

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

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Chronic Diseases Require Changes in Health Care Practice

- ❖ The goal is function and comfort, not cure
- ❖ The role of the health care provider changes from principle care giver to teacher and partner
- ❖ The sites of care change from clinic and hospital to community
- ❖ The role of the patient changes

How Does the Role of the Patient Change?

- ❖ They must manage the disease (s)
- ❖ They must maintain their life roles
- ❖ They must deal with the emotional consequences of the disease (s)
- ❖ They are sometimes the only carrier of vital information.



Self-Management Support Prepares Patients for these Roles

They become
Self-managers

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Self-Management: What Is It?

Self-management is defined as the task that individuals must undertake to live with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions

Self-Management Support

Self-management support is defined as the systematic provision of education and supportive interventions by health care system to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support

Institute of Medicine 2003

Self-Management and Patient Education

	<u>Self- Management</u>	<u>Patient Education</u>
Needs Assessment:	Patient Problems	What Patients Need to Know
Content:	Disease, Role, & Emotional Management	Disease Management
Outcomes:	Health Status/ Utilization	Knowledge/ Behaviors

Stanford Self-Management Programs

- ❖ Built on structured patient and professional needs assessments (usually focus groups)
- ❖ Systematically use strategies to enhance self-efficacy
 - Skills Mastery
 - Modeling
 - Reinterpretation of Symptoms
 - Social Persuasion

Stanford Self-Management Programs

- ❖ Peer led small groups
- ❖ Standardized training for leaders
- ❖ Highly structured teaching protocol
- ❖ Standardized participant materials
- ❖ Several topics per session
- ❖ Evaluated in randomized trials for long term outcomes

Stanford Self-Management Programs

- ❖ Arthritis Self-Management (English/Spanish)
- ❖ Chronic Disease Self-Management (English/Spanish)
- ❖ Tomando Control de Su Diabetes
- ❖ Positive Self-Management (HIV/Aids)
- ❖ Internet Self-Management Programs (Chronic Disease and Arthritis)

Chronic Disease Self-Management Program - What Is It?

- ❖ Small groups 10-16 people
- ❖ People with different diseases in same group
- ❖ 2 ½ hours a week for 6 weeks
- ❖ Peer taught
- ❖ Content: symptom management, exercise, nutrition, problem solving, communications, advanced directives
- ❖ Process: Self-efficacy, action planning, sharing

Chronic Disease Self-Management Program - Randomized Trial

Demographic Data

❖ Age	62 years
❖ Male	27%
❖ Education	14 years
❖ No. Diseases	2.2

Percent With Common Diseases

❖ Lung Disease	21%
❖ Heart Disease	24%
❖ Diabetes	26%
❖ Arthritis	42%

Chronic Disease Self-Management

6-Month Improvements in Health Outcomes

- ❖ Self-Rated Health
- ❖ Disability
- ❖ Social and Role Activities Limitations
- ❖ Energy/Fatigue
- ❖ Distress with Health State

P<.05 treatment vs. control

Chronic Disease Self-Management

Improvements in Utilization and Costs

- ❖ Average .8 fewer days in hospital in the past six months ($p=.02$)
- ❖ Trend toward fewer outpatient and ER visits ($p=.14$)
- ❖ Estimated cost of intervention \$100-\$200

Chronic Disease Self-Management

Rural North Carolina

Demographic Data

❖	Age	64 yrs
❖	Male	22%
❖	Education	11.8 yrs
❖	More than 2	76%

Diseases

Unpublished data “Yes We Can Study”
Jean Goepfinger PhD

Chronic Disease Self-Management

Rural North Carolina

4-Month Improvements in Health

N=approximately 75

- ❖ Pain
- ❖ Fatigue
- ❖ Social and Role Activities Limitations
- ❖ Distress with Health State

P<.05

Chronic Disease Self-Management

Improvements in Utilization and Costs

- ❖ Average 1 fewer visit to physicians
- ❖ -.22 fewer days in hospital in the past four months

Chronic Disease Self Management

Hispanic Diabetics N=143

❖ Age	61 years
❖ Female	83%
❖ Mean Ed.	8.6 years
❖ Married	55%
❖ Born in Mexico	82%

4 Mo and 1 year Improvements

Hispanic Diabetics N=143

- ❖ Role function
- ❖ Health distress
- ❖ Self-reported health
- ❖ Shortness of breath
- ❖ Pain
- ❖ Exercise
- ❖ Self-efficacy

P<.05

Chronic Disease Self-Management

Cardiac disease (N=126)

Baseline Characteristics

❖ Mean Age	67 (35-88)
❖ Mean Education	14 years (8-22)
❖ Gender	46% male
❖ Married	69%
❖ Caucasian	86%
❖ Exercise/wk	94 Minutes

6-Month Changes in Behavior

- ❖ 23% increase in range of motion exercise
- ❖ 25% increase in use of coping skills
- ❖ 10% improvement in skills communicating with health care providers

All $p < .05$

6-Month Changes in Health Status

10% decrease in shortness of breath

6% decrease in depression

21% decrease in fatigue

All $p < .05$

6-Month Changes in Utilization

❖ 58% decrease in days in hospital
(-.81 days per person)

P<.05



Characteristics of Healthy Living @ Stanford

- 20-25 people with heart disease, lung disease, or diabetes type 2 participate together
- No “real time” commitment
- Peer led by two moderators
- Highly interactive
- Participants asked to log on 2-3 times a week
- Six-week workshop (entirely on-line anywhere there is Internet access)



Study Recruitment

- Randomized: 958 participants with heart disease, lung disease, and type 2 diabetes
- Mean Age : 55 years (range 20-87 yrs)
- Mean Education Level : 15 years
- Gender: 70% female



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Workshop Topics

- Disease-Related Problem Solving
- Managing Emotions
- Exercise
- Cognitive Symptom Management
(*relaxation, distraction, self-talk, visualization*)
- Communication Skills
- Using the Health Care System
- Nutrition
- Managing Medications
- Advanced Directives

Participation of treatment subjects

- 10% never logged on

Of those logging on once

- 57% completed 5 sessions
- 69% completed 4 sessions
- 83% completed 2 sessions
- 91% completed 1 session

1-Year changes (treatment/control)

N=782

Improvements in:

Communicating with Providers *

Exercise **

Fatigue **

Health Distress **

Shortness of Breath *

Pain **

*P<.1

**P<.05

Treatment vs.
control

Characteristics of successful Programs

- ❖ Based on Patient needs assessment
- ❖ Emphasis on:
 - Problem solving
 - Goal setting
 - Improving self-efficacy
 - Patients helping patients
 - self-tailoring

Where is the CDSMP Used?

- ❖ State Health Departments (Indiana, Nebraska, Nevada, NJ, NY, Oregon, Texas, Vt.)
- ❖ Local AAA (MA, WI, MI, NB)
- ❖ Health Plans (Kaiser Permanente, Group Health Cooperative, HIP New York)
- ❖ Other Governmental Health Programs (Calgary Health Region Canada, National Health Service England, National Health Service Denmark, Commonwealth Programs Australia)

Implementation Challenges

- ❖ Partners buy in
- ❖ Secure internal funding
- ❖ Logistical, managerial and program coordination staff.
- ❖ Organizational leadership support.

Implementation continued

- ❖ Significant Marketing and Start up
- ❖ Program recruitment
- ❖ Participant Retention
- ❖ Recruitment and retention of peer leaders



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Questions and Discussion

Please!!

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