

HAWAI'I PRIMARY CARE ASSOCIATION



2011 ANNUAL CONFERENCE
JOURNEYS OF TRANSFORMATION





CONCURRENT SESSIONS SOUTH PACIFIC I

Chronic Disease Self Management

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Chronic Disease Self Management Program *Empowering the Person*

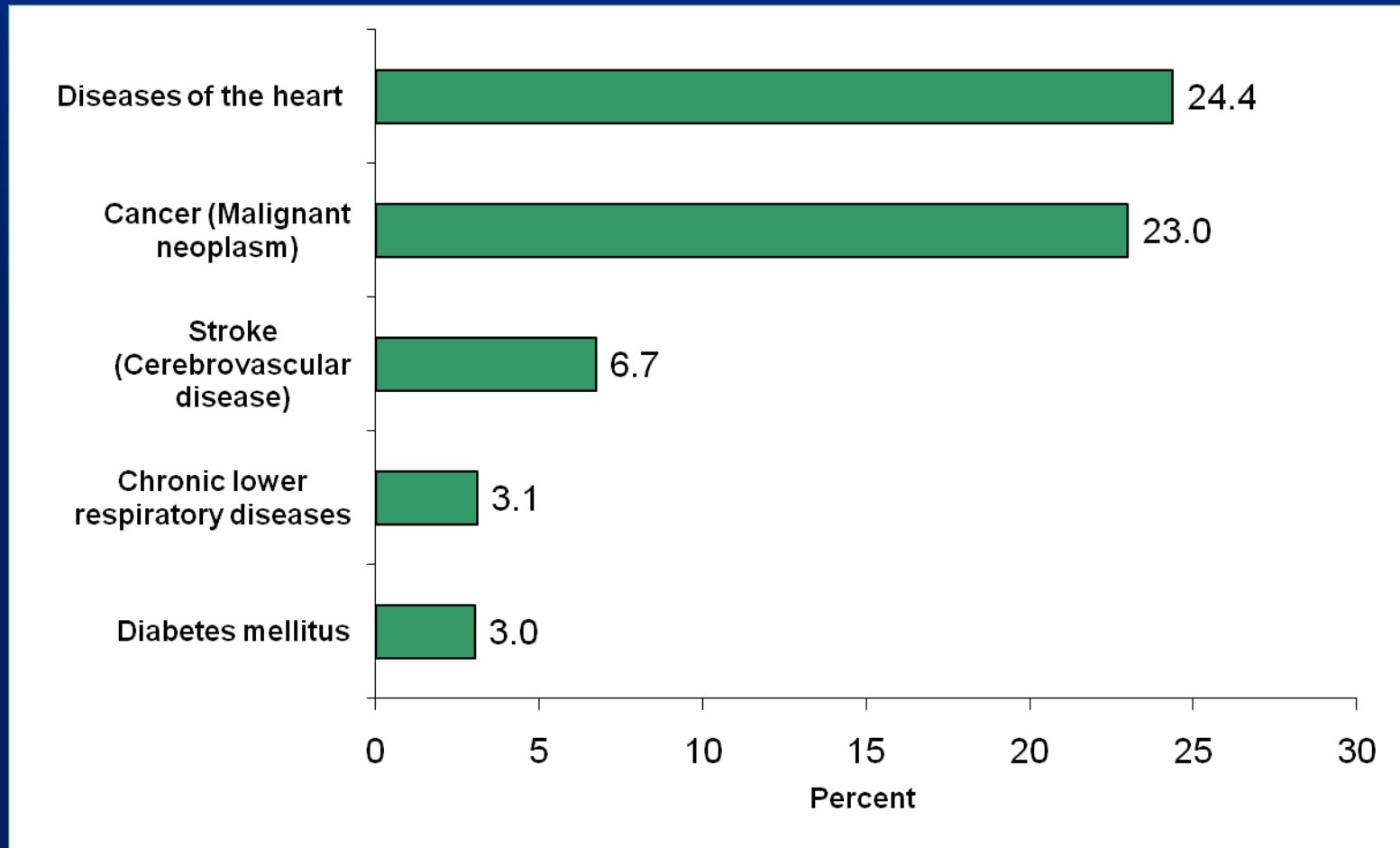
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Management and Control Branch

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September 29th, 2011

Top 5 Chronic Diseases Leading Causes of Death



1.7+ million Americans die of a chronic disease each year.

7 out of 10 deaths = chronic diseases

Chronic Conditions Are Common

- There are disparities in the prevalence of chronic conditions and functional loss associated with income, race and ethnicity, and other factors.
 - Almost 1 out of every 2 adults have at least one chronic condition
 - About $\frac{1}{4}$ of people with chronic conditions have 1+ daily activity limitations
 - 80% of Hawaii older adults have at least 1 chronic condition

Chronic Conditions Are Costly:

75% of \$2 Trillion

1980

\$245 billion

an average of \$1,066 per person

2001

\$1.4 trillion

an average of \$5,039 per person

2008

\$2.3 trillion

an average of \$7,681 per person

Economic Impact of Chronic Disease in Hawai'i, 2003 (Annual Costs in Billions)

Treatment Expenditures: \$1.1

Lost Productivity: \$3.9

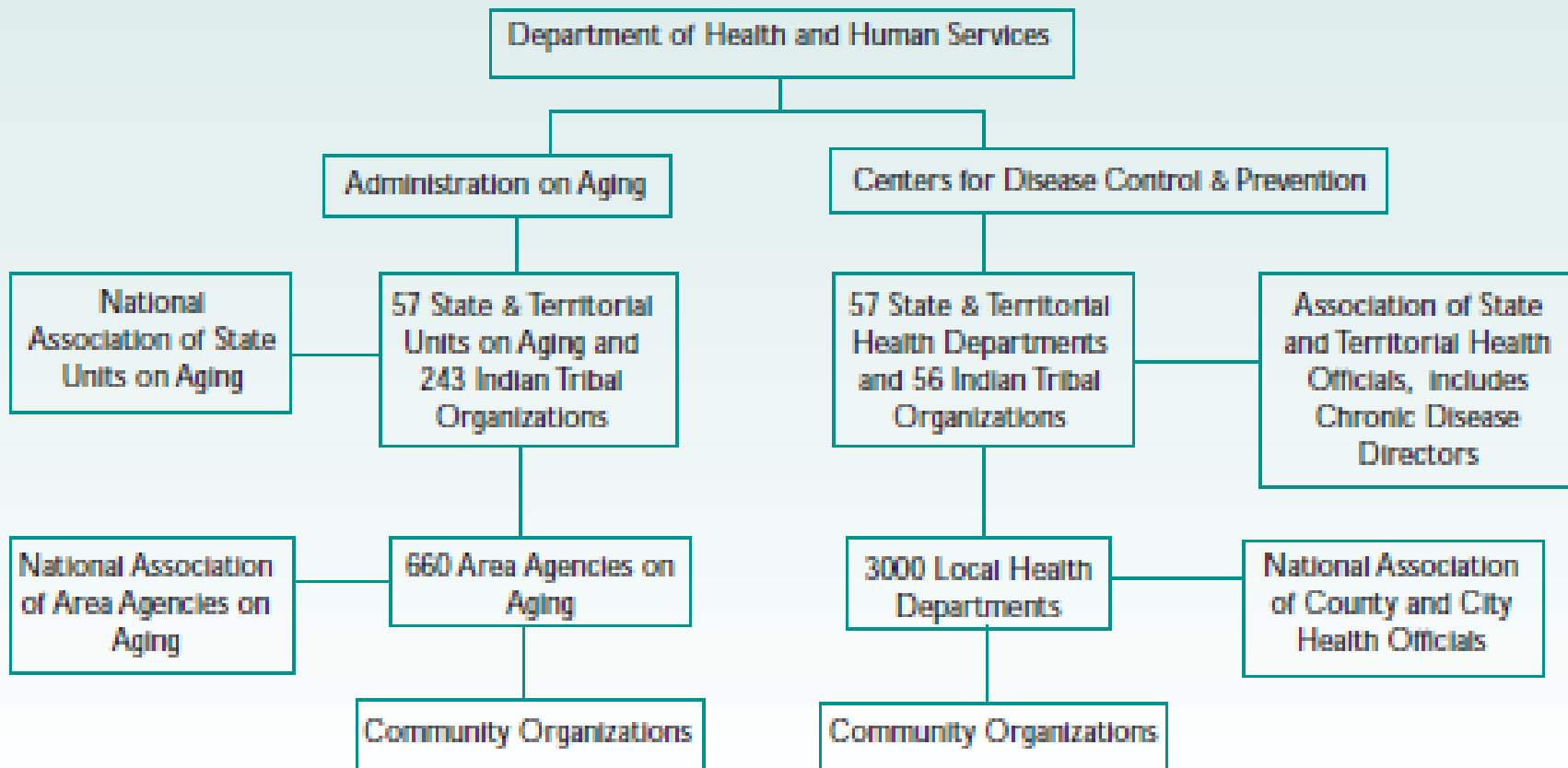
Total Costs: \$4.9

Chronic Conditions Are Preventable

- Quitting smoking
 - Heart attack risk ↓, risk for heart disease ↓, and lung function ↑
- Diet & Exercise
 - Delay the onset of type 2 diabetes, risk of getting diabetes ↓, and weight ↓
- Healthy behaviors and practices during youth
 - For every dollar invested, almost \$20 in medical care costs would be saved

National Vision: Public Health & Aging Services Networks

Exhibit 3: Schematic representation of the public health and aging services networks

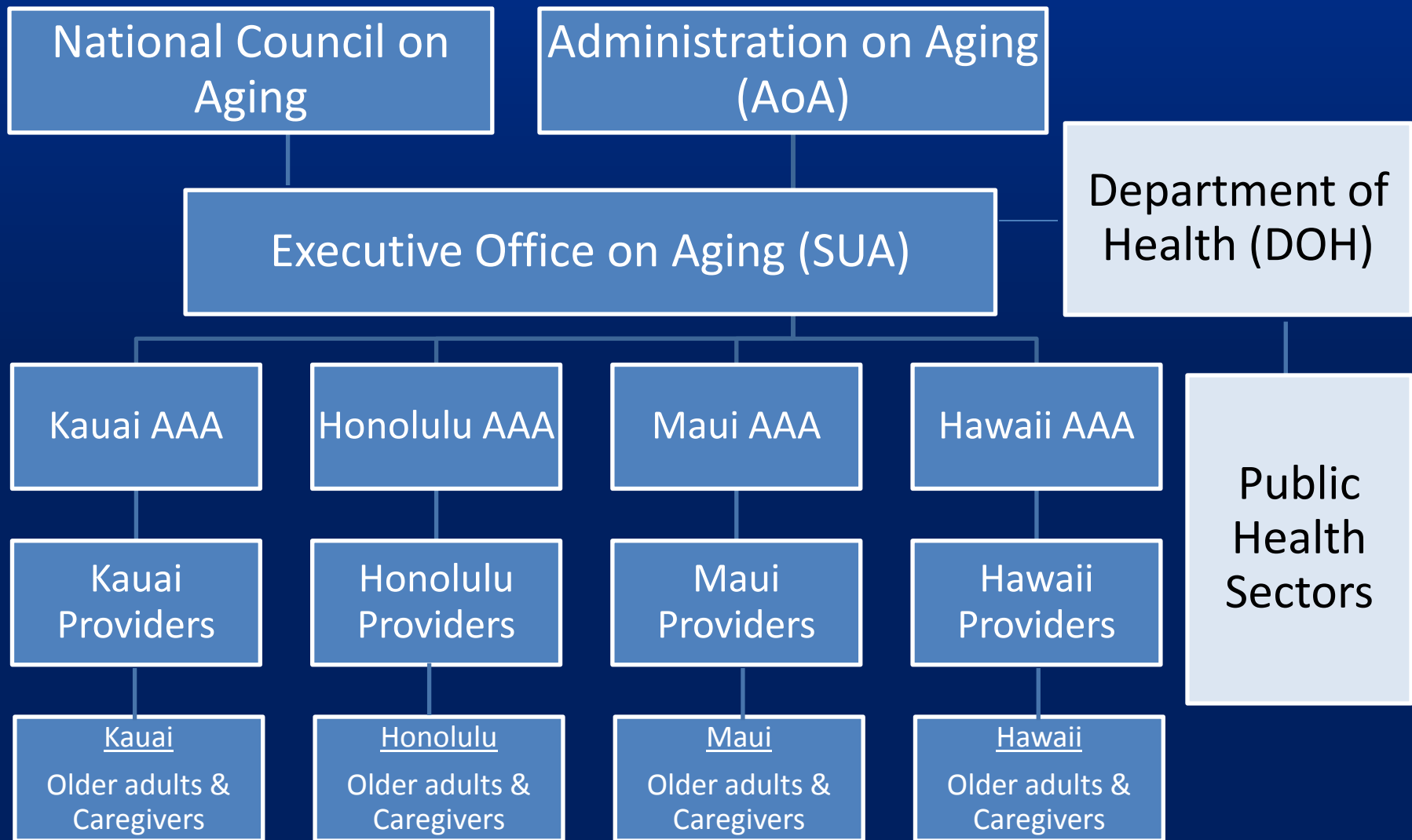


Hawaii Healthy Aging Partnership

A statewide partnership whose mission is to improve the health status of older adults

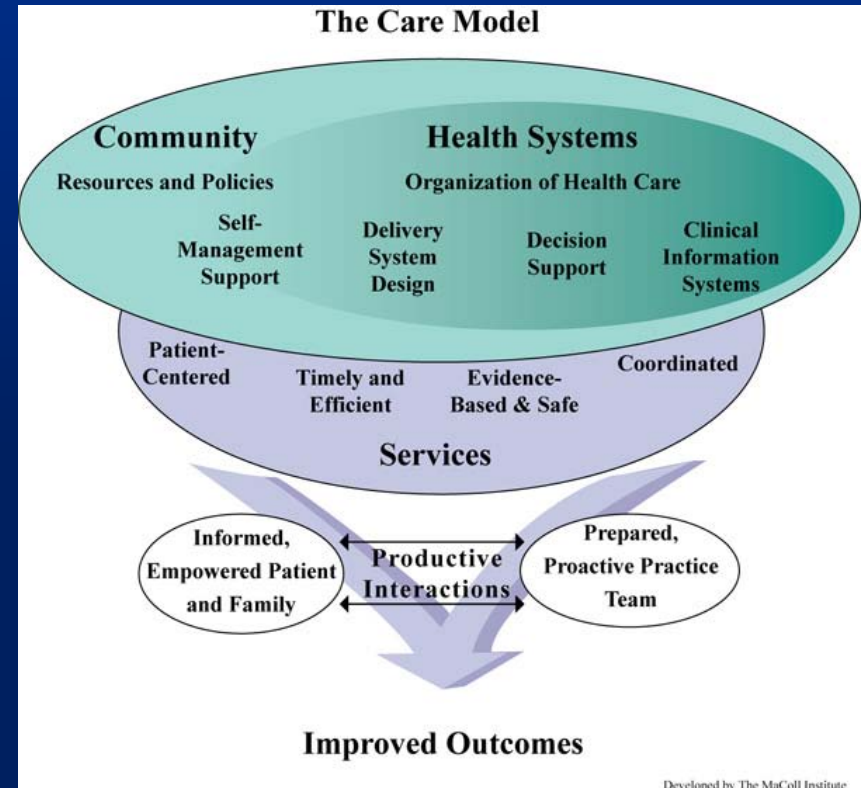


Healthy Aging Partnership-Empowering Elders Grant from U.S. AoA & NCOA



Why Self Management?

- Integral part of Care Model
 - Emphasize the patient's central role
 - Use effective self management support strategies that include assessment, goals setting, action planning, problem solving and follow up
 - Organize resources that provide support
- Aligns with Patient/Consumer Driven Care and Patient Centered Medical Home concepts



CDSMP - Program Overview

- Developed by Stanford University Patient Education Research Center
- Purpose
 - To empower people with various chronic diseases (such as heart disease, arthritis, and diabetes) to take control of their health
 - To gain knowledge of self-management
 - To improve skills and increase healthful behaviors



CDSPM Sessions

- Educational style
 - Lead by two trained leaders
 - Once a week for six weeks



Leaders from Naalehu



Stanford trains Hawai'i Master Trainers, August 2008

CDSMP Sessions

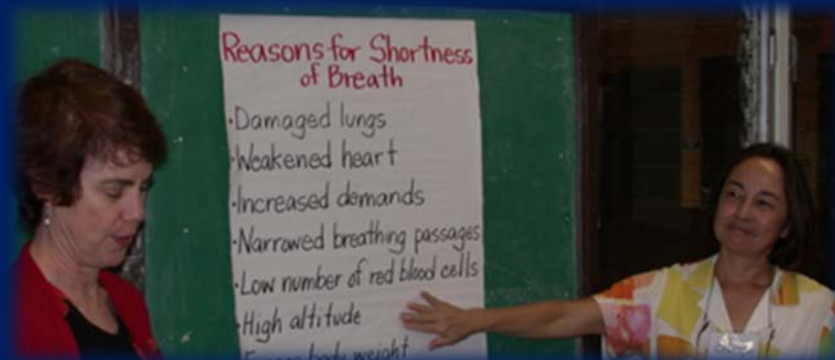
- Feedback/ Problem solving
 - Group support
 - Building self-efficacy
- Short lecture
 - Variety of topics
 - Brainstorming
 - Problem solving
- Action planning
- Closing



1. Identify the problem
2. List ideas
3. Select one
4. Assess the results
5. Substitute another idea
6. Utilize other resources
7. Accept that the problem may not be solvable now

Every week, participants must develop an “Action Plan.”

- Something YOU want to do
- Reasonable and behavior-specific
 - *By next week, I will buy walking shoes.*
 - *I will walk with my friend for 60 minutes on 4 out of 7 mornings*
 - *I will eat dessert only 2 of 7 nights*
- High confidence that you can do it.
- Buddy system for support and problem-solving



How KKV adapted CDSMP?

1. Examined the content of the CDSMP:
Does the program fit with our clients?

- Offered informational session



2. Provided additional support

- Helped to complete evaluation forms
- Used client's first language during the break & before/after the class to support understanding the content



How KKV adapted CDSMP?

3. Explored approaches for encouraging participants to complete CDSMP
 - Along with group discussion at end of each session, provided culturally appropriate local-style snacks.
 - Had graduation ceremony at end of last session
 - Offered “Certificate of Completion”
4. Planned event to collect 6-month follow-up data
 - Conducted 6-month reunion



Anecdotal Stories

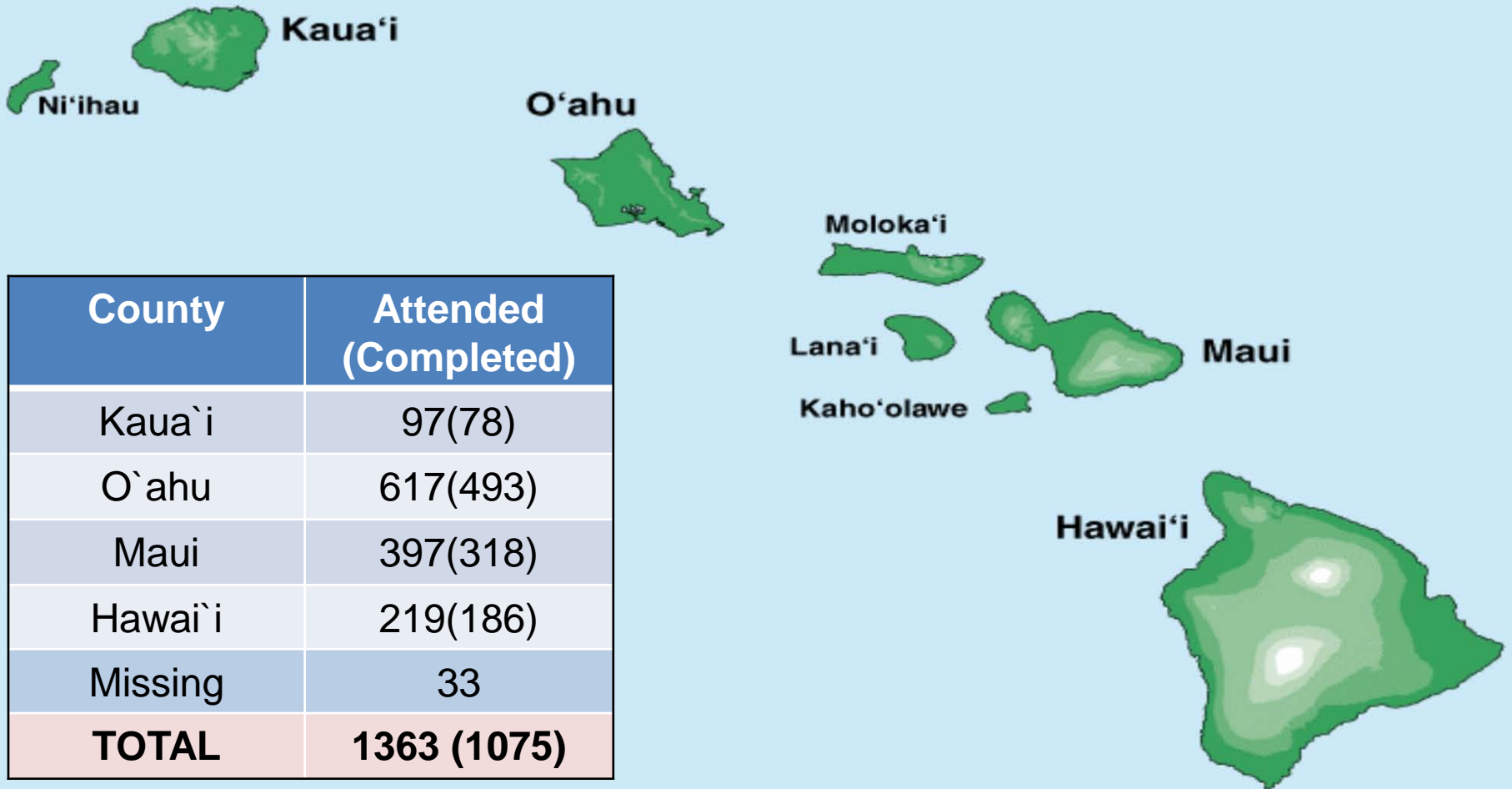
From KKV participant

“I attended the CDSMP Workshop in February. We learned many things especially how to manage your own self despite having chronic disease. Increasing knowledge how to better manage chronic disease helped me get some relief from the symptoms of my chronic disease. With completing the CDSMP workshop, I became stronger, healthier, and I find life more worth living. I give my heartfelt thanks to KKV staff who work so hard, and are always kind, considerate, friendly, and helpful. Thank you for teaching us and your patience is appreciated. I shall be forever grateful to you.” (Female; 78 years old)

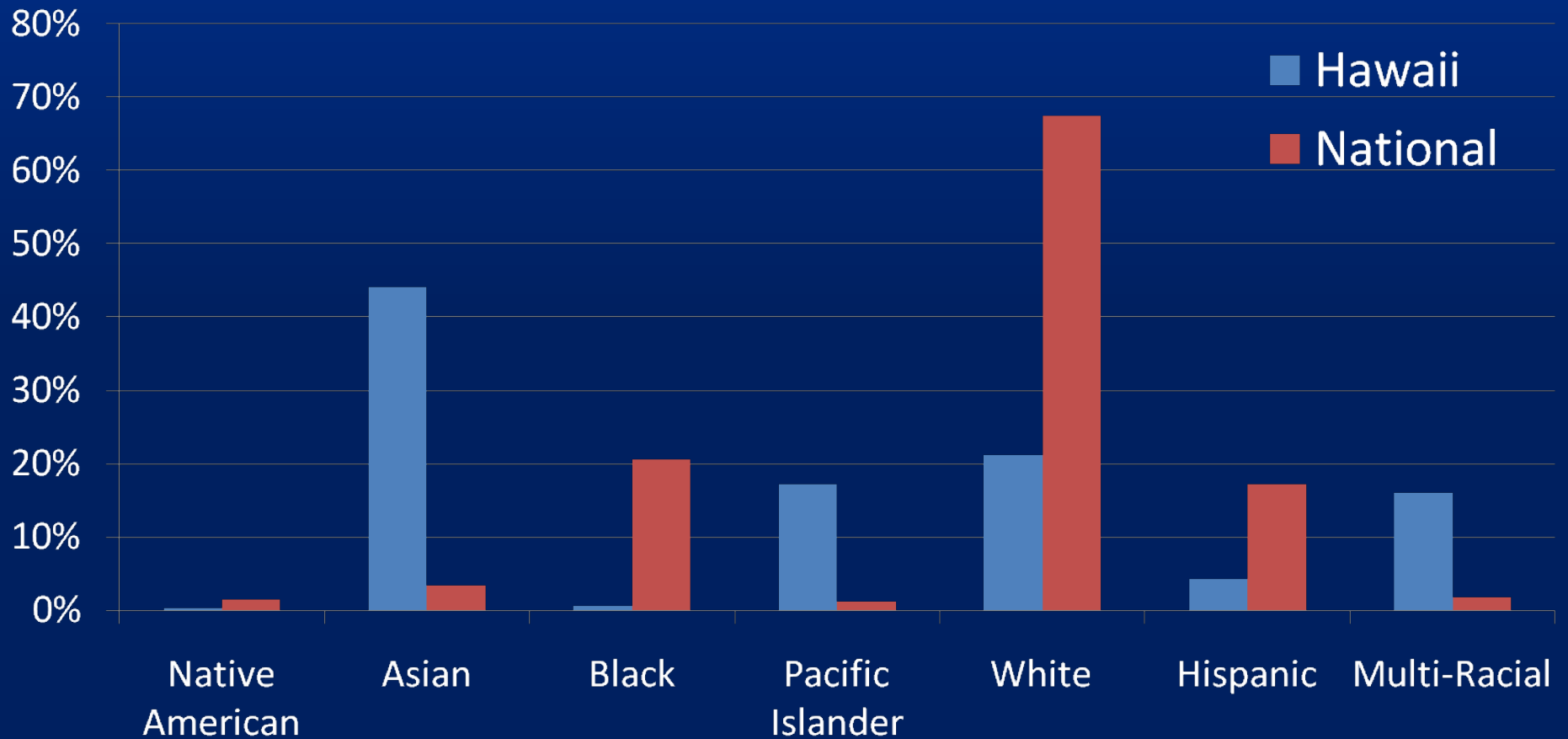


How Many Have We Served So Far?

1363 people!



We serve more Asian Pacific Islanders

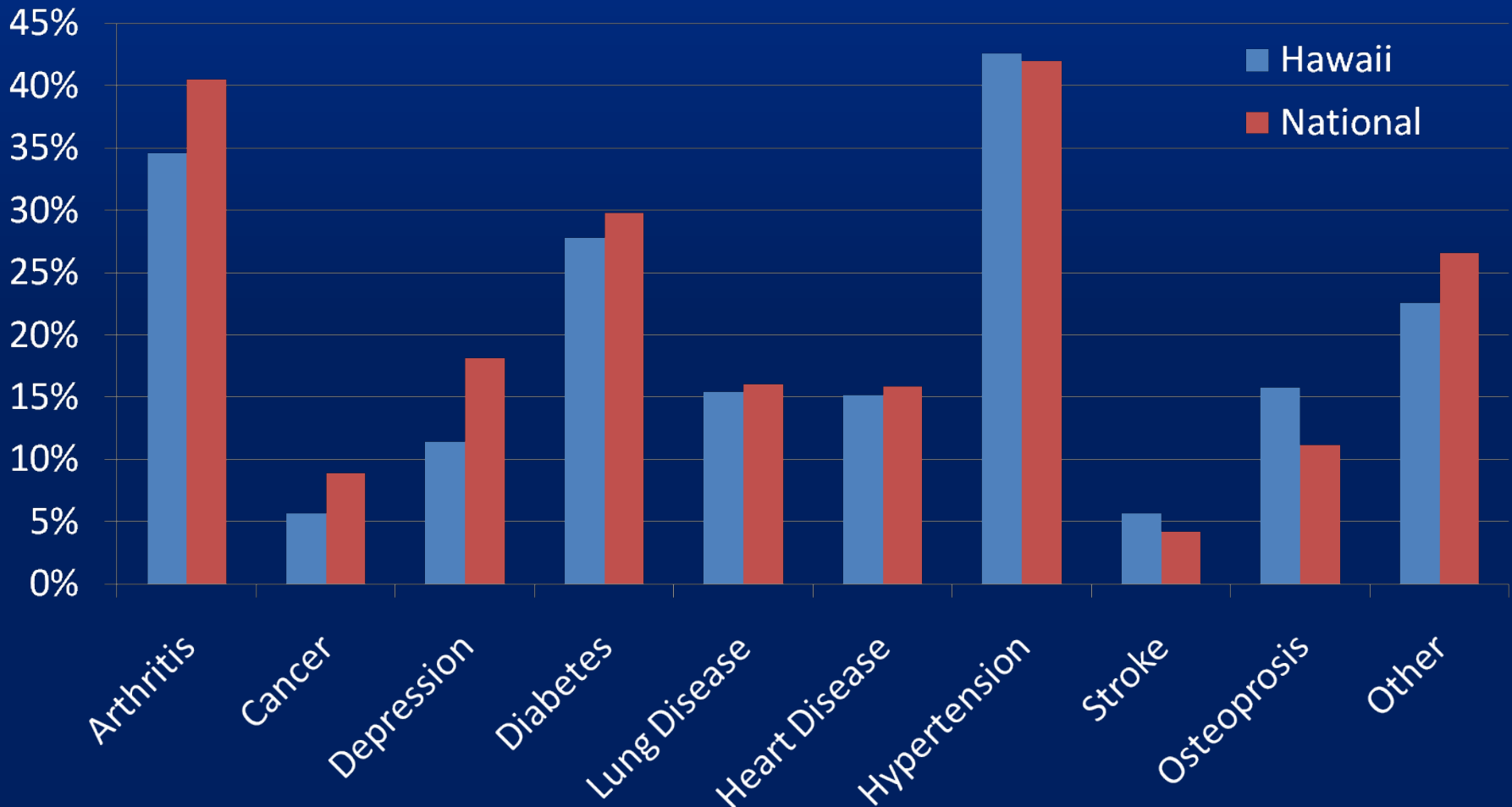


From ARRA Database (August 2011)

Hawaii: N=526

National: N=55491

We served people with variety of chronic conditions.



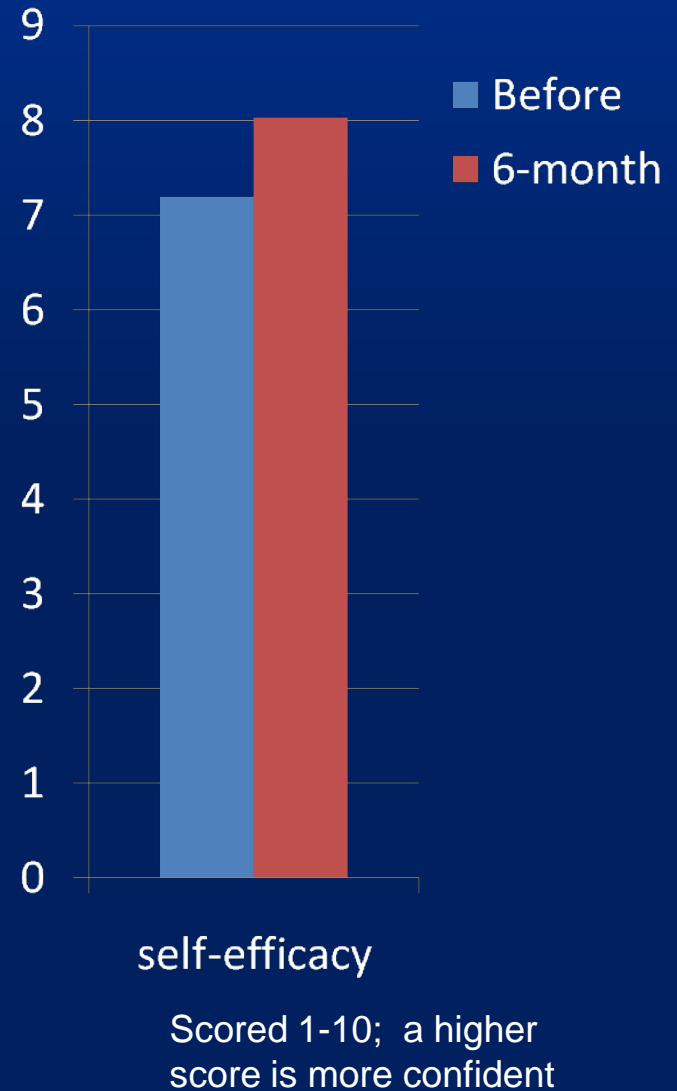
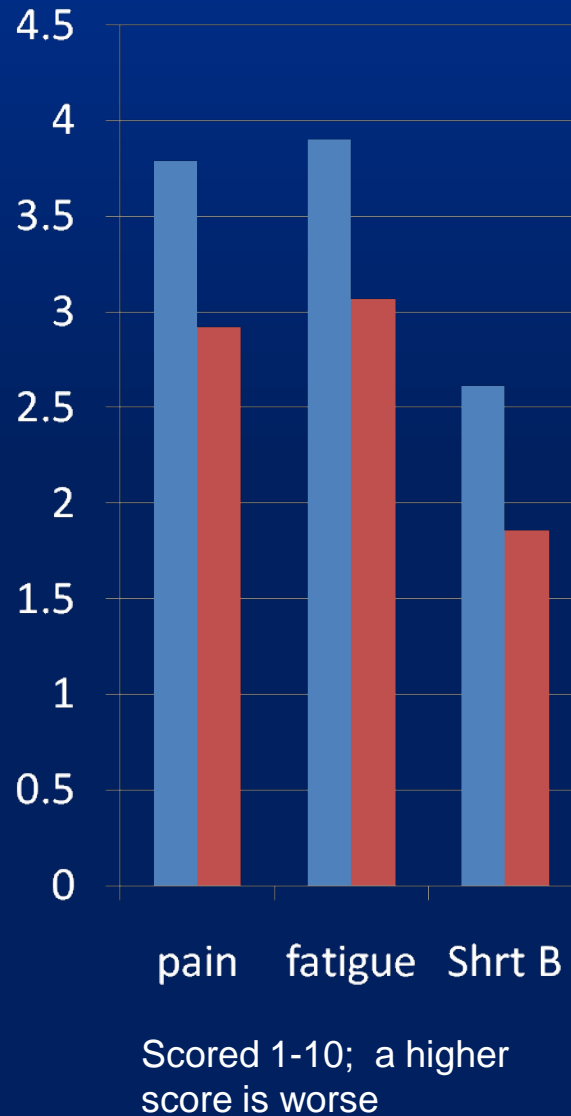
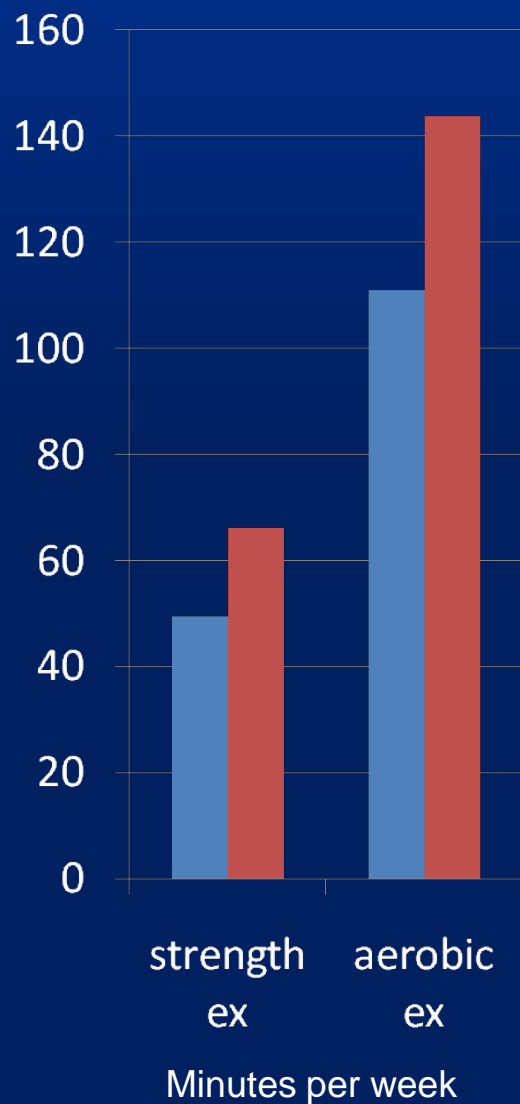
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Hawaii: N=526

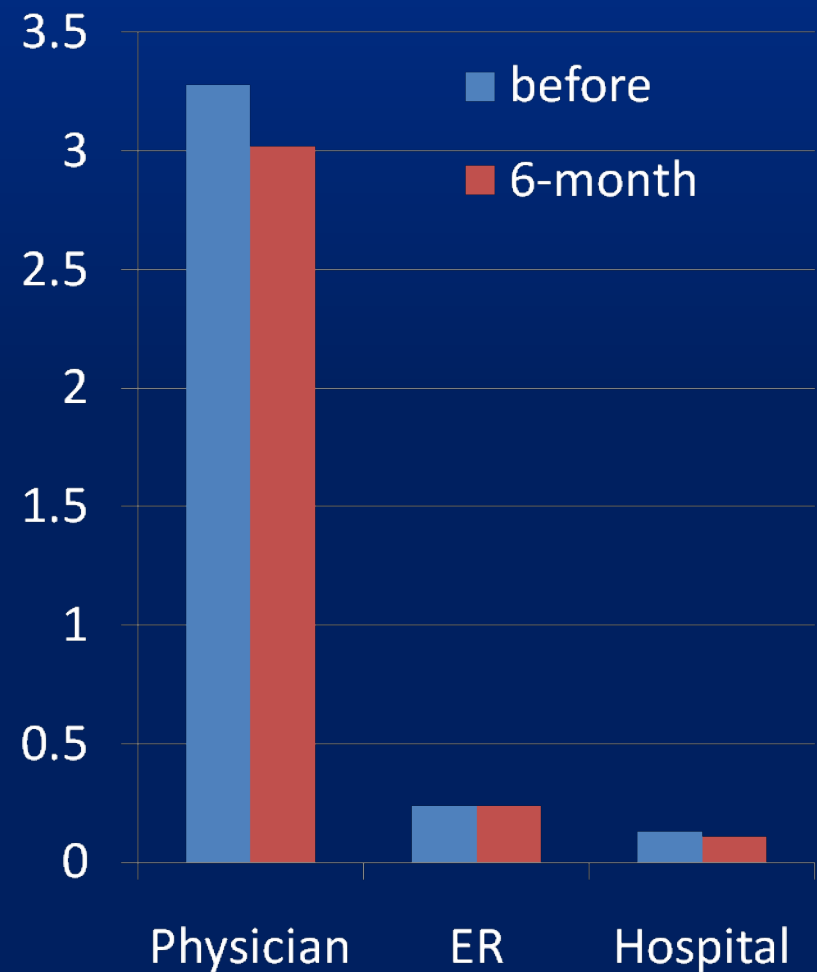
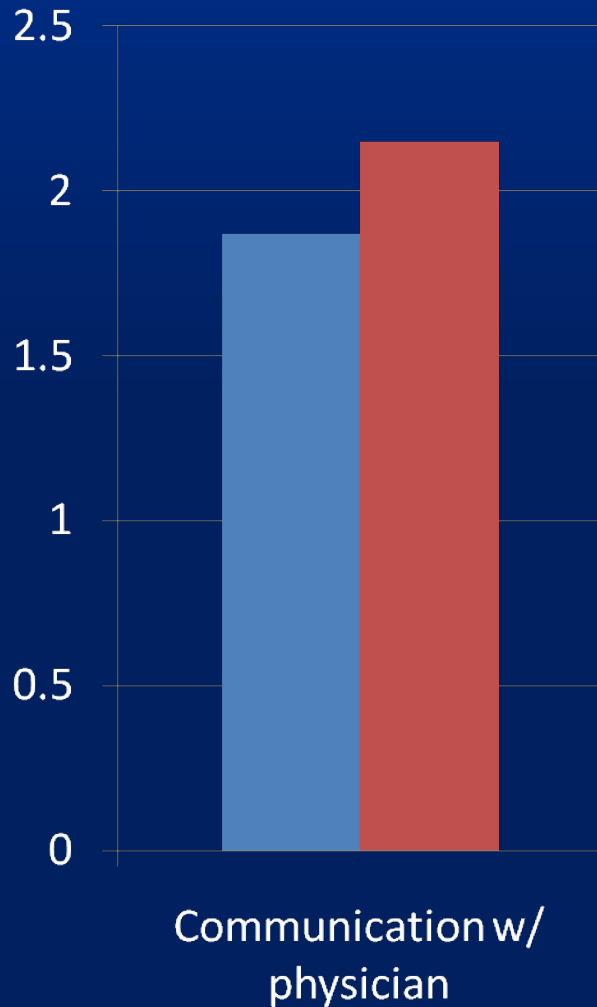
National: N=55491

CDSMP Impact: Statewide (N=632)

Based on matched t-test



6-month results: reporting communication skills \uparrow and \downarrow medical services



Scored 0-4; a higher score is better communication

Times in the past 6-month

CDSMP is not only improving health, but also lowering costs, and reducing utilization

- Other studies found:
 - 2 year savings of between \$390 and \$520 per participant based on reduced hospitalizations and outpatient visits.
 - Improved healthcare utilization.
 - Visits to doctors and ER dropped by 8 percent, while participants spent 40 percent less time in the hospitals (in the first year).

Improving health status of Hawaii residents

Shared responsibility

- Engages Federal, State, and local private sectors
- Has potential to slow the growth of Medicare and Medicaid
- Builds on our successful Hawaii State and County aging network and public health agencies partnership (2003-present)

Move Forward Together

- Learn more about HAP, contact:
 - Caroline Cadirao, 586-0100

- Join the CDSMP
 - All counties – Contact Liz Meahl
(535-1327)

Questions?

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