National Council on Aging

FACT SHEET

The Value of the Stanford University Chronic Disease Self-Management Program

The Chronic Disease Self–Management Program (CDSMP) contributes to improvements in both psychological and physical health status, self–efficacy, and selected health behaviors, and many of these improvements are maintained over 12 months, according to a meta-analysis using data from more than 20 studies.[1]

For Patients

- **Patient-centered.** Builds primary role for patients in understanding and managing their own health conditions.
- **Active engagement.** Coaches patients in becoming a full member of their health care team with enhanced partnerships with their providers.
  "I've developed a new relationship with my doctors. I'm not afraid to ask questions…I'm a member of the team."
- **Group support.** Builds mutual support through an interactive environment to increase confidence in the ability to manage health and maintain a fulfilling life.
  "The class helps you live life, not just endure it."
- **Quality of life.** Results in a measurable and positive effect on physical and emotional outcomes and health-related quality of life.
  "I learned that there are some things in my control and things that are beyond my control, that I can't control everything."
- **Gateway to additional support services** when workshops are provided by a community-based agency.
  "I am not as isolated."
- **New knowledge.** Provides timely information on health topics affecting chronic conditions.
  "My health happens between visits, outside the hospital and office."
- **Active lives.** Increases physical activity and maintains this activity over time, despite condition-related barriers.
  "I learned new strategies for keeping depression and pain at bay, ways to relax my mind and body, and eye-opening ideas for exercise that I could do.

[1] Brady, Teresa J. Executive Summary of ASMP/CDSMP Meta-Analyses. CDC, May 2011. *http://www.cdc.gov/arthritis/docs/ASMP-executive-summary.pdf*

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CHRONIC DISEASE SELF-MANAGEMENT FACT SHEET

For the Integrated Community Health Care System[2]

- **Outcomes/Results.** Provides measurable improvements in patient outcomes and quality of life. Maintains physical activity and cognitive symptom management over time.

  "We are moving to proven programs and away from non evidence-based ones." (Health plan representative)

- **Self-management skills.** Builds patients' knowledge, skills, and confidence to manage problems across all conditions.

- **Confidence.** Increases self-efficacy, the belief in one's ability to manage his or her condition.

  "Patients with self-management skills decompress my front office and waiting room." (Family physician)

- **Communication.** Enhances communication skills between patients and providers.

- **Patient-Centered Medical Home.** Meets core standards for self-management required by NCQA.

  "CDSMP has gained traction with physicians as they embed it into their practice." (State health plan representative)

- **Potential Impact on health care use.** In one study, Sobel et. al. found a small but significant reduction of days in the hospital at four-six months; a prior study found fewer visits to physicians at two years, and no significant increases in hospitalization despite worsening disability[3].

  "From the clinical perspective, patients with self-management skills become the important third leg of the stool with hospitals and physicians." (Family physician)

- **Potential cost savings.** Some research, such as the Lorig study, identified a reduction in health care utilization.[4]

  "Patient self-management is the core to patient-centered care." (Community provider)

Recommendations for Clinical Practice

- Incorporate CDSMP recommendation or referral into standards of care, care protocols, and other policies that guide the provision of high-quality chronic disease care.
- Encourage participation in CDSMP as part of routine care of individuals with chronic disease.
- Include the small-group English versions of CDSMP in comprehensive chronic disease management and self-management support initiatives.
- Invest public and private resources (financial and human capital) to support wide-scale delivery of CDSMP to reach large population groups with chronic disease. Appropriate financing systems need to be identified.
- Use CDSMP as a strategy to help people with chronic disease become more physically active.
- Provide both generic and disease-specific interventions to meet the needs of individuals with multiple chronic diseases and those with a single dominant chronic condition.

The U.S. Department of Health and Human Services *Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions (MCC)* states:

"Even the highest quality provision of care to individuals with MCC alone will not guarantee improved health outcomes for this population. Individuals must be informed, motivated, and involved as partners in their own care. Self-care management can be important in managing risk factors that lead to the development of additional chronic conditions."

About NCOA

The National Council on Aging is a nonprofit service and advocacy organization headquartered in Washington, DC. NCOA is a national voice for millions of older adults—especially those who are vulnerable and disadvantaged—and the community organizations that serve them. It brings together nonprofit organizations, businesses, and government to develop creative solutions that improve the lives of all older adults. NCOA works with thousands of organizations across the country to help seniors find jobs and benefits, improve their health, live independently, and remain active in their communities. For more information, please visit: *www.ncoa.org, www.facebook.com/NCOAging, www.twitter.com/NCOAging.*

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[2] Includes care providers, care managers and payers.

[3] Sobel, Lorig and Hobbs, *The Permanente Journal,* Spring 2002, Vol 6, No. 2.

[4] Lorig, Ridder, et al, Medical Care, 2001 Vol 39, #11, pp 1217–1223.

UPDATED: AUG2012