Chronic Disease Self-Management Program (CDSMP©)
Congestive Heart Failure Program

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Catholic Healthcare West: A Leading Not For Profit Health System 1

FY2009

- 8th largest health system in the nation
- Largest hospital provider in California
- Hospitals: 41 acute care hospitals in Arizona, Nevada and California
- Clinics: 45
- Mobile Health Clinics: 8
- Trauma Centers: 9
- Assets: $11.1 billion
- Acute Care Beds: 8,800
- Active Physicians: 10,000
- Employees: 54,000
- General Acute Patient Care Days: 1.8 million
- Community Benefits & Care of the Poor: $1.2 billion*

* Including unpaid costs of Medicare

CHW Mission Statement

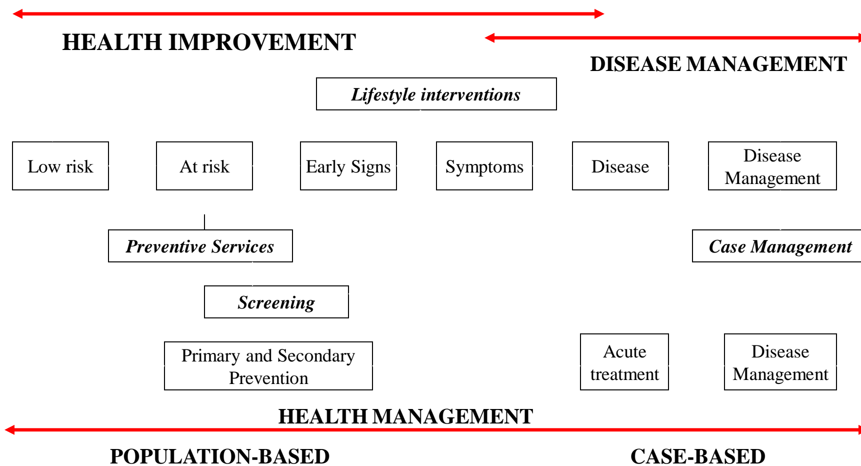
Catholic Healthcare West and our sponsoring congregations are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Environmental Trends

- Chronic conditions account for 81% of hospital admissions, 91% of all prescriptions filled, and 75% of all physician visits.
- They account for 75% of all healthcare expenditures.
- 99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition.
- 45% of Americans live with a chronic condition and that number is expected to rise 1%/year by 2030.

Full Integration: Population Based and Chronic Care Case Based Model



Solution Summary

- Chronic Disease Self-Management Program© was designed by KR Lorig, et al. of the Stanford Patient Education Research Center, Stanford University.
- Based on self-efficacy theory
- Complements traditional patient education
- Co-facilitated Group Learning / Peer Led

Underlying Assumptions of CDSMP

- People with chronic conditions have similar self-management problems and disease-related tasks.
- Patients can learn to take responsibility for the day-to-day management of their diseases.
- Confident, knowledgeable patients practicing self-management will experience improved health status and will utilize fewer health care resources.

Stanford Chronic Disease Self-Management Program

- Small groups 10-16 people of mixed ages and chronic conditions
- Family members and/or caregivers are encouraged to participate
- 2 ½ hours per week for 6 weeks
- Peer taught by 2 lay leaders
- Meetings are highly interactive, focusing on enhancing self efficacy, sharing experiences and support

Best Practice - Impact

- Prospective, randomized controlled trial of CDSMP© completed in 1996
  - 1,000 people with various chronic diseases followed for 3 years.
  - Participants demonstrated improved health behaviors and health status, as well as decreased health care utilization.
- Results replicated by Kaiser Permanente hospitals and Group Health Cooperative of Puget Sound.

Key Learnings

- It is the *process* in which the CDSMP© is taught that makes it effective.
- Enthusiastic, culturally competent leaders
- Easily accessible and acceptable community meeting sites
- Timing of sessions
- Patient recruitment process

Best Practice - Impact

- Proven effective internationally
  - Curriculum Available in multiple languages, including
    - Arabic, Bengali, Chinese, Dutch, German, Hindi, Italian, Japanese, Korean, Norwegian, Somali, Turkish, Vietnamese and Welsh
- US Dept of Health and Human Services
  - In 2009 HHS awarded States, through Area Agencies on Aging, ARRA Funding to advance this evidence-based program

Transferring of Best Practice

- CDSMP© has
  - A standardized training curriculum for Program Leaders and Master Trainers
  - A highly structured manual that must be followed
  - A comprehensive tool kit for leaders
  - A special listserve for leaders

Transferring of Best Practice - Costs

- Training costs
  - For health professionals $1600; for a lay person with a chronic disease $900
- Facility license fee
  - 3-Year License is based on the number of workshops offered:
    - $500 for up to 10 workshops each year,
    - $1,000 for up to 30 workshops each year
- Classroom Materials
  - Participant Book and Relaxation Tape

Transferring of Best Practice

- Master Trainers or trained volunteer lay leaders facilitate 6 session course and commit to conducting at least 2 courses/year
  - Suggest stipend for volunteer lay leaders
  - Suggest refreshments for participants
- A manager focuses on patient / participant recruitment & site logistics
  - Partnerships may include local congregations, physicians, primary care clinics

Resources

- Chronic Disease Self Management Program© and Video
  - http://patienteducation.stanford.edu/programs/cdsmp.html
  - http://aging.ca.gov/ebhp/videoPlayer.aspx?videoName=cdsmp1.wmv
- CDSMP© Training Information
  - http://patienteducation.stanford.edu/training/
- CDSMP© Licensure
  - http://patienteducation.stanford.edu/licensing/

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Mission Fulfillment: Quality of Life

"I am ninety years old and this program has been very helpful in my way of life… the importance of daily exercise and less worry over my health problems… I am much more relaxed than I have been in a long time."

"We learned to deal more effectively with anxiety, anger, pain, depression and emotions. I now have more confidence in myself…"

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Congestive Heart Failure

- Heart Failure is one of the leading chronic disease and is identified as a major contributor to escalating healthcare expenditure (estimated $34 billion in the United States by the American Heart Association)

Gaps in the medical and educational needs were identified.

Collaborative Program was designed to facilitate a continuum of care utilizing a hospital-to home bridge for care management model.

Congestive Heart Failure Programs

Marian Medical Center – sister CHW hospital began Telephonic Disease Management Program 2002

French Hospital Medical Center and Arroyo Grade Community Hospital mirrored program in 2008

Congestive Heart Failure Program

Care Management Model

- Education
- Support and reiterate the treatment plan
- Monitor patient's self- management knowledge
- Implement primary and secondary interventions
- Coordinate services

Care Management Program Coordinator works with health care providers and case managers in the community.

Telephone support

- Dietary recommendations
- Sodium and liquid intake
- Medication management
- Exercise
- Daily weight monitoring
- Basic health maintenance

1st quarter of 2010

Marian Medical Center – 1% readmission rate among 98 patients

Arroyo Grande Community Hospital – 0 readmission rate among 24 patients

French Hospital Medical Center – 2.3% readmission rate among 33 participants

Intangible Benefits

- Improved communication among providers of patient status
- Improvement of coordination of care across the continuum
- Increased level of patient knowledge and self-management skills
- Improved quality of life for CHF patients