



Patient Activation with the Evidence-Based Chronic Disease Self-Management Program

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Partners in Care Foundation

- Non-profit
- Focus on aging issues
- Change the shape of health care
- Develop and promote innovative programs to improve care for everyone
- Emphasis on evidence-based programs



Our Mission

- **Partners is a think-tank and a proving ground.**
- **Partners changes the shape of health care by creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities.**
- **Partners' direct services are a safety net and a platform to test, measure, refine and replicate innovative programs**
- **We work to spread successful new models in California and across the nation.**



Linking Medicine and Community Care

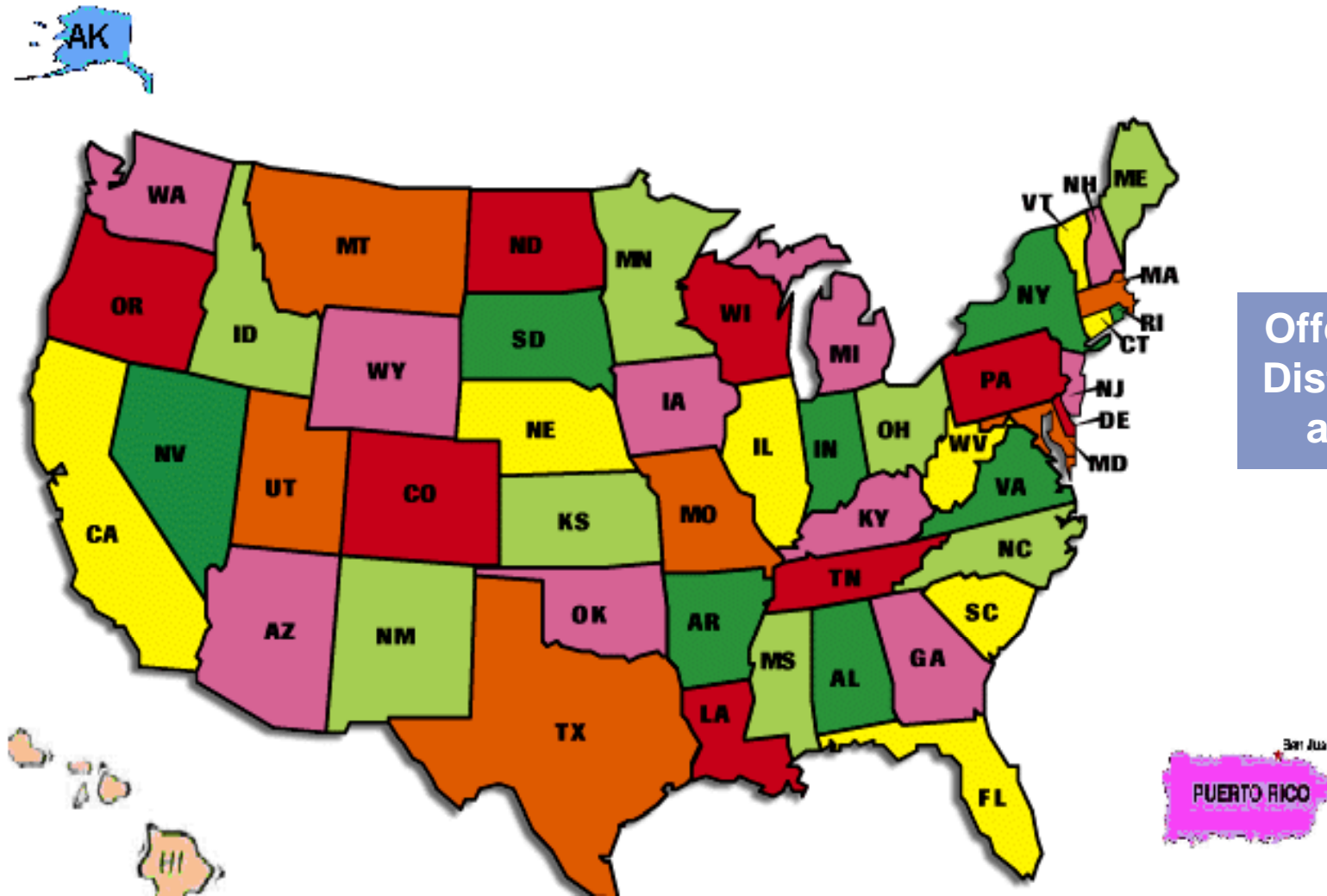
- Management of chronic conditions occurs at home and in the community
- Medical results are very dependent on ability of patients to manage lifestyle and adherence issues
- Community systems of care can be linked to office practices to enhance medical results cost-effectively
Partners in Care is a leader in building community service integration – single point of entry
- Home care management is key for complex cases

Background: California's Evidence-Based Initiative

- Brings evidence-based programming to community-based organizations
 - Stanford University's Chronic Disease Self-Management Program (CDSMP/ Healthier Living) is the core program
- California Departments of Aging and Public Health awarded grant from U.S. Administration on Aging in 2006
- American Recovery and Reinvestment Act (ARRA) Funding
 - \$27 million available for up to 50 states/territories
 - Dramatically increase program reach throughout the U.S.



CDSMP Across the Nation



Offered in 48 States,
District of Columbia,
and Puerto Rico

CDSMP Throughout the World

22 Countries Host CDSMP!



Stanford School of Medicine. Patient Education. Organization Licensed to Offer the Chronic Disease Self-Management Program. *Stanford School of Medicine. Patient Education.* Available at: <http://patienteducation.stanford.edu/organ/cdsites.html>. Accessed on March 1, 2010.

California Evidence-Based Initiative

California Departments of Aging and Public Health awarded 4-year grant from U.S. Administration on Aging

Brings evidence-based programming to community-based organizations

Partners in Care is the state program office, California Health Innovation Center (CHIC)



Capturing Interest in Medical Circles

- Right Care Initiative selected CDSMP/Healthier Living as one of two evidence-based interventions to address diabetes and heart disease HEDIS measures through Comparative Effectiveness Research by RAND/UCLA – pending federal funding
- A number of managed care practices have adopted this program to enhance clinical outcomes



California's Partnership for Health Promotion

Non-profit and healthcare organizations include:

- California Association of Physician Groups-CAPG
- Kaiser Permanente of Southern California
- Catholic Healthcare West
- Area Agencies on Aging
- Health Care Partners
- Facey Medical Foundation



Chronic Disease Self-Management Program

An Evidence-Based Health Promotion Program



Chronic Conditions: The Scope of the Problem

- **Chronic diseases affect the quality of life of 133 million Americans (nearly 1 in 2 adults)***
 - More than 14 million in California**
- **Chronic diseases represent more than 80% of the health care dollar*****
- **80% of Americans 65 and older have at least one chronic condition***
 - 50% have at least two chronic conditions

*Centers for Disease Control and Prevention, 2009

**California HealthCare Foundation, 2006

***Robert Wood Johnson Foundation, 2004

Chronic Conditions: The Scope of the Problem

- **Chronic conditions account for:**
 - 76% of inpatient hospitalizations*
 - 88% of all prescriptions filled*
 - 72% of all physician visits*
 - 7 out of 10 deaths each year in the US**
- **99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition*****

*Johns Hopkins University, 2003

**Centers for Disease Control and Prevention, 2009

***Thorpe & Walker, 2010

CDSMP: About the Program

- Award-winning program developed by Stanford University
- Designed to help people better manage chronic health conditions and live a happier, healthier life
- Consists of six 2½ hour sessions led by 2 trained leaders
- Groups are small (10-15 people)
- Highly scripted

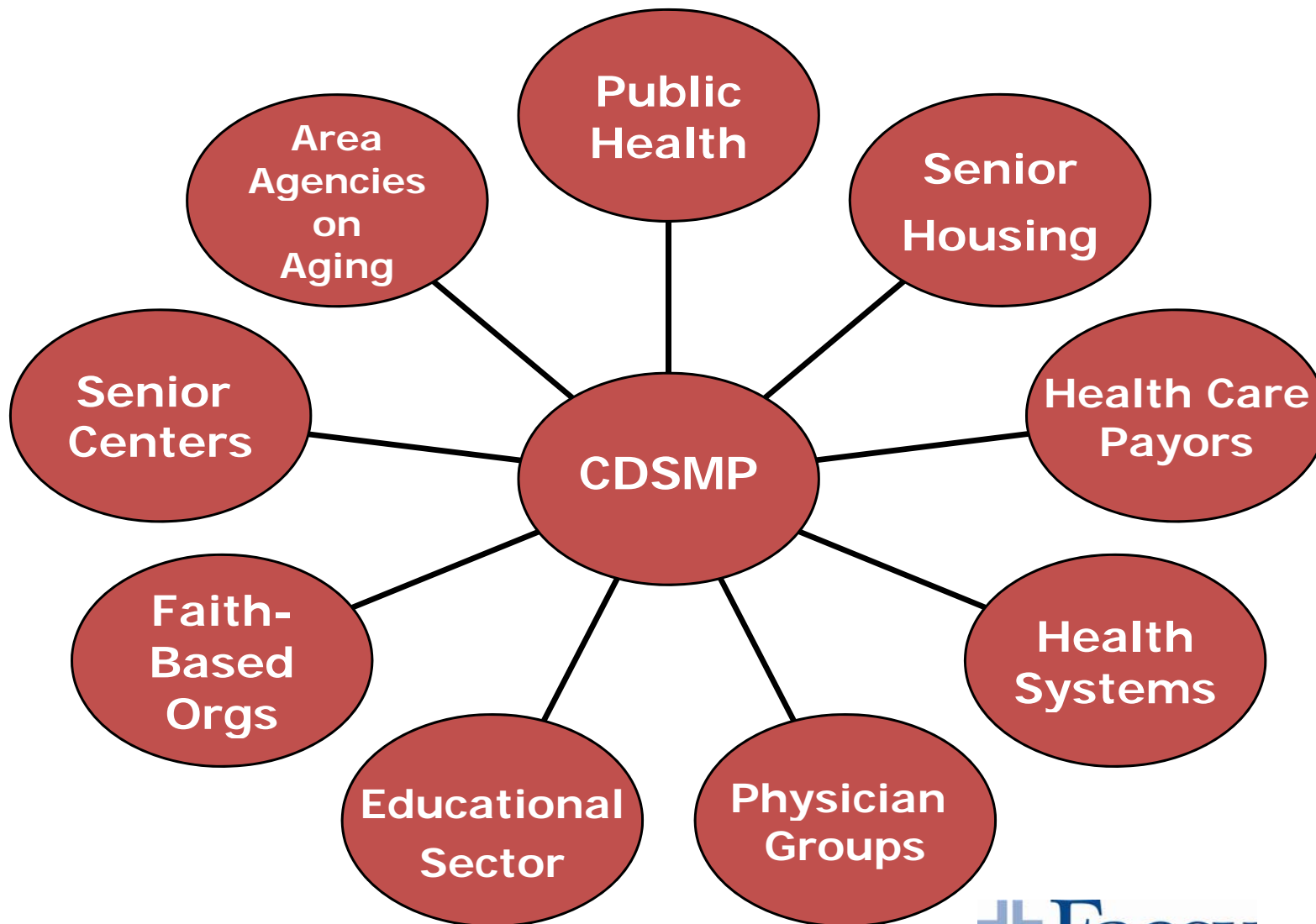
Workshop Overview

- Managing symptoms
- Dealing with difficult emotions (frustration, anger, pain)
- Relaxation techniques
- Tips for eating well
- Medication “how to’s”
- Improving communication (family, friends, doctors)
- Effective problem-solving
- Setting weekly goals

Target Population

- Have at least 1 chronic condition
 - Arthritis, diabetes, heart disease, depression, chronic pain, etc.
- Family members, friends, or caregiver of someone with a chronic condition can also attend
- Must have stamina to attend 2 ½ hour class
- Must have cognitive function to participate
- Diverse adults in underserved communities

Target Sectors for Program Engagement



Facey Medical Group Est. 1923

- **Multi-Specialty Medical Group**
 - 80 PCP's, 60 Specialists
- **Clinics in San Fernando, Santa Clarita & San Gabriel Valleys**
- **AAAHC Accredited**
 - Accreditation Associates for Ambulatory Healthcare
- **CAPG Standard of Excellence Elite Status**
- **175,000 active patient population, includes 105,000 HMO patients**



Facey Care Management Committee

- 2006:** Facey Care Management Committee formed IHA P4P Standards; CAPG Standards of Excellence
- 2007:** Facey physicians and staff design depression intervention
- 2008:** Facey Depression Program in Primary Care “Problem Solving Therapy in Primary Care”
- 2009:** Facey implements *Healthier Living* for depression patients with chronic conditions



Facey Competencies

2006

Existing

- Reportable electronic data and IT analyst
- Electronic health record (Allscripts)
- Clinical quality (as evidenced by P4P scores)
- Use of evidence-based programs
 - IMPACT, Healthier Living
- Strong UM, Case Management, Patient Education Teams

2010

Developed/Developing

- Multi-disciplinary Care Management Committee and Sub-Committee
 - Physician Champion, Chair of Psychiatry
 - Physician Coding HCC/ICD-9 Major Depression
 - Dedicated and engaged staff member (0.6 FTE for 603 patients)
- Administrative Support
 - More IT Analysts
 - Support Systems: *Scheduling; Billing; Coding; Population Data Management*
 - Communication Tools; Customized and Actionable Message

2009

Healthier Living Implementation Plan

Depression Care Management Program

- Patient outreach and enrollment
- *Healthier Living Program* (culturally adapted)
- Telephonic follow up and documentation

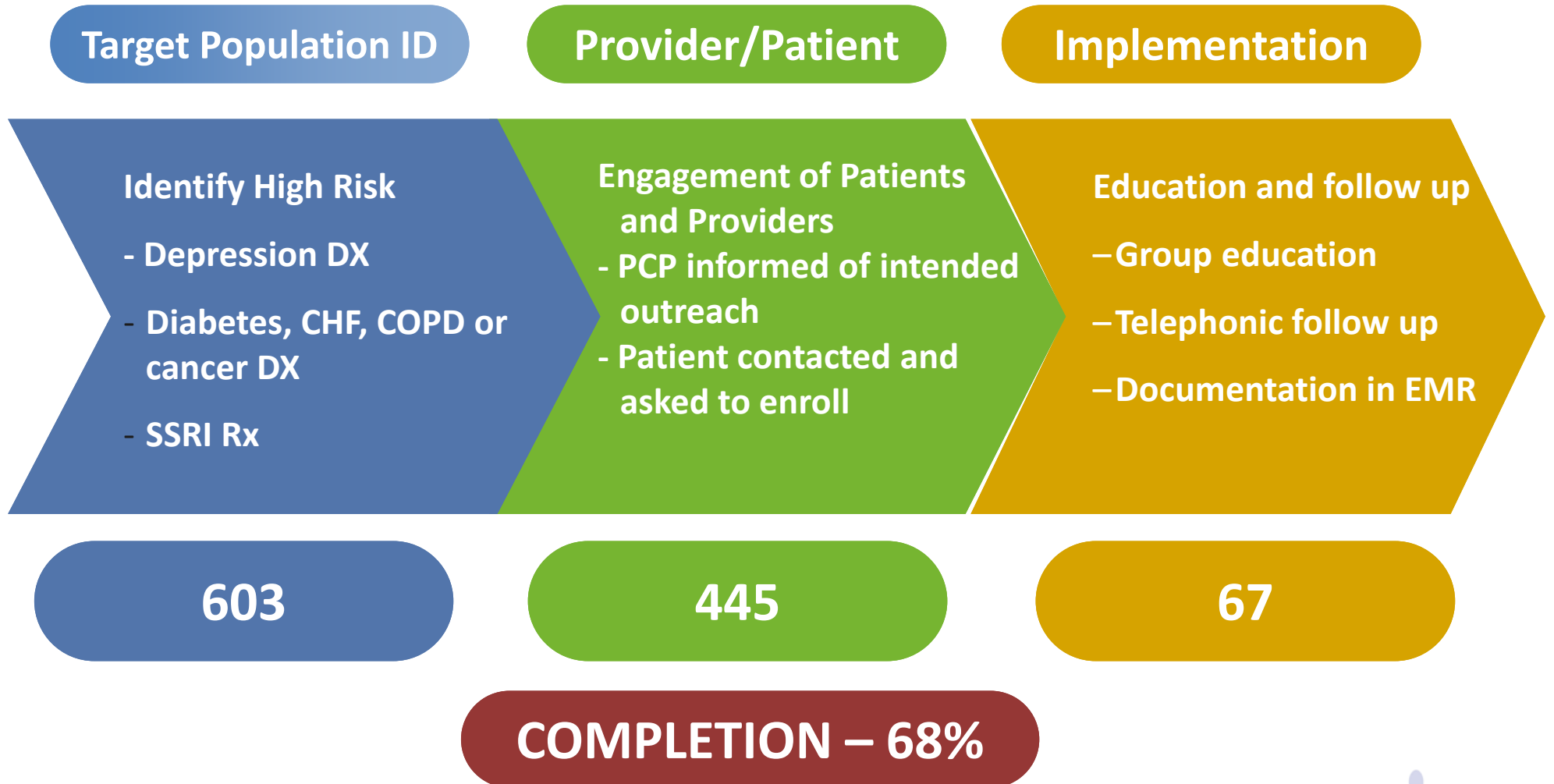
Clinical Training/Coaching: Care Management Providers
Train-the-trainer sessions

Stress Management Classes

Open to all Facey patients / families / friends



Healthier Living Depression Program Process



Chronic Disease Program for Depression?

- Evidence based model
- Culturally adapted
- PCP championed program, clinical staff support at appropriate level of expertise
- PCP awareness/engagement in patient behavioral change is critical
- Create excitement; It's is a tough sell

Participant Health Effects

- Greater energy/reduced fatigue
- Increase in exercise
- Better psychological well-being
- Enhanced partnerships with physicians
- Improved health status
- Decrease in pain
- Decrease in depression
- Decrease in shortness of breath
- Improved quality of life
- Greater self-efficacy and empowerment

Health Care Utilization Effects

- Fewer outpatient visits
- Fewer emergency room visits
- Fewer hospitalizations
- Fewer days in hospital
- Saves enough money through reductions in health care expenditures to pay for itself within the first year
- Results in more appropriate utilization of health care resources
 - Health care needs addressed in outpatient settings vs. ER visits and hospitalizations

Facey *Healthier Living* Outcomes

2009-2010

PHQ 9 – Range 0-27 Depression Screening Tool

Pre – Program

7 (range 0-24)

Post – Program

4 (range 0-16)

- Patient Satisfaction -
 - Average score 3.7 (scale 0-4)
- Provider Satisfaction-
 - More feedback about patient progress
 - Multiple communication tools about program value;
 - Value to Facey, value to PCP practice, value to patient wellbeing

Models of Implementation

- External model - partnership with community agencies
- Internal model – practice staff are trained to provide workshops

What does it take to start?

- Contact Partners in Care to express interest
 - www.picf.org or email gflaming@picf.org
- Establish target patient population & class location
- Train staff to connect patients to program
- Evaluation of results

Questions?



Conference Presentation Online

- Conference presentation will be available online at www.picf.org
- Select EVENTS>PRESENTATIONS

