CHRONIC DISEASE SELF-MANAGEMENT

MARCIA G. ORY, PH.D., MPH
REGENTS AND DISTINGUISHED PROFESSOR

TEXAS A&M HEALTH
Center for Community Health and Aging

OBJECTIVES*

- Describe key components of chronic disease self-management programs
- Describe how to select the best program for patients and settings
- Describe how to integrate chronic disease self-management programs into clinical practice for older adults in your community

Material adapted from Ory et.al. Chronic Disease Self-Management Education: Program Success and Future Directions. M.L. Malone et al. (eds.), Geriatrics Models of Care: Bringing 'Best Practice' to an Aging America, Springer International Publishing Switzerland Forthcoming 2023

TEXAS A&M HEALTH
Center for Community Health and Aging

WHY BE CONCERNED ABOUT CHRONIC CONDITIONS ---

- The magnitude of chronic conditions among older patients
- Anticipated increased burdens with rapidly aging population
- Recognized shortage of geriatricians and other healthcare professionals
- ➢Growing appreciation that chronic illness can be prevented or managed

Health and Aging

B UT…..A TYPICAL SCENARIO

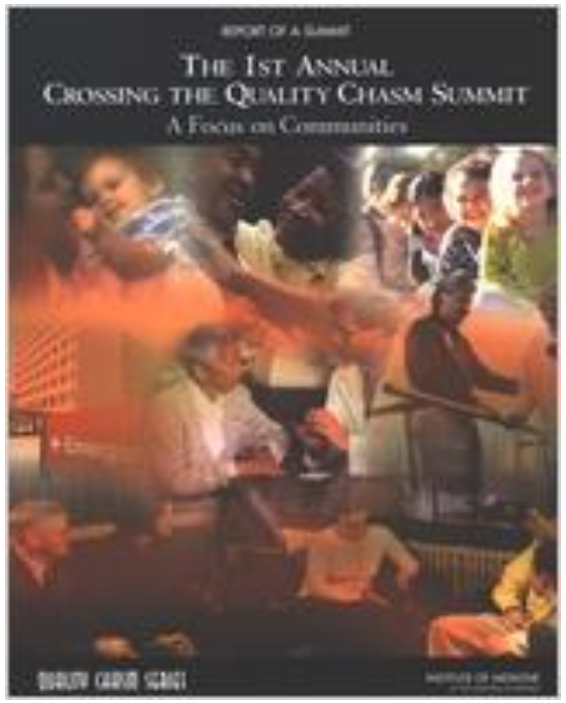
- You have older patients with multiple chronic conditions like diabetes, hypertension, respiratory problems that are lifestyle related
- You see them regularly prescribe medications and offer lifestyle recommendations
- For many, their conditions remain out of control

WHAT IS THE ROLE OF SELF MANAGEMENT?

- Recognition that most health care is self-care outside of traditional clinical settings
- Self-management is increasingly recognized as an essential element for improving chronic illness care in America
- Self-management is part of a continuum of care not replacing health care

TEXAS A&M HEALTH
Center for Community Health and Aging

DEFINING SELF-MANAGEMENT



Institute of Medicine (US) Committee on the Crossing the Quality Chasm: Next Steps Toward a New Health Care System; Adams K, Greiner AC, Corrigan JM, editors. Washington (DC): National Academies Press (US); 2004.

- IOM Summit to discuss strategies for improving patient care for five common chronic illnesses
- Definition
  - Tasks that individuals must undertake to live with one or more chronic conditions.
  - Tasks include having confidence to deal with medical management, role management, and emotional management of their conditions
- Application
  - Has spurred many SM programs

TEXAS A&M HEALTH
Center for Community Health and Aging

THE GENESIS OF CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

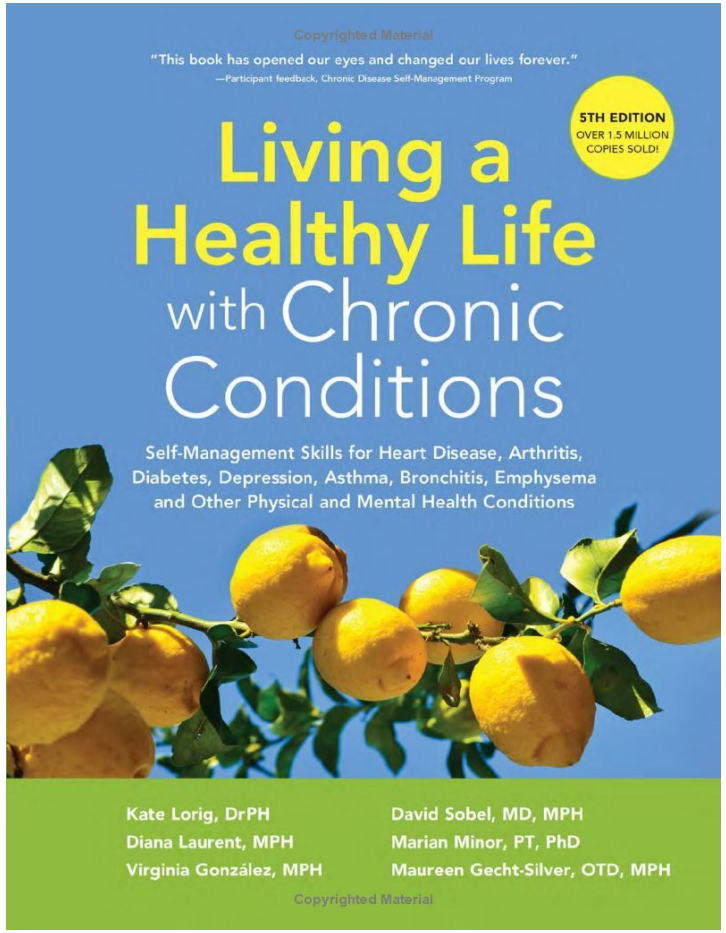
- Originally developed at Stanford University in the 1990s
- Kate Lorig vision: Help people be active partners in managing their own health
- Like other innovations—a long history of research and dissemination—40 years!
- From CDSMP to a suite of CDSME programs
- Now coordinated through Self Management Resource Center

SMRC
Self-Management
Resource Center

https://selfmanagementresource.com/

TEXAS A&M HEALTH
Center for Community
Health and Aging

CRITICAL CDSME RESOURCE



- Redesigned for easy reading and fully updated with the latest research and information on current practice, medication, legal matters, and specific conditions
- Identifies tips, suggestions, and strategies to deal with chronic illness and symptoms, such as fatigue, pain, shortness of breath, disability, resources and support
- Includes the feedback of medical professionals and people with chronic conditions all over the world
- Aimed at letting people become self-managers of their own illness.
- Encourages readers to develop individual approaches to setting goals, making decisions, and finding resources and support

TEXAS A&M HEALTH
Center for Community Health and Aging

PROGRAM REACH THROUGH ACL INITIATIVES

From January 2010 to January 2023

- Nearly 500,000 participants enrolled
- More than 40,000 workshops
- More than 18,000 unique implementation sites
- Most common delivery sites
  - health care organizations, senior centers, residential facilities, faith-based organizations, and Area Agencies on Aging

Evidence-Based Programs for Professionals
The National Reach of Chronic Disease Self-Management Education Programs: Participant Demographics and Program Outcomes

https://www.ncoa.org/article/the-national-reach-of-chronic-disease-self-management-education-programs-participant-demographics-and-program-outcomes

TEXAS A&M HEALTH
Center for Community Health and Aging

3 M'S TO SUCCESS

MOMENT

- Recognition of the prevalence and costs of chronic conditions
- Recognition of the power of EBPs
- Recognition of translational research

MOVEMENT

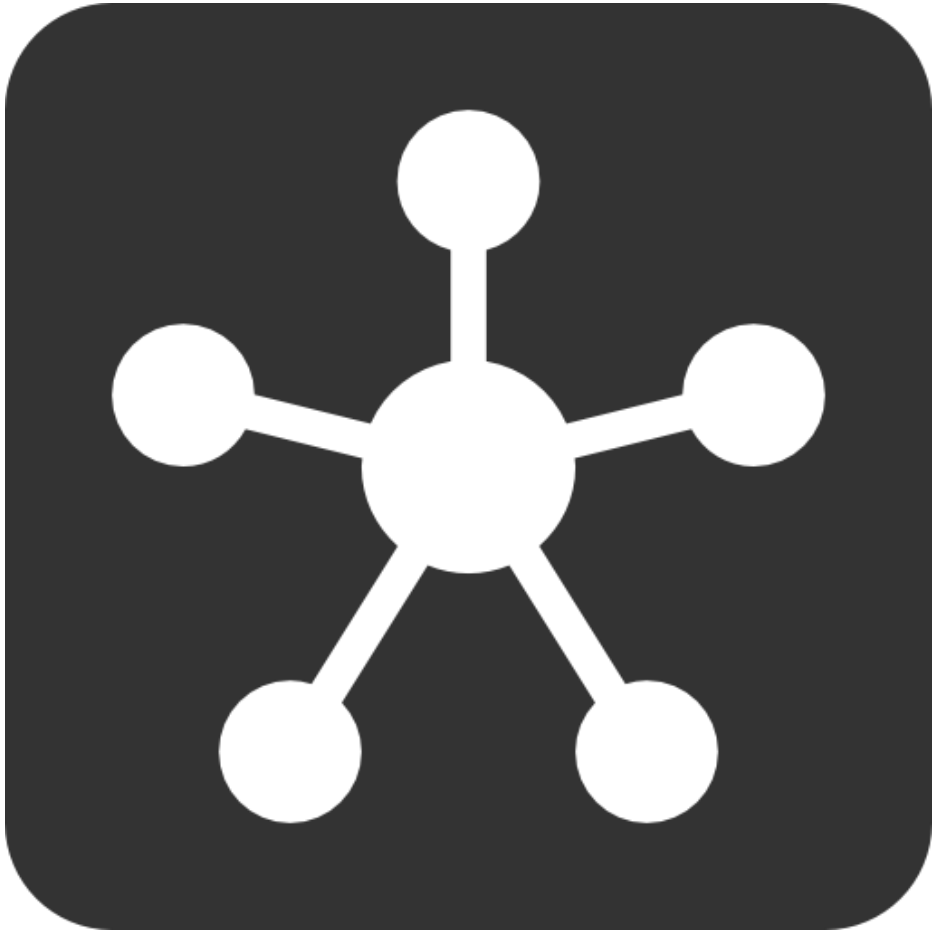
- ACL
- NCOA as technical assistance arm
- Aging services network

MOMENTUM

- Person-centered care
- Reimbursements for EBPs
- D&I science and practice

TEXAS A&M HEALTH
Center for Community Health and Aging

PROGRAM INFRASTRUCTURE



- American Recovery and Reinvestment Act of 2009 and Affordable Care Act's Prevention and Public Health Fund
- The Administration for Community Living awards two grant mechanisms that support CDSME delivery
  - capacity-building grants to help communities develop the needed delivery infrastructure for CDSME implementation;
  - sustainable systems grants to create integrated systems and innovative collaborations to support the ongoing delivery of CDSME programs.

TEXAS A&M HEALTH
Center for Community Health and Aging

CDSME PROGRAM ASSUMPTIONS

Common themes among people with different, ongoing health conditions

- Have similar self management problems, tasks and concerns
- Deal not only with their specific condition but its impact on their lives and emotions
- Individuals can learn to take day-to-day responsibility for their conditions

TEXAS A&M HEALTH
Center for Community Health and Aging

BASIC ELEMENTS OF THE CDSME PROGRAM MODEL

- Uses structured protocol that outlines content and methods
- Emphasis on group participation, problem solving, decision making, goal setting, and action planning
- 2½-h group sessions that meet once per week for 6 consecutive weeks (incorporates a CD and participant book)
- Uses two trained lay leaders in each workshop
- Targets people with any chronic condition
- Works to increase self-efficacy through skill mastery, modeling, reinterpreting symptoms, and persuasion
- Fidelity monitoring protocol

CORE COMPONENTS AND STRUCTURES LEADING TO SUCCESS

Behavior change techniques:

- Goal setting
- Decision-making
- Problem-solving
- Action planning
- Constant modeling and feedback
- Effective communication
- Cognitive restructuring

Mechanisms:

- Peer education
- Social interaction
- Social support

TEXAS A&M HEALTH
Center for Community Health and Aging

WHAT'S IN THE CDSMP TOOLBOX

Example of week-by-week topical foci

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Overview of self-management and chronic health conditions	★					
Making an action plan	★	★	★	★	★	★
Relaxation/cognitive symptom management	★		★	★	★	★
Feedback/problem-solving		★	★	★	★	★
Difficult emotions		★	★			
Fitness/exercise		★	★			
Better breathing			★			
Fatigue			★			
Eating well				★		
Advance directives				★		
Communication				★		
Medications					★	
Making treatment decisions					★	
Depression					★	
Informing the health care team						★
Working with your health care professional						★
Future plans						★

TEXAS A&M HEALTH
Center for Community Health and Aging

DOCUMENTED BENEFIT

Success in addressing triple aims of health care:

- Better health
- Better care
- Better value

Ory MG, Ahn S, Jiang L, Smith ML, Ritter PL, Whitelaw N, Lorig K. Successes of a national study of the Chronic Disease Self-Management Program: meeting the triple aim of health care reform. Med Care. 2013 Nov;51(11):992-8. doi: 10.1097/MLR.0b013e3182a95dd1. PMID: 24113813.

TEXAS A&M HEALTH
Center for Community Health and Aging

PATIENTS WHO BENEFIT

- Accommodate a wide range of patients with a variety of chronic conditions
- Both generic and disease-specific programs
- Benefits across different socioeconomic and racial and ethnic populations
- Benefits across different geographic areas

TEXAS A&M HEALTH
Center for Community Health and Aging

HOW TO DECIDE WHAT PROGRAM AND MODALITY BEST FOR YOUR PRACTICE

What patient needs are you trying to meet?

Do you want a generic or disease-specific program?

Do you want in English or another language?

What modality will work best for you?

In person
Virtual online small groups
Mailed toolkit
Internet asynchronous groups

CHOOSING AMONG DIFFERENT PROGRAMS

- The SMRC Suite of CDSME is often preferred because of its long history and infrastructure but there are other options
- See NCOA for a complete listing of evidence-based programs

https://ncoa.org/evidence-based-programs

TEXAS A&M HEALTH
Center for Community Health and Aging

ADDRESSING THE 3 C'S

- Low Cost- community-based CDSMP workshop approx. $50/person/session x 6 sessions = $300. Fees may be subsidized; Medicaid clients on COPES waiver $50/person/session paid to host organization-need DSHS case manager referral
- Convenience- workshops offered in community
- Credibility-designed by researchers at Stanford University; evidence based from study design to outcomes; all leaders take 32 hour training; ability to implement program to a wider population in various settings

TEXAS A&M HEALTH
Center for Community Health and Aging

HOW TO GET STARTED WITH EBPS

- No need to start from scratch
- Many different programs tested
- Growing inventory of evidence-based programs that are “shelf-ready”
- Rated on implementation and dissemination factors
- Training and technical assistance available from program developers

Center for Community Health and Aging

https://www.ncoa.org/evidence-based-programs

TIPS FOR INTEGRATION WITH CLINICAL PRACTICE: PROGRAM PLANNING

- Articulate your goals for CDSME
- Identify your population and setting
- Select the CDSME program you think will fit best
- Identify a local champion or someone responsible for program integration
- Assess your current infrastructure including delivery capacity and potential for sustainabilty
- Determine if you plan to host programs yourself –or refer out to CBOs who are delivering these programs in your community
- If offering in-house determine who will offer and what training needed and how you will recruit patients
- Refer to a program planning and evaluation model such as RE-AIM

SPECIFIC STRATEGIES

- Identify patients from Electronic Medical Record
- Consider SM RX
- Practice motivational interviewing strategies
- Make referrals within or external to your practice
- Follow-up with patients

TEXAS A&M HEALTH
Center for Community Health and Aging

RE-AIM PLANNING TOOL

Improving Public Health Relevance and Population Health Impact

https://re-aim.org/applying-the-re-aim-framework/re-aim-guidance/use-when-planning-a-project/planning-tool/

- Reach--Who will take part?
- Effectiveness--What Results?
- Adoption--Where will the program be conducted?
- Implementation--How consistently will you deliver the program?
- Maintenance/Sustainability--How can your program be sustained over time?

TEXAS A&M HEALTH
Center for Community Health and Aging

WHAT IF MY PATIENT NOT IMPROVING

MAJOR DETERMINANTS OF HEALTHY AGING

TEXAS A&M UNIVERSITY
Center for Population Health and Aging

XAS A&M HEALTH
enter for Community
lealth and Aging

RESOURCES

Organizations

- **Administration for Community Living**

  https://acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs

- **National Council on Aging**

  https://www.ncoa.org/article/the-national-reach-of-chronic-disease-self-management-education-programs-participant-demographics-and-program-outcomes

- **Self Management Resource Center**

  https://selfmanagementresource.com/

- **RE-AIM Planning & Evaluation Group**

  https://re-aim.org/

References

- Ory, M. G., Ahn, S., Jiang, L., Smith, M. L., Ritter, P. L., Whitelaw, N., & Lorig, K. (2013). Successes of a national study of the chronic disease self-management program: meeting the triple aim of health care reform. Medical care, 992-998.
- Ahn, S., Basu, R., Smith, M. L., Jiang, L., Lorig, K., Whitelaw, N., & Ory, M. G. (2013). The impact of chronic disease self-management programs: healthcare savings through a community-based intervention. BMC Public Health, 13(1), 1141.
- Ory et.al. Chronic Disease Self-Management Education: Program Success and Future Directions. M.L. Malone et al. (eds.), Geriatrics Models of Care: Bringing 'Best Practice' to an Aging America, Springer International Publishing Switzerland Forthcoming 2023

TEXAS A&M HEALTH
Center for Community Health and Aging

CONTACT INFORMATION

CONTACT US

ccha.tamu.edu
https://re-aim.org/

mory@tamu.edu

TEXAS A&M HEALTH
Center for Community Health and Aging

Marcia G. Ory, PhD, MPH
Regents and Distinguished Professor
Texas A&M School of Public Health