Replication Report

Partners on the PATH
"Personal Action Toward Health"

A Chronic Disease Self-Management Program

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Area Agency on Aging of Western Michigan (AAAWM) is a nonprofit organization that plans, funds, and advocates for older adult programs in nine West Michigan counties. AAAWM was responsible for overall coordination of the project and receipt and distribution of funds.

Grand Valley State University (GVSU) is a comprehensive, regional institution that is categorized in the Carnegie classification as a "Large Masters" university. It provides educational services to all of West Michigan. Grand Valley State University offers more than 100 academic and career preparation areas of instruction, with over 80 majors.

Priority Health (Health Maintenance Organization) is rated one of the top health insurance plans in the nation. It was founded in 1986 and is based in Grand Rapids, Michigan. It serves over 460,000 employers in 43 counties throughout Michigan. Priority Health assisted in the recruitment of members to classes and the introduction and adoption of CDSMP into the health care provider system.

ACSET – Latin American Services (LAS) serves the needs of the Hispanic community in the Kent County area. The agency serves Spanish-speaking seniors from several Latin American countries with congregate meals, outreach, and assistance, including translation and interpretation services, health education classes, and transportation.

Gerontology Network (GN) seeks to enhance the qualify of life and promote the independence of older adults, their families, and care providers by offering a wide variety of programs, such as adult day services, personal care services, nursing home consultations, health education, and case management for older adults with long-term mental health needs.

Senior Neighbors (SN) has been providing services and programs to seniors in Kent County since 1972. Senior Neighbors has five senior centers; offers outreach and assistance, congregates and home-deliver meals; provides transportation, prescription assistance, tax preparation, minor home repair, housing information, counseling, daily telephone calls to homebound or isolated seniors; and conducts the Retired and Senior Volunteer Program (RSVP).

United Methodist Community House (UMCH) has been meeting the needs of and offering opportunities to the Grand Rapids core community since opening its doors in 1902. United Methodist Community House provides services to individuals from the age of two weeks and continuing into its program for seniors, with recipients over the age of 100. The senior program offers daily programming that includes a congregate meal, exercise, arts and crafts, choir, and health education classes.

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I. INTRODUCTION AND BACKGROUND

Chronic health conditions are the major cause of illness, disability, and death in the United States, affecting almost 100 million Americans and accounting for 70% of all deaths in the United States.[1]

Older persons are especially affected by chronic health conditions. Eight-seven percent of older persons have at least one chronic condition, and 67% have multiple conditions.[2] The most common chronic conditions affecting older adults are hypertension, heart disease, arthritis, diabetes, hearing impairments, and major depression.[3]

The chronic conditions most common to older adults typically require more care, are more disabling, and are more expensive to treat than those common among younger people.[4] In fact, 25% of older adults with chronic conditions are limited in their ability to perform activities of daily living as a result of their disease, including 12 million seniors who still live at home.[5,6]

The economic and social costs of chronic disease and associated disability are well documented. Persons with chronic conditions and activity limitations are the heaviest users of healthcare services, including physician visits, prescription medications, hospitalizations, and home healthcare visits.[7] Persons with chronic conditions account for 83% of all healthcare spending and 99% of Medicare spending.[8]

Minority elders, including African-American and Hispanic older adults, bear an even greater burden of chronic disease and disability compared to Whites. For example, a 2002 self-reported study of adults of all ages living in Kent County, Michigan, found 10.7% of Hispanics and 9.9% of African Americans had diabetes compared to 6.8% of Whites and non-Hispanics.[9] African Americans also lead Whites in Kent County in deaths related to chronic conditions such as hypertensive disease and some forms of heart disease.[10] Additionally, national health data shows that increases in atherosclerosis and diabetes in the African-American population are two to three times higher than in the White population.[11]

All of the leading causes of death have strong behavioral risk components. Research shows that people with chronic health problems can play a major role in effectively managing their

[1] National Center for Chronic Disease Prevention and Health Promotion, "Chronic Disease Overview." http://www.cdc.gov/nccdphp/overview.htm
[2] Partnership for Solutions, 2004. "Chronic Conditions: Making the Case for Ongoing Care" – Sept. 2004 Update. Baltimore, MD. Johns Hopkins University.
[3] National Academy for an Aging Society. "Chronic Conditions: A Challenge for the 21st Century." Nov. 1999.
[4] Ibid.
[5] Goldman, Dana P., Cutler, David, Shang, Baoping, and Joyce, Geoffrey. "The Value of Elderly Disease Prevention." Washington DC. Centers for Medicare and Medicaid Services. 2005.
[6] National Center for Chronic Disease Prevention and Health Promotion. "Healthy Aging: Preventing Disease and Improving Quality of Life among Older Americans." Atlanta, GA. Baltimore, MD. Johns Hopkins University. 2005.
[7] Partnership for Solutions. "Chronic Conditions: Making the Case for Ongoing Care." Baltimore, MD. Johns Hopkins University. Update – Sept. 2004.
[8] Ibid.
[9] Kent County Health Department. "Kent County Behavioral Risk Factor Survey." 2002.
[10] Assessing the Health of Older Adults in Kent County: A Report to the Community. 2000.
[11] Ibid.

disease, and that successful programs emphasize chronic disease self-management, risk reduction, and increasing self-efficacy.[12,13]

PATH (Personal Action Toward Health) – The Model

To help older adults in Kent County with chronic conditions gain more control of their health and increase their confidence in dealing with the challenges of living with a chronic disease, the Area Agency on Aging of Western Michigan (AAAWM) selected PATH (Personal Action Toward Health), a program based on the research-proven Stanford model of Chronic Disease Self-Management (CDSMP). This program can be offered in a number of languages, including Spanish.

PATH is a 15-hour course taught by two trained leaders, one or both of whom are non-health professionals living with a long-term health condition. The program is not disease-specific and is appropriate for anyone living with long-term health challenges. Participants develop weekly "action plans" that help them build skills to work successfully toward goals of their choosing. Positive participant outcomes for this model based on research completed in 1996 include:

- Improved health status (significant improvements in disability, fatigue, social/role limitations, self-reported general health)
- Decreased healthcare utilization (fewer days spent in the hospital, trend toward fewer outpatient visits and hospitalizations)
- Improved health management behaviors (significant improvements in exercise, cognitive symptom management, communication with physicians)[14]

Choosing PATH

AAAWM had been funding a small, locally developed health education program that used single-session classes. No research had been conducted on the health outcomes of this program, and there was no measurable benefit to participants. The Stanford model, in contrast, had strong, documented, positive outcomes addressing the health and self-efficacy of adults with chronic health conditions.

Area Agency on Aging of Western Michigan and our partners (see below) chose CDSMP for several reasons:

- The model was well-developed and tested. The comprehensive training curricula for lay leaders and the CDSMP classes, along with impressive research outcomes and strong fidelity checks and balances, made this a good choice for our first experience in delivering an evidence-based program.
- The lay-leader model allowed us to use Community Aging Service Provider (CASP) staff along with lay peer leaders to implement the program.
- The program fit closely with the mission of all partners to enhance the dignity, quality of life, and empowerment of older adults in the community.

[12] Lorig, K., Sobel, D., Stewart, A., Brown, B., Bandura, A., Ritter, P.L., et al. "Evidence Suggesting that a Chronic Disease Self-Management Program can Improve Health Status while Reducing Hospitalization: A Randomized Trial." Medical Care, 37 (1), pp 5-14.

[13] Fries, J.F., Koop, C.E., Sokolov, J., Beadle, C.E., & Wright, D. "Beyond Health Promotion: Reduce the Need and Demand for Medical Care." Health Affairs, Vol. 17 (2) pp. 70-84. 1998.

[14] Lorig, K., Sobel, D., Stewart, A., Brown, B., Bandura, A., Ritter, P.L., et al. "Evidence Suggesting that a Chronic Disease Self-Management Program can Improve Health Status while Reducing Hospitalization: A Randomized Trial." *Medical Care*, 37 (1), pp 5-14.

- The model embraced all chronic conditions, enabling a broad base of potential partners, recruitment opportunities, and sites.
- The model was well-known to our healthcare partner and strongly supported its commitment to implement self-management strategies as described in the Chronic Care Model of Health Care Delivery.[15]

Moving from Health Promotion to Evidence-Based Programming

The move into evidence-based programming brought a number of advantages. The curriculum and methodology needed to implement a Stanford chronic disease self-management program were already developed, saving time and resources. In addition, we knew that implementing the program as designed increased the likelihood of replicating the Stanford model's positive outcomes and provided a benchmark to determine whether we achieved our goals.

Finally, implementing a successful program made it easier to market the program, engage partners, and secure additional funding. This evidence base was critical in engaging our healthcare partner and physicians. It also enabled us to secure additional funding from a local foundation so we could offer the classes in Spanish.

In general, we recommend an evidence-based health promotion approach to programming. This strategy employs a thoughtful process of planning, implementing, and evaluating programs adapted from *tested* models or interventions. Evidence-based programs enhance an agency's ability to use common health indicators and match tested health programs to recognized community needs. They also make it easier to defend or expand health promotion programs, increase the effective use of resources, provide hard data to advocate for new programs, and increase general new knowledge about "what works" and "how to do it" that can help others.

For additional information on evidence-based health programming, please see the Center for Healthy Aging's Issue Brief, "Using the Evidence Base to Promote Healthy Aging," Number 1 Revised. Spring 2006 at: www.healthyagingprograms.org/content.asp?sectionid=15&ElementID=97.

PATH – Our Adaptations

We made several adaptations to the original Stanford CDSMP model in creating PATH. We

- Targeted adults were age 60 or older, with one or more of four diagnoses: arthritis, chronic lung disease, diabetes, or cardiovascular disease. Our funding through the Administration on Aging (AAA) and the target population we serve in the aging network fell into this age range. This created some difficulty with our healthcare partner, which had younger members who could have benefited from PATH.
- Named the classes "Personal Action Toward Health" or "PATH," and referred to our program as "Partners on the PATH," to avoid any confusion with the CDSMP name.
- Partnered with a managed care organization to recruit participants and create a stronger tie to a healthcare system.
- Used CASP outreach workers and trained lay leaders from the community to deliver the classes and recruit participants. This allowed CASP staff to increase its ability to respond

[15] Wagner, E.H. "Chronic Disease Management: What will it take to Improve Care for Chronic Illness?" Effective Clinical Practice. (1) pp. 2-4. 1998.

to health issues and assisted staffers in responding to health-related issues from an empowering perspective.
- Trained CASP staff in the Stages of Change model and motivational interviewing to enhance their effectiveness in recruiting and responding to PATH participants as well as other clients.
- Completed outcome surveys at baseline, immediately after the program ended, and six months after classes ended to assess the sustainability of changes over time. In addition, CASP staff followed participants for six months after classes ended, and participants completed the final research survey to provide ongoing support and connection to health promotion options in the community. However, we had very little contact with participants during these six months.

Partners on the PATH – Our Partners

In addition to the Area Agency on Aging of Western Michigan, our partnership to deliver PATH included four aging service providers, a research institution, and a healthcare organization. A brief description of our partners and their roles follows:

- ***Area Agency on Aging of Western Michigan (AAAWM)*** is a nonprofit organization that plans, funds, and advocates for older adult programs in nine West Michigan counties. The agency was responsible for overall coordination of PATH and the receipt and distribution of funds.

- ***Community Aging Service Providers (CASPs)*** included the following:

    - ACSET – Latin American Services
    - Gerontology Network
    - Senior Neighbors, Inc.
    - United Methodist Community House

  We chose these aging service providers based on their ability to reach specific subgroups within our target population. For example, one served the needs of Hispanic older adults; another largely served the African- American population; the third worked with older adults with mental health needs; and the fourth had strong connections to senior centers and meal sites.

  As trained lay leaders, CASP staff taught PATH classes, helped recruit participants and host sites, and assisted in completing outcome surveys. They were also trained in motivational interviewing and Prochaska's Stages of Change model.

- ***Grand Valley State University (GVSU)*** managed the evaluation and research component of the project.

- ***Priority Health***, a health maintenance organization, served as our healthcare partner and assisted in recruiting members and introducing and adopting CDSMP into the health-care provider system.

In addition to the primary partners, a local foundation, the Grand Rapids Community Foundation, awarded our project $10,000 to bring the Spanish version of the CDSMP to Kent County.

Benefits to Our Partners

PATH involvement resulted in several benefits for our partners, particularly the CASPs. For example:

- CASP agencies and the aging network, including AAAWM, began to discuss complementary roles and benefits each could provide to meet the needs of older adults.
- Using the aging network to deliver a research-proven program provided agencies and AAAWM with credibility in the outcome-oriented healthcare industry.
- Using CASP outreach workers to deliver the program built agency capacity and knowledge around translating evidence-based programming to culturally specific audiences, paving the way for implementation of other evidence-based interventions.
- PATH strengthened the image of the aging network with its constituents and shareholders by providing a new and valuable service.

Priority Health (PH) also benefited from participation in PATH. It was able to give its primary care physicians a tool to help patients manage chronic conditions through a behavioral approach, complementing the traditional medical services doctors offered their patients. This program created a venue to implement self-management strategies as a part of Priority Health's focus on the Chronic Care Model of Health Care Delivery. Partners on the PATH also increased Priority Health's visibility as a partner in an innovative, federally-funded initiative. Finally, the research-proven positive outcomes of PATH have the potential to improve member health, quality of life, and provider-patient relationships.

Grand Valley State University's (GVSU) involvement in PATH allowed the institution to contribute to the local community in a way that advanced its mission. Through this project, GVSU also gained the opportunity to evaluate the translation model, furthering its understanding of what is required to successfully collaborate, design, and translate scientifically proven programs to community-based settings. Additionally, GVSU strengthened its relationship and collaboration with community organizations not usually within its sphere of influence.

How PATH is Making a Difference

Today, PATH is making a palpable difference for older adults in our community. The program benefits older adults by promoting positive healthcare habits and providing peer support and encouragement. It empowers participants to assume an active role in their health, managing their symptoms and health to enhance their daily function and live the highest possible quality of life.

Our evaluation of participant outcomes finds many healthy lifestyle changes. For example, preliminary results from approximately 170 participants in the program show significant improvements in aerobic exercise, cognitive symptom management, levels of pain and discomfort, health distress, fatigue, and shortness of breath.

Based upon our experience with PATH, as well as the extensive implementation of the Stanford-based CDSMP model nationally and internationally, we believe PATH can effectively improve the quality of life of older adults with chronic conditions in communities across the country. We encourage other communities to take advantage of this important health promotion program.

II. PLANNING AND PARTNERS

Identifying Local Needs

There are a variety of ways to identify local needs regarding the prevalence and impact of chronic disease in older adults. Local and/or state health departments are a good place to start in identifying available data for use in planning. You should review any relevant epidemiological data and other available state and local data on community-residing older adults to identify key health issues, rates of functional disabilities, and/or risk factors that could be addressed through a chronic disease self-management program.

At the same time, it is important to develop a clear sense of the local older adult community. You should learn about older adults' income levels, educational attainment, culture and ethnicity, geographic spread, and service access. Many of these issues will affect how you identify, shape, and plan a health-promotion or disease-prevention program. At this point, you may wish to specify the characteristics and context of the population or sub-population you are most interested in serving.

Once the health issues are identified and the target population defined, it is important to scan the environment to locate available services that address chronic disease self-management strategies and identify service gaps. This scan may also identify additional partners and existing collaborations that can be leveraged in your work.

Another important step is to begin a review of the relevant research on proven interventions or models, such as PATH, that address chronic disease self-management and are applicable to your target population.

Data and Planning

Using the data and feedback from this kind of environmental scan, as well as discussions with any current partners, you can identify and recruit new community agencies interested in chronic disease self-management. To be most effective, include groups that serve or represent older adults, as well as older adults themselves in your planning activities. These partnerships can help further assess the data and research findings on potential interventions.

As your partnership or group forms, it is important to come to a consensus on clear goals and objectives for this initiative. In general, it may be helpful to access resources on effective partnerships to learn more about building and maintaining these important relationships.

You and your partners should then collaboratively select from a variety of program options and agree upon an intervention and expected outcomes. Everyone should be clear on the expected contributions and roles of each partner as the initiative moves forward. In addition, all should agree on the most appropriate interventions for the target population, ensuring a consistent sensitivity to its cultural characteristics, history, values, and belief systems.

Choosing Partners – Getting Started in Kent County

Our partners for this project were carefully chosen for their access to diverse, high-risk populations and the healthcare community, and for their research expertise. All had a vested interest in making Kent County a healthier community. A detailed description of our partners, along with a review of their functions within the project follows.

Area Agency on Aging of Western Michigan (AAAWM) is a nonprofit organization that plans, funds, and advocates for older adult programs in nine West Michigan counties. Its primary purpose is to promote independence and dignity for individuals aged 60 or older. The agency has a network of more than 80 organizations delivering a wide range of services to improve the quality of life for older adults. The agency was responsible for the overall coordination of the project and the receipt and distribution of funds.

ACSET – Latin American Services (LAS) serves the needs of the Hispanic community in the Kent County area. The agency serves Spanish-speaking seniors from several Latin American countries with congregate meals, outreach, and assistance, including translation and interpretation services, health education classes, and transportation. The agency assisted in recruiting and delivering PATH classes to Hispanic older adults.

Gerontology Network (GN) seeks to enhance the qualify of life and promote the independence of older adults, their families, and care providers by offering a wide variety of programs including adult day services, personal care services, nursing home consultations, and health education and case management for older adults with long-term mental health needs. Gerontology Network, which already offered an education component for older adults in the community, recruited and referred clients for PATH from its client base.

Senior Neighbors has been providing services and programs to seniors in Kent County since 1972. Senior Neighbors has five senior centers. It offers outreach and assistance, congregate and home-delivered meals, transportation, prescription assistance, tax preparation, minor home repair, housing information, counseling, and daily telephone calls to homebound or isolated seniors. It also conducts the Retired and Senior Volunteer Program. Senior Neighbors assisting in participant recruitment in senior centers and meal sites and adoption of these sites for PATH classes.

United Methodist Community House (UMCH) has been meeting the needs of and offering opportunities to the Grand Rapids core community since 1902. United Methodist Community House provides services to individuals of all ages, with some recipients over 100 years old. The senior program offers daily programming including a congregate meal site and choir, and exercise, arts and crafts, and health education classes. United Methodist Community House assisted in recruiting and delivering PATH classes to African-American adults.

As a result of services provided to older adults in the community, staff from the various CASPs (LAS, GN, Senior Neighbors, and UMCH) had ties to a number of other organizations, such as senior apartment complexes, which assisted in the adoption of PATH. Once trained, CASP staff taught PATH classes, participated in recruiting participants and host sites, and assisted with completing outcome surveys. Staff was also trained in motivational interviewing and stages of change.

Grand Valley State University (GVSU) is a comprehensive, regional institution that provides educational services for west Michigan. Dr. Cynthia Coviak of the GVSU School of Nursing managed the evaluation and research component of the project. She had recently completed research on a neighboring county's use of the Stanford CDSMP for African Americans with diabetes, so she was familiar with the model.

Priority Health. This health maintenance organization is rated one of the top health insurance plans in the nation. It was founded in 1986 and is based in Grand Rapids, Michigan. It serves

more than 460,000 employers in 43 counties throughout Michigan. Priority Health assisted in recruiting its members for classes and the introducing PATH to healthcare providers.

In addition to the primary partners, the Grand Rapids Community Foundation (a local foundation in Michigan), awarded the project $10,000 to bring the Spanish version of the CDSMP to Kent County.

Though all involved agreed on the value of PATH in the community, it took time to learn how each organization functioned, create an infrastructure for the collaboration, and clarify roles. Thus, it is important that you allow time and opportunities for feedback and adjustments in procedures, especially in the early stages of implementation. We held monthly meetings, rotating partner sites, so all could gain an appreciation of the other organizations involved.

Additional Thoughts on Partnering

Due to the broad and varied target population that can benefit from this intervention, the range of partners can be very diverse. Virtually any agency concerned with the health and empowerment of older adults could be considered for some form of partnership. If you are working at the state level, you may investigate collaborations with the state Office of Services to the Aging (OSA) or the department of community or public health, and state associations related to aging or health. Partnering with your public health department may provide access to grants or other funds through its chronic disease division. Other agencies may also have access to expertise for creating databases or other helpful technical skills.

If you are working regionally (as we did) or locally, partners could include aging service providers, public health departments, university extensions, healthcare providers, disability advocates (Centers for Independent Living in some communities), diabetes outreach networks, or disease-specific organizations (e.g., the Arthritis Foundation, Multiple Sclerosis Society, etc.). Senior centers, senior housing sites, assisted living and faith-based communities, YMCAs, and adult education locations may be good choices for partners to refer and recruit members from their spheres of influence, promote and market classes, or offer sites for meetings/trainings.

Additionally, some partners have access to target populations that are important to reach, such as Hispanic, African American, or other sub-groups. Some may offer financial backing or expertise for some or all program components, as the Grand Rapids Community Foundation did for PATH. You might also look to the marketing departments of larger organizations in the community or local marketing firms to donate their expertise to create marketing materials. Our local university extension received a grant through the university to assist with collaboration and marketing in our area.

We have developed a number of recommendations based on what we learned through our partnering experiences:

- Explore the mission and goals of potential partners so you can tailor your approach to meet the organization's needs and values.
- Diversity in partners is good. However, you must take the time to learn about, appreciate, and understand each other organizationally as you work together around common goals and tasks.
- If you partner with agencies to implement classes, choose well-established agencies that offer a variety of resources and an appreciation of evidence-based programming. Make sure this appreciation trickles down from administration to other staff.

- Evaluate partnership collaboration efforts regularly to assess the effectiveness of group process and function, perceptions regarding participation in achieving goals, and satisfaction with levels of support. Section VIII includes tools used to assess collaboration efforts.
- Partnering with physicians/provider practices to adopt the program and recruit patients to classes can be very difficult, even if they initially express agreement with the program's approach and benefits. We tried a number of approaches, from academic detailing "lunch and learn" sessions to regular contact by letter/e-mail/telephone calls with only modest success. We are now sending letters from the physicians' patients after the patient completes PATH.

Tools

A number of tools and resources were helpful in our partnering efforts. Please refer to Section VIII for more information on these.

III. Adoption/Recruiting Implementation Sites and Staff/Volunteers

Getting the Right Fit

The PATH program can fit within a variety of adopting agencies. Including people with diverse chronic illnesses allows the intervention to work in almost any location in which older adults congregate. The lay peer model allows classes to be delivered without the need for health professionals.

To be a good fit for this intervention, agencies that work with adults should:

- Be interested in promoting optimal health
- Support an approach that fosters participant empowerment
- Support the evidence-based program model

Using aging service providers worked well for us. Other potential adopting agencies include retirement communities, senior centers, healthcare providers, YWCAs and YMCAs (especially those that offer water and exercise classes for people with arthritis). Any disease-specific organization (such as the Multiple Sclerosis Society, the Parkinson's Foundation, or the American Diabetes Association, etc.) could benefit from complementing their disease-specific training curriculums with these classes. Public health departments and university extension programs have also adopted the program.

Choosing Sites – Key Requirements

The main requirements for a program site are that:

- It is accessible to participants, with mass transit access and/or reasonably close parking.
- It is open and operating the days and times on which the program is scheduled.
- The organization operating the site has a room that can accommodate 12-16 individuals, is accustomed to welcoming outsiders to its facility, and has people available to direct visitors, set up furniture, etc.

The intervention is designed to be held in community settings. While site selection was left largely in the hands of the CASP agencies, all partners participated in suggesting sites and discussing the program with potential adopting agencies. The CASP staff began with sites they often use, including their agency location, especially if a significant number of older adults regularly came to the site and it had accommodations suitable for small groups.

In general, when selecting sites, choose places where older adults congregate and in which they are comfortable. We have had success with senior centers, meal sites, aging service providers, senior housing sites, assisted living facilities, churches, and the Salvation Army. Other sites could include libraries, local health departments, healthcare organizations/systems, YMCAs, physician offices, and disease-specific organizations.

Approaching Sites

When recruiting a site, first meet with the manager of the proposed site to discuss the benefits of the program and your expectations. Gain management support before scheduling classes. We made the error of marketing and scheduling classes through someone other than the site manager once, only to have access fall through due to lack of management support and understanding of PATH.

When discussing the program with organizations, emphasize the proven benefits to the participants as outlined in the research. Actual examples of success stories are a plus. We emphasized the international dissemination and acceptance of this model, along with participant experiences related to problem-solving skills, group support, and positive role models for managing their lives in the face of chronic health conditions.

Stress benefits to the sites, such as the fact that the classes are free, refreshments are included, and training materials are provided at no cost. We now use a lending library, but with the AoA grant, participants were allowed to keep the materials. Some sites may require you to present plans for scheduled programming for their residents. Our local housing commission, for example, was very pleased with the PATH programming at its HUD sites.

You will have much more success securing and establishing a site if a trusted member of that organization is willing to advocate for the program. For example, in our experience, cold calls to churches were not always successful, but two church sites worked out well. In one, the facilitator was a retired priest from that parish. In the other, one of the facilitators was a member of the congregation, and the pastor attended classes and promoted them. In our senior housing sites, resident managers assisted with recruiting participants and securing a room for classes.

Tools for Marketing to Sites

We used a number of tools to assist in marketing sites and encouraging the adoption of the PATH program in the community. Materials you use will depend upon your audience. For example, physicians and other health-related organizations may be interested in research and need a clearer understanding of self-management education. Other sites may be most interested in success stories and how to talk to potential participants about PATH classes. It is a good idea to track your efforts. Please refer to Section VIII for tools we found helpful in recruiting sites and adopting organizations.

IV. Reach: Outreach and Recruiting Participants

There may be multiple audiences for your outreach, including but not limited to funding organizations, public officials, organizational leadership, staff and volunteers, and, of course, participants. The following addresses strategies we found effective, particularly in recruiting and retaining participants in the PATH program:

Determine Who Can Participate in PATH
The PATH program was designed to benefit adults with chronic health conditions. Participants should have enough stamina to attend a two-and-a-half hour class, plus travel time, and have cognitive function allowing their participation. We required that the person transfer independently or have a caregiver available to assist. We provided transportation to classes if needed.

Individuals with well-managed chronic conditions that are not perceived as adversely affecting their life may not feel the classes are appropriate. People looking for hard, technical knowledge in a lecture format with health experts may not find the interactive and experiential learning activities a good fit. Overall, the majority of older adults with chronic diseases, however, can benefit from PATH.

Create a Recruitment Plan
In developing a recruitment plan, it is important to keep the target population clearly in mind. It may be helpful to identify potential participants and, through focus groups or interviews, have them inform your strategy development. It generally helps to understand potential participants' culture and background. For example, where is your target population located and how do they access program information? Are there community champions who could help spread the word? Your partners may bring a wealth of ideas for effective recruitment, as well. It is also important to set realistic recruitment goals and periodically assess your progress. Once we got started, we also obtained information from PATH participants on how they learned about the program and used this information to hone our dissemination efforts.

Our main recruitment strategy was to work with partners who already had good connections with people who were part of our target audience. Priority Health, our healthcare partner, had members with chronic conditions as well as contracted providers treating these members. It was Priority Health's plan to recruit members directly and work with their physicians to identify and refer seniors with chronic health conditions. Direct recruitment worked to some extent; working through physicians has been less successful despite significant efforts.

The Community Aging Service Provider (CASP) agency partners each had groups of seniors they serve, a number of whom have been part of our target population. These agencies recruited people to the program. They also capitalized on contacts with other organizations that attract seniors.

Recruitment Tactics
Successful approaches to attract PATH participants include:

Presentations. Our strongest response with presentations came from approaching already-formed groups of older adults. It proved most effective to meet older adults where they normally gather and offer incentives if they signed up for PATH or stayed for the entire

presentation. Presentation sites included senior centers, churches, meal sites, senior apartments, health clinics, and health fairs.

We used the 12-minute CDSMP video, "Chronic Disease Self-Management Program (The Healthier Living Program)" created by Kaiser Permanente as part of our presentation. The video, which can be ordered through the Stanford web site, is available in a version for healthcare professionals and potential participants.[16] It provides a short yet clear description of class activities and participant experiences. It worked best for us to sell the program in "steps" so potential participants had a sense of what classes are like before agreeing to attend the entire six weeks. We also kept presentations focused on "what's in it for them."

We kept a list of people who were not interested in PATH during the presentation and used it as a mailing list for future classes. If people were interested in attending PATH classes, we enrolled them immediately following the presentation. It helped to look for the informal "leader" of the older adult group and use their influence, support, and belief in the benefits of the program to gain the trust and interest of their peers.

Media. We participated in a number of radio interviews, television promotions, newspaper and newsletter articles for senior centers and public school systems. Newspaper articles generated a number of inquiries to the program. Other media contacts proved less effective.

Printed materials. We used brochures and posters to advertise for classes. These were effective if coupled with in-person contact.

Word-of-mouth. Participants often recruited friends or family members. We offered incentives (like a $5-$10 gift card) to anyone who brought another person to a meeting.

Direct mail. Priority Health sent two mailings of about 3,000 letters each to its members. The response rate to the first mailing was under 10%. These letters were coupled with telephone contact from a PH case manager. The second mailing went to members identified from disease registries. There was no follow-up, nor was there any appreciable response to this mailing.

Recruitment Challenges

Our recruitment challenges often came from a lack of understanding about PATH and how it differs from traditional, disease-specific health classes. This lack of understanding was evident in participants when they first came to classes as well as with health-related organizations and healthcare providers as they attempted to recruit people into the program. It was also difficult at times to explain the program in two to three sentences.

Despite several strenuous efforts of our managed care partner to have physicians refer their patients, this recruitment effort has not been successful. We are not certain whether we need to examine our message or whether we simply need more time to build relationships and effective referral strategies with physicians. We also lacked a physician champion in the community willing to promote PATH to his/her peers. We believe these types of "champions" can be very effective in bringing healthcare providers to the program.

[16] Chronic Disease Self-Management Program (The Healthier Living Program). Videotape. Kaiser Permanente.

Stages of Change: Overcoming Common Recruitment Barriers

Evidence-based health promotion programs are designed to help participants make informed decisions about their health and support appropriate behavior change. Change interventions are especially useful in addressing lifestyle modification for chronic disease self-management and similar activities. The failure of participants to make appropriate behavior changes or to even participate in programming is often ascribed to a lack of motivation.

We found that the Stages of Change model offered a better way to understand participant readiness to make change, appreciate barriers to change, and help older adults anticipate relapses. Developed by Prochaska and others[17], the Stages of Change model reflects that changes in behavior occurs slowly for most people, regardless of age. Individuals go through several stages, beginning with being uninterested, unaware, or unwilling to make a change (precontemplation). The person then begins considering whether a change is warranted (contemplation), before deciding and preparing to make a change (preparation). Ultimately a person takes genuine, determined action and, over time, attempts to maintain the new behavior (action). Relapses are almost inevitable and become part of the process of working toward life-long change (maintenance). We suggest you learn more about the Stages of Change model and how it can be used to enhance recruitment and retention of PATH participants.

Effective recruitment and retention strategies consider which stage potential participants may be in, since each stage requires a different approach. By considering potential participants' readiness for programs like PATH, you can tailor your recruitment efforts. We provided training on the Stages of Change and motivational interviewing for our outreach workers, along with refresher practice sessions to assist with this.

Tools

In addition to the methods described above, we also developed PowerPoint presentations for use with potential participants and healthcare providers. Please refer to Section VIII for these and other tools we found useful in recruiting participants to PATH classes.

[17] Prochaska, J.O., DeClemente, C.C., Norcross, J.C. "In Search of How People Change." *Am. Psychol*. 47:1102-4. 1992.

V. IMPLEMENTATION

Primary Components of Partners on the PATH

The Partners on the PATH program is unique in several ways. The program is designed to be taught by trained lay persons who themselves have a chronic health condition. People with many different chronic diseases come together to talk about what it is like to live with a chronic condition, learn how to manage their conditions better, and take more control of their lives. There is a strong emphasis on creating personal action plans and setting practical, achievable goals.

Self-management and education is based on the premise that improved self-efficacy results in improved quality of life and better clinical outcomes. These classes are not the same as traditional, disease-specific patient education; however they do complement disease-specific materials.

Program topics include effectively coping with problems such as frustration, fatigue, pain, and isolation. Also included are appropriate exercises for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments.[18]

Additionally, each person in the program receives the supplemental text developed by Stanford, "Living a Health Life with Chronic Conditions," and "Time for Healing," a relaxation tape/CD to assist in guided imagery and progressive relaxation.[19]

The Stanford model is also offered in Spanish, with similar research-proven, positive participant outcomes. The program is called "Tomando Control de su Salud" and is not a direct translation of the English program but is culturally sensitive to the Hispanic population.[20] This program includes the text, "Tomando Control de su Salud: Una guia para el manejo de las infermedades del Corazon, diabetes, asma, bronquitis, enfisema y otros problemas cronicos" (Taking Control of Your Health: A guide for the self-management of heart disease, diabetes, asthma, bronchitis, emphysema, and other chronic problems) and two participant tapes/CDs, one for relaxation and one for exercise.[21] We offered PATH in English and Spanish.

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[18] Lorig, K.R. "Self-Management Education: More than a Nice Extra." *Medical Care*. 41 (6). pp. 699-701. 2003.

[19] Lorig, K., Holman, H., Sobel, D., Laurent, D., Gonzolez, V., and Minor, M. "Living a Healthy Life with Chronic Conditions: Self-Management of Heart Disease, Arthritis, Diabetes, Ashthma, Bronchitis, Emphysema and Others." Palo Alto, CA. Bull Publishing Co. 3rd Edition. 2006. Also, "Time for Healing: Relaxation for Mind and Body" (long version). Two, 30-minute relaxation exercises with background music and the voice of Catherine Regan, Ph.D. Bull Publishing Company. 1994.

[20] Lorig, K.R., Ritter, P.L., Gonzalez, V.M. "Hispanic Chronic Disease Self-Management: A Randomized Community-Based Outcome Trial. Nursing Research, 52 (6), pp. 361-369. 2003.

[21] Gonzalez, Virginia, MPH, Hernandez-Marin, Maria, Lorig, Kate, RN DrPH, Sobel, David, MD, Laurent, Diana, MPH, and Minor, Marian, RPT PhD. Tomando Control de su Salud: Una guia para el manejo de las infermedades del corazon, diabetes, asma, bronquitis, enfisema y otros problemas cronicos. (Taking Control of Your Health: A Guide for the Self-Management of Heart Disease, Diabetes, Asthma, Bronchitis, Emphysema and other Chronic Problems.) Bull Publishing. 2002. Also, **"**Programas educativos para la salud: Relajación muscular progresiva y Un jardín de flores**."** *Two 20-minute relaxation exercises with background music and the voice of Virginia Nacif de Brey. Stanford Patient Education Research Center, 1995. And* "¡Hagamos ejercicio!" (Let's Exercise!) *Exercise audio cassette tape with background music and the voice of Virginia Nacif de Brey. Stanford Patient Education Center, 1995.*

How It Works

The program is delivered in one, two-and-a-half hour session per week for six weeks. Groups are small, ranging from 10 to 16 participants, allowing for easy discussion and sharing. The curriculum, while highly scripted, encourages group discussion and learning from each other. The nature of the script allows the facilitator to deliver the material in a natural and seemingly extemporaneous manner, so the script does not get in the way of easy discussion. Each class is taught by two trained facilitators. The core components of the program are:

- Creating an informed patient
- Peer-led learning experiences
- Positioning the facilitator as a positive role model
- Standardized leader training with highly structured teaching scripts to maintain fidelity
- Social support for change
- Skill building for decision making and follow through, with action plans created and discussed each week

Roles and Qualifications

Sound implementation that maintains fidelity to the PATH model requires clear role definitions and adequate training for key staff and volunteers at adopting sites. Key roles include:

- ***Master Trainers.*** At least two master trainers are required for lay leader training. These individuals must be trained by Stanford staff, as described below in the Budget section. They do not need to be health professionals, although they should be willing to commit to this endeavor over time. Master trainers lead classes and train lay leaders. They can train up to 20 lay leaders in each session.

- ***Lay leaders.*** Lay leaders actually facilitate the workshops. Ideally, they are adults with chronic health conditions, although they can also be professionals and staff members. Two lay leaders must be present at each workshop, and we recommend at least one have a chronic health condition. These individuals must successfully complete the four-day lay leader training, as described earlier.

- ***Coordinator.*** Oversight of the project is necessary to maintain fidelity and quality assurance. The coordinator organizes training needs, workshop materials, schedules, marketing, and marketing materials, as outlined earlier. The coordinator also recruits and select leaders, and oversees any Stanford requirements (i.e., re-licensure, annual reporting, etc.)

Maintaining Fidelity to the PATH Model

Evidence-based programs are grounded in research. Specific core components or constellations of components are the essence of the program. In order to ensure the health outcomes ascribed to the program, these must be maintained in your implementation. This is called maintaining “fidelity” to the model.

To implement PATH in your community and better match the program to your target population, you may wish to alter some characteristics of the program. However, before making changes be sure you understand what adjustments can be made without affecting the core components of the Stanford CDSMP model, thus possibly affecting the outcomes. The following provides information on the core elements of CDSMP:

- Lay leaders are taught by master trainers who receive four-and-a-half days of special instruction and certification from Stanford.
- Lay leaders receive training for four days with a highly scripted training curriculum used in the training.
- Instruction includes several “practice teaching” sessions
- At the end of the lay leader training, the master trainers must attest to the fitness of lay leader to be an approved facilitator.
- Master trainers observe new lay leaders co-teaching their first set of classes and make a final recommendation for approval of the facilitator. (Please note that offering CDSMP in Spanish requires additional training, as described in the budget section of this document.)
- To ensure ongoing fidelity, master trainers observed leaders teaching classes 12 to 18 months after the leaders completed their original training.
- Classes should be spaced one week apart, and their curriculum and format should not change. Holding classes more often undermines participants’ ability to implement and adapt their action plans. This is a critical skill, modeled and facilitated through the format of the classes.

We made very few adaptations in the original project model. We paired lay leaders with CASP staff who were trained facilitators and used these teams to conduct the workshops. We will begin using two lay leaders in upcoming summer classes.

At some sites, illiteracy was a concern, but illiterate participants still benefited greatly from the discussion, and we offered audio books for their use.

We conducted annual refresher trainings for lay leaders to review key elements of the program, discuss how they managed difficult situations, and learn new skills. We also tracked class attendance and participant feedback regarding workshops and instructors. Generally, if less than 75% of the participants are attending four or more of the six scheduled classes, it is important to assess fidelity and/or lay leader performance. We tracked reasons for class drop off to monitor this factor.

Implementation and Fidelity: Lessons Learned

We learned several important lessons from our implementation of the Stanford CDSMP. These include:

- Ongoing training and support is crucial if the program is to continue successfully over time. The supply of lay leaders needs to be replenished. Lay leader trainings need to be held at least annually. Veteran leaders should attend training/refresher/support sessions at least annually.
- Recognition events for lay leaders are very valuable. Other incentives include $10 per session stipends, occasional small gifts, and the supportive atmosphere of the refresher sessions.
- Lay leaders must be thoughtfully chosen. A list of characteristics and expectations for successful leaders is found in Section VIII, as well as some interview questions. Formalizing the lay leader commitment can be helpful. Potential lay leaders can be recruited from earlier PATH classes. Our workshop leaders approached individual class participants they felt would make good future leaders.

The Budget

There are several implementation tasks and associated costs to consider when starting PATH and planning a budget. One-time costs include:

Initial staff/partner training on evidence-based health promotion, PATH, Stages of Change, and motivational interviewing (recommended, not required). This training is recommended to provide a solid foundation in these principles, but it is certainly not mandatory. Allow eight to 12 hours for training, with some practical application. Budget approximately $10 per person for lunches, breaks, handouts, and speaker fees (if necessary).

Training at least two Master Trainers. You must have at least two master trainers to sustain your program and continue to train lay leaders. Unless an organization pays to have Stanford staff come to your region (which is not common), you must send trainers to Stanford for the four-and-a-half day training. You must also purchase an organizational license from Stanford to provide the Stanford CDSMP. Cost of the training includes:

Registration: $1,500 per health professional or $800 per lay person with a chronic disease for English classes; $450 per participant for Spanish cross-training.

Stanford licenses: $500 per organization ($250 discount if training at Stanford). If you also want to train in Spanish, you must attend an additional one-and-a-half day training and purchase another license ($500). The $250 discount applies to only one license per organization.

Travel/accommodations/food
Budget for at least six nights hotel for English training and an additional two nights for Spanish cross-training. Breakfasts and lunches are included in the training.

Participant materials: CDSMP books and tapes. If you are planning on a lending library, this is a one-time cost with occasional replenishment. Otherwise, this will be an ongoing cost.

"Living a Healthy Life with Chronic Conditions" workbooks. $15.50 to $17 each based upon the number ordered, with at least 20 per organization offering classes needed. Pricing is the same for Spanish versions.

Tapes/CDs. $10 to $12 each, based upon the number and type ordered. English classes require one tape per participant; Spanish classes require two. Purchase enough for at least 20 participants.

Easels/Whiteboards/Newsprint/Markers/Nametags. You will need two easels/flip charts for each class. One can be a whiteboard, but the other must hold permanent charts used for each workshop. Easels/whiteboards are $50 to $200 each. Purchase sturdy equipment because classes are held at multiple settings and the equipment gets frequent use. Newsprint pads are $30. Markers and name tags cost approximately $20.

Translation. Workshop evaluations, participant marketing materials, reminder postcards, outcome surveys, etc., must all be translated to Spanish if you are using anything other than Stanford materials. We spent $850 during our three-year project on translation services; however we made several adaptations based on research project needs, as well as

changes for participants who were not involved in the research portion of the project. We now have Spanish language workshop evaluations, reminder postcards, brochures, and outcome surveys.

Staff time. Plan for a minimum of three to five hours for preparing the permanent charts used in the PATH workshop.

Infrastructure. You will need to design attendance sheets, fidelity forms, workshop evaluations, policies and procedures, marketing materials and schedules, tracking forms, and defining coordination activities. Sample forms are included in Section VIII.

Ongoing costs may include the following:

Stanford re-licensure fees (every three years). These are $200 every three years if the organization teaches 10 or fewer workshops per year. Fees are higher if you teach more.

Lay leader training. These are recommended at least once a year. They cost about $2,684 (plus staff time) for 20 lay leaders and two master trainers, less for fewer participants. Lay leader stipends are less if staff from partner organizations attend instead of volunteer lay leaders since organizational staff don't receive stipends. The total cost includes:

- Lunch and snacks: $9 per attendee, per day ($792)
- Materials (books, tapes, leader manuals, name tags, easel paper, etc.)
    - 20 books @ $17 per book = $340
    - 20 leader CDs @ $10.22 per CD = $204.44
    - 20 leader manuals (including binders and section dividers, copying), name tags, easel paper, postage for confirmation letters = $148
- Lay leader stipends: $15 per day for gasoline/time x 20 participants x 4 days = $1,200

If you factor in staff time for the Master Trainers, you can add another $1,800 ($25 per hour x 2 trainers).

Follow-up observations by Master Trainers. Each newly trained leader needs to be observed teaching before he or she can receive final approval to teach the program. Allow two hours of staff time (minimum) per observation (more if there is significant travel time).

Costs of running the PATH workshops

- Materials: $27 per participant (you can also develop a lending library for books and tapes).
- Snacks for six sessions: $15 per session
- Staff time: Three-and-a-half hours per session (add one hour for travel per session)
- Volunteer lay leader: $10 per session
- Additional costs: Staff time for marketing, calling enrollees, sending reminder postcards, preparing materials, monitoring for fidelity, ongoing refresher training
- Assume no room rental fee
- Agency fees: $1,100 to $1,200 per series of workshops.

Marketing costs. A marketing budget varies depending on the approach, products, and available in-kind services. We offered 14-16 workshops per year and used approximately 1,800 brochures annually marketing to organizations, physicians, and older adults. In developing marketing materials, it is important to consider literacy levels and the appeal to your audience. Costs may include:

- Stanford CDSMP videos from Kaiser Permanente: $20 each. These are excellent for capturing the class experience in 10 to 12 minutes.
- Color print copying for brochures: 32 cents to $1.31 per copy. One partner (MSU Extension) received a marketing grant that allowed us to revise and print brochures at no cost for a year. Another partner designed the brochure and poster. If professional assistance is required, that cost must be factored into the marketing budget.
- Travel costs, program incentives, and postage
- Staff time for the coordinator and lay leaders. See "Administrative/Staff Time" below for more detailed information.

We offered PATH graduation events every quarter. These can be done simply, although there is a cost to mail information to participants and presenters, and for snacks and small incentive gifts.

Recruitment time. Allocate at least four hours staff time per series to secure sites, recruit participants, purchase snacks, obtain incentives, send reminder postcards, make telephone calls, etc. The time required may be considerably more depending on the success of recruiting participants and securing sites.

Ongoing staff training. Costs of facilitator and staff recognition events and training ranged from $220 to $400 (approximately $10 per person). This included snacks or lunch (for all-day events), small gifts of appreciation, etc. Fees for presenters are an additional expense. Ongoing trainings and refresher events should be conducted on at least an annual basis.

Administrative/staff time. If you have several partners, it is important to hold regular monthly meetings at least initially to discuss infrastructure, ongoing marketing ideas, scheduling, leader availability, and the flow of data, fidelity, and the overall process. A coordinator is required to monitor class attendance, locations, scheduling, fidelity, and workshop and outcome evaluations (if used). Additionally, the coordinator should arrange leader trainings, ongoing staff, and facilitator trainings; support volunteer leaders and master trainers; arrange for class materials; assess and arrange for marketing materials; and conduct ongoing fidelity assessments. Ongoing funding for a coordinator is a priority.

The coordinator may conduct presentations to potential referral sources and will likely be responsible for broad marketing to the community. The amount of time required depends on the size of the program, how long it has been in existence, and how well it runs. We offered 14 to 16 trainings per year and had six grant partners and four regional partners. Based on our experience, the coordinator will need about 10 hours a week when the program begins; five to 10 hours a week once it operating smoothly**.**

Useful Implementation Tools

We found a number of tools helpful in the implementation and budgeting of the program. Please refer to Section VIII for a description of these tools.

VI. Program Maintenance

To sustain PATH over time, you will need to:

- Continue to recruit new sites, new lay leaders, and new participants.
- Maintain existing partnerships and/or seek new partners.
- Identify new sources of funding to assist with recurring costs of implementation, such as the cost of ongoing lay leader trainings and refresher/recognition events, PATH workshops, Stanford license renewals, and Stanford training materials.
- Provide ongoing training and support for volunteer lay leaders.
- Identify a coordinator to maintain local and regional CDSMP class schedules; prepare training materials; assess marketing materials and opportunities; track and report on class attendance, fidelity, and workshop evaluation results; evaluate participant outcome data, peer leader, and master trainer information, and support lay leaders.

We formed local, regional, and statewide collaborations to promote sustainability. Today, our regional collaboration includes PATH lay leaders from rural counties who participated in lay leader trainings to replenish staff. They also attended ongoing support and training functions with other regional lay leaders and master trainers.

Locally we formed the Kent County PATH Group, which includes lay leaders and master trainers from such partners as the local health department, MSU extension staff, Diabetes Outreach Network staff, and the largest healthcare system in Grand Rapids. These partners bring opportunities to reach new sites and audiences, and access additional resources including other grant funding streams, and other general skills or expertise. For example, MSU extension received a $50,000 grant to assist in PATH collaboration and sustainability efforts in Kent County.

We are working on the state level with the State Office of Services to the Aging (OSA) and the Department of Community (Public) Health, the Michigan State University Extension office, and other interested groups to disseminate the PATH model across the Michigan. This will bring funding, expertise, and an infrastructure from which all will benefit. Additional resources that support PATH may come from:

- ***Older Americans Act funding.*** This funding supported CDSMP classes in our nine-county region.
- ***Local senior millage funding*.** This funding supported classes, ongoing lay leader trainings, and a full-time health promotion coordinator for Kent County. This individual manages coordinator responsibilities as described earlier.

Some recurring costs, as described herein, may be offset by in-kind support from partners.

Maintenance tools. Section VIII includes three samples of requests for funding.

VII. Effectiveness/Performance Measures/Other Outcomes

Appropriate participant outcomes and performance measures can assess whether the program is producing benefits comparable to the tested intervention. This is critical because the Stanford CDSMP's positive outcomes generate interest in the program among public and private funders and other sponsoring organizations, as well as older adults.

Key Outcome Measures
With our PATH partners, we selected the key outcome measures and evaluation instruments used in the original research and outlined on the Stanford website so we could compare our outcomes to those of the original study. See: http://patienteducation.stanford.edu/research/index.html.

Key areas for measurement include self-management behaviors, self-efficacy, health status, healthcare utilization, and demographic information. We adapted the Stanford evaluation form to include additional information pertinent to older adults, such as the types of medication taken and life situations/changes that may affect participants' ability or readiness to make or sustain behavioral changes. We collected data via surveys of program participants at the beginning of classes, immediately upon completion, and again six months later. (Stanford's Kate Lorig, in the original study of the intervention, did not conduct the survey at the end of the class, only after six months.) Participants also noted how many classes they attended.

Participant Outcomes
With complete data at baseline and follow up for 170 people, PATH participants demonstrated significant changes in:

- Minutes of aerobic exercise
- Cognitive symptom management
- Pain*
- Health distress*
- Fatigue*
- Shortness of breath*
- Healthcare utilization. This marker showed increases, and we are examining any outliers that may have affected this data.

* These changes were not significant until six months after the class. Details of the interim analysis results compared to Lorig's original research findings[22] can be found in the interim reports and article prepared by the consultant from Grand Valley State University School of Nursing. See Section VIII.

Allow plenty of time and additional assistance for participants to complete the surveys, particularly if they have literacy issues. We now use abbreviated pre/post surveys for Spanish and English language classes, capturing key outcome categories and areas where significant changes are noted.

We also hold PATH graduate events quarterly, inviting all PATH graduates from throughout the project. An informal survey (show of hands) is conducted at that time to gather information

[22] Lorig, K., Sobel, D., Stewart, A., Brown, B., Bandura, A., Ritter, P.L., et al. "Evidence Suggesting that a Chronic Disease Self-Management Program can Improve Health Status while Reducing Hospitalization: A Randomized Trial." *Medical Car*e, 37 (1), pp 5-14.

on how long it's been since participants completed the program, and how many still use the techniques they learned and demonstrate ongoing improvement in health behavior.

In our classes, we saw the tremendous power of role modeling and social support through the comments and behavioral changes of our participants. One of the most common comments was that it was good to talk to other people facing similar issues. Participants formed such strong bonds over the six-week period that many times they did not want the classes to end.

This program allows the participants to focus on what is most important to them, not what a health professional decides is most important for them to know. The self-direction and social support for behavioral change are two of the most important factors in PATH's success in improving health and quality-of-life outcomes.[23]

Recommended Performance Measures
In Michigan, the following tools were used for tracking performance measures:

- Pre/post shortened participant outcome survey
- Fidelity worksheet for each workshop
- Participant feedback workshop evaluations
- Participant drop-off (reasons participants dropped out)
- Workshop attendance sheets and class attendance summary. These are used to track the number of participants attending individual workshops and completing the entire six sessions. This information is reported to funders and provides early indications of any problems implementing the program. We found that those who attended the first and second sessions rarely dropped out. If significant drop off is noted after the second session, something may be wrong with the process or the facilitators.

Tools for Participant Outcomes and Project Performance
Please refer to the Section VIII for tools described here. As English and Spanish language classes were implemented, all evaluation tools were translated into Spanish, as well.

[23] Lorig, K.R. "Self-Management Education: More than a Nice Extra." *Medical Care*. 41 (6). pp. 699-701. 2003.

VIII. APPENDIX OF TOOLS

Section I: Introduction/Background

(Articles on the Original Stanford CDSMP Intervention)

Bodenheim, T., Lorig, K.R., Holman, H.R. & Grumbach, K. "Patient Self-Management of Chronic Disease in Primary Care." *JAMA*, 228, 19; Research Library Core pg. 2469, Nov. 20, 2002.

Lorig, K.R. "Self-Management Education: More Than a Nice Extra". *Medical Care,* 41 (6), pp. 699-701. 2003.

Lorig, K.R. & Holman, H.R. "Self-Management Education: History, Definition, Outcomes and Mechanisms". *Ann Behav. Med*., 26 (1), pp. 1-7. 26 August, 2003.

Lorig, K.R., Ritter, P.L., Gonzalez, V.M. "Hispanic Chronic Disease Self-Management: A Randomized Community-Based Outcome Trial. Nursing Research, 52 (6), pp. 361-369. 2003.

Lorig, K.R., Sobel, D.S., Ritter, P.L., Laurent, D., Hobbs, M. "Effect of a Self-Management Program on Patients with Chronic Disease." *Effective Clinical Practice*, 4 (6), pp. 256-262. 2001.

Lorig, K.R., Ritter, P.L., Stewart, A.L., Sobel, D.S., Brown, B.W., Bandura, A., Gonzalez, V.M., Laurent, D.D., Holman, H.R. "Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes." *Medical Care*, 39 (11), pp. 1217-1223. 2001.

Sobel, D.S., Lorig, K.R., Hobbs, M., "Chronic Disease Self-Management Program: From Development to Dissemination." *The Permanente Journal*, Vol. 6, No. 2. Spring 2002.

Section II: Planning and Partnerships

Resources on Partnerships
Center for Healthy Aging Web site
www.healthyagingprograms.org

Partnering to Promote Healthy Aging: Creative Best Practice Community Partnerships which may be found at:
http://www.healthyagingprograms.com/resources/HApartnerships.pdf

MD Link: Partnering Physicians with Community Organizations
http://www.healthyagingprograms.com/resources/MD%20Link.pdf

Tools
Permanente Journal Summary of 3 Studies on CDSMP. One of the most concise research articles summing up relevant research from three separate studies. Healthcare organizations and providers are especially interested in the outcomes. This is also a good tool for getting buy-in from board members and potential partners, as positive outcomes are clearly documented.

Readiness Checklist. Tool to assess organizational readiness to take on Evidence-Based Health Promotion Programs. We used this for our CASP agencies as part of our partner assessment.

Partner Collaboration Survey. One of the tools we used to assess our partnership. Active members from each of the partner agencies complete a survey every 6-12 months. Results are compiled and shared and used as framework for discussion.

PATH Partner Survey-6-05. Another example of a partner survey we used in '05 and '06.

Section III: Adoption

PATH brochures (English and Spanish). Examples of two different brochures we used. The physician's office preferred the one with the photos. Some of our CASP clients preferred the one with less wording. The Spanish brochure was translated into one version, only.

Permanente Journal Summary of 3 Studies on CDSMP. One of the most concise research articles summing up relevant research from three separate studies. Healthcare organizations and providers are especially interested in the outcomes. This is also a good tool for getting buy-in from board members and potential partners, as positive outcomes are clearly documented.

Traditional vs. CDSMP Education. Hand-out outlining the main differences between the two types of education. Helpful if talking to healthcare professionals.

Talking Points. Example of a tool outlining main points when talking to someone about the CDSMP classes. Our outreach workers found this helpful to give a complete, consistent message. We also gave this to provider staff to assist in discussing CDSMP with patients.

PATH Success Stories. Example of participant success stories. Can be used in a variety of ways—quotes for posters, exhibits, newsletters, or brochures; readily accessible interviewees for newspaper or radio spots; one-page story with photo for marketing materials

Physician-PATH Communication- Master and Sample. This tool can be used to track dissemination efforts, ongoing contacts, and subsequent referrals. Can be adapted to track dissemination activities to organizations, groups, and create a contact list for distribution of updated schedules and program information.

Sample Newspaper Articles. Can be very effective in creating interest in the program. Examples are included.

Dr. letters. These are examples of letters we sent to physicians with updated class schedules.

Script for Physician Contacts. Sample script for physician marketing call if you have a lunch presentation (30 minutes or so).

Self-Management Support Power Point Presentation. Can be used with healthcare providers.

Section IV: Reach

Partners on the PATH Interest Sheet. This tool can be used to collect information about interested participants at recruitment presentations. Aids in creation of a mailing list when new schedules come out, etc.

PATH brochures.

Participant recruitment PowerPoint presentation. Can be used with older adults at recruitment presentations

PATH Poster. Example of a poster which can be personalized with the class info for an upcoming workshop.

PATH Promotional Letter. Example of a letter sent to people who ask for more information about classes. Typically sent with a class schedule and brochure. Keep track of all names and contact information of people that call, as they can be added to a mailing list for future classes if they do not enroll in a class right away.

PATH Success Stories. Example of participant success stories. Can be used in a variety of ways — quotes for posters, exhibits, newsletters or brochures; readily accessible interviewees for newspaper or radio spots; one-page story with photo for marketing materials.

Sample Newspaper Articles can be very effective in creating interest in the program. Examples are included.

Sample Questions for Radio Interviews. This can be helpful to submit to the interviewer prior to taping, to assure important points about the program are discussed.

Priority Health letter to members. Example of a letter sent by a healthcare organization to recruit potential PATH participants.

Spring-Summer-Fall 2006 Schedule. Example of a class schedule.

Talking Points. Example of a tool outlining main points when talking to someone about the CDSMP classes. Our outreach workers found this helpful to give a complete, consistent message. We also gave this to provider staff to assist in discussing CDSMP with patients.

Section V: Implementation

Masters for all Stanford CDSMP Training Manuals are issued by Stanford. Must work under a Stanford CDSMP organizational license and have approved training certifications as either a Master Trainer or Lay Leader. See Stanford website for further info: http://patienteducation.stanford.edu/programs/.

Class Attendance Summary. This is used to track attendance, enrollment and location, and number of classes taught. There are hidden rows to allow you to add workshops as they are scheduled, and the totals are automatically recalculated. This also allows you to look at drop-off rates, if people start classes and don't continue. Per experience, at least 75% of participants should complete four or more classes, or there may be a problem with the facilitators or fidelity.

Instruction Forms for Facilitators. This form reviews the logistics of documentation for classes, where and when to turn forms in, etc. During the lunch hour of the last facilitator training session, we typically meet with the newly trained leaders and discuss these logistics along with where they get their Stanford materials, easels, felt-tip pens, CD player/cassette recorder, etc. and answer any other question they may have.

Leader Training Evaluation Form. This is an evaluation completed by the newly trained facilitators at the completion of their 4-day training. This form is adapted from one that comes from Stanford.

New Facilitator Feedback Form. This is completed by Master Trainers as they observe practice teaching during the facilitator training and also observe new facilitators teaching their first set of classes. We are also using these for the annual observation of facilitator fidelity.

New Facilitator Feedback for Master Trainers. This is used by facilitators to track questions or concerns during their teaching and used as a basis of discussion with follow-up calls from master trainers. After a period of time, these are no longer typically needed.

Fidelity Tool. This tool is completed after each class and turned in at the completion of the 6-week series. This documents key fidelity components of the Stanford Model for CDSMP. In addition, we also have Master Trainers go out to observe annually or so to verify fidelity.

Postcard- 4 to a page (English and Spanish). These postcards are sent to enrollees prior to the scheduled start of the workshop. They are followed up with a phone call reminder a day or two before the start of classes.

Partners on the PATH Lay Leader Characteristics/Job Description and Potential Interview Questions. May help in selection of CDSMP lay leaders.

PATH Invite - April 2006. Example of an invitation for a facilitator event.

PATH Class Cover Sheet. A checklist to verify that all required forms were turned in to the coordinator at the end of the six-week series.

Peer Leader Information- Master and Sample. This is used to track master trainers and facilitators, when they were trained, how many classes they taught, trainings and required updates. A pared-down version of this can be distributed to the master trainers and facilitators, so they have access to contact information to schedule observations or look for training partners for a set of classes.

Spring-Summer-Fall 2006 Schedule.

Workshop Attendance Sheet. Sample class attendance sheet .

Section VI: Maintenance

Sample Proposals for Funding

AoE Competitive Funding Program Proposal. Proposal for $50,000 grant to assist Kent County PATH Group in developing unified collaboration, marketing and sustainability efforts

Grand Rapids Community Foundation Proposal. Request for $10,000 to bring the Spanish CDSMP to Kent County.

CASP proposal for Millage/OAA funding.

Section VII: Effectiveness/Efficacy

How Did You Hear About Us? This tracking sheet allows you to look at which dissemination activities are most effective and tailor your efforts accordingly. This can be completed for each individual person, or the facilitator can gather the aggregate info at the first class and write the totals in for each category. This form is updated regularly and cumulative totals are kept for the entire program.

Participant Drop-Out. Tracks why people either register and never come to classes or start and then stop coming. Used for CQI, based on reasons they stop (e.g., location, didn't understand what classes were about, etc.) Can be filled out by lay leaders and turned in with the attendance sheet at the end of the series of classes. An alternate option would be to document reasons right on the attendance sheets. This form is updated regularly and cumulative results are kept.

Class Attendance Summary.

Intake Survey (English and Spanish). This is the long participant outcome survey (based on the one Lorig used for her research) given prior to the start of the six-week series of classes. We gave it up to four weeks ahead of time, but no further out. We added questions specific to the older population at the beginning of the survey. We are using an abbreviated survey now that the research component of our classes is completed.

Session Evaluation (English and Spanish) – CDSMP Classes.

After Classes Survey (English and Spanish). This is the long participant outcome survey (based on the one Lorig used for her research) given immediately after the six-week series of classes are completed. We added questions specific to the older population at the beginning of the survey.

Participant Feedback-Workshop (English and Spanish). This is a workshop evaluation completed by participants at the end of the six-week series. Also has release to send their physician a letter, documenting their attendance at P.A.T.H.

Six-Month Survey (English and Spanish). This is the long participant outcome survey (based on the one Lorig used for her research) given six months after the six-week series of

classes are completed. We added questions specific to the older population at the beginning of the survey.

Pre-Post Survey-Shortened (English and Spanish). This is the abbreviated participant outcome survey we use pre- and post-classes. Follow-up at a later time after classes is recommended, as some changes in our participant outcomes occurred months after classes were done.

Post Graduation Survey (English and Spanish). Tool used on PATH graduates to assess ongoing positive behaviors as a result of the CDSMP classes. Informally collected (show of hands) during PATH graduate get-togethers. You could actually mail them out or have participants fill them out.

GVSU Evaluation Reports (Interim).

In addition, these performance tools were discussed earlier under Implementation/Fidelity:

- *Leader Training Evaluation Form*
- *New Facilitator Feedback Form*
- *New Facilitator Feedback for Master Trainers*
- *Fidelity Tool*