Why Personalization is Critical for Persistent High-Cost Members

3 Cases with the Same 5 Chronic Conditions

OBESITY/ MORBID OBESITY | **DIABETES/ PRE-DIABETES** | **HYPERTENSION** | **JOINT PAIN** | **ANXIETY**

Behaviors, Mental Health & Social Needs	Level of Issue		
	Case 1	**Case 2**	**Case 3**
Sleep	8 hours	5 hours	5.5 hours
Health Engagement Level	Moderate	Moderate	**Significant**
Mental Health	None	**Significant**	**Significant**
Social Need: Economic Stability *(poverty, food insecurity, housing instability)*	None	Moderate	**Significant**
Social Need: Social & Community Context *(isolation, civic participation, discrimination)*	None	**Significant**	**Significant**
Social Need: Health & Health Care *(access to care, health literacy)*	Moderate	**Significant**	**Significant**
Social Need: Neighborhood & Built Environment *(access to foods, quality of housing)*	None	None	Moderate
Social Need: Education *(education level, language and literacy)*	None	Moderate	Moderate
Time in Program	**15 months**	**24 months***	**23 months**

These individuals require very different support to achieve health improvement.

Case #1

Latter half of 50s, empty nester with dog and new grandchild. Wants to help with grandchild, but was prevented by her chronic joint pain and GI issues related to lingering effects of a surgery that happened a year prior. Social needs are not great. Completely sedentary.

INSPERA HEALTH PROGRAM

First get her moving: gently due to pain, yoga, stretching, progressed to more vigorous activity as joint pain improved. This led to greater engagement in life and continued increase in more exercise; debilitating GI issues resolved. Now exercises 450 min/week, diabetes much improved; needs less insulin. Lost 18 pounds, BMI was 37.7 down to 34.9 and able to engage with her granddaughter. She was most excited that her dog lost 10 pounds.

15 months in program.

TRANSFORMATIVE AREAS OF CHANGE

Exercise/activity; physical pain and corresponding physical capacity primarily due to post-surgical complications which were leading to overall health deterioration.

ADDITIONAL IMPROVEMENTS

Diabetes now requires reduced amount of insulin.

Case #2

Mid 30s, 2 preschool children, diabetic but not engaged with diabetic care, some significant anxiety. Moderate issues with social needs. Completely sedentary.

INSPERA HEALTH PROGRAM

Started with sessions with diabetes educator to improve condition literacy. Then focused on improved fitness, nutrition and started mental health counseling. The counseling revealed significant issues with the marriage. During marital counseling decided that ending the marriage is best course for her and the children. Throughout ending the marriage, she continues to work on mental health, diabetes, nutrition, and exercise.

*24 months in program (*extended several months to provide support through mid-program divorce)*

TRANSFORMATIVE AREAS OF CHANGE

Understands and committed to lifelong optimization of diabetes; A1C started at 8.3 and was 6.7 at program graduation. Lost 31 pounds with improved fitness and nutrition, no longer obese. Anxiety under control.

ADDITIONAL IMPROVEMENTS

Sleep improved from 6.5 to 8 hours; overall physical health improved 20%. Has long term plan to stay healthy and has taken the additional energy to go back to school to enhance her skillset to better provide for her children.

Case #3

Early 40's, super obese, major issues with social needs: financial issues, history of trauma, insecurity around basic needs. Completely sedentary.

INSPERA HEALTH PROGRAM

Initial recommendation was for mental health counseling. This was not consistent with her values, so behavioral clinician pivoted to provide information on community resources and psychoeducation regarding principles of interpersonal relationships, as well as curating self-help resources. Participant requested to work on finances as the first step, program met this request and set up financial counseling. Through building trust, participant reached out and engaged with community resources identified by the program. When housing and household were more stable, participant got household members to agree to address poor nutrition and lack of exercise together. All pulled together and made progress.

23 months in program.

TRANSFORMATIVE AREAS OF CHANGE

Participant lost 72 pounds, joint pain gone, off blood pressure medications, no longer pre-diabetic, no longer had medical debt, and resolved IRS issues.

ADDITIONAL IMPROVEMENTS

Received 2 promotions at work and son also lost 50 pounds.

OVERALL HEALTH IMPROVEMENT

MCC HEALTH IMPACT INDEX®

CASE #1	CASE #2	CASE #3
72%	47%	82%

Index measures: Closing care gaps, SF36v2® instrument for mental and physical health, blood pressure, blood sugar, cholesterol, sleep, physical activity, weight, and health activation (PAM® instrument)

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