



# 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

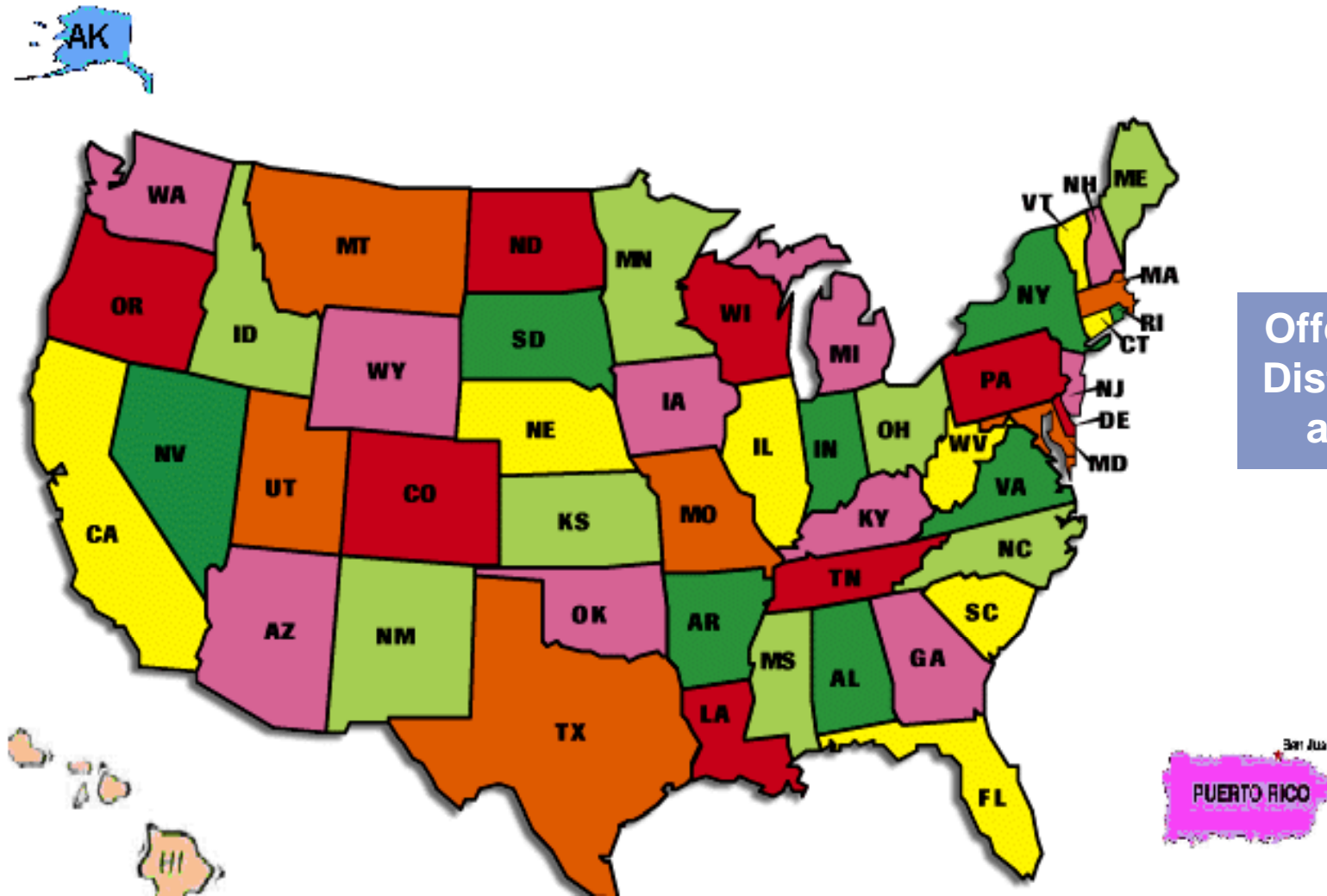


# Background: California's Evidence-Based Initiative

- 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

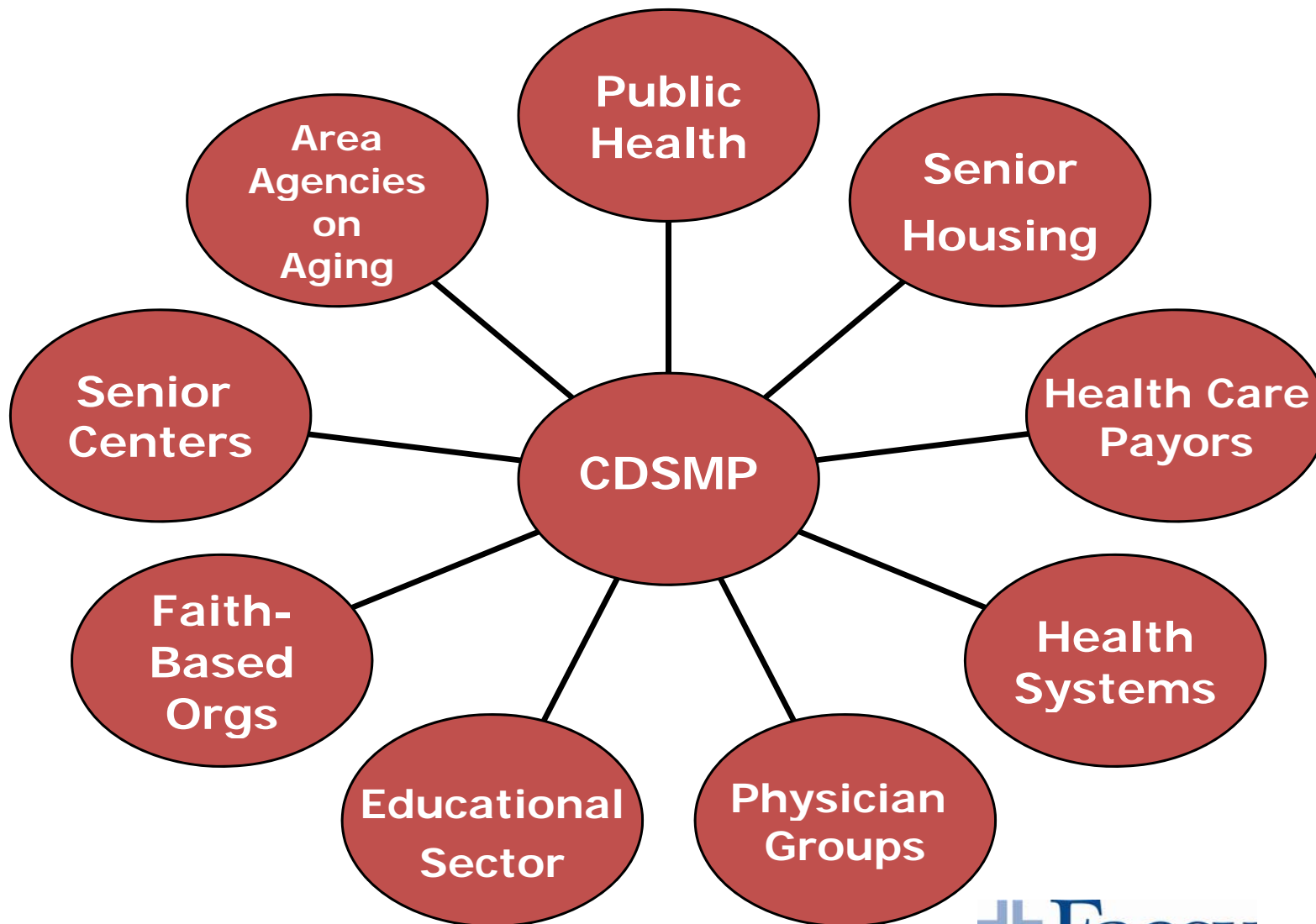
# Workshop Overview

- 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

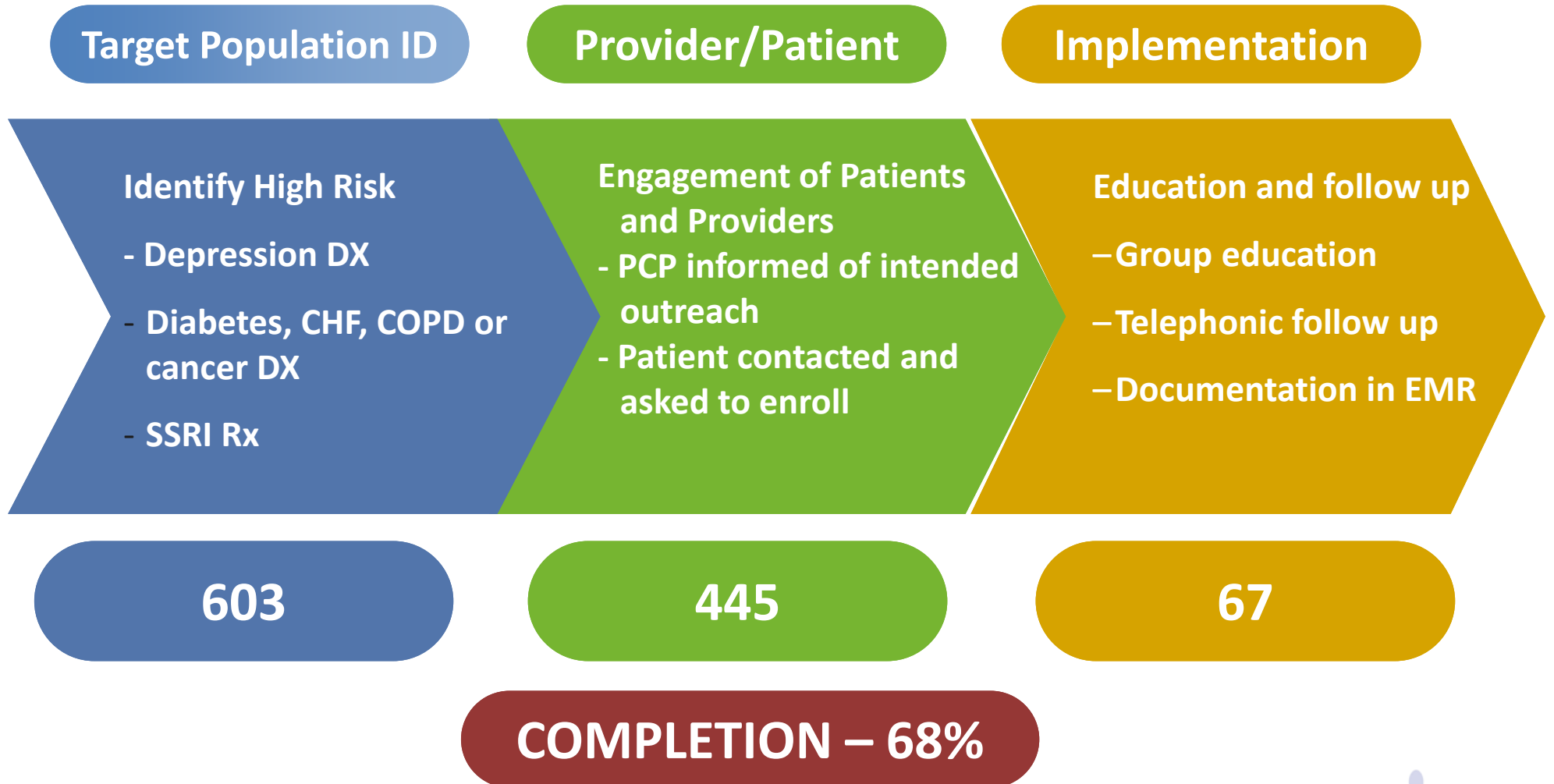
**Clinical Training/Coaching: Care Management Providers**  
Train-the-trainer sessions

### 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](http://www.picf.org) or email [gflaming@picf.org](mailto: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](http://www.picf.org)
- Select EVENTS>PRESENTATIONS

