



Lessons in Patient Engagement: Motivating Patients to Manage Their Chronic Conditions and Health Care Utilization

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

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Seattle, Washington

FRIDAY, OCTOBER 2, 2009

11:45AM–12:15PM—Lunch

12:15PM–2:15PM—Discussion

LOCATION

Reserve Officers Association

One Constitution Avenue, NE

Congressional Hall of Honor

Fifth Floor

(Across from the Dirksen

Senate Office Building)

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OVERVIEW

Throughout the current health care debate, ways to manage the care of chronic conditions have received a great deal of attention. Management of chronic care is an issue for providers and payers, but patients have a role in managing their conditions as well. Bills being considered by Congress contain proposals for Medicare patient-centered "medical homes" that include support for patient self-management strategies. But finding effective ways to encourage patient self-management has long been a challenge. This Forum session will discuss evidence-based strategies being used to help patients manage chronic conditions and reduce health care utilization. Speakers will address the role of patient self-management and review a model that has shown success, the Chronic Disease Self-Management Program (CDSMP) developed by Stanford University. Speakers will also discuss state agency and health plan implementation of CDSMP and other interventions to encourage healthy behaviors.

SESSION

A recent *Wall Street Journal* article reported a story about a cardiac patient who, against medical advice after discharge from the hospital, ate a hot dog at a July 4th celebration. The sodium content of the hot dog caused dangerous fluid retention in the patient, who landed back in the hospital a few days later.¹ Surely, not all patient noncompliance brings about such a serious medical episode, but the patient's behavior resulted in negative consequences both for the patient and for the Medicare program, which paid for the rehospitalization. This anecdote highlights the difficulties physicians and other health care providers face in finding ways to encourage patients, even those who have experienced serious illnesses, to actively manage their chronic conditions, avoid risky behavior, and take charge of their health. Ways to involve patients in managing their own care are referred to by various terms, such as patient self-management, engagement, empowerment, activation, and self-efficacy.

Despite major advances in medical care for chronic conditions, and evidence that motivated patients are more likely to have better health care outcomes,² relatively little effort has been devoted to educating and activating patients to manage the effects of their conditions.³ Clinicians tend to see patients for very short periods of time, limiting their ability to discuss how lifestyles may affect their health or ways

to self-manage chronic conditions. Self-management could include instruction on how to recognize and act on symptoms, using medication appropriately, maintaining nutrition and exercise programs, interacting effectively with health care providers, and managing psychological responses to illness.

In recent years, many health care leaders have recognized the importance of evidence-based patient self-management strategies, and some health plans have incorporated them into patient care protocols. Various strategies exist to motivate patients to self-manage their conditions.⁴ Some focus on direct, one-on-one interaction with patients by clinicians and other health care personnel; others take place in small group settings in the community. One of the widely implemented strategies is the Chronic Disease Self-Management Program (CDSMP) developed by Dr. Kate Lorig and her colleagues at Stanford University and supported by the Agency for Healthcare Research and Quality (AHRQ).⁵ CDSMP is a workshop for people with chronic conditions, offered in group settings over a 6-week period and sponsored by a variety of organizations, such as public health departments, hospitals, senior centers, and area agencies on aging. Led by trained lay people, it is intended to teach participants how to manage their chronic conditions, adhere to medication regimens, and maintain functional ability.

The CDSMP is premised on certain assumptions: that patients can learn to take responsibility for the day-to-day management of their conditions; that knowledgeable patients who practice self-management can improve their health status and use fewer health care resources; and that patient self-management programs should be inexpensive and widely available. It also assumes that patients with different chronic conditions have similar self-management problems; therefore, the workshop is not targeted to specific diseases, but to patients with many different conditions.⁶ In a randomized controlled test of CDSMP, participants were shown to have improved their health behavior, such as exercise, symptom management and communication with physicians, and maintained or improved their perception of their health status. Participation in CDSMP reduced hospitalizations and hospital days.⁷

Finding the right venues in which to implement self-management programs can pose challenges. Some health care educators believe that providing community-based programs that are available to groups of patients may help in expanding the number of people who can benefit. While it may be desirable to link these programs with primary care practices and other providers, finding the resources, personnel,



and time may be difficult. In a project to integrate self-management into operations of health care providers, such as health centers, medical practices, and county health departments, the California Health-Care Foundation found that providers need concrete strategies and new organizational capacity to carry out these activities.⁸

Some health plans such as Group Health and Kaiser Permanente have implemented CDSMP and other evidence-based patient education programs. And, in recent years, the U.S. Administration on Aging (AoA) has devoted resources to support evidence-based strategies for older people with chronic conditions,⁹ including CDSMP; A Matter of Balance, a program to help older people avoid falling and guard against the fear of falling; and EnhanceWellness and EnhanceFitness, programs to increase healthy behavior among older people. The ability of community-based organizations to implement self-management strategies may be difficult without dedicated resources. The key is to identify patients who can benefit from community-based programs offered in group settings, and forge partnerships among health care providers, health plans, aging network agencies, and others to make self-management programs successful and sustainable.

Factors such as education level, age, income, availability of insurance, and the presence of multiple chronic conditions affect the level of patient engagement and activation.¹⁰ While community-based programs offered in group settings, like CDSMP, can be beneficial to many patients, some may need more support over a long period. Health care providers and payers who want to implement successful self-management strategies will need to take such factors into account in the planning and implementation phases.

KEY QUESTIONS

- What role can patient engagement and empowerment strategies play in achieving positive health outcomes, improving quality of care, and controlling health care utilization? How can both patients and clinicians benefit from these strategies?
- What is the purpose of the CDSMP? How extensively is it used, and what short- and long-term effects does it have on patient outcomes and health care utilization?
- What types of patients benefit most from self-management programs implemented by community-based providers in group settings? Which patients might need more intensive programs?

- How can physicians promote patient engagement and empowerment strategies? What role can community-based health care providers and aging network agencies play? How can they work together to implement these strategies?

SPEAKERS

Ken Brummel-Smith, MD, Charlotte Edwards Maguire Chair and Professor, Department of Geriatrics, Florida State University College of Medicine, will begin the discussion by describing the importance of developing and implementing patient engagement and empowerment strategies and how both patients and clinicians can benefit. **Kate R. Lorig, DrPH**, professor emerita at the Stanford University School of Medicine, and director of the Stanford Patient Education Research Center, will discuss the Chronic Disease Self-Management Program (CDSMP) and its effects on patients and health care utilization. **Patricia A. Polansky**, assistant commissioner, Division of Aging and Community Services, New Jersey Department of Health and Senior Services, will comment on implementation of CDSMP and other healthy behavior programs being carried out by the aging network in New Jersey. **Margaret Haynes**, director, Partnership for Health Aging at MaineHealth, an integrated health care system, and **Kim Wicklund**, manager, Health Information & Promotion at Group Health in Seattle, a premier HMO, will each comment on how their organizations have implemented patient engagement and empowerment strategies.

ENDNOTES

1. Ron Winslow and Jacob Goldstein, "Cutting Repeat Hospital Trips – Simple Idea, Hard to Pull Off," *Wall Street Journal*, July 28, 2009; available at <http://online.wsj.com/article/SB124873545269485081.html>.
2. David M. Mosen *et al.*, "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management*, 30, no. 1 (2007): pp. 21–29; and Thomas Bodenheimer, Kate MacGregor, and Claire Sharifi, "Helping Patients Manage Their Chronic Conditions," prepared for the California HealthCare Foundation, June 2005, available at www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf.
3. Kate Lorig *et al.*, "Chronic Disease Self-Management Program. 2-Year Health Status and Health Care Utilization Outcomes," *Medical Care*, 39, no. 11 (November 2001): pp. 1217–1223.
4. See citations in Judith H. Hibbard and Martin Tusler, "Assessing Activation Stage and Employing a 'Next Steps' Approach to Supporting Patient Self-Management," *Journal of Ambulatory Care Management*, 30, no. 1 (2007): pp. 2–8; and Bodenheimer, MacGregor, and Sharifi, "Helping Patients Manage Their Chronic Conditions."

5. Barbara Kass-Bartelmes, "Preventing Disability in the Elderly with Chronic Disease," Agency for Healthcare Research and Quality, *Research in Action*, Issue #3, April 2002; available at www.ahrq.gov/research/elderdis.pdf.
6. Kate Lorig *et al.*, "Evidence Suggesting that a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization, A Randomized Trial," *Medical Care*, 37, no. 1 (January 1999): pp. 5–14.
7. Lorig *et al.*, "Evidence Suggesting that a Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization"; and Lorig *et al.*, "Chronic Disease Self-Management Program. 2-Year Health Status and Health Care Utilization Outcomes."
8. Susan Baird Kanaan, "Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned," prepared for the California HealthCare Foundation, April 2008; available at www.chcf.org/documents/chronicdisease/SelfMgmtLessonsLearned.pdf.
9. Description of the Health, Prevention, and Wellness Program at the Administration on Aging Web site: www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Evidence_Based/index.aspx#purpose. See also the National Council on Aging, Center for Healthy Aging Web site, www.healthyagingprograms.org, a resource for AoA evidence-based healthy aging programs.
10. Judith H. Hibbard and Peter J. Cunningham, "How Engaged Are Consumers in their Health and Health Care, and Why Does It Matter?" Center for Health Systems Change, Research Brief No. 8, October 2008; available at www.hschange.com/CONTENT/1019.