier Washington Practice Transformation Support Hub	Supports transformation of the health delivery system through investment in knowledge, training, and tools, that effectively coordinate care, promote clinical-community linkages, and transition to value-based care.
Department of Health – Health Equity Workgroup	A cross-agency workgroup charged with identifying policy options to promote health equity
Diabetes Network Leadership Team (hosted by DOH)	To identify priorities and develop strategies to align with the goals and mission of the participating organizations; made up of 40 members from the public, private, tribal, educational, healthcare, public health, non-profit, and governmental organizations
Washington State Falls Prevention Coalition (hosted by DOH)	To discuss updates in falls prevention data, learn about new programming and exchange ideas
Washington Traumatic Brain Injury Strategic Partnership Advisory Council	To bring together expertise from the public and private sector to address the needs and gaps in services for this community
Dementia Action Collaborative	To prepare Washington state for the growth of the dementia population; a group of public-private partners
ALTSA's Office of Chronic Care, Wellbeing, and Performance Improvement	Seniors and people with disabilities living with good health, independence, dignity, and control over decisions that affect their lives.

- While this list makes it appear that the Partnership would be dominated by state agencies, the majority of the potential partners listed here are themselves partnerships or coalitions which include private, nonprofit, and public-sector organizations

APPENDIX: TARGET MARKET PROFILES

These initial target market profiles can serve as a starting point for more in-depth research.

Conformer Target Market Profiles

Target Market	Profile
New & Overwhelmed	▲ Newly diagnosed, likely late-30's to late-50's ▲ Fearful, uncertain, overwhelmed by information and looking for certainty ▲ May have a loved one with a similar condition or otherwise been witness to the potential negative consequences they could face ▲ Motivated by promise of avoiding/mitigating negative consequences, messages of empowerment, specific, credible advice
Transitioners	▲ Likely diagnosed for some time ▲ Older adults (65+) or young adults (late teens to mid-20s) ▲ Recently experienced (or anticipating) a catalyzing event (a recent hospitalization, transition out of a nursing care facility, leaving the family home, etc.) that is bringing the consequences of poorly managing a chronic condition into focus ▲ Have been shielded from the negative consequences of their condition until now ▲ Motivated by desire to be independent, to not let their condition dictate where or how they live their lives, positive messages about their future
Connected & Informed	▲ May be newly diagnosed or diagnosed for some time ▲ Have a strong connection to a community, organization, or institution that they trust, turn to for advice or information, and interact with regularly • For example: place of worship, senior center, community or recreation center, a community-focused health care provider, network, or clinic, stakeholder group ▲ Likely social, friendly, open to information and advice ▲ Motivated by norms of the community, organization, or institution; messages from peers, community leaders, related publications

Reformer Target Market Profiles

Target Market	Focus	Motivating Factors
Private payers	▲ Medicare Advantage plan providers (24 contractors offering 99 plans); enrollment: 354,103 (2017)	▲ Prevention ▲ Effective management of chronic conditions ▲ Low hospitalization and readmission rates ▲ Overall cost savings
Public payers	▲ Apple Health (Medicaid); enrollment: 1,855,500 (2016)	▲ Overall cost savings ▲ Transitioning/maintaining individuals in home and community-based living situations

	▲ Medicare; enrollment: 1,190,127 (2015)	▲ Postponing Medicaid enrollment ▲ Health outcomes for older adults, people with disabilities, and people from disparate populations
ACHs & MCOs	▲ All 9 ACHs ▲ All 5 MCOs (cover over 1.4M Medicaid enrollees)	▲ Regional-level health outcomes ▲ Enacting transformation and reform efforts ▲ Achieving key indicators tied to financial incentives and disincentives (i.e., ER usage, readmission rates, etc.) ▲ Maximizing payments under value-based payment model
Health care providers	▲ Primary care providers, community health workers, etc. ▲ Mix of individuals and networks	▲ Patients' health and quality of life outcomes ▲ Activated, informed patients ▲ Adherence to medication/instructions
Hospitals/ health care systems	▲ Private nonprofit and public hospital districts; FQHCs; Indian Health Services	▲ Patient populations ▲ Mission-related goals and priorities ▲ Overall cost savings
Policy makers	▲ State and regional elected and appointed officials and agency staff focused on health care, behavioral health, public health, healthy aging, etc.	▲ State and regional health outcomes ▲ Decreasing health care costs related to chronic conditions ▲ Decreasing readmission rates, ER utilization, etc. ▲ Clinical-community linkages

APPENDIX: OUTREACH STRATEGIES

These preliminary strategies will be further refined based on market research and testing

Preliminary Strategies: Contemplators

Target Market	New & Overwhelmed	Transitioning	Connected & Informed
Strategy	▲ Be an easy-to-find answer	▲ Target those who aid the transition (CDSME as a valuable tool in the toolkit)	▲ Reach via a trusted messenger
Obstacles	▲ Denial/fear ▲ Time (work, family obligations)	▲ Urgency ▲ Higher-priority needs (housing, etc.) ▲ Access (transportation, language, internet, mobility)	▲ Language ▲ Competing priorities ▲ Access (transportation, language, internet, mobility)
Messaging	▲ The basics: what, where, when, how, why ▲ Diagnosis isn't destiny – you can take charge of your health and wellness	▲ CDSME is key to attaining/ reclaiming your independence ▲ Manage your condition, don't let it manage you	▲ Testimonials from peers or individuals with common background
Placement	▲ Health care providers ▲ Payers (esp. payer patient-education staff) ▲ AAAs	▲ Hospital staff (discharge planners, ER, social workers) ▲ Centers for Independent Living ▲ Nursing facilities, rehab facilities ▲ HCBS providers and senior nutrition providers	▲ Senior centers ▲ Recreation and community centers in areas with high % of older adults ▲ Faith communities ▲ Rural, tribal, FQHC clinics and providers
Outreach Strategies	▲ Targeted web ads (e.g., WebMD) ▲ Promotional agreements with payers, ACHs, etc. ▲ Provider outreach and education (in partnership with other support services) ▲ Promote HCHB	▲ Program materials that can be co-branded ▲ Ability to help an individual sign up for a workshop ▲ Partnership with health care providers and systems focused on reducing ER usage or readmission rates	▲ Customized/ customizable program materials and presentations ▲ Newsletters, websites, e-news of community organizations ▲ Speakers bureau (past participants) ▲ Workshops delivered in the community site

	▲ Tool/checklist that highlights pros and cons of CDSME	▲ Industry communications (hospital association conference, association newsletters, etc.) ▲ Training HCBS and other service providers in who benefits from CDSME (eyes and ears)	

Preliminary Strategies: Reformers

- ▲ The Office needs reformer target markets to take a very diverse set of actions
  - With state-level reformers, the strategies are long-term and aim at securing a variety of one-time policy changes
  - With region-level reformers, the strategies are also long-term, but aim at securing ongoing action and engagement

State-Level

Category	Desired Action	Outreach Strategy
Private payers Public payers	▲ Reimburse CDSME ▲ Cover expenses associated with CDSME (e.g., transportation) ▲ Promote CDSME to insured individuals who have chronic condition	▲ Be where they are (WA Health Alliance, conferences, meetings, etc.) ▲ Identify and build relationships with specific offices within state Medicaid agency; invite involvement in Partnership ▲ Hold 'informational interview'-type meetings with payers, key informants, etc. to build relationships ▲ Pursue specific requests and proposals to elicit desired actions
Policy makers	▲ Incentivize use of CDMSE	▲ Build relationships and communication channels to stay up on speed on initiatives and opportunities ▲ Incorporate updates re: CDSME and the Partnership in updates and reports that go 'up the chain' in state agencies ▲ Identify offices, departments, and committees involved in relevant decision-making processes and hold educational meetings to explain CDSME outcomes ▲ When appropriate, provide access to network of regional coordinating bodies and local CDSME providers (e.g., to promote an upcoming policy change, etc.)

Regional Level

Category	Desired Action	Outreach Strategy
ACHs & MCOs	▲ Contract with regional coordinating bodies to provide CDSME	▲ Be where they are (regional decision-making tables) ▲ Build relationships
Health care providers	▲ Refer patients to CDSME	▲ Ally with other community service providers to coordinate and streamline provider outreach and education ▲ Identify ways to incorporate CDSME screening and referral into existing health care provider systems and SOPs ▲ Devote sufficient capacity to carry out ongoing, consistent outreach to providers
Hospitals/ health care systems	▲ Connect patients with chronic conditions to CDSME	▲ Research individual hospital/system initiatives where financial incentives overlap with CDSME outcomes ▲ Compile comprehensive list key 'gatekeepers': discharge planners, social workers, etc. ▲ Build partnerships based on overlap ▲ Direct in-person outreach to gatekeepers

Position and Messaging

- Most reformers are part of the health care system; for these target markets, terms like 'evidence-based' or CDSME may have little or no meaning; it is important to translate to more familiar language to effectively communicate the value of CDSME, for example:
  - Patients or insured lives instead of program participants
  - Health- or patient-education program instead of evidence-based program
- It is also paramount to place CDSME into the wider context that each specific target market uses
  - For payers – the population they ensure
  - For ACHs & MCOs – their region; their transformation project; etc.
- One dominant framework the vast majority of reformers are familiar with is the chronic care model – when in doubt, explain CDSME to reformers by how it relates to this model

Position/Niche

- Positioning means how CDSME is defined in relation to others it may be compared to
  - Communicating CDSME's position or niche (the unique role it plays) can also be helpful with these target markets

Other Supports	How CDSME is Unique
'Ask a nurse' type follow up	▲ Participants build real-life relationships with people in their community ▲ They choose the time and place of the workshop they attend (vs. trying to catch people when they have time to talk on the phone)
Follow up medical appointments	▲ Workshops include six 90-minutes sessions, providing much more time to teach skills, answer basic questions, and reinforce messages
Written educational materials	▲ Participants receive in-depth, proven educational materials that inform them about all the skills they need and can ask questions to clarify what they read

Messaging

▲ The following table provides preliminary messaging to be refined

Category	Messages
Private payers	▲ CDSME lowers hospitalization and readmission rates ▲ CDSME lowers the health care costs of your most expensive insured lives
Public payers	▲ CDSME is a proven health-education program that teaches skills that help individuals continue to live in community-based settings ▲ CDSME lowers the health care costs of your most expensive insured lives
Policy makers	▲ How CDSME (or the policy change being proposed) meetings their specific policy outcome
ACHs & MCOs	▲ How CDSME relates to specific regional-level health outcomes ▲ CDSME can help you meet your goals for financial incentive/value-based payments
Health care providers	▲ This health-education program is proven to help patients become active partners in managing their chronic conditions and learn the skills they need to improve their health and quality of life ▲ CDSME workshops are provided by trainers from our community who have gone through a rigorous training process and pass regular program fidelity checks to maintain quality and integrity of the program
Hospitals/health care systems	▲ This health-education program is proven to help patients learn the skills they need to better manage their chronic condition – improving the chances of a successful transition home/ lowering readmission rates ▲ How CDSME meets their community support requirements or strategic goals (esp. nonprofit hospitals)

Coordination of Marketing Roles

Level	Marketing Role & Responsibilities
Office	▲ Conducing marketing research and planning for contemplator market segment ▲ Developing marketing strategies and tactics and creating core marketing and outreach materials, messages, tools, and templates for contemplator market segment ▲ Developing messaging, materials, proposals, etc. to support the Partnership's marketing and outreach efforts
Partnership	▲ Implementing state-level reform strategies
Regional Level	▲ Implementing region-level reformer strategies ▲ Customizing Office-provided marketing strategies, tools, etc. for the region ▲ Implementing contemplator marketing and outreach strategies

APPENDIX: ACTION PLAN

18-Month Action Plan Summary

Objectives	Milestones	Q1	Q2	Q3	Q4	Q5	Q6
Establish the Partnership	▲ Strategic partner agreement	X	X				
Identify initial Partnership priorities and begin work	▲ Discrete list of priorities ▲ Partnership work plan			X	X	X	X
Hire and onboard specialists	▲ Updated job descriptions ▲ New staff on board	X	X				
Build/ upgrade Office systems	▲ Data tracking/analysis system upgraded ▲ Updated website and database	X	X	X	X		
Complete market research (reformers)	▲ Reformer target market profiles			X	X		
Develop strategies and tools to support Partnership's work	▲ Reformer marketing, outreach, and partnering strategies ▲ Reformer relationship-building toolkit (talking points, data of interest, etc.)				X		
Begin market research (contemplators)	▲ Market research plan and schedule					X	X
Share blueprint and determine next steps with local/regional providers and partners	▲ Blueprint update call or meeting	X	X				
Provide regular updates to keep CDSME network informed	▲ Communications calendar ▲ First update			X	X		
Establish regional centers in 2 regions	▲ Short list of high-priority regions ▲ Co-operative agreement complete and/ or regional center responsibilities approved and adopted by lead agency			X	X	X	X
Provide TA support to new regional centers	▲ Outcome-drive TA agreements ▲ Deliverables per TA agreements					X	X

18-Month Action Plan by Objective

Establish the Partnership

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Host exploratory meeting with core partners (Office, DOH, other key organizations that participate with many of the potential partners such as Qualis, Sounder Generations, etc.)	▲ Host organization ▲ List of potential partners	1			
Meet with each potential partner to share Partnership purpose and define who/if interests and goals overlap	▲ List of members ▲ Understanding of shared interests	1-2			
Organize initial meeting	▲ Date, location	2			
Hold initial meeting	▲ Defined shared purpose and goals ▲ Outline of roles & responsibilities (specific to each partner) ▲ Draft partnership agreement	2			

Identify initial Partnership priorities and begin work

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Hold organizing meeting 1	▲ Finalized partnership agreement ▲ Discrete list of priorities for first 12 months	3			
Hold organizing meeting 2	▲ Strategies and work plan ▲ Committees/ work groups ▲ Meeting schedule	3-4			
Additional tasks to come from Partnership work plan	▲	4-6			

Hire and onboard specialists

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Write job descriptions	▲ Technical/ TA specialist job description ▲ Partnership/ strategy specialist job description	1			
Decide how to fill positions	▲ Assessment of current staff ▲ Alignment of existing positions ▲ Timelines for hiring and/ or reorganizing	1			
If reassigning: align job responsibilities	▲ Tasks assigned to appropriate staff	1-2			
If hiring: announce and promote position and screen applicants	▲ Finalists for interviews ▲ Hiring committee	1-2			
If hiring: Interview and select candidates	▲ Positions filled	2			

Build/ upgrade Office systems

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Inventory issues / needs for data gathering system	▲ List of system requirements	1			
Identify and evaluate data system options	▲ Top 2-3 system options	1-2			
Select data system solution and build out system to meet needs	▲ New or upgraded data system ▲ Accurate, timely reports	2-3			
Review website and define upgrades needed	▲ List of website update priorities	2			
Implement website upgrades	▲ Refreshed website	3-4			

Review and evaluate current database(s) that house CDSME network information	▲ Inventory of existing databases ▲ List of contact management needs and priorities	2			
Identify and evaluate contact management system options	▲ Top 2-3 system options	2			
Select data system solution and build out contact management system to meet needs	▲ Central contacts database of all CDSME network members	2-3			
Define tools, templates, and systems needed to deliver TA services	▲ List of TA tools, templates, etc.	2			
Create TA-related tools, templates and systems	▲ Outcome-driven TA system	2-4			
Define market research system needs	▲ List of research sources/ database access needed ▲ List of outside expertise needed (design, etc.)	2			
Select and put in place needed market research systems and tools	▲ Access to research resources and expertise needed	3-4			
Identify and evaluate project management system options	▲ Top 2-3 system options	2-3			
Select and build out project management system	▲ Project management system to organize incubator work flow	3-4			

Complete market research (reformers)

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Review preliminary market profile and define research plan	▲ Research plan	3			
Interview key informants	▲ Understanding of trends, issues, motivations, goals/priorities	3			

Conduct secondary research and review of documents	▲ Map of overlapping goals and initiatives ▲ Understanding of reformer networks and key contacts	3-4			
Complete marketing analysis and updated profile	▲ Updated profile	4			

Develop strategies and tools to support Partnership's work

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Review Partnership priorities and work plan	▲ Map of priorities and profile information	3-4			
Design customized outreach, communication, and partnership development strategies	▲ Strategies to accomplish Partnership priorities	4			
Identify materials and tools needed	▲ List of materials to develop	4			
Design materials and tools	▲ Reformer relationship-building toolkit	4			
Define measures of success for marketing and outreach strategies	▲ Plan to monitor effectiveness of strategies	4			
Review strategies and toolkit with the Partnership	▲ Partnership skills	4			

Begin market research (contemplators)

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Review preliminary market profile and define research plan	▲ Research plan	5			
Begin key informant interviews / focus groups	▲ Understanding of trends, issues, motivations, goals/priorities	5-6			

Share blueprint and determine next steps with local/regional providers and partners

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Customize blueprint for audience	▲ User-friendly presentation materials	1			
Schedule and plan presentation (meeting, webinar, or call)	▲ Date, location, invitations	1			
Share presentation with providers and partners	▲ Summary of feedback	2			
Define next steps	▲ Clear follow up	2			

Provide regular updates to keep CDSME network informed

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Ensure CDSME network contact information is complete and up to date	▲ Reliable contact information	3			
Define communications goal, audiences, messages, frequency, and means	▲ CDSME network communication plan	3			
Develop communications calendar and tools and templates to systematize communications	▲ Efficient communications processes	3-4			
Begin executing network communication plan	▲ First update	4			

Establish regional centers in 2 regions

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Develop criteria and process for reviewing and prioritizing regions	▲ Credible process and buy in	3			
Analyze and select regions to focus on	▲ Short list of high-priority regions	3			
Convene regional work groups	▲ Regional and local involvement	3			
Hold exploratory meetings with regional work groups	▲ Regional decisions about whether to develop a regional center	3-4			
Develop outcome-driven TA agreements with regional work groups	▲ Clearly defined support role for technical/TA specialist ▲ Regional ownership of process	4			
Provide TA services and supports per agreements	▲ Regions develop and begin implementing plans ▲ Regional center agreements	5-6			

Provide TA support to new regional centers

Task	Outcome	Q	Responsible	Hrs/FTE	Notes/Resources
Review work plans and needs with regional centers	▲ Updated TA agreements	5-6			
Provide TA services and supports per agreements	▲ Outcomes and deliverables per TA agreements	Ongoing			
Review regional outreach and marketing practices to inform market research and planning (contemplators)	▲ Understanding of existing marketing and outreach capacity	5-6			