Future of Health

Case Study: Omada Health

Research collaboration led by

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*Inclusion in this case study does not imply any endorsement of an organization's or company's products or services by the AMA.

Case study introduction

Omada Health, founded in 2011, is an evidence-based virtual care provider that helps patients manage chronic conditions, offering supplemental support between their clinical visits. Core programs within Omada's platform support patients with prediabetes, diabetes, hypertension, and musculoskeletal (MSK) conditions and utilize evidence-based interventions that adhere to clinical standards. Chronic care programs, such as Omada's, help primary care physicians (PCPs)—with an average panel size of more than 2,000—meet the ongoing clinical needs of their patients, by offering supplemental support to help patients achieve their health goals.

Omada provides its services through payers and self-insured employers, is a Health Insurance Portability and Accountability Act-covered (HIPAA) entity, and is exploring direct relationships with health care organizations. It enables data exchange through CommonWell Health Alliance and Carequality Health Information Networks to increase care coordination and reduce the risk of fragmentation with the patient's PCP. Its services include data-powered human coaching, connected devices, patient-tailored curricula, and enhanced care coordination.

One example of Omada partnering directly with health care organizations is its relationship with Castell and Intermountain Health to establish an integrated virtual care option for diabetes management and prevention. Intermountain is an integrated health care system with 385 clinics and 33 hospitals, and Castell is Intermountain Healthcare's value-based care subsidiary. In this partnership, Castell helps target and enroll eligible patients who are a part of Intermountain's health plan into Omada's Diabetes Prevention and Diabetes programs.

Today, Omada is working with Stanford Medicine on a randomized control study with its primary care clinics to assess the impact of its remote monitoring programs. Omada shares data that is seamlessly integrated into Stanford's electronic health record. This allows PCPs to access blood pressure (BP) and blood glucose data from patients who are participating in the Omada program.

To date, Omada has enrolled 1 million patients across diverse industries of 1,900+ employer and health plan customers.

The Omada Health care model

The following figures depict the Omada care model. **Figure 1** illustrates an Omada member's journey from checking enrollment through program kickoff for Omada's hypertension program. **Figure 2** outlines components of Omada's care model consisting of the care team, mobile application, web portal, connected devices (e.g., scale and glucose tester), and program tools for care management. **Figure 3** depicts Omada's automated data exchanges that enable member information to be collected and shared between the member, Omada care team, and other clinicians to enhance care.

FIGURE 1: Overview of patient journey in hypertension program

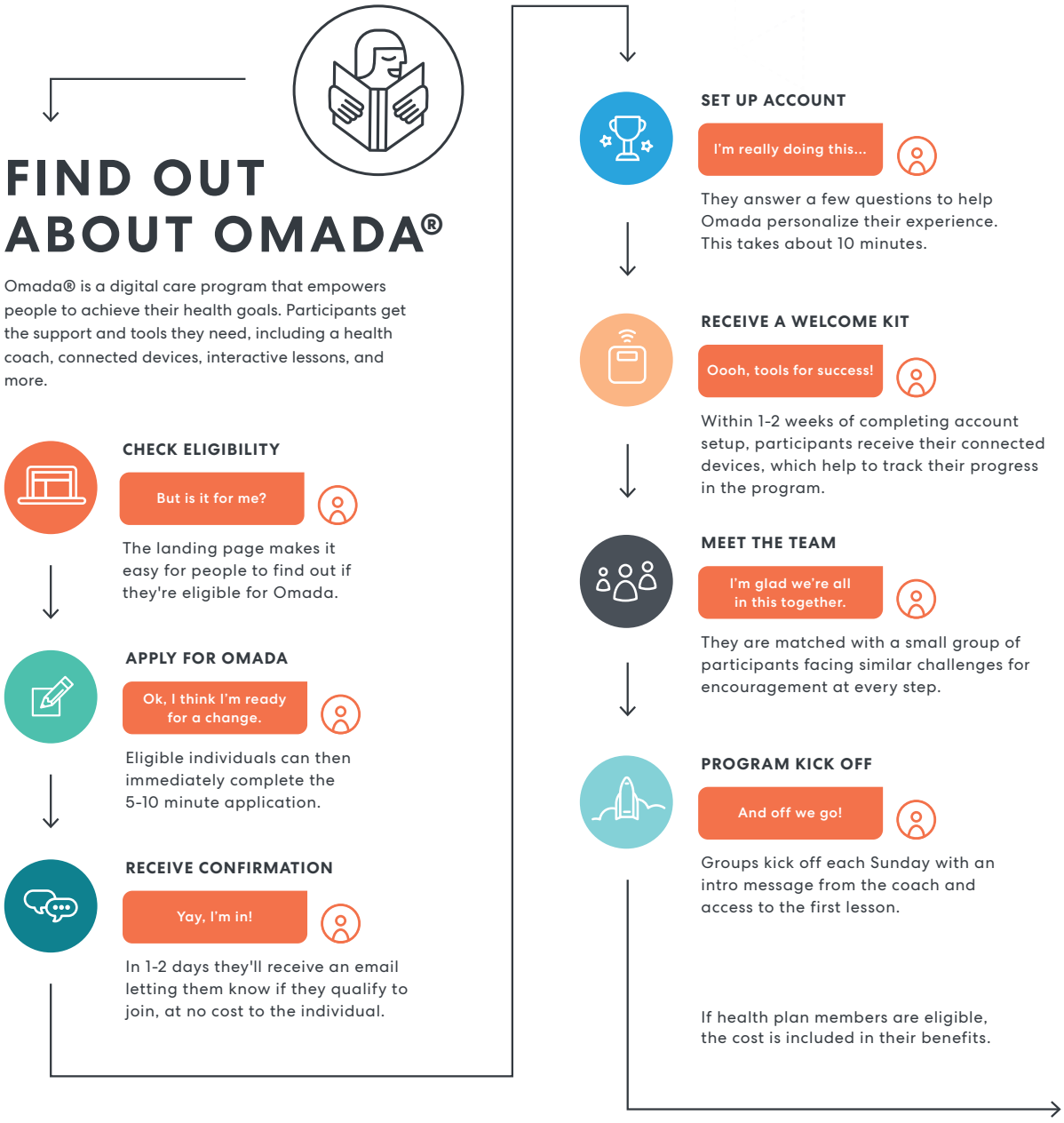


FIGURE 2: Overview of care model

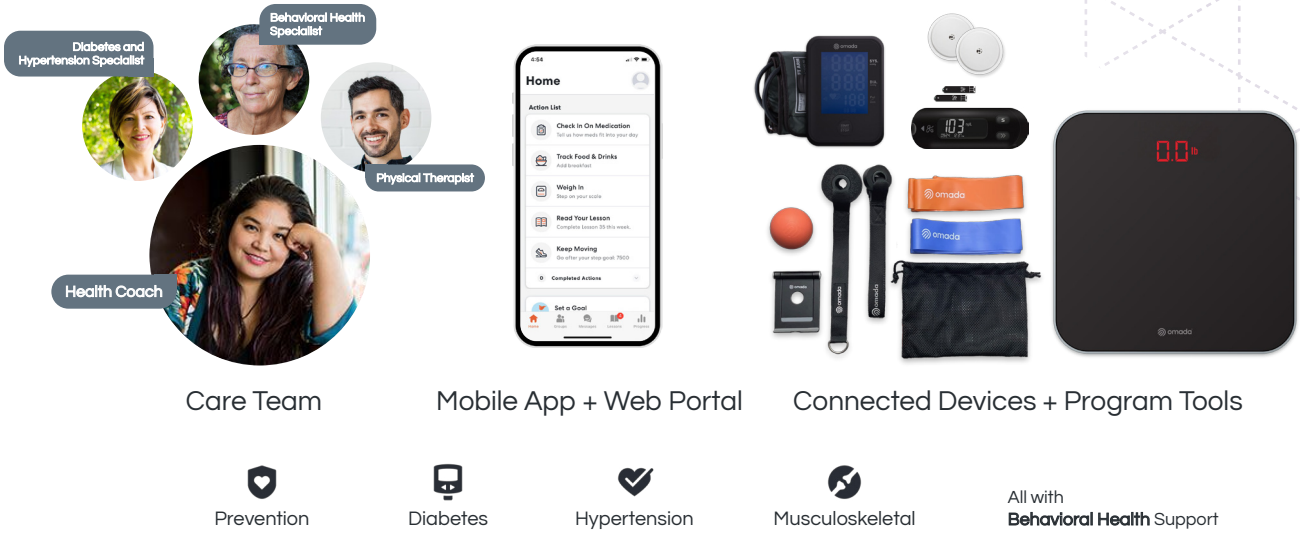
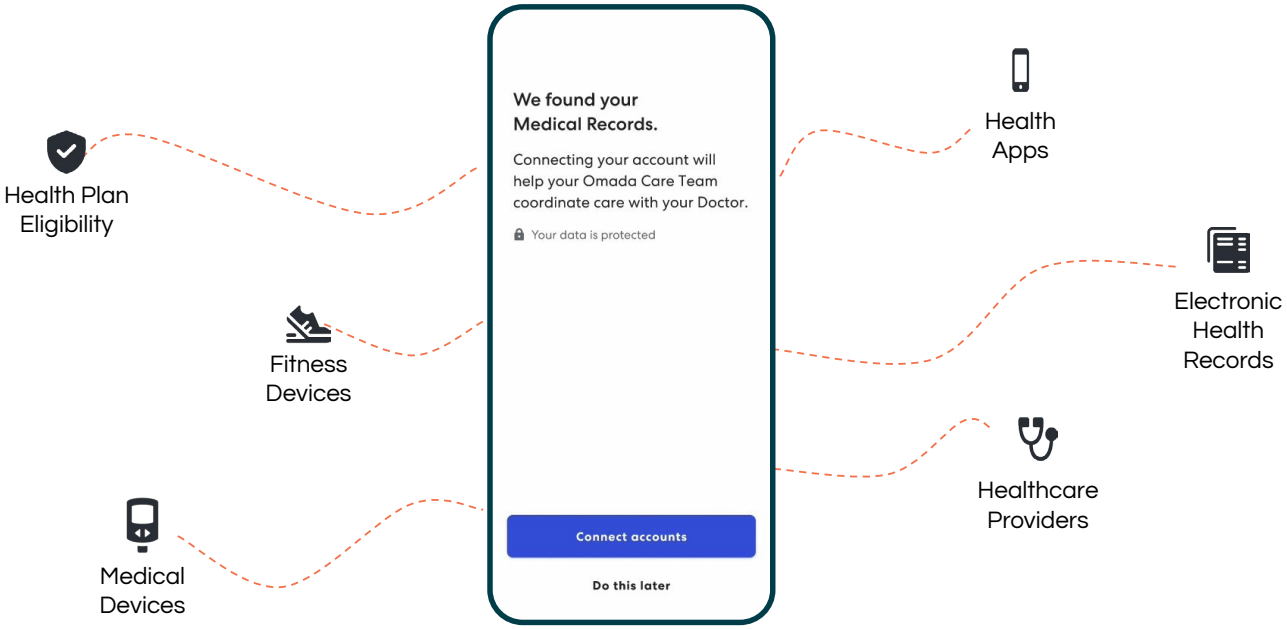


FIGURE 3: Enhance care coordination with ecosystem connectivity



Disclaimer: This chat image reflects a mock-up based on a composite and does not reflect information about a specific person.

The Future of Health blueprint for optimizing digitally enabled care

How is Omada Health leveraging the blueprint's Foundational Pillars to achieve digitally enabled care?

The American Medical Association's "Closing the Digital Health Disconnect: A Blueprint for Optimizing Digitally Enabled Care" report provides a blueprint to address the digital health disconnect and achieve optimized digitally enabled care. **Table 1** highlights how Omada's digitally enabled care programs support adherence to care plans developed by a patient's primary clinician and leverage the Future of Health Foundational Pillars.

TABLE 1: The Future of Health Foundational Pillars

THE FUTURE OF HEALTH FOUNDATIONAL PILLARS	OMADA HEALTH
Build for patients, physicians and clinicians	Patients have 24/7 access to a multidisciplinary care team—diabetes and hypertension specialists, behavioral health specialists, physical therapists, and health coaches—who support patients' efforts to achieve and sustain health goals. The care team accounts for social determinants, outside stressors, and life context when developing tailored goal-setting and health plans to treat the person, not the disease. Patients can easily navigate the platform to engage with their care team, participate in weekly interactive lessons within a tailored curriculum, and receive encouragement from supportive online peer groups. Health data collected from their connected devices—wireless scales, continuous glucose monitors (CGMs), blood glucose meters, and/or BP monitors—are shared in real-time to Omada's platform, which care teams and providers can access via CommonWell/Carequality.
Design with an equity lens	Omada embeds behavioral health self-management tools across its core programs—diabetes prevention, diabetes management, hypertension, and MSK. Its approach to integrating mental and physical health equally seeks to remove barriers and enable members with access to: • An upfront assessment of mental health symptoms for anxiety and depression • Detailed resources to address social determinants of health (SDOH) • Tools to address specific behavioral challenges • Behavioral health specialist support embedded in a care team • Guided immediate interventions in moments of crisis

THE FUTURE OF HEALTH FOUNDATIONAL PILLARS	OMADA HEALTH
Recenter care around the patient-physician relationship	Omada's programs enable patients and clinicians to focus their time on the most critical aspects of care management and treatment planning, leveraging Omada to reinforce lifestyle changes and other evidence-based interventions. The five components of the Omada program: 1. **Targeted outreach and enrollment.** Individuals at risk or living with type 2 diabetes, hypertension, or MSK conditions. 2. **Smart tools and technology.** Scale, CGMs, blood glucose meters, and BP monitors that automatically sync to the patient's account. 3. **Supportive online peer groups.** Online community of peers with similar health conditions and challenges to provide social support. 4. **Interactive lessons.** Weekly interactive lessons that help patients explore physical, social, and psychological components of healthy living. 5. **Professional care team.** Ongoing one-on-one guidance to help patients navigate their conditions in ways that work for them. Omada's evidence-based interventions follow clinical standards and integrate behavioral health: • **Diabetes.** Diabetes Self-Management Education & Support • **MSK.** Guideline Adherent Physical Therapy • **Prevention.** Diabetes Prevention Program • **Hypertension.** Self-Monitoring Blood Pressure
Improve and adopt payment models that incentivize high-value care	Omada's activity-based billing strategy gives incentives to improve members' lifestyle habits to prevent chronic disease or manage diabetes and hypertension. Payers are billed monthly for members who meet the specified activity threshold. Omada uses contracted CPT codes as agreed upon with payers, such as the following: • Diabetes Prevention Program (CPT 0488T) • Diabetes Program. Digital Evaluation and Management (CPT 98970) • Hypertension Program. Remote Patient Monitoring (CPT 99454) • MSK Initial Consultation (CPT 97161) • MSK Recovery Program – Physical Therapy (PT) – Guided Managed Care (CPT 97110)
Create technologies and policies that reduce fragmentation	Omada invested in its data exchange capabilities through its partnership with Particle Health. In partnership with Particle Health—an interoperability platform that delivers actionable patient data and insights to health care companies—Omada can enhance care coordination with connections to CommonWell Health Alliance and Carequality Health Information Networks.
Scale evidence-based models quickly	Omada has 1,900+ employer and health plan customers across diverse industries, including 19 national and regional health plans, government and education institutions, hospitals and health, manufacturing, and retail, with 1 million members enrolled (cumulatively). In 2023, Omada joined the Institute for Healthcare Improvement Leadership Alliance as the first virtual provider organization and recently received URAC (Utilization Review Accreditation Commission) accreditation. Omada is also accredited by the NCQA (National Committee for Quality Assurance).

Measuring the value of digitally enabled care

How is Omada Health leveraging the Return on Health framework to assess impact?

AMA's "Return on Health: Moving Beyond Dollars and Cents in Realizing the Value of Virtual Care" report offers a framework to illustrate the various ways in which virtual care programs may increase the overall "return on health" by generating a positive impact for patients, clinicians, payers, and society going forward. **Table 2** includes the five environmental variables that can affect the value generated by any virtual care program and highlights the Omada model. **Table 3** includes the six value streams that define the ways in which virtual care models can generate value and provides examples of how Omada's model drives value in a measurable way.

TABLE 2: Return on Health—environmental variables

ENVIRONMENTAL VARIABLES	
Type of practice	Virtual chronic care management: offers direct patient care via relationships with employers, payers, and select clinicians.
Payment arrangement	Activity-based billing.
SDOH of patient population	Broad.
Clinical use case	Digitally enabled care for individuals at risk or with chronic conditions (including diabetes, hypertension, high cholesterol, and MSK conditions).
Virtual case modality	Video visits (MSK), secure messaging to both care team and small groups, and other modalities.

TABLE 3: Evidence of impact across the Return on Health value streams

VALUE STREAM	EVIDENCE OF PROGRAM IMPACT
Clinical outcomes, quality and safety	**Effective for self-managing hypertension.** A retrospective cohort study evaluating the Omada's hypertension program found the following: • 48% with uncontrolled BP at baseline experienced enough change in BP to improve their BP category. • Members with uncontrolled systolic blood pressure (SBP) at baseline also had significant reductions in diastolic BP. • Members (including members with controlled and uncontrolled BP at baseline) and those with uncontrolled SBP at baseline experienced significant mean reductions in SBP at 12 months.

VALUE STREAM	EVIDENCE OF PROGRAM IMPACT
Access to care	**Partners and employer customers.** Omada partners with national and regional health plans and employers to provide its health care services to members.
Patient, family and caregiver experience	**Satisfaction with services.** With 25 million messages sent between the care teams and members, more than 90% of members report satisfaction with Omada programs. The Omada Insights Lab analysis of programs over the last 10 years show: • Members are more than 250% more likely to achieve positive health outcomes when Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) goals are completed with care team support. • Members have 2x more weight loss on average when messaging the Omada care team compared to those who do not.
Clinician experience	**Clinician satisfaction.** Omada's program, centered on health coaching, behavior change and chronic disease management, unbundles the traditional care model which has historically placed the responsibility for these critical activities on the PCP. Offloading this time consuming and challenging work not only restores a significant portion of time back to the primary care visit, but also allows the clinician to practice to the top of their scope, improving clinician satisfaction.
Financial and operational impact	**Effective ROI and Pricing Benefits.** Employers have seen an average cost savings of $1,000+ per employee from year 1. **Medical cost savings.** Omada reports cost savings for members within the following programs: • Prevention: $1,169 annual gross medical cost savings per program member. • Diabetes: $1,300 cost savings for members at one year. • Hypertension: $1,981 potential gross annual savings per member in program. • MSK: 27% overall reduction in medical spend for program members.
Health equity	**Prevention program for low-income patients.** From 2016–2018, a University of Southern California non-randomized control study assessed the effectiveness of Omada's Digital Diabetes Prevention Program with low-income, underserved populations. While diabetes prevention efforts have increased, the prevalence of type 2 diabetes and obesity remains disproportionately higher among low-income individuals, including those from underrepresented racial and ethnic groups. The study found that low-income participants with prediabetes benefited from this intervention, and nearly 40% of participants lost at least 5% of their starting body weight. **Improvement in program engagement.** Omada's focus on addressing SDOH early has resulted in an 8% improvement in member-coach engagement.