SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

EBP Series:
Chronic Disease Self-Management

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SAMHSA HRSA Health Resources & Services Administration

integration.samhsa.gov

Why Self-Management?

"Patients are in control. No matter what we as health professionals do or say, patients are in control of these important self-management decisions. When patients leave the clinic or office, they can and do veto recommendations a health professional makes."

Glasgow. Diabetes care 1999; 22: 288:1775-9.

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Self-Management of Medical Conditions in Mental Health Consumers

- Self-management programs have been demonstrated to improve health and self-management in MH consumers
- Most of these have been conducted with professionals rather than peers

Gen Hosp Psychiatry. 2014;36(3):233-44.
Psychiatr Serv. 2014 Jul 15

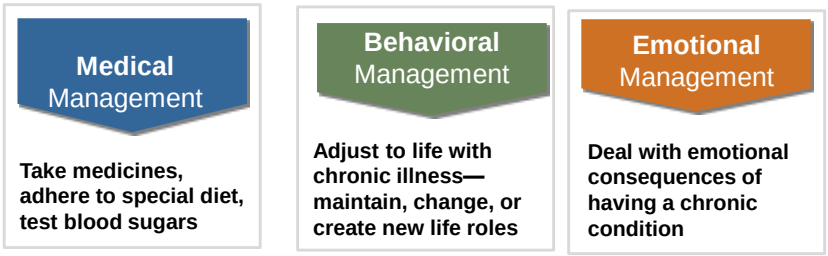
What is Chronic Disease Self-Management Support?

The systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.

- Adams et al 2004

Self-management as the organizing framework for behavior change

Living with a chronic condition requires patient self-management in three key areas:



So Why Should We Care?

Self-management programs focus on preparing people with chronic conditions for the 99% of the time they live outside of the health care system

Poll Question # 1: What best describes your current thinking or plans to address the needs of clients with chronic health conditions?

A. We have or plan to organize a CDSM group for a variety of conditions using a structured protocol or curriculum
B. We have or plan to organize a group for a specific condition such as diabetes.
C. We have or plan to focus on support provided in individual meetings
D. We have or plan to collaborate and coordinate with the clients primary care provider.
E. Other (please type or raise hand)

Poll Question #2: What best describes the staff who will be involved in providing CDSM in your organization?

A. Behavioral health staff only
B. Behavioral health staff plus primary care provider on site
C. BH staff with collaboration with primary care off site
D. Behavioral health staff including peer providers
E. Primary care setting with BH support
F. Other (please state in the chat box)

CDSM Self-Assessment as Planning and Decision Support

The goal of the CDSM Organizational Self-Assessment is to assist organizations to…

1. Understand the elements of high quality CDSM supports and interventions
2. Determine the degree to which your PBHCI initiative is currently aligned with best practices in CDSM
3. Select elements to improve that are practical, feasible and meaningful in light of the organization's realities.

CDSM Self-Assessment Structure and Content

- 7 Key Domains (A thru G)
- Each Domain has a set of Performance Standards
- Each standard represents an organizational and programmatic set of approaches aligned with CDSM practices
- Each standard may be quantitatively scored on a scale from zero to exemplary
- Organizations can calculate scores and graphically represent their current alignment with the CDSM domains

The Key Domains

A. Knowing Your Population
B. Team-based Care
C. Structured and Systematic CDSM Individual and Group Options
D. Best Practices
E. Wellness and Healthy Lifestyle
F. Addressing Harmful Behaviors
G. Use of Population Specific Data to Monitor Outcomes

Domain A:
Knowing your population

Standard 1: We have a system in place to identify patients who have chronic health conditions such as diabetes, asthma, cardiovascular disease, respiratory disease, arthritis, HIV, or other conditions.

Standard 2: We have a system in place to identify patients with a chronic health condition that is inadequately managed.

Standard 3: We have a system in place to regularly monitor specific mechanical and blood chemistry health indicators for each patient's chronic health condition. This information enables our organization to regularly monitor the patient's condition (the same, getting better or getting worse)

Domain B:
Team Based Care

Standard 1: We have a system in place that insures a coordinated and team based approach to disease self-management. The scoring identifies the number of helpers involved who work as a team.

Standard 2: The team (at least 2 or more staff) meets at least weekly to review the progress of patients with chronic health conditions.

Standard 3: The staff involved in addressing the needs of patients with chronic health conditions have **a timely and accurate** system in place to share information related to the patient's condition with other key supporters.

Standard 4: We have a system to review and address the impact of psychotropic medications on a person's health condition that includes communication between the behavioral health prescriber and the primary care provider.

Domain C:
CDSM Modalities

Standard 1: Group work - We use a group delivered, structured, systematic and curriculum supported approach to chronic disease self-management. This includes the use of educational materials, worksheets, goal plans, action step planning, progress monitoring and other tools and resources such as peer support.

Standard 2: Individual work- In individual meetings with patients we employ structured, systematic and curriculum supported approaches to chronic disease self-management. This includes the use of educational materials, worksheets, goal plans, action step planning, progress monitoring and other tools and resources such as peer support..

Standard 3: Client centered approach - Prior to engagement of clients in a CDSM program, clients are asked about their felt need for managing a health condition; what they hope to gain, why is it personally important to manage a chronic condition, the personally meaningful problems associated with living with a chronic health condition.

DOMAIN D: Promising Best Practices in Chronic Disease Self-Management

Standard 1: **COMPREHENSIVENESS**- Our individual or group service plan to assist patients with chronic disease self-management includes addressing the needs of individuals related to 3 key areas:

1. Treatment adherence and healthcare partnership,
2. Coping with the emotional reactions to chronic health conditions
3. Making critical lifestyle changes to support health

Standard 2: **TREATMENT FOCUSED SUPPORT**

- Communicating and working with your mental health and physical healthcare providers in a way that works for you
- Understanding the basics of your illness: What is it? Why is it important to manage successfully?
- Understanding and using medication in a way that works for you
- Making informed treatment decisions and solving problems

DOMAIN D: Promising Best Practices in Chronic Disease Self-Management

Standard 3: COPING WITH THE EMOTIONAL RESPONSES ASSOCIATED WITH MANAGING A SERIOUS AND CHRONIC HEALTH CONDITION

- Understanding and coping with feelings of anger, depression, fear and emotional stress
- Learning and using stress management and relaxation approaches
- Managing stress through the use of meditation, relaxation and social networking.
- Managing fatigue, low energy, avoidance of health services

Standard 4: LIFESTYLE CHANGES AND HEALTH PROMOTING BEHAVIOR

- Understanding and making informed decisions about healthy eating
- Increasing physical activity through a variety of activities that work for you
- Understanding and addressing the impact of unhealthy habits and activities on your health condition (e.g., smoking, harmful use of prescribed, over the counter and street drugs
- Taking small and meaningful action steps to improve health

Domain E:
Wellness and Healthy Lifestyle Support

Standard 1: Physical Activity - Our organization has a system in place to offer individuals opportunities to engage in physical activities such as calisthenics, walking/hiking activities, swimming, dancing, yoga, exercise on gym equipment, sports, and other activities that promote healthy increase in physical movement.

Standard 2: Healthy Eating and Nutrition - Our organization has a system in place to offer individuals opportunities to acquire important information about healthy eating habits and to apply their knowledge in the context of their living environment. In addition to nutritional information, the organization offers hands-on learning through visits to local supermarkets, demonstrations, and practice of healthy cooking techniques and healthy food choices.

Domain E:
Wellness and Healthy Lifestyle Support

Standard 3: Cultural Alignment: The organization offers wellness interventions related to physical activity and eating habits that are respectful of a person's cultural perspectives, religious beliefs and preferences. This is demonstrated by the creation of personalized wellness plans aligned with the person's wants.

Standard 4: **Peer Support**- The organization engages and involves peers in roles such as health coaches, personal trainers, co-leaders of wellness focused group programs and other wellness activities.

Domain F: Addressing harmful lifestyle habits and behaviors

Standard 1: **Smoking reduction -** the organization offers smoking reduction/cessation supports that includes individual, group, and peer led approaches along with access to medication assisted treatments. Services are provided by staff trained in best practices in smoking cessation treatments and interventions.

Standard 2: **Harmful substance use reduction -** the organization has a system in place to directly provide or make referrals to substance use services that compromise the patient's self-management of a chronic health condition.

Domain G: Population and patient specific data

Standard 1: Progress Monitoring - our organization has a system in place to identify sub cohorts of patients based on the type of serious and chronic health condition and demographic characteristics and to monitor progress and outcome of disease self-management efforts.

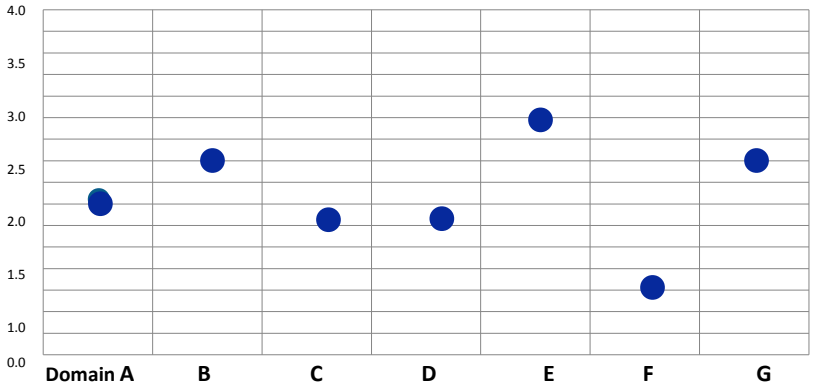
Standard 2: Outcome Measures - our organization has a system in place to employ measures of health improvement, reduction in emergency department and hospital use, and patient utilization of wellness, chronic disease self-management programs, and smoking cessation and substance use services .

Scoring Guide

The self-assessment rating scale is scored from 0-4 indicating the degree to which the organization meets or doesn't meet each standard.

0 = we don't meet this standard at all
1 = we minimally meet this standard
2 = we partially meet this standard
3 = we mostly meet this standard
4 = we are exemplary in meeting this standard
NA = Not applicable to our organization

Control Chart: A Method to Monitor Progress with the CDSM Organizational Self-Assessment



CDSM Evidence Informed Approaches and Resources

- Stanford CDSM Model
- Health and Recovery Program (HARP)
- Whole Health Action Management (WHAM)

Stanford Model

http://patienteducation.stanford.edu/programs/cdsmp.html
English

http://patienteducation.stanford.edu/programs_spanish/tomando.html
Spanish

Classic Stanford Model: Structural Elements

- Small groups of 10-16 people
- People with many different disease and comorbid conditions in same group
- 2½ hours per week for 6 weeks
- Peer facilitated
- Use of a curriculum
- Community settings such as senior centers, churches, and hospitals.
- People with different chronic health problems attend together.
- Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

The Evidence

- Over 1,000 people with heart disease, lung disease, stroke or arthritis participated in an randomized, controlled test of the Program, and were followed for up to three years.
- Subjects who took the Program demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations.
- They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:4. Many of these results persist for as long as three years.*** Studies by others have reported similar results (see our bibliography - http://patienteducation.stanford.edu/bibliog.html).

CDSMP: Additional Findings

Significant improvement areas:

- **Communication with MD**
- **Medication adherence**
- **Health literacy (confidence filling out medical forms)**
- **Self-assessed health**
- **PHQ depression**
- **Quality of life**
- **Unhealthy physical days**
- **Unhealthy mental days**

CDSMP: Additional Findings

Significant improvement areas:

- Percentage with emergency room (ER) visits in the past 6 months
- Number of ER visits among those with any ER visit
- Percentage hospitalized in the past 6 months
- Number of hospitalizations among those with any hospitalization

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

All p<.05

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 $300

Sample of Research Bibliography

A complete report on the measures used and their psychometric properties can be found in *Outcome Measures for Health Education and Other Health Care Interventions*, by Lorig, Stewart, Ritter, González, Laurent and Lynch, Sage Publications, 1996.

Lorig KR, Sobel DS, Stewart AL, Brown Jr BW, Ritter PL, González VM, Laurent DD, Holman HR. Evidence suggesting that a chronic disease self-management program can improve health status while reducing utilization and costs: A randomized trial. *Medical Care*, 37(1):5-14, 1999.

Lorig KR, Ritter P, Stewart AL, Sobel DS, Brown BW, Bandura A, González VM, Laurent DD, Holman HR. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. *Medical Care*, 39(11),1217-1223, 2001.

In HMO setting: Lorig KR, Sobel DS, Ritter PL, Laurent D, Hobbs M. Effect of a Self-Management Program on Patients with Chronic Disease. *Effective Clinical Practice*, 4(6),256-262, 2001.

Classic Stanford Model: Content Elements

- Each participant in the workshop receives a copy of the companion book, *Living a Healthy Life With Chronic Conditions, 4th Edition*, and an audio relaxation CD, *Relaxation for Mind and Body*.*

Classic Stanford Model: Content Elements

- Managing Symptoms - *pain, fatigue, depression, shortness of breath*
- Exercise
- Relaxation Techniques
- Healthy Eating
- Communication Skills
- Medication Management
- **Problem-Solving**
- **Action-Planning**
- **Decision-Making**

What people report about the most helpful parts of the Stanford Model

- Sharing (social networking)
- Action Planning
- Problem Solving

Multimedia Kits
The Toolkit for Active Living with Chronic Conditions.

The Kit (https://www.bullpub.com/catalog/Chronic-Disease-Self-Management-Program-Tool-Kit-for-Active-Living) includes the basic building blocks for each individual to use in constructing a personal approach to the management of their chronic conditions through exercise, pain management, and relaxation. It encourages goal-setting, action-planning, proactive thinking and acting ahead.

Each kit contains: *Living a Healthy Life with Chronic Conditions*, Information Sheets briefly describing common problems and helpful solutions, Self-Test that helps individuals identify the elements and set priorities for a personal self-management plan, Action Plan description with instruction and examples for developing unique plan, Exercise Action Plan with hints and instruction on use of the other exercise and activity materials, Relaxation CD and Exercise CD. Also available in Spanish (https://www.bullpub.com/catalog/Chronic-Disease-Self-Management-Program-Tool-Kit-for-Active-Living-Spanish). Available from Bull Publishing (quantity discounts available)

Bull Publishing Company
(https://www.bullpub.com/catalog/categories/chronic-diseases-conditions)
PO Box 1377 • Boulder CO 80306 USA
Call toll free: 1-800-676-2855 • FAX: (303) 545-6354

Training Supports: Video Tapes/DVDs

http://patienteducation.stanford.edu/materials

This 12-minute VHS or DVD video, designed to introduce the CDSMP to providers, includes footage of actual classes and leaders' trainings, with commentary by professionals. Available from Bull Publishing Company (quantity discounts available): Bull Publishing Company • PO Box 1377 • Boulder, CO 80306
Call toll free: 1-800-676-2855 • FAX: (303) 545-6354

Healthier Living: Managing Ongoing Health Conditions. *Kaiser Permanente, 2002.* $20.00 US

This 10-minute VHS or DVD video, designed to introduce patients to the Chronic Disease Self-Management Programe, includes footage of actual classes with commentary. Available from Bull Publishing Company (quantity discounts available): Bull Publishing Company • PO Box 1377 • Boulder, CO 80306
Call toll free: 1-800-676-2855 • FAX: (303) 545-6354

The Learning Center

The Discussion Center

HARP (Health and Recovery Peer) Program

http://www.integration.samhsa.gov/integrated-care-models/HARP_-2-.pdf

- Pilot study 2006-9 adapted the Chronic Disease Self-Management Program (CDSMP), to be delivered by and for MH consumers
- Current study (2011-) multisite trial underway
- 6 group sessions diet and exercise training, specific disease management techniques.

1. Funded by NIMH R34MH078583\
2. Lorig K et al. Med Care. 2001 Nov;39(11):1217-23.

HARP: Adaptation to match the special needs of individuals with serious mental illness

Streamlined and focused on 6 key areas:

Session One: Overview, Introduction to Action Planning

- *Coaching session: Becoming a self-manager, developing a PHR*

Session Two: Introduction to Physical Activity and Exercise:

- *Coaching session: Understanding your chronic illnesses*

Session Three: Breathing, Relaxation

- *Coaching session: Relaxation and dealing with stress*

Session Four: Healthier Eating, Advance Directives

- *Coaching session: Better diet and exercise on a limited budget*

Session Five: Medication Use, Making Informed Decisions

- *Coaching Session: Communication Skills*

Session Six: Working with Your Health Care Provider

- *Coaching Session: Summary and plans for the future*

Modifications -- Clinical Factors

- Reinforcement: Meetings between sessions with peer leader to reinforce key messages
- Health literacy: Simplified health and disease-specific materials for the population
- Recovery-focus: Mental health advance directives

Modifications -- Social Factors

Social support: Use a buddy system to enhance support network outside of groups, added a section on finding support and reducing isolation

Income: Added a section on eating healthy and physical activity on a budget

Modifications – Recovery Factors

- Holistic care: Added a section on mind-body health interactions, added a section on physical activity
- CPS training: Incorporated more sharing of information and positive reinforcement

Action Planning: Helping individuals apply learning in day to day living

- Something YOU want to do
- Reasonable
- Behavior-specific
- Answer the questions:
  - What?
  - How much?
  - When?
  - How often?
- Confidence level of 7 or more (scale of 1-10)

What is Whole Health Action Management (WHAM)?

- Designed for behavioral health peer workforce by SAMHSA-HRSA Center for Integrated Health Solutions
- Training is a Peer-led intervention to activate whole health self-management to create and sustain new health behaviors in
  - Community Mental Health Centers, Federally Qualified Health Centers, Health Homes, and Veterans Administration programs.

WHAM 5 Keys to Success

- A person-centered goal focused on 10 science-based whole health and resiliency factors
- A weekly action plan that breaks the goal into small, achievable successes
- A daily/weekly personal log
- One-to-one peer support
- A weekly WHAM peer support group

WHAM *10 Science-based health and resiliency factors*:

- Stress management
- Healthy eating
- Physical activity
- Restful sleep
- Service to others
- Support network
- Optimism based on positive expectations
- Cognitive skills to avoid negative thinking
- Spiritual beliefs and practices

Self-Management Skills

- Engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors.
- Write an achievable whole health goal using the IMPACT process and weekly action plans.
- Participate in peer one-to-one and peer support groups to create new whole health habits.
- Elicit the relaxation response to manage stress.

IMPACT
Criteria Questions for Goals

I - Does it ***Improve*** the quality of my health and resiliency?

M - Is it ***Measurable*** in terms of knowing if I have accomplished it?

P - Is it ***Positively*** stated as something new I want in my life?

A - Is it ***Achievable*** in my present situation and with my current abilities?

C - Does it ***Call forth*** actions that I can take on a regular basis to begin to create healthy habits?

T - Is it ***Time limited*** in terms of when I will begin and when I plan to accomplish it?

Self-Management Skills, Cont.

- Engage in cognitive skills to avoid negative thinking.
- Know basic whole health prevention screenings and how to prepare for them.
- Use shared-decision-making skills for more engaging meetings with doctors.

Gifts Peer Providers Bring

- Lived experience of illness impact and recovery
- Hope role models: “I am the evidence of recovery!”
- Empathy: grateful for recovery and desire to support others
- Trust essential to recovery, especially trauma
- Focus on what’s strong rather than what’s wrong
- Activation of self-management
- On-going support

Peer Whole Health and Wellness Billing

- CMS approves GA whole health and wellness billing
- Billing code: H0025
- Rate: 15 minute units ranging from $15.34 to $24.36 depending on peer provider experience/education and location of services

Medicaid Peer Services Billing

2007 CMS guidelines proclaim “Peer support services are an evidence-based mental health model of care” with following 3 key criteria for Medicaid billing:

- Supervision by mental health professional as defined by state
- Care-coordination of peer services in an individualized plan of care
- Completion of state approved training and certification with ongoing continuing education

Group or 1 to 1 meetings?

- 1 on 1 offers more personalized work, more scheduling flexibility
- Group offers social reinforcement and clinical efficiency
- Hybrid may be ideal

What are the Training and Supervision Needs?

- How much medical knowledge is needed to serve as a wellness coach?
- What sorts of supervision are needed?

WHAM Summary

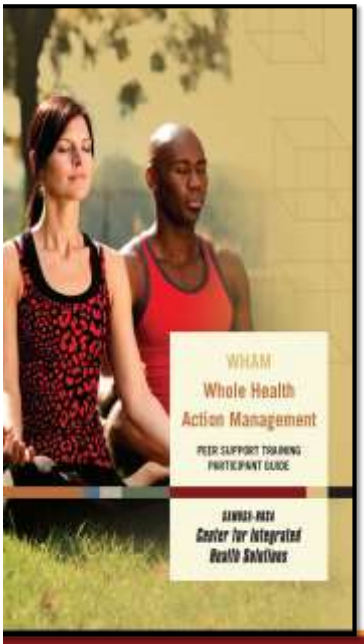
- Opportunity for peers to help address whole health of MH consumers and to fill gaps in the MH workforce
- Still questions about best way for them to be trained and to practice
- The MH field can learn from, and help lead, the rest of medicine in defining these emerging roles for peers

Tips for Supporting a Strong Peer Workforce

- Program readiness training on peer provider role and how to promote culture of strength-based, holistic self-management
- Financial sustainability by ensuring peer services meet criteria for funding like Medicaid billing and managed care reinvestment
- Address potential boundary issues like peers employed where once received, or continue to receive, services, and dual roles as peer and provider

Tips for Supporting a Strong Peer Workforce, Cont.

- Peer providers formal training teaching competencies to implement holistic self-management skills
- Clear job descriptions
- Supervisors trained on role of peer providers and how to support them
- Peer providers create personal self-management tools like a **Wellness Recovery Action Plan (WRAP)** (http://mentalhealthrecovery.com/wrap-is/) to promote ongoing recovery and whole health



http://www.integration.samhsa.gov/health-wellness/wham

http://www.integration.samhsa.gov/health-wellness/wham/WHAM_Participant_Guide_April_2015.pdf

integration.samhsa.gov

Poll question: What best describes the role of peer providers promoting CDSM in your program?

A) We currently have peer providers promoting CDSM
B) We are in the process of hiring peer providers to promote CDSM
C) We expect to hire peer providers to promote CDSM in the next 3 months
D) We do not plan to hire peer providers

integration.samhsa.gov

Poll Question: Based on this webinar we are likely to do the following:

A. Form a workgroup to begin planning EBP approaches to CDSM
B. Bring this information into an existing CDSM workgroup to make a decision
C. Put CDSM on the back burner
D. Definitely made a decision on the approach we will take
E. Not sure what our next steps will be