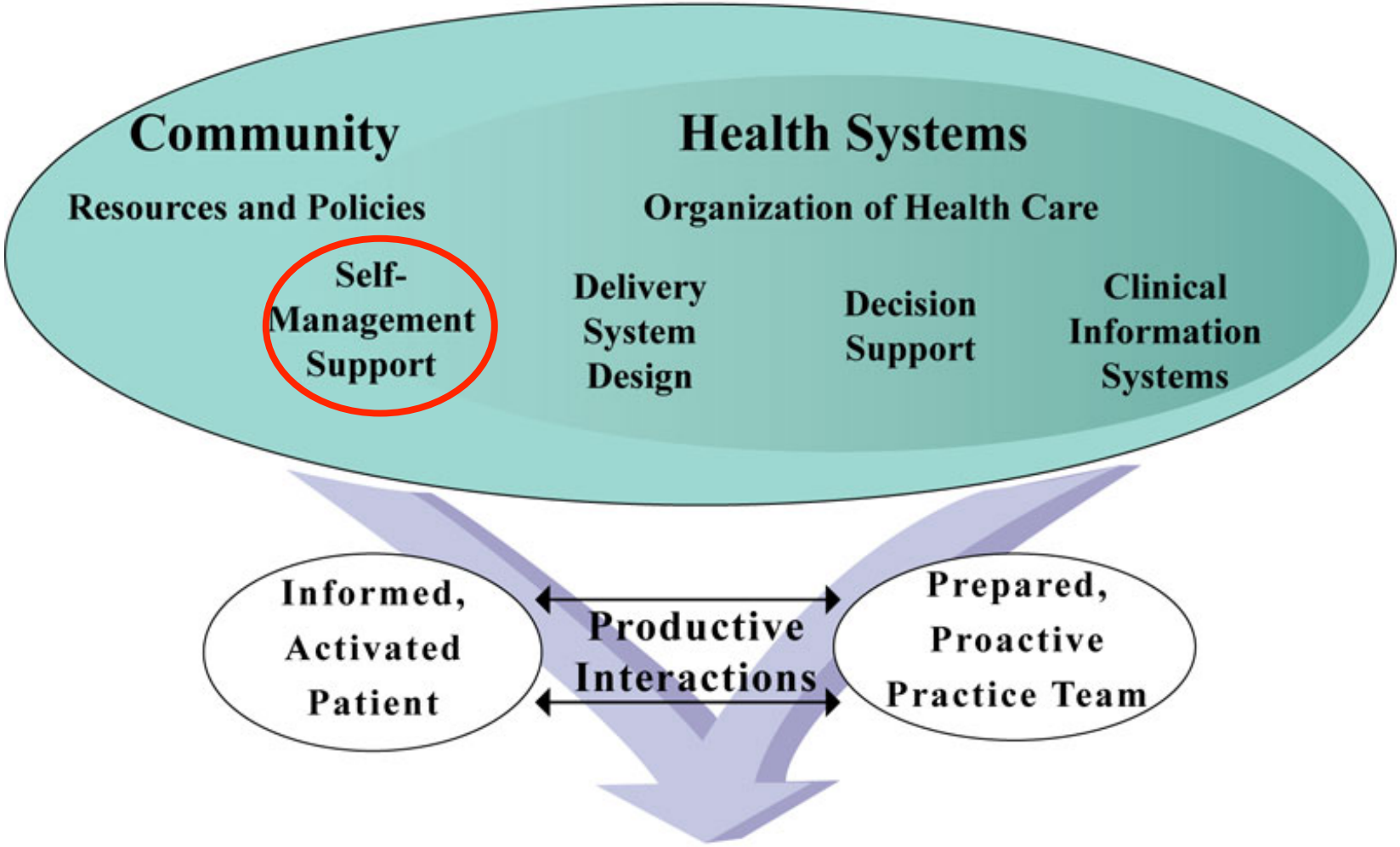
Chronic Disease Self Management: Stanford University Model

The Chronic Care Model



Improved Outcomes

Barriers to Self Management Support (SMS)

- **Expert Panel Findings**:
- Clinicians assume patients know more than they actually do.
- Physicians are used to having control; of being “in charge.”
- Physicians are intervention-driven, action-oriented.
- Providers don’t recognize distress, only behavior.
- Lack of belief that SMS will work.
- Lack of understanding of the whole context for the patient
- A (false) assumption that knowledge leads to action

Lachenmayr et al. (Nov. 20, 2012)

Barriers to Self Management Support (SMS)

- **Expert Panel Findings (continued)**:
- 99% of patient care is done by the patient him/herself.
- SMS is not just getting people to do what the clinician wants them to do.
- Recognizing the barriers to adopting SMS are similar to those faced by patients
- Providing SMS requires a team effort.
- Communication skills are key

Lachenmayr et al. (Nov. 20, 2012)

Barriers to Self Management Support (SMS): Interviews with U.S. Health Care Systems

- Health Care Culture:
  - Prefer professional vs. peer led services
  - Measure and focus on clinical outcomes vs. quality of life outcomes

- Primary Care Physicians: On-going need for information about SMS available

- Priority: Current focus on high risk/high cost patients whereas lower risk patients may see greatest benefit from self-management

Lachenmayr et al. (Nov. 20, 2012)

State Plan: Strategic Direction

Community-Clinical Linkages (CDC)

Clinical and Community Prevention Services

•Implement evidence-based programs for individuals to prevent and manage their chronic diseases

National Prevention Council, *National Prevention Strategy, Washington, DC:*
U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

Chronic Disease Self Management in SD

- Assess current realities of existing self management resources in the state
- Themes from stakeholders survey:
  - Scarcity of self management resources in SD
  - Not coordinated on a community level
  - Only VA offering Stanford Univ. model (CDSMP)
- Exploration of Self Management Programs to meet the need and create strategic plan

Strategic Plan: Chronic Disease Self Management in SD

- Stanford University model of Chronic Disease Self Management (CDSMP)
  - Research/outcomes
  - Designed to be disseminated in communities
  - Cost effective
  - Lay leader model
  - Not disease specific

National Perspective: Stanford University Model of Chronic Disease Self Management Programs (CDSMP)

- 27 countries use Stanford Univ. model (CDSMP)
- 46 States
- National Council on Aging (NCOA),
- Funding from Admin. On Aging and CDC (over 100,000 seniors)

SD Department of Health Strategic Plan

- Identify and engage partners to develop strategic plan for implementation and support for Stanford University model (CDSMP)
- Input from partners at 2 retreats and conference calls
- Consultation with other states and National Council on Aging

Chronic Disease Self Management: People are not diseases!

3 Self Management tasks

1. ***Take care of health problem (medical & health behavior)**
2. Carry out normal activities
3. Manage emotional changes

*Most pt ed programs focus on #1 and few systematically cover all 3 tasks (Lorig and Holman, 2003)

Self Management vs. Patient Education

Self-management

- Empowers patient
- Increases confidence & focus on process (self efficacy)
- Builds skills/knowledge
- Supports problem solving and decision making
- Patient defines the problem

Patient Education

- Informs behavior change
- Increases knowledge & focus on content
- More directive “teach”
- Focus on disease process and treatment
- Now more self efficacy, motivational interviewing, etc.

Adapted from Ferretti, Lisa A. February 16, 2012

Self Management vs. Patient Education (Traditional Model)

Self-management

Patient Education

Group Based Self Management Education: Self Efficacy

- Self efficacy: **Confidence** that one can carry out a behavior or skill necessary to reach a desired goal
- Skill mastery: action plans, problem solving, relaxation skills
- Modeling: lay leaders, group problem solving
- Reinterpretation/ reframing: identifying and changing beliefs about disease, health behaviors, own abilities
- Persuasion: social persuasion, verbal persuasion

Core Self Management Skills

- Problem solving and decision making
- Find & use resources
- Form partnership with provider/care team
  - Communication skills
  - Self Advocacy
- Planning
  - Self directed Action plans
  - Proactive mindset

Other Self Management Skills…

- Cognitive Symptom Management Techniques
- Dealing with difficult emotions
- Dealing with pain and fatigue

- Exercise
- Making healthy food choices
- Communication skills
- Medications
- Evaluating treatment choices

Stanford Univ. Model: Chronic Disease Self Management Program (CDSMP)

- 6 week workshop held weekly at community sites or online
- Facilitated by highly trained lay leaders
- Covers several self management skills to help patients with 3 main self management task
- Evidence based
- Self efficacy because knowledge not enough!
- Self directed learning
- Based on patient's perception of the problem

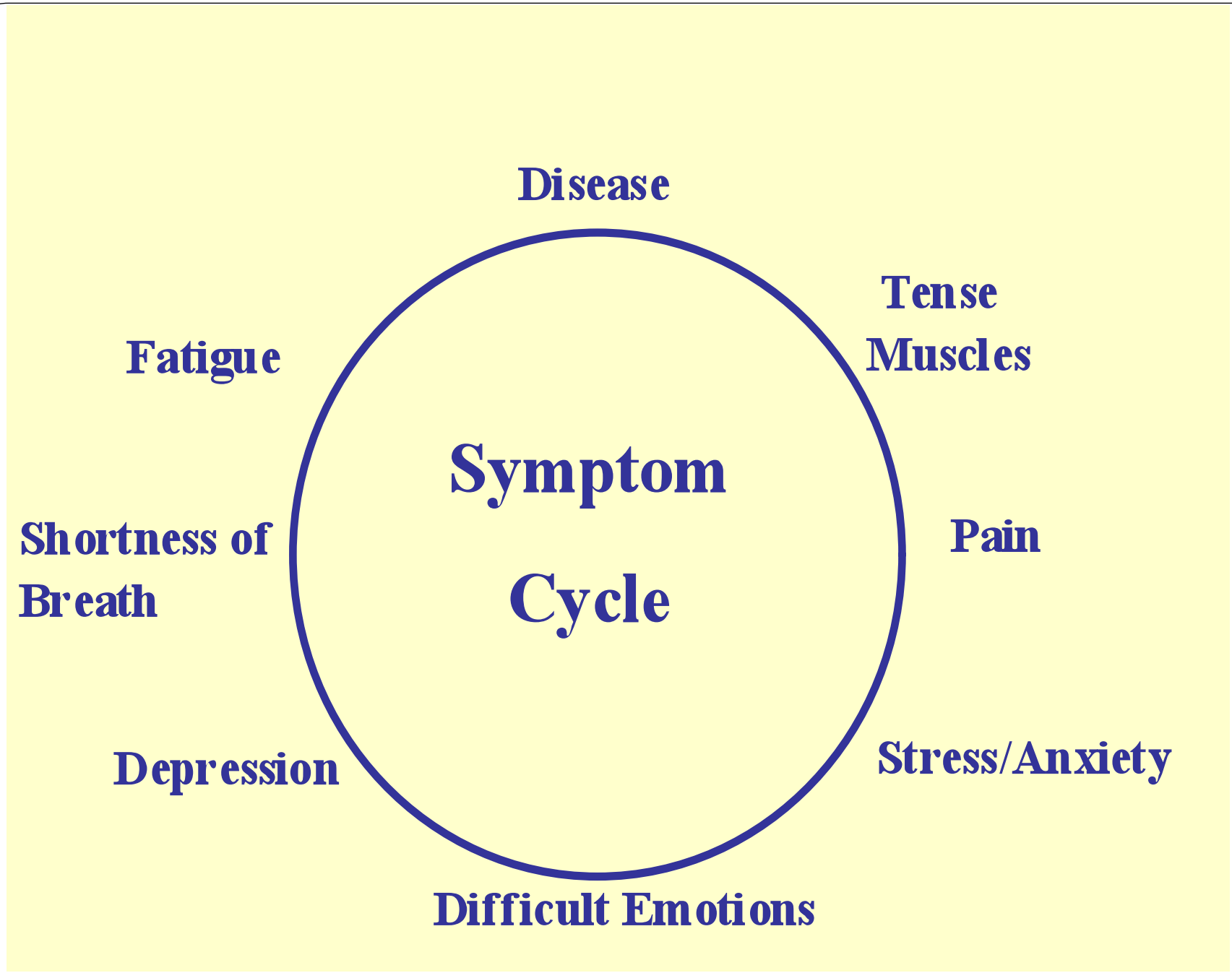
Stanford Univ. Model: Chronic Disease Self Management Program (CDSMP)

- 10-15 participants meet weekly for 2 ½ hour sessions for 6 weeks

- Community locations or online

Assumptions: CDSMP

- People with different chronic conditions have similar problems and challenges
- Must not only deal with their disease but also the impact on their lives and emotions
- Process is more important than just giving info
- Highly trained lay people with chronic conditions as effective or more effective than HCPs for workshop facilitation


Disease
Tense Muscles
Fatigue
Symptom Cycle
Shortness of Breath
Pain
Depression
Stress/Anxiety
Difficult Emotions

Self Management Skills: Action Plans

1) Something patient wants to do
2) Achievable
3) Action-specific
4) Answer: What? How much? When? How often?
5) Confidence level (scale of 0-10)

Self Management Skills: Problem Solving

1) Identify the problem (most difficult)
2) List ideas
3) Select one to try
4) Assess the results
5) Substitute another idea
6) Utilize other resources
7) Accept that the problem may not be solvable *now*

Research Outcomes

- Physical/emotional outcomes and health related quality of life *CDC: Gordon & Galloway review of major published studies
- Reduced fatigue, more exercise, fewer social role limitations, improved self efficacy, better relationship with physicians, improved health status
- Reduced health care costs

- ***The Permanente Journal, Spring 2002, Vol 6, No 2 (Sobel, Lorig, and Hobbs)**

CDSMP & Lower Health Care Costs

- Reductions in hospitalizations and ER visits
- ~$740 per person savings in ER and hospital utilization
- ~$390 per person net savings after considering program costs at $350 per participant
- Reaching even 10% of Americans with one or more chronic conditions would save ~$4.2 billion!

Whitelaw, N., Lorig, K., Smith, M. L., & Ory, M. G. (March 19, 2013). *National Study of Chronic Disease Self-Management Programs (CDSMP). Retrieved March 20, 2013, from www.ncoa.org/cha*

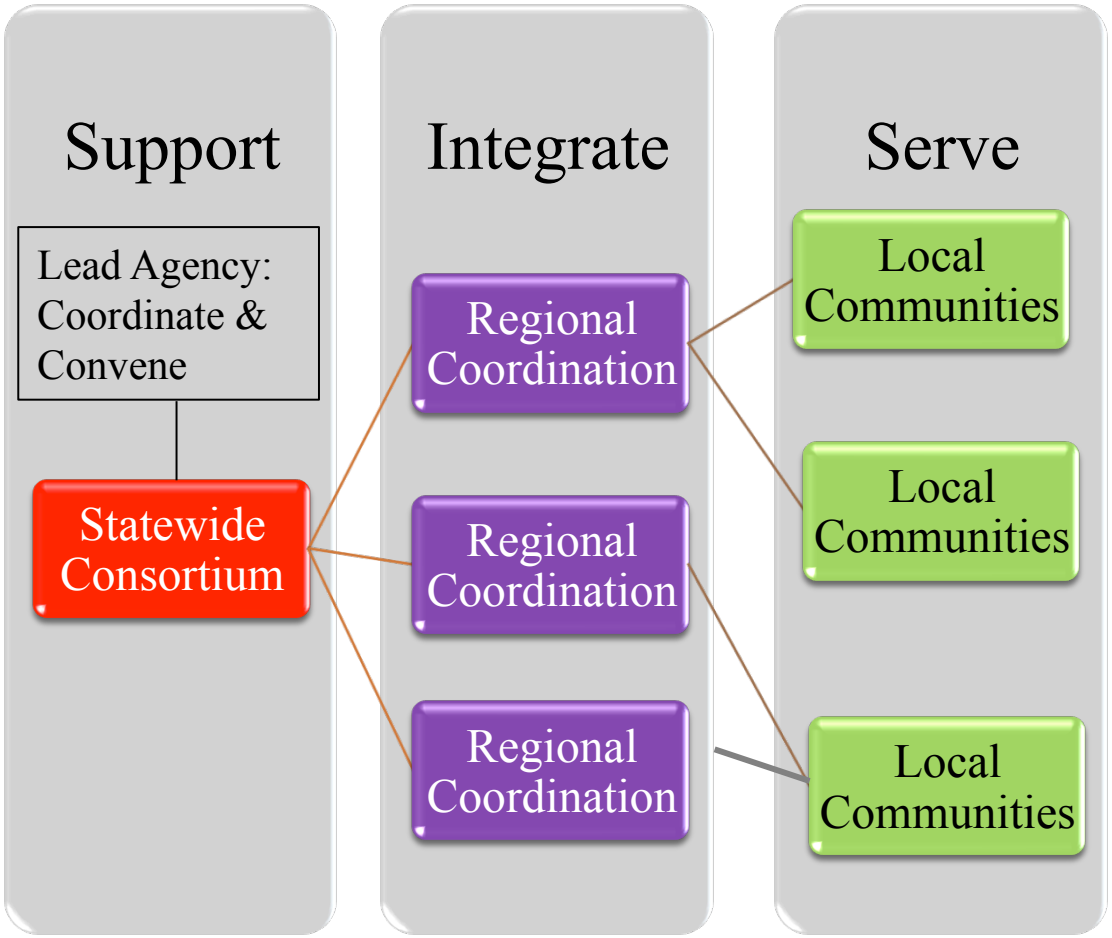
South Dakota Chronic Disease Self Management Strategic Plan: Core Components

1. Vision/Purpose/Infrastructure
2. Operations & Program Services
3. Outcome Measurements
4. Communications, Funding & Sustainability

Strategic Plan: Vision Statement

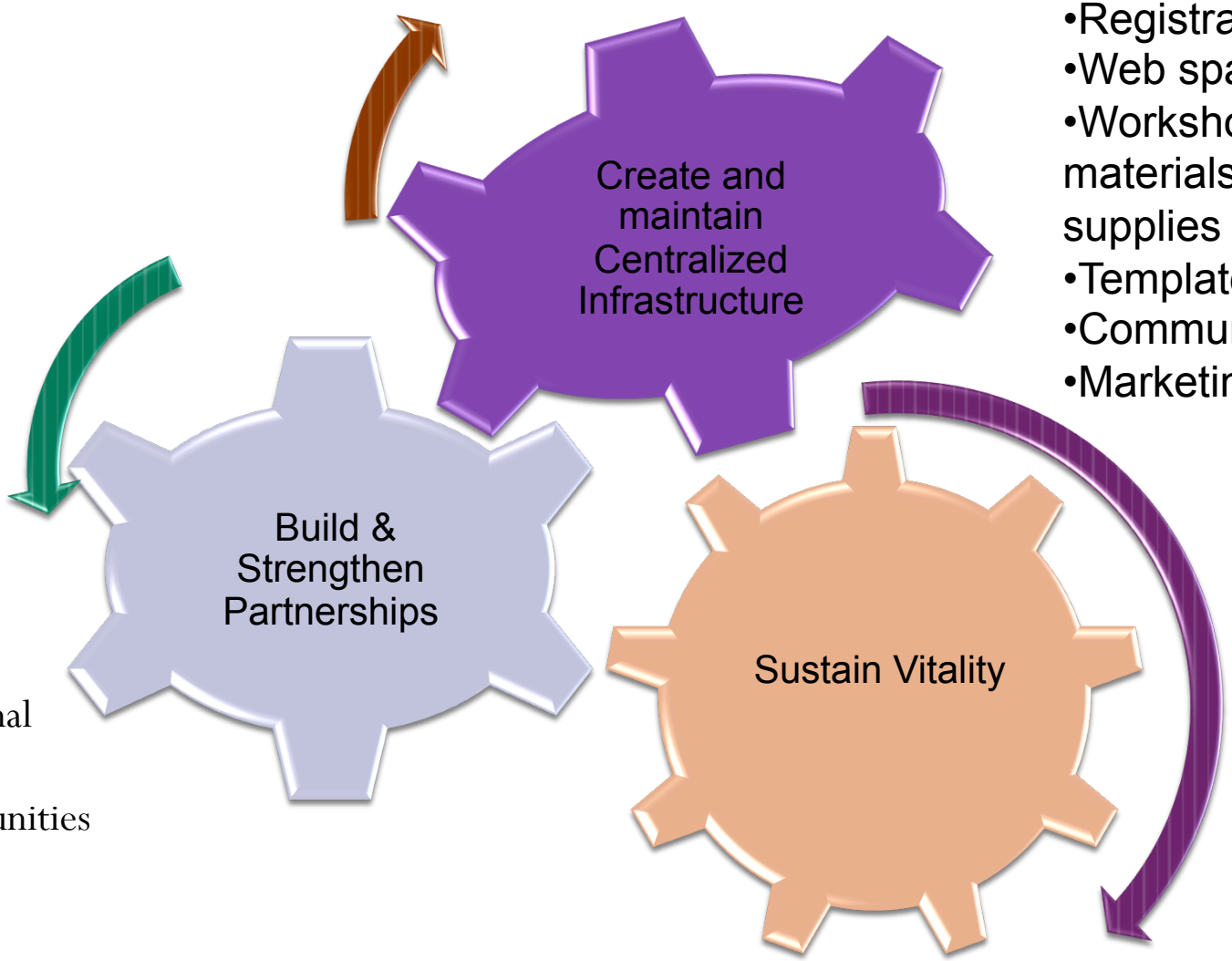
The creation of an innovative state collaboration that ensures evidence-based chronic disease self management programs to reach those affected by chronic disease, positively impacts quality of life, promotes access to care, and reduces health care costs.

Infrastructure: Statewide Consortium: Centralized Collaborative Model



Regional Coordinators support several communities—also collaborate with other Coordinators

Infrastructure: Statewide Consortium



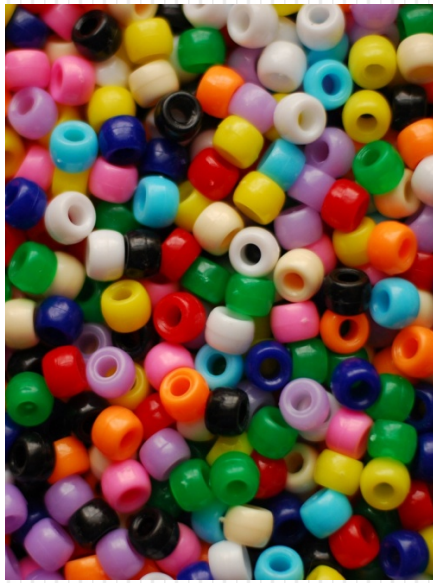
- Licenses
- Registration
- Web space
- Workshop materials & supplies
- Templates
- Communication
- Marketing

- State
- Regional
- Local Communities

- QI
- Funding
- Sustainability

CDSMP Plan for South Dakota

- Partners at state, regional & local level
  - Aging Services
  - SD Department of Health
  - Tribal Health
  - Health Systems
  - Faith Communities
  - Many, many more!



We need you!

- State Consortium
- Work Groups
- Steering Committee
- Partnership opportunities

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References

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