Section of Chronic Disease Prevention and Health Promotion

Chronicles

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Welcome to the first issue of *CDPHP Chronicles*, a web-based publication designed to provide our partners with updates on new data, program results, and other topics of importance as they relate to preventing chronic disease and promoting health in Alaska. *CDPHP Chronicles* will be published as new data or issues arise, rather than on a regular schedule. To receive email announcements about newly-released issues, please email cdphp@health.state.ak.us.

Living Well Alaska

Abstract

Living Well Alaska, based on the Chronic Disease Self-Management Program (CDSMP), is a six-week workshop designed to help adults manage their chronic conditions. In January 2006, 37 Alaskans were trained by a team from Stanford University in the CDSMP model. This *Chronicle* describes how Living Well Alaska evolved in the year following the training.

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Background

The Chronic Disease Self-Management Program (CDSMP) was developed by the Stanford University Stanford Patient Education Research Center, where self-management programs for people with chronic health conditions have been tested and evaluated for the past 20 years. Initially developed to address arthritis, the program was subsequently expanded to be applicable to a wide range of chronic conditions. Each variant of the CDSMP has been designed to help people gain self-confidence in their ability to manage their symptoms and to understand how their health problems affect their lives. Programs are released by Stanford University for dissemination only after they have been shown to be safe and effective through randomized control trials.[1]

The CDSMP operates on several assumptions:

- People with chronic conditions have similar concerns and problems;
- People with chronic conditions must deal not only with their disease(s), but also with its impact on their lives;
- The process or the way the CDSMP is taught is as important as the subject matter; and
- Lay people who complete the CDSMP training, can effectively teach the CDSMP.

All of these assumptions have been evaluated in published studies. [2] [3] [4] The CDSMP was first evaluated in a five-year randomized study involving more than 1,000 subjects. This study found that people who participated in the program, when compared to people who did not, improved their healthful behaviors (exercise, cognitive symptom management, coping and communications with physicians), improved their health status (self-reported health, fatigue, disability,

social/role activities, and health distress), and decreased their days in the hospital. The decrease in hospital days was associated with a cost savings of 1:4.[2] In a recent randomized trial, it was found that although subsequent health service utilization did not differ between the two groups, the treatment group did report considerably greater health-related quality of life, which is translatable as a cost savings since quality of life can be quantified.[5]

The CDSMP is a patient education program designed to be led by trained lay persons, although health professionals can also co-lead the workshops. These leaders meet with groups of 10 to 15 persons with chronic conditions. The sessions are 2 1/2 hours long, once each week for six consecutive weeks. The workshop is designed for persons experiencing any type of chronic health condition; their significant others and caretakers are encouraged to attend.

The CDSMP addresses the following:

- starting an exercise program;
- cognitive symptom management;
- healthy eating;
- breathing exercises;
- relaxation;
- creating and modifying an action plan;
- problem solving;
- communicating with family, friends, and health care providers; and
- dealing with the emotions of chronic illness, particularly anger and depression.

In the traditional model of patient education, an educator communicates disease specific information with the hope that compliance will improve clinical outcomes. In contrast, the CDSMP targets improving self-efficacy, that is, the self-confidence in one's capacity to make life changes. The CDSMP does not replace traditional patient education but rather complements and reinforces it. In the CDSMP, participants obtain new information, learn new skills and abilities, and develop new ways to manage and cope with their chronic conditions. Participants give and receive support from others who have comparable challenges from living with a chronic health condition.

Sessions are highly interactive and emphasize strategies to help individuals more effectively manage their chronic conditions. The theoretical basis of the CDSMP include skills mastery, which is accomplished through weekly action plans or self-contracts to do specific behaviors, as well as feedback and modeling. During the workshops, leaders frequently use group problem-solving strategies as well as brainstorming.

Context

An aging Alaskan population, an increase in chronic disease prevalence, risk factors, and co-morbidities, and the lack of health education programs appropriate for persons with multiple chronic conditions all served as the impetus for implementing a CDSMP in Alaska. Our goal was to train individuals to teach CDSMP within vulnerable and high-risk communities. Because chronic disease disproportionately affects people of color, the elderly, and persons of low Social Economic Status, we directed our initial recruiting efforts to community health centers and rural clinics.

In the CDSMP model, there are course leaders and master trainers. Course leaders are trained to teach the six-week workshop, and master trainers are trained to teach the six-week workshop as well as to train course leaders to teach the workshop. Whereas course leaders are relatively restricted to teaching within their community, master trainers have the flexibility to train in multiple communities. This is an important factor to take into consideration in terms of spreading the model.

In 2005, Dr. Kate Lorig from the Stanford Patient Education Research Center was contacted to provide CDSMP training in Alaska. In January 2006, Dr. Lorig and her training team from Stanford and Canada provided both master training and course leader training. This training was sponsored by the Alaska Diabetes Prevention and Control Program and the Alaska Arthritis Program. It qualified 37 persons to teach the 6-week workshop and 12 persons to teach the 4-day course leader course as well as the 6-week workshop.

In order to teach the Stanford CDSMP, one must hold or be covered under a licensed agreement with Stanford University. In Alaska, the license is held by the Section of Chronic Disease Prevention and Health Promotion (CDPHP), Division of Public Health, Department of Health and Social Services. The licensing agreement with Stanford University was negotiated and finalized in August 2006. Each of the 37 persons trained in January 2006 is covered under this license as well as the subsequent course leaders and master trainers whose training is sponsored by the State. All course leaders and master trainers are required to sign a memorandum of agreement with

CDPHP indicating that they will teach the 6-week workshop or conduct the 4-day training as it was written by Stanford University and that they will complete and submit the workshop and leader training evaluation forms. The CDSMP in Alaska was named, Living Well Alaska. Living Well Alaska is maintained and supported by the Alaska Diabetes Prevention and Control Program and the Alaska Arthritis Program.

Methods

Following the initial training, leaders returned to their communities to elicit interest in having a Living Well Alaska workshop. After interest was determined and the participants were recruited, the course leaders contacted the State (CDPHP) to request copies of *Living a Healthy Life with Chronic Conditions*[6] for the participants. The books were mailed to the course leaders along with attendance and evaluation forms. The evaluation forms were intended for both the course leaders and the participants to complete at the final session of the 6-week workshop. The following section describes the data derived from these evaluation forms for workshops taught between March 1 and December 31, 2006.

Participant Demographics

Table 1. Characteristics of Living Well Alaska participants, 3/1-12/31/2006 (n=46)	
Gender	
Female	33 (72%)
Male	12 (26%)
Age	
≤ 45	10 (22%)
45-64	22 (48%)
≥ 65	13 (30%)
Chronic conditions listed	
Arthritis	23 (50%)
Diabetes	15 (33%)
Heart disease	7 (15%)
Other	22 (48%)*
Reason for taking workshop	
To learn about self-management	23 (50%)
Lived with / cared for someone with a chronic condition	9 (20%)
Other	11 (24%)**

* Most participants listed more than one chronic condition.
** Some participants listed more than one reason.

Consequences

Of the 37 leaders trained, a total of 20 persons have taught at least one workshop in the 12 months since the initial training by Stanford. Ten persons indicated that although they did not teach a class in 2006, they are planning to teach a class in 2007. Of the remaining seven persons trained, three did not respond to follow-up calls, two have left the state, and two expressed no interest in teaching a class in the future.

There were ten Living Well Alaska workshops in the first year following the initial CDSMP training. The workshops were facilitated in Anchorage, Juneau, Soldotna, and Talkeetna. A total of 114 participants attended the first session; the total number dropped off to 71 participants at session six, yielding a completion rate of 62%. Of these 71 participants, 46 (65%) returned a completed workshop evaluation form. The following data are based on these 46 forms.

Participant Feedback

A series of questions assessed participants' experience and satisfaction with the Living Well Alaska course, each rated on a 1 to 10 Likert-type scale. Means for each question are reported in Table 2.

Table 2. Participant Experiences and Satisfaction with Living Well Alaska (n = 46)		
Question	**Response Options**	**Mean**
Contact with buddy between sessions	1 (no contact) to 10 (frequent contact)	4.7
Satisfied with workshop leader	1 (not at all) to 10 (completely)	8.9
Likelihood of applying what I learned	1 (not at all) to 10 (certain to use)	8.2
Confident can revise my action plan	1 (not at all) to 10 (totally)	8.1
Confident can manage symptoms	1 (not at all) to 10 (totally)	7.6
Confident can manage health problems to reduce doctor visits	1 (not at all) to 10 (totally)	7.6

Interpretations

Of the initial group of 37 persons trained by the Stanford team in January 2006, 20 persons (54%) had taught a workshop in the subsequent 12 months and planned to teach at least one more class in 2007. Follow-up calls indicated that an additional ten (27%) persons who had not taught a workshop in 2006 planned to teach a workshop in 2007. Most of the persons who delayed teaching a workshop indicated that finding time was the biggest challenge. The next most commonly cited challenges were not having access to persons with chronic conditions and not having a location to teach the workshops.

Participant attrition was a big problem in nearly all the Living Well Alaska workshops. This seems to be particularly true of the workshops offered at the community health centers. This could be related to multiple factors including workshop content, teaching/ learning styles, participant expectations, and scheduling. It has been suggested that participants be pre-screened to assess their motivation for taking the workshop.

Getting participant evaluation forms from either the participants or the course leaders was a challenge. It appeared that not all participants completed or returned the evaluation forms. In the future, it would be helpful for course leaders to remind participants to complete them and then collect them at the last session before they leave rather than ask participants to mail them back.

We were discouraged by the low engagement level of participants with their buddies. The buddy system is an intrinsic part of the CDSMP model because it facilitates peer learning and provides encouragement for participants to accomplish their action plans. The buddy system also helps to reduce social isolation, which is common among persons with chronic conditions. If participants are resistant to sharing their contact information with others, perhaps they could be encouraged to meet with their buddy during the break or contact one of the course leaders between sessions.

Participants reported a high level of satisfaction with the course leaders and the content. By the conclusion of the workshop, the majority had gained enough information and experience with creating and revising action plans that they reported a high level of confidence in being able to continue to modify action plans. Slightly lower levels of confidence were associated with managing their actual health problems.

Conclusion

We are heartened by the initial response to Living Well Alaska. We believe that it is an effective program and that it is useful for Alaskans with chronic conditions. It is our goal to train more course leaders in rural Alaska, and to meet this goal we have planned seven course leader trainings in 2007.

Chronic conditions place increased responsibilities on the individual. The reality is that it is the people living with the chronic conditions, and their families and support systems, that really manage these conditions, not the health care system. With that degree of responsibility, it is our obligation as public health professionals to help patients to become better self-managers.

References

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