National Chronic Disease Self-Management Education Resource Center Video Companion Guide

National Council on Aging | Center for Healthy Aging
The Chronic Disease Self-Management Education (CDSME) program video, entitled ‘Improving Quality of Life and Health Care Outcomes through Chronic Disease Self-Management Education Programs’, is intended for use by community-based organizations offering CDSME programs to complement their outreach and engagement with health care organizations when promoting this suite of self-management programs originally developed by Stanford University. This video, developed by the National Council on Aging’s National Chronic Disease Self-Management Education Resource Center, was designed to appeal to a broad array of health care entities from hospitals to health plans to physician practices. This companion guide will define and enhance your understanding of specific terms and concepts to better prepare you for presenting the video to health care entities. The guide covers only those terms that are used in the video and provides context and resources related to the terms. It is not meant to be a comprehensive guide of health care terminology.

**Recommended Use of the Video**

Before you present the video to a health care entity, we encourage you to take some time to become versed in community-integrated health care (CIHC) concepts and nomenclature specific to the organization that you are approaching. NCOA has developed a multi-layered online Roadmap to Community Integrated Health Care, which includes a detailed toolkit of information and resources to increase your understanding of the concepts and essential steps for developing effective partnerships with a variety of health care organizations.

As you plan for your presentation, you may also want to seek out a champion within the potential partner organization to help you understand the culture, expectations, and best approach for promoting CDSME programs.

**Terminology in the Video**

- Accreditation
- Admissions/Readmissions
- Community-based organizations (CBOs)
- CLAS/Cultural competency
- Chronic disease
- Emergency room utilization
- Health care costs
- Health care outcomes
- Health care system
- Health care utilization
- High-risk patients
- Individual plan of care (IPC)
- Medicare Advantage plans
- Nurse practitioners (NPs)
- Patient activation
- Patient engagement
Patient experience
Primary care physician or provider (PCP)
Quality and quality measures
Self-management
Support mechanism (in CDSME context)
Treatment plan
Triple Aim
Value-based payment system
Evidence-based Chronic Disease Self-Management Education (CDSME) programs

Accreditation

Accreditation is an evaluative, rigorous, open, and comprehensive process in which a health care organization undergoes an examination of its systems, processes, and performance by an impartial external organization (accrediting body). This process ensures that the health care entity is conducting business in a manner that meets predetermined criteria and is consistent with national standards. The accreditation process includes a review of key documents, policies/procedures, patient records, provider/delivery system contracts, staff credentials, complaints, and grievances. The process also considers patient experience/patient satisfaction as recorded in consumer satisfaction surveys.

Medicare requires that its contracted hospitals and health plans be accredited. Many state Medicaid agencies also require that their contracted health plans be accredited. CDSME can impact accreditation rating by improving individual health outcomes which are measured in accreditation reviews. CDSME participants tend to fare better in outcomes measures such as depression symptomatology, medication adherence, and diabetes management. Standard accrediting bodies in the US health system vary by type of health care entity and include:

- Hospitals—The Joint Commission
- Health Plans –
  - National Committee for Quality Assurance (NCQA)
  - Utilization Review Accreditation Commission (URAC)
- Behavioral Health – CARF International
- Providers – Primary Care Medical Homes

Admissions/Readmissions

For the purposes of the video, admission/readmission rates refer to inpatient stays in hospitals, nursing homes, or other non-community/home-based settings. Integrated care initiatives emphasize the reduction of inpatient stays through provision of community-based supports and services. In-patient care is more costly and older patients are at higher risk for hospital acquired illnesses during these stays. Additionally, hospital admissions/readmissions are standard quality measurements—high rates drive down quality ratings.

For affected hospitals, the Affordable Care Act’s Medicare Hospital Readmission Reduction Program penalizes certain hospitals for certain readmissions, including heart attack, heart failure, chronic obstructive pulmonary disease, and hip/knee replacement, within 30 days of discharge. In 2017, affected hospitals could be hit with nearly $500M in penalties. Hospitals and health plans alike are interested in reducing inpatient stays through expanded preventive health initiatives. CDSME programs can be a complementary aspect of their strategies since the conditions targeted by the hospital readmission reduction program can be addressed by CDSME programs. Investment in CDSME can save money for health care organizations.

Community-based organizations (CBOs)

CBOs are local organizations offering community living services and supports to advance the health, well-being, independence, and community participation of older adults and people with disabilities. Examples include: Area Agencies on Aging, Aging and Disability Resource Centers, aging services organizations, behavioral health organizations, Centers for Independent Living (CILs), developmental disability organizations, faith-based organizations, tribal organizations that serve American Indians/Alaskan Natives/Native Hawaiians, nutrition program providers, protection and advocacy agencies, University Centers for Excellence in Developmental Disabilities Education, research & service, and other local service providers for persons with disabilities and/or older adults.

CLAS Standards / Cultural competency

The National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation’s increasingly diverse communities. Many health care organizations strive to meet the National CLAS Standards because of the diversity of the populations they serve and because some accreditation standards and/or government contracts require them to address cultural competency as part of their strategic plans.

CBOs can offer CDSME programming in multiple languages and in more than one media—in-person and online—to assist health care organizations in meeting the National CLAS Standards.

Chronic disease

Chronic diseases, also referred to as on-going health conditions, last three months or more and generally cannot be prevented by vaccines, cured by medication, or eliminated over time. Chronic diseases become more common as we age, with 88% of Americans aged 65+ living with at least one chronic condition. It is estimated that by 2020, 81 million Americans will have multiple chronic diseases. According to Medicare, the leading chronic diseases among older adults include hypertension, high cholesterol, arthritis, ischemic heart disease, and diabetes.
Many of the health care industry quality indicators focus on how effectively the organizations provide support and treatment for patients with chronic diseases. Additionally, failure to provide preventive treatment, engagement and support could lead to higher utilization of emergency room (ER) services and avoidable hospitalization—which adversely impacts health care costs. CDSME programs complement preventive treatment plans and encourage patients to manage their health and conditions more effectively, reducing utilization of ER and inpatient admissions/readmissions.

- Center for Managing Chronic Disease at University of Michigan

**Emergency room utilization**

This term refers to the rates at which an enrolled population uses ER services. High ER utilization is generally thought to be an indication of poor preventive treatment interventions, poorer access to care, or the result of poorly managed chronic conditions. The health care system is focused on reducing avoidable ER utilization by providing more education and access to preventive services. With its emphasis on self-management and wellness, CDSME can be an effective complement to these preventive services. Patients who over-utilize ER services may be considered high-risk.

**Health care costs**

These are the actual costs of providing services related to the delivery of health care, including the costs of procedures, therapies, medications, etc.

**Health care outcomes**

Health outcomes refer to the impact that health care activities have on patients, their symptoms, their ability to do what they want or need to do, and ultimately on whether they live or die. Health outcomes include whether a given disease process gets better or worse, what the costs of care are, and how satisfied patients are with the care they receive. Health outcomes also focus on the results of treatment, as well as patient self-management. Health outcomes are measured in a variety of ways. For example, patient satisfaction is usually measured via surveys. Functional status, how well someone can do what they want to do given their symptoms, is measured through health-related quality of life measures. Overall quality of the delivery of health care services may be measured through population health-based tools such as Healthcare Effectiveness and Data Information Set (HEDIS). HEDIS is a survey tool designed by the National Committee for Quality Assurance (NCQA) to measure managed care quality performance outcomes. HEDIS includes 83 measures that are divided into five domains of care, including:

- Effectiveness of care
- Access/Availability of care

The HEDIS survey is conducted annually and the results can impact health plan accreditation status, which can also impact the contracts and rates. Medicare utilizes HEDIS results from Medicare Advantage plans as part of the Star ratings quality evaluation program. Many state Medicaid programs use HEDIS results in determining health plan contracting and rate setting (see Medicare Advantage Plans).

Hospitals also utilize standardized quality outcome tools such as the Leapfrog Group Surveys, which are designed to drive better outcomes for patients. Hospitals across the country voluntarily complete the Leapfrog surveys annually and the survey data is used to track and share hospitals’ progress on key issues of safety and quality.

CBOs should emphasize the value of CDSME on improving health outcomes for individuals which positively impacts population health outcomes for HEDIS, Leapfrog Group Surveys, and other quality surveys. Additionally, more activated, self-motivated patients tend to rate their satisfaction with their health care experience higher—another benefit to offering CDSME to participants.

**Health care system**

As referenced in the video, the term health care system, encompasses the primary health care entities where CDSME participants access services, such as physician practices, clinics, hospitals, nursing homes, etc. Health plans and insurers are also included in this definition.

**Health care utilization**

Health care utilization is the consumption of services or supplies, such as the number of office visits a person makes per year with a health care provider, the number of prescriptions filled, or the number of days a person is hospitalized. When health care consumers over utilize costly services because of limited access to preventive services or poorly managed chronic illnesses, it drives up the overall cost of health care. CDSME programs help educate consumers about best practices to manage their chronic conditions, which have been shown to reduce ER visits and avoidable hospitalizations.

**High-risk patients**

This term refers to those patients whose health, safety, or social conditions predispose them to frequent use of the ER or inpatient hospital stays. High-risk patients may also be defined as those who have multiple chronic conditions that need complex care management.
Individual plan of care (IPC)

An integral component of person-centered planning, the IPC is a summary of the needs and service options for a patient which are identified in the assessment process and is developed by the client and case manager (and other stakeholders). The IPC is to be revised or updated as warranted by any changes in the patient’s needs. In general, the IPC is reviewed with the patient at six months, annually, or as necessary.

Medicare Advantage plans

**Medicare Advantage** Part C plans are private managed care organizations under contract with Centers for Medicare & Medicaid Services (CMS) to enroll Medicare beneficiaries who have Parts A & B into health plans. Medicare Advantage plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans, and Medicare medical savings account plans.

**Medicare star ratings** are a quality measurement system utilized by CMS to evaluate Medicare Advantage plans, including those that cover health services only, those that cover prescription drugs only, and those that cover both. The star ratings fall into several categories (that vary by type of plan) such as: managing chronic illness, member experience, member complaints/appeals, medication safety, etc. The star ratings range from 1-5, with 5 being the highest rating. The scores are publicly reported and are used by consumers to evaluate Medicare Advantage plan selection. Plans with high scores receive payment premiums from Medicare, while plans with consistent ratings below 3 are at risk of being placed in corrective action status and could be dismissed from the Medicare program. CBOs offering CDSME should highlight their ability to support star rating improvement initiatives, such as member satisfaction, prescription drug safety and other quality measurement outcomes through improved member engagement, education, and activation.

Nurse practitioners (NP)

NPs are advanced registered nurses who are educated and trained to provide diagnosis and treatment for acute illnesses or chronic conditions. According to the International Council of Nurses, “NPs manage acute and chronic medical conditions, both physical and mental. They are qualified through state legislation/licensure to diagnose medical problems, order treatments, perform some procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice which is established state to state, if there is a supervising physician overseeing their work closely. NPs at physician practices, clinics, and hospitals can be good contacts for organizations to connect with to promote their CDSME programming.”

- American Association of Nurse Practitioners
**Patient activation**

This term refers to the active participation by a patient in his or her own health care decisions and interventions. With the education and guidance of professional caregivers, the patient promotes his or her own optimal health or recovery.

- **Why Does Patient Activation Matter? An Examination of the Relationships Between Patient Activation and Health-Related Outcomes**

**Patient engagement**

This term refers to providers and other health care system stakeholders (health plans, hospitals, CBOs, etc.) and patients working together to improve health. A patient’s greater engagement in health care contributes to improved health outcomes and satisfaction. Patients want to be engaged in their health care decision-making process and those who are engaged as decision-makers in their care tend to be healthier and have better outcomes, which impacts quality outcomes and cost.

- **Healthcare Information and Management Systems Society (HIMSS): What is Patient Activation**

**Patient experience**

Health care organizations utilize a variety of tools to demonstrate quality for their patients (also referred to as consumers). Among these tools is the assessment of consumer’s health care experience and satisfaction. The consumer experience is defined as the kinds of interactions that they have with the health care system, including their care from health plans, doctors, nurses, and hospital staff, physician practices, and other health care facilities. The Affordable Care Act references consumer experience as one of the factors in the **Triple Aim of health care**.

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** is the most widely utilized patient assessment survey tool. It is used by Medicare as part of the star ratings evaluation and by leading accreditation organizations like the National Council on Quality Assurance (NCQA). CBOs offering CDSME programs should address their ability to increase consumer experience ratings. Consumers who complete CDSME programs are more likely to better manage their health care, be more effective utilizers of their care, interact more with their providers and have a stronger sense of satisfaction with their health care experience as a result. Several versions of the CAHPS are used by specific types of health care organizations, such as hospice providers, hospitals (H-CAHPS), and patient-centered medical homes and provider offices (CG-CAHPS).

**Primary care physician or provider (PCP)**

The PCP is the principal care coordinator for health care services provided to members enrolled in health maintenance organizations (HMOs), which also may be called managed care organizations (MCOs). The PCP is under a contract with the HMO to
deliver primary care services such as preventive screenings, treatment, and well care. The PCP is the point person for coordinating any specialty care, such as surgery or rehabilitation. CBOs reaching out to PCPs can promote CDSME as a strategy to help activate patient compliance with treatment and care plans. An activated patient is more likely to follow care plan instructions, which improves health care outcomes and positively impacts PCP performance standards with health plans.

**Quality and quality measures**

The definitions of health care quality may vary by the organization measuring the health care outcomes. In general, quality refers to the level or extent that health care services for consumers increase the potential for anticipated health outcomes. Different quality tools are used by different health care entities.

- **Health Plans:** The Health Effectiveness Data Information Set (HEDIS) is the most commonly utilized tool for measuring health plan quality outcomes of health plans, including Medicare Advantage plans. HEDIS is a product of the National Committee for Quality Assurance (NCQA) and collects health plan data on measures, such as the number of diabetics enrolled in the health plan who received annual eye or podiatric exams.

- **Hospitals:** Hospital-specific quality measurement tools include the Joint Commission's ORYX and the Agency for Healthcare Research and Quality’s National Inpatient Quality Measures, as well as Leapfrog Group’s Hospital Survey Tool.

- **Physicians:** Physician practices that are designated as Primary Care Medical Homes (PCMH) are measured by quality tools administered by their various accrediting bodies such as NCQA, Joint Commission, and URAC. Performance standards are generally established via a contract or agreement and may include quality measurements, such as effectiveness at managing chronic illnesses and reduction of hospital readmissions. Performance standards may also include non-clinical standards, such as network adequacy, timely claims payment, etc.

CDSME participants tend to be more compliant with treatment plans, adherent to medication use, and have fewer emergency room visits and hospital admissions/readmissions. Improved self-management skills can result in higher quality and performance outcomes for health care organizations.

- National Committee for Quality Assurance (NCQA): The Essential Guide to Health Care Quality
- Agency for Healthcare Research Quality (AHRQ): Major Hospital Measurement Sets
- National Committee for Quality Assurance (NCQA): Patient-Centered Medical Home (PCMH) Recognition

Self-management

Self-management is active participation by a patient in his or her own health care decisions and interventions. With the education and guidance of health care professionals, caregivers and other natural supports, the patient promotes his or her own optimal health or recovery. Patients enrolled in CDSME programs tend to be more motivated and more effective at managing their health care and this positively impacts health care outcomes and costs.

Support mechanism (in CDSME context)

This term refers to any formal system or method of providing support or assistance to a patient or consumer. In the context of this video, support may be provided by a range of staff in health care organizations, CBOs, and through an individual’s social network of family and friends.

Treatment plan

This is a documented plan that describes the patient's condition and procedure(s) that will be needed, detailing the treatment to be provided, expected outcome, and expected duration of the treatment prescribed. The patient and/or his/her representatives should be engaged in treatment planning. The patient's own self-management of his/her treatment plan objectives, such as diet, medication adherence, physical activity, smoking cessation, and sleep hygiene can have the most impact on the successful attainment of treatment plan goals, including management, disease prevention, and wellness.

Triple Aim

Introduced under the Affordable Care Act, the Triple Aim for health care is a conceptualized health care philosophy that transforms the approach to health care by concurrently accomplishing three key objectives:

1. Improve the health of the population served (quality outcomes)
2. Improve the experience of each individual (quality and satisfaction)
3. Reduction of overall per capita cost of health care

Health care delivery strategies, including development of medical homes or accountable care organizations, have goals to produce results in all three of the Triple Aim dimensions. CDSME programs can support health care organizations in realizing the Triple Aims’ critical objectives. (See health care outcomes for more information on tools to measure these outcomes.)

Value-based payment system

Value-based payment (VBP) is a transformative reimbursement system utilized to incentivize health care providers to improve quality and performance outcomes. Under VBP, health care providers, including health plans under contract with CMS or state
Medicaid agencies, as well as hospitals and physicians, are paid to enhance quality outcomes. This is a change from the former fee-for-service reimbursement and volume/quantity-based payment for the number of services rendered or patients seen. VBP payment systems often provide enhanced payments/incentives for meeting quality and performance targets; there may also be penalties for failing to meet performance benchmarks such as withholding part of monthly payments or reducing reimbursement amounts.

CDSME programs can produce significant impact on participants and on quality of care outcomes for physician practices, health plans, hospitals, thereby enhancing their ability to capitalize on VBP.

- What is Value-Based Care, What It Means for Providers?

**Evidence-based Chronic Disease Self-Management Education (CDSME) programs**

Originally developed by Stanford University, the suite of CDSME programs includes the Chronic Disease Self-Management Program, in English and Spanish, which is appropriate for participants with any ongoing health condition. The programs are available both in-person and online through Canary Health. In addition, there are four condition specific versions of CDSMP, including:

- Cancer: Thriving and Surviving
- Chronic Pain Self-Management Program
- Diabetes Self-Management Program (in English and Spanish)
- Positive Self-Management Program for HIV

The group-based workshops are conducted in two and a half hour sessions, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. Workshops are facilitated by two trained peer leaders, one or both of whom have at least one chronic disease themselves. Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and, 7) how to evaluate new treatments.

The [Self-Management Resource Center](https://www.cdc.gov/chronicdisease/resources/programs/cdsme/) administers the program, which includes training and licensing. Additional information about the suite of programs can be found at the Self-Management Resource Center web site and NCOA’s [National CDSME Resource Center](http://www.ncoa.org/national-cdsme-resource-center).
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