



# Chronic Disease Self Management & PCMH Fact Sheet

## **Chronic Disease Self Management: Overview**

Self-management programs empower people to take an active role in managing their chronic illnesses. These programs help participants make lifestyle choices and changes, adhere to prescribed medical treatments, and become educated, responsible and informed patients. Based on its wide availability, proven results, and fulfillment of several of the NCQA's Physician Practice Connections® – Patient Centered Medical Home (PCC-PCMH-CMS™) guidelines, the CDSMP is a key resource for providers in meeting the requirements to become a medical home.

**The Stanford University Chronic Disease Self Management Program (CDSMP)**, created by Dr. Kate Lorig and her colleagues at Stanford University's Patient Education Research Center, is the best known and most highly regarded self-management program for people with chronic conditions. The program is built on three underlying assumptions:

1. Regardless of the chronic condition, people have similar challenges with self management.
2. People can learn the skills needed to better manage their diseases day to day.
3. People who understand and take control of their condition will be healthier and happier.

The program includes six weekly workshops focused on pain management, eating, exercise, medication use, emotional management, and communication with clinicians. Participants share practical advice on how to live with their health conditions using action plans and interactive learning. Workshops meet in settings such as senior centers, libraries and clinics. The meetings include people with many different health conditions and are run by trained peer leaders who also are living with a chronic condition.

The program has been proven through more than 20 years of development and evidence gathering, supported by grants from the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control & Prevention. It has been implemented in 43 states and 18 other nations, including Canada, Australia, China, Japan, Norway, and Great Britain. There are also courses specifically designed for persons with arthritis, diabetes and HIV/AIDS, along with Spanish language and online versions of the course.

Through a partnership with the U.S. Administration on Aging and the Atlantic Philanthropies, NCOA has introduced Stanford's CDSMP to 27 states, helping more than 30,000 diverse older adults better manage their chronic conditions since 2003.

## **CDSMP is Improving Health, Lowering Costs, and Reducing Utilization**

Nearly two decades of peer-reviewed data reveal impressive results for the Stanford CDSMP. In a number of major published studies, this model has resulted in significant, measurable, and

sustainable improvements in health status, self efficacy, and psychological well-being, along with increased exercise, reduced fatigue, and enhanced partnership with physicians.

The program may also save enough through reductions in healthcare expenditures to pay for itself within the first year.<sup>1,2</sup> One U.S. study found a two-year savings of between \$390 and \$520 per participant based on reduced hospitalizations and outpatient visits, using a program cost of \$70 to \$200 per participant.

Studies have also shown improved healthcare utilization, with measures including fewer emergency room visits, hospitalizations, inpatient days, and/or outpatient visits. One study found that in the first year, visits to doctors and emergency rooms dropped by 8 percent, while participants spent 40 percent less time in the hospitals.

NCOA has surveyed organizations about why they offer CDSMP and other evidence based programs. The most common answer by far: because they deliver results.

### **Meeting NCQA PCC-PCMH™ Standards**

CDSMP is one of many evidence-based health promotion programs available in communities throughout the United States. The NCQA has developed Physician Practice Connections® – Patient Centered Medical Home CMS Version (PCC-PCMH™-CMS) guidelines for becoming a certified medical home. One of the required elements for Level 1 recognition is PPC 4, Element B: Self-Management Support. Practices must score at least 50% in this element to achieve Level 1, meaning that 25-49% of patients seen in the last three months must have at least three activities that support patient/family self-management documented.

Referring patients to CDSMP workshops offered in your community will help qualify your practice to meet the following activities:

- Provides or connects patients/families to self-management support programs
- Provides or connects patients/families to classes taught by qualified instructors
- Provides or connects patients/families to other self-management resources where needed

### **CDSMP Workshops in Your Community**

Twenty-seven states are currently implementing evidence-based programs through the Evidence-Based Disease Prevention Grants Programs. The network has reached nearly 30,000 older adults since 2003, offering these programs in over 1,000 community organizations under the oversight of state aging and public health agencies. Please contact Nancy Whitelaw at [nancy.whitelaw@ncoa.org](mailto:nancy.whitelaw@ncoa.org) for more information.

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<sup>1</sup> Gordon C, Galloway T. Review of findings on Chronic Disease Self-Management Program (CDSMP) outcomes: Physical, emotional, & health-related quality of life, healthcare utilization and costs. National Council on Aging. 2007.

[www.healthagingprograms.org/resources/Review\\_Findings\\_CDSMP\\_Outcomes1.8.08.pdf](http://www.healthagingprograms.org/resources/Review_Findings_CDSMP_Outcomes1.8.08.pdf)

<sup>2</sup> Schneider, Ellen. Chronic Disease Self-Management Program (CDSMP): Evidence-based Chronic Disease Self-Management Program for Older Adults. National Council on Aging. 2002.

[www.healthagingprograms.org/resources/EBSummary\\_CDSMP\\_Overview.pdf](http://www.healthagingprograms.org/resources/EBSummary_CDSMP_Overview.pdf)