An Exploration of Stanford's Chronic Disease Self Management Program (CDSMP) by Five Ohio BH Agencies

The Wellness Management and Recovery Coordinating Center of Excellence (WMR CCOE)

The Centers for Families and Children, Inc.

Decision Support Services, Inc.

Ohio Integrated Care and Health
Home Learning Community Webinar Series
2-18-15

Center for Integrated Healthcare Solutions of the National Council

Goals for the Webinar

- Introduce presenters and participants
- Examine self-management as a core element of BH Homes
- Hear from The Centers for Families and Children about the agency's journey with self-management
- Seek reactions from participants about issues germane to the webinar
- Share preliminary findings from an exploratory investigation of Stanford's CDSMP in Ohio
- Summarize next steps for the CDSMP pilot study

We want to hear from you!

- Please participate in polling questions.

- Use the Chat Box. Type comments and questions into the "Chat Box" then hit "Send".

Our National Council hosts, Joan King, Jennifer Bright, and Kirsten Reed, will support these activities.

Introductions

Wellness Management & Recovery CCOE

www.wmrohio.org

An Ohio Coordinating Center of Excellence

Kelly Wesp,
Director

Stephanie Ozbun,
Coordinator for
Training & Inclusion

- Technical assistance center to Ohio behavioral health organizations since 2005
- Facilitate transformation toward recovery-oriented, person-centered, systems of care
- Charged by OhioMHAS with implementing evidence-based and promising practices in disease self-management
- Leading the CDSMP pilot study

Mary Hull -

Vice President, Program Services

Nicole Martin

Director, Program Operations and Healthcare Integration

Leslie Valentine

Clinical Supervisor and CDSM facilitator

THE CENTERS
FOR FAMILIES AND CHILDREN
Go Further.

A multiservice human-service agency in Cleveland, Ohio

- 20,000+ clients/year (most live in inner-city and inner-ring suburbs).
- Key programs: Early Learning; Workforce Development; Food Centers; Behavioral Health & Wellness; Children/ youth counseling and prevention, and family preservation services.
- Four Health & Wellness Centers
  - Served 8500 clients last year
  - Integrated care to adults with severe and chronic BH problems
  - Core services: Psychiatry, Psychiatric Nursing, Community Psychiatric Supportive Treatment, Counseling, On-site Primary Care , On-site Pharmacy, Wellness programming
- Cohort 1 SAMHSA PBHCI grantee

Decision Support Services
Incorporated

Panelists:

Phyllis C. Panzano, PhD
Emily Bunt, MA

1. Research, evaluation, and consulting; Columbus, OH since 1990
2. Expertise
   - I/O Psychology
   - Health services research and evaluation
   - Adoption and Implementation of innovations (e.g., EBPs)
3. Recent/current work:
   - Evaluation subcontractor: 3 SAMHSA PBHCI, & 2 HRSA Healthy Start Grants
   - Principal/Co-Principal investigator, 10 federal and state grants

Poll Question #1

1. **When it comes to integrated healthcare services, my organization currently is**

   a. a certified Health Home organization (CHHO).

   b. ***not a CHHO but is offering*** some type of integrated healthcare programming (e.g., via a referral model; a co-located/partner model, and/or a solo model/with primary care professionals on staff.

   c. ***not a CHHO but is planning to offer*** some type of integrated healthcare programming (e.g., via a referral model; co-located/partner model, and/or a solo model/with primary care professionals on staff.

   d. not offering or planning to offer IHC services in the foreseeable future.

   e) Other or NA

Poll Question #2

2. **Which of the following job role classifications best describes your current job?**

   a. Top/Upper Management or Administration

   b. Provider, Behavioral Health Organization

   c. Provider, Primary Care Organization

   d. Peer Support

   e. Other: Please send note/elaborate in ”Chat Box”

Self Management

Key Terms
Core Element of BH Homes
The Centers and Self Management
WMR CCOE and SMART

Self Management

- A set of tasks that individuals must undertake to live well with one or more chronic conditions. It is what the person with a chronic disease does to manage their own illness, not what the health service provider does[1].

Self Management Support

- What others do to assist individuals with chronic illness develop and strengthen their self-management skills.[2]
- Education and supportive interventions, regular assessment of progress/problems, goal-setting; problem-solving support
- Peers are an important source of self-management support

Poll Question #3

3. **Has your organization offered an evidence-based or promising self-management program to clients at your agency (e.g., WMR, WRAP, WHAM, CDSMP)?**

    a. Yes, we currently offer one or more programs.

    b. Yes, we offered one or more programs in the past.

    c. No, we have not offered one of these programs.

Poll Question #4

4. **Does your organization offer self-management support education and/or training programs to agency staff?**

    a. Yes, we currently offer SM support training.

    b. We used to offer SM support training.

    c. No, we have not yet offered SM support training.

Self Management:
A Core Element of BH Homes

"Initial Set" of Core Elements

1. Based on 3 key frameworks[3]
   - CMS Health Home Service Requirements
   - Chronic Care Model (CCM), essential elements for high-quality chronic disease care
   - Four Principles of Effective Care (AIMS Center, University of Washington, 2011)
2. "Initial Set" identified through inductive review process[4]

[3]Alexander & Druss (May, 2012); [4]Crane & Panzano, 2014;

Reviewed Standards & Regulations[5]:

1. CARF Health Home
2. CARF Integrated Behavioral Health and Primary Care
3. Ohio Health Home Certification Criteria
4. The Joint Commission, Behavioral Health Home Certification
5. The Joint Commission, Primary Care Medical Home
6. SAMHSA Primary Behavioral Health Integration Projects
7. Federally Qualified Health Centers
8. NCQA PCMH 2011

"Elaborated Set" of Core Elements of BH Homes[6]

1. Patient & Family Centered Care
2. Culturally Appropriate Care
3. Comprehensive Care Plan
4. Use of continuing care strategies: to include
   - Care Management
   - Care Coordination
   - Transitional Care
5. **Self-Management**
6. Multi-disciplinary Team
7. Full Array of Services (e.g., PC, MH, SA, Health Promotion)
8. Quality Improvement Processes
9. Evidence Based Practice
10. Outcomes measurement
11. Health Info Technology
12. Enhanced Access to care
13. Miscellaneous Org. Level

[16] Panzano, PC; Crane, D; Kern, MD; Faber, L. and Stephenson, S.; "Regulations and Standards for IHC Programs – Real World Challenges and Synergies", SAMHSA Annual PBHCI Grantee Meeting, Washington, DC., August 12, 2014

Birdseye View of "Elaborated Set"[1]

Working Set of Core Elements	CARF IBHPC	CARF – HH	OHH	TJC HH Cert	TJCPC MH	PBHCI Pgm	FQHC App	NCQA
Patient and Family Centered Care	✓	✓	✓	✓	✓	✓	✓	✓
Culturally Appropriate Care		✓	✓	✓	✓			✓
Comprehensive Care Plan	✓	✓	✓	✓	✓	✓	✓	✓
Continuing Care Strategies (Care Mgmt., Coordination, Transitional Care)	✓	✓	✓	✓	✓	✓	✓	✓
Self-Management	✓	✓	✓	✓	✓	✓	✓	✓
Multi-disciplinary Team	✓	✓	✓	✓	✓	✓	✓	✓
Full Array of Services (e.g., PH, MH, Health Promotion, LTC)		✓		✓	✓	✓	✓	✓
Quality Improvement Processes	✓	✓	✓	✓	✓	✓	✓	✓
Evidence Based Practice			✓	✓	✓	✓	✓	✓
Outcomes measurement		✓	✓	✓	✓	✓	✓	✓
Health Info Technology		✓	✓	✓	✓	✓	✓	✓
Enhanced Access to care	✓	✓	✓	✓	✓	✓	✓	✓

[1] Panzano, PC; Crane, D; Kern, MD; Faber, L. and Stephenson, S.; "Regulations and Standards for IHC Programs – Real World Challenges and Synergies", SAMHSA Annual PBHCI Grantee Meeting, Washington, DC., August 12, 2014

Differences in how core elements are put into action[6,7]

A ✓≠✓

TJC-PCMH:

Demonstrate that consumers are responsible for participating in self-management activities.

CARF HH & CARF IBHPC:

Organization must identify/specify staff responsibilities for supporting and monitoring clients' implementation of their self-management plan

Ohio Health Home & NCQA:

Connect Consumers with Peer Supports for Self Management

(e.g., Self Management Advocacy Groups)

[7]Crane, Panzano, Kern and Stephenson, 2014; 2015

Poll Question #5

5. **Has your organization received any federal, state or local funding to support self-management or self-management support activities?**

    a) Yes, federal or state funding

    b) Yes, local or foundation funding

    c) Yes, more than one source of funding

    d) No , and we do not offer those activities

    e) No, but we have found ways to offer those activities

The Centers on Self Management

Our Philosophy

- Self Management
  - Key component of Integrated Healthcare Programs
  - Necessary to achieve improved health outcomes for populations served
  - Essential link as organizations transition from provider "instruction" to client ownership of healthy habits and lifestyles
- Self Management Support
  - Central element of care coordination

THE CENTERS
FOR FAMILIES AND CHILDREN
Go Further.

Our Journey
Toward Self Management

1. CDSMP was recommended by our primary care partner for SAMHSA PBHCI grant (FFY 2010 – FFY 2013)
2. PBHCI funds covered staff training and workshop material costs
3. Initial strong skepticism about likelihood that SPMI clients would complete the program
4. Lessons Learned
   - Case managers make very effective CDSMP facilitators
   - Clients react positively to the program
   - If experienced leaders champion the program, new and prospective leaders are more likely to be open and receptive to it
   - It's important to experiment with/tweak approaches to marketing the program to clients

Poll Question #6

6. **Which of the following issues presents the biggest obstacle to offering and/or sustaining SM programming at your organization?**

    a. Resources: Too expensive, not enough time or capacity

    b. Lack of support from agency leadership

    c. Difficulty engaging clients

    d. Staff Attitudes

    e. Other factors (Please send note/explain in “Chat Box”)

The WMR CCOE And SMART*

* Self Management and Recovery Tools/Technologies

WMR CCOE and SMART

- Promote and facilitate the adoption and implementation of self-management and recovery tools (SMART) in Ohio
- Provide technical assistance in *health promotion* and *disease prevention.*
- Workforce development beyond symptom monitoring and medication.
- Emphasis on person-centered care
- Increase self-efficacy and activation through educational resources and practical decision making tools
- Cost containment

CDSMP Pilot Project

What is CDSMP?

1. Stanford University's Chronic Disease Self Management Program (http://patienteducation.stanford.edu/)[8]
2. Developed by Kate Lorig, PhD and colleagues
3. Geared to help clients with chronic illness gain confidence to manage symptoms and health conditions and take action
4. Interactive, 6-week long workshop (1 day/week; 2.5 hour session), led by persons who have a chronic health condition or care for someone who does
5. General and health-condition specific options (e.g., diabetes)
6. Widely used nationally and internationally
7. Recommended by federal health agencies (e.g. SAMHSA, Department of Aging)

Is CDSMP Effective?

1. Numerous studies found positive health impacts for adults with chronic physical health conditions
   - RCT involving 1000+ individuals; improved self-efficacy, reduction in negative health symptoms such as pain and fatigue; improved health behaviors[9]
   - See: (http://patienteducation.stanford.edu/)
2. Encouraging findings for adults with severe and persistent mental illness but studies for this population are limited in number.
   - Druss et al, 2010, HARP study[10]
   - Lorig et al, 2013, Michigan study[11]
3. Ohio_MHAS is seeking information and reactions from BH providers and clients in Ohio

Aims of Pilot Project

1. To conduct an exploratory investigation of the costs, benefits, and feasibility of implementing the CDSMP program for adults with SPMI *among Ohio BH agencies that operate under different circumstances (e.g., health home, current and former PBHCI, FQHC, traditional).*

2. To disseminate findings and suggest recommendations for CDSMP implementation to Ohio MHAS and other stakeholders.

3. To build capacity in Ohio MHAS system to offer CDSMP in the future.

Support for Pilot Project

1. ***Ohio Department of Aging***
   - CDSMP Leader Training (state license for "Healthy U")
   - Fidelity monitoring of CDSMP Workshops in pilot
   - Administration of paperwork required by Stanford
2. ***Ohio_MHAS***
   - Project implementation support through WMR CCOE
   - Invited WMR CCOE to partner in providing training and TA to Learning Communities (IHC; HH)
   - Purchased CDSMP Participant Workbooks and CDS
3. ***Southeast, Inc***.
   - Two years funding to support project implementation

Sites

1. Five Ohio BH Organizations
    - CSS, Inc. (Akron)
    - Centers for Families and Children, Inc. (Cleveland)
    - Harbor, Inc. (Toledo)
    - Southeast Inc. (Columbus; St. Clairsville)
    - Zepf Center, Inc. (Toledo)
2. Includes:
    - Two Phase I Ohio Health Home agencies
    - Three current SAMHSA PBHCI grantees
    - Two former SAMHSA PBHCI grantees
    - One HRSA-funded FQHC for the Homeless

Sites

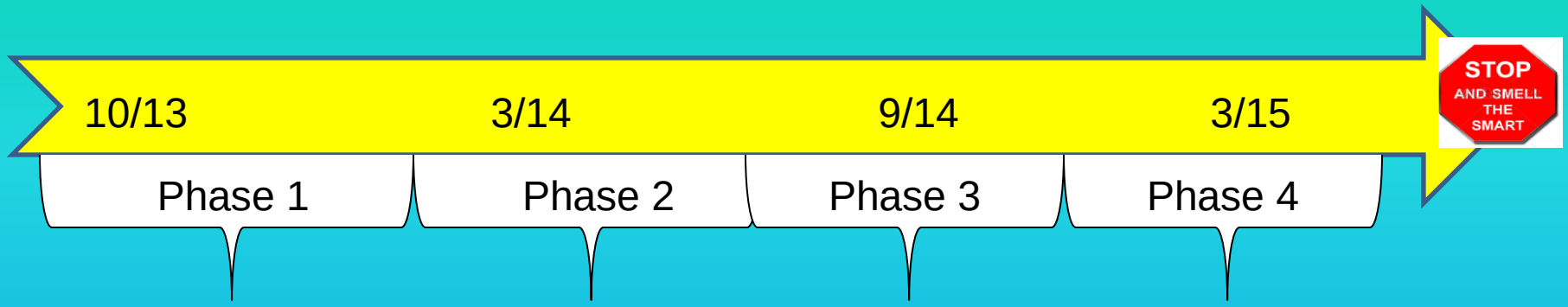
2. Contributions
    - Send a minimum of 4 staff and/or peers to CDSMP Leader Training (4 days general training; 1 day diabetes – specific)
    - Recruit clients for the project (workshop participants and comparison group)
    - Implement ≥ 2 CDSMP workshops in FY 2015 involving a total of 25-30 clients
    - Carry out data collection protocol for workshop participants (clients), comparison group members, and facilitators (leaders)*
    - Participate in debriefings (e.g., leader training) and focus groups (e.g., findings review and reactions)

* See next slide

Data Collection Protocol

Timing: When Gathered	Source of Information			
	Workshop Leaders	Workshop Participants	Comparison Group	Non-participants
Pre CDSMP Leader Training	✓ Screening Form ✓ Agreement Form	NA	NA	NA
Baseline: At formal enrollment	✓ Informed Consent ✓ **Baseline survey**	✓ Informed Consent ✓ **Baseline Survey** ✓ Physical Health Indicators (PHi)	✓ Informed Consent ✓ Baseline Survey ✓ PHIs	✓ Informed Consent
Post CDSMP Workshop	✓ Workshop evaluation	✓ Workshop evaluation	NA	NA
Follow-up: At six months after baseline	✓ Follow-up survey	✓ Follow-up Survey ✓ PHIs	✓ Follow-up Survey ✓ PHIs	NA
Post-Analyses: Focus Groups	✓	✓		

Progress



1. Phase I: Conduct literature review; propose/get approval for study design; negotiate with ODA; develop recruiting materials; kick-off site recruiting

2. Phase II - Continue recruiting sites; kickoff CDSMP Leader Training ; finalize data collection instruments; begin gathering Leader IC and Baseline Surveys; design and implement data monitoring and collection systems; begin data entry

3. Phase III – Continue recruiting sites; continue CDSMP Leader Training; administer Client IC and Baseline surveys; begin collecting Physical Health Indicator (PHI) data; kickoff CDSMP workshops;

4. Phase IV - Stop recruiting sites; conduct leader training debriefing; continue implementing workshops; collect, monitor and analyze data

Preliminary Findings: Baseline Surveys ONLY

Content of Baseline Survey

	Leaders n = 43 (5 of 5 sites)	Participants n= 68 (4 of 5 sites)
Demographics	X	X
Chronic Health Issues	X	X
Experience w/other Self-Management Programs	X	X
Beliefs About "Healthy U" (CDSMP)	X	
Patient Activation Measure (PAM)[12, 13]	X	X
Patient Assessment of Chronic Illness Care (PACIC)[14, 15]	X	X
Psychological Distress Scale (NOMS)[16,17]		X
Stanford: Symptoms Scale[8]		X
Positive Affect		X

Demographic Information

PROFILE	Leaders (n = 43)	Clients (n = 68)
Gender	• 80% female	• 75% female
Race	• 70% White • 25% Black/African-Am • 5% Multi-racial	• 50% White • 32% Black/African-Am • 6% Multi-racial • 12% Other/Missing
Ethnicity	• 2% Hispanic or Latino	• 10% Hispanic or Latino
Age	• Not collected	• Average=50; range 26-78
Education	• 50% with Master's degree	• 50% HS/GED • 37% received additional education • 13% <HS/GED
Role at Organization	• 30% supervisors/team leaders • 28% case managers • 26% peer support positions • 12% care coordinators • 4% other (RNs, Voc. Specs.)	• Not collected
Insurance	• Not collected	• 62% Medicaid • 38% Medicare • 32% SSI • 6% Private • 26% Other
Other Self-Management Program Experience	• 44%	• 24%

Chronic Health Issues

(Baseline Surveys: Self-Report)

- 65% of Leaders and 78% of Participants ***have*** a chronic PH condition
- 25% of Leaders and 100% of Participants ***have*** a chronic MH condition
- Percentage of Leaders/Participants with:

	Diabetes	Asthma	Arthritis	Heart Disease	COPD, Emphysema, Bronchitis	Cancer	High Blood Pressure	Other Health Cond.
Leaders	19%	26%	33%	5%	5%	2%	26%	14%
Part.	21%	28%	41%	12%	12%	4%	43%	24%

- 46% of Leaders and 26% of Participants ***care for*** someone with a chronic PH condition
- 12% of Leaders and 6% of Participants ***care for*** someone with a chronic MH condition

Medical Care:
Workshop Participants

- **Health Care Visits in the Past 6 Months:**

ER	PCP sick	PCP well
50%	48%	65%

- **Regular Source of Healthcare:**

Private Doctor or Community/ Hospital Clinic	Emergency Room	No Regular Source	Other
81%	3%	7%	9%

Patient Activation Measure (PAM)

Self Management

PAM Background

1. Activation: capacity and motivation to manage one's health
2. 13 item measure; developed by Hibbard et al at the University of Oregon
3. Clients: Research and practice suggests patient activation predicts a broad range of client/participant health behaviors and outcomes
4. Leaders: Administered to leaders in pilot study. Leader activation regarding own health may be an important moderating variable
5. PAM now owned by Insignia Health and must be purchased.

PAM®
Patient Activation Measure®

Level 1 | Level 2 | Level 3 | Level 4

Insignia Health®

Measure. Engage. Activate.

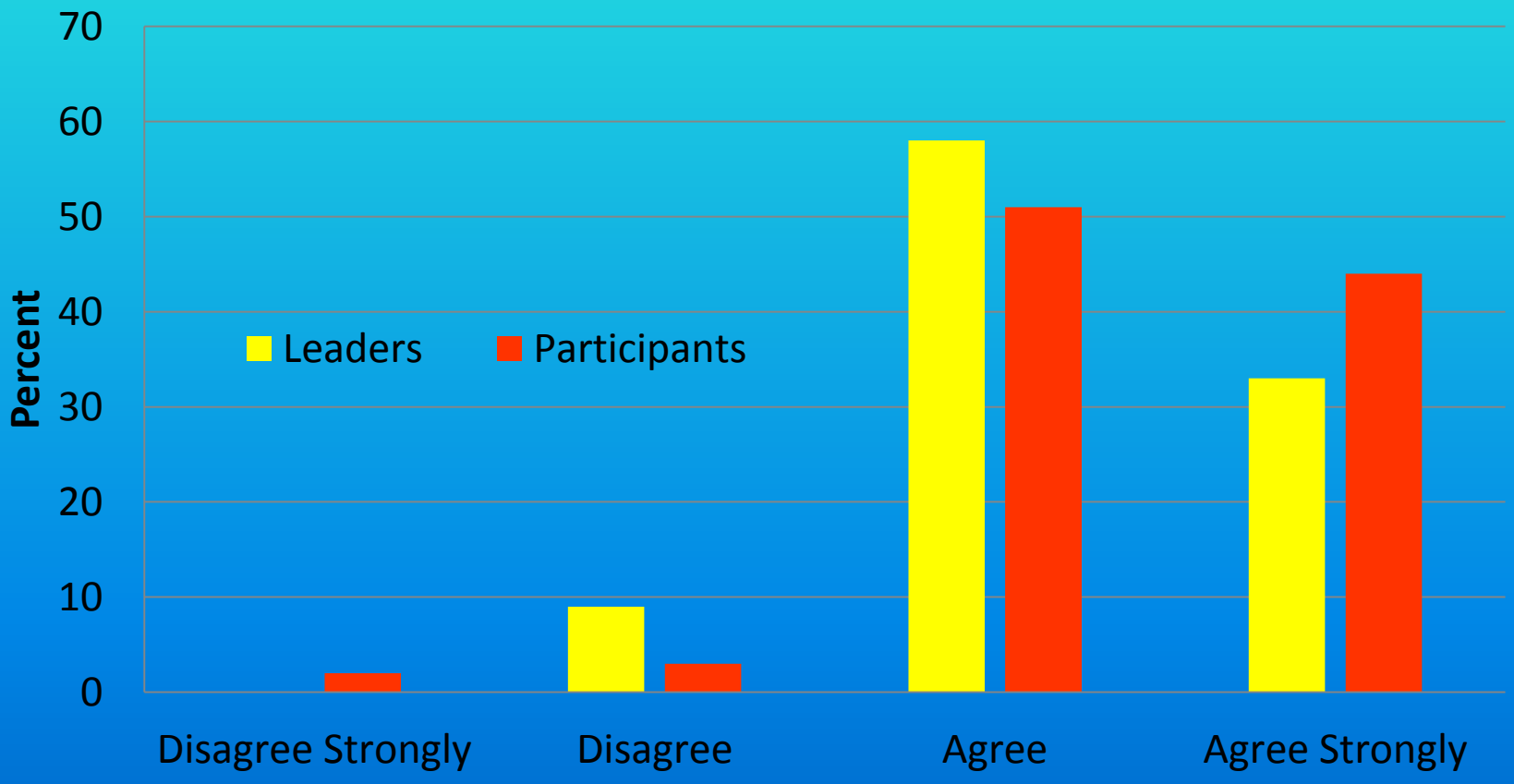
http://www.insigniahealth.com/products/pam.html

PAM Results Sneak Preview

1. The 13-item PAM has been assessed in terms of 4 subscale scores in the academic literature
   - Beliefs
   - Confidence
   - Action
   - Sustainability
2. Preliminary analysis from pilot suggest leaders' and participants' have beliefs, attitudes, and engage in behavior that is consistent with higher levels of activation.

Belief Scale

When all is said and done, I am the person who is responsible for managing my health condition(s).



Beliefs*

	Disagree Strongly, Disagree	Agree, Strongly Agree	Don't Know	Mean (SD) (4 point scale)
When all is said and done, I am the person who is responsible for managing my health condition(s).	Leader: 5% Participant: 6%	L: 95% P: 91%	L: -- P: 3%	L: 3.4 (.58) P: 3.5 (.72)
Taking an active role managing my health condition(s) is the most important factor in determining my health and ability to function.	Leader: 9% Participant: 6%	L: 91% P: 92%	L: -- P: 2%	L: 3.3 (.60) P: 3.4 (.66)
I am confident that I can take actions that will prevent or minimize symptoms or problems associated with my health condition(s).	Leader: 9% Participant: 9%	L: 91% P: 86%	L: -- P: 5%	L: 3.3 (.59) P: 3.2 (.70)

Four-point response scale: 1=Disagree Strongly, 2=Disagree, 3=Agree, 4=Agree Strongly

Patient Assessment of Chronic Illness Care (PACIC)

Self Management Support

PACIC Background

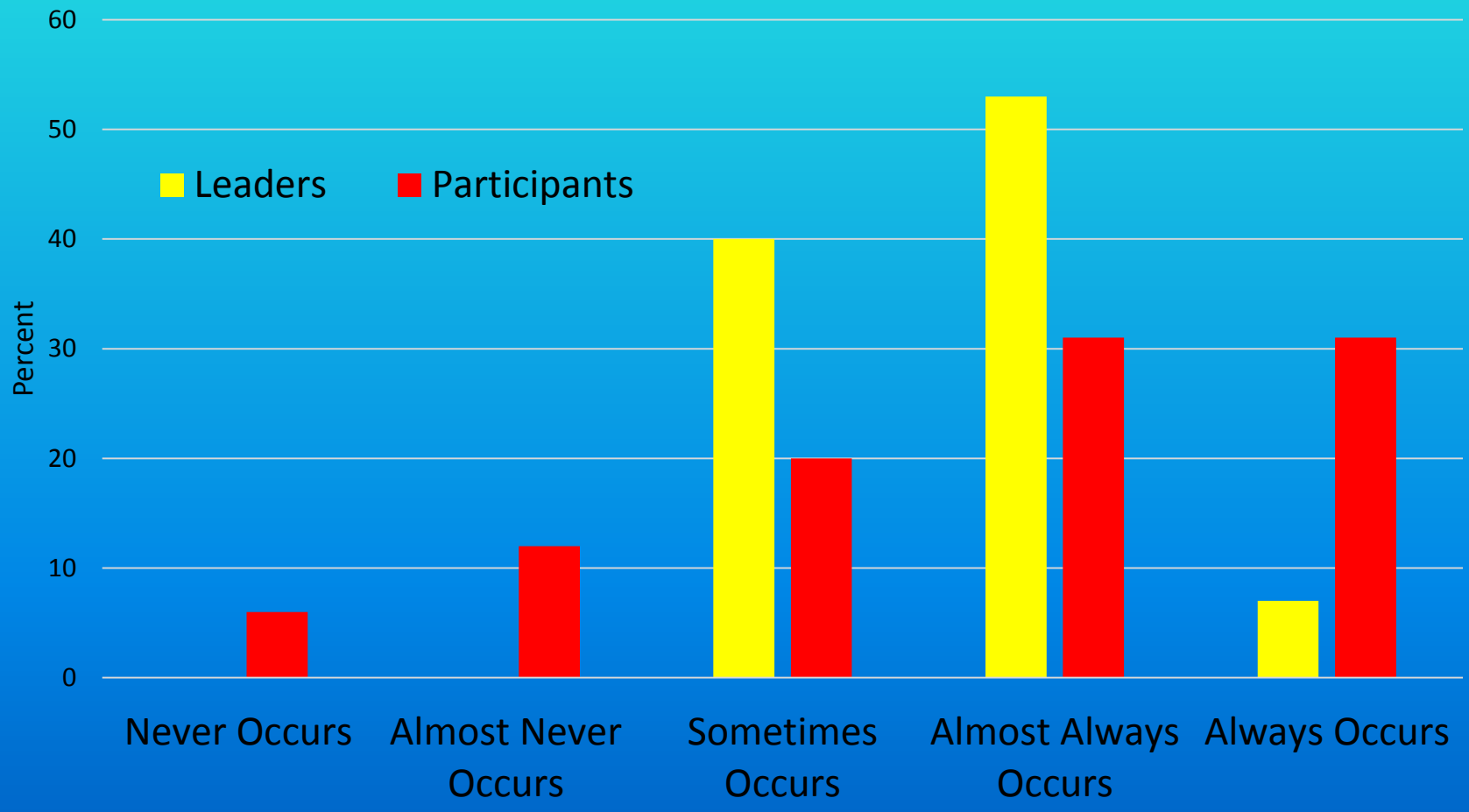
1. Assesses the "quality" of chronic illness care from the perspective of clients along four dimensions:
   - Activation
   - Delivery System
   - Patient-Centeredness
   - Problem Solving
   - Follow-up
2. Rationale for pilot
   - Pertinent to assessing organizational culture and climate for CIC
   - "Apples to Apples" comparison: client versus leader views
   - ACIC (Asst of Chronic Illness Care, Bonomi et al, 2002)); valuable for OD purposes but not seen as good of a fit for pilot

PACIC Response Scale

1. PACIC items: Two perspectives:
   - Client : first- hand/person (e.g., “I” and “My”)
   - Leaders: SME perspective (e.g., typical client experience)
2. Stem: How often over the past six months, did each statement take place?
3. Response Scale:
   - Never Occurs
   - Almost Never Occurs
   - Sometimes Occurs
   - Almost Always Occurs
   - Always Occurs

PACIC: Patient Activation

" I am asked for ideas when my treatment plan is developed".



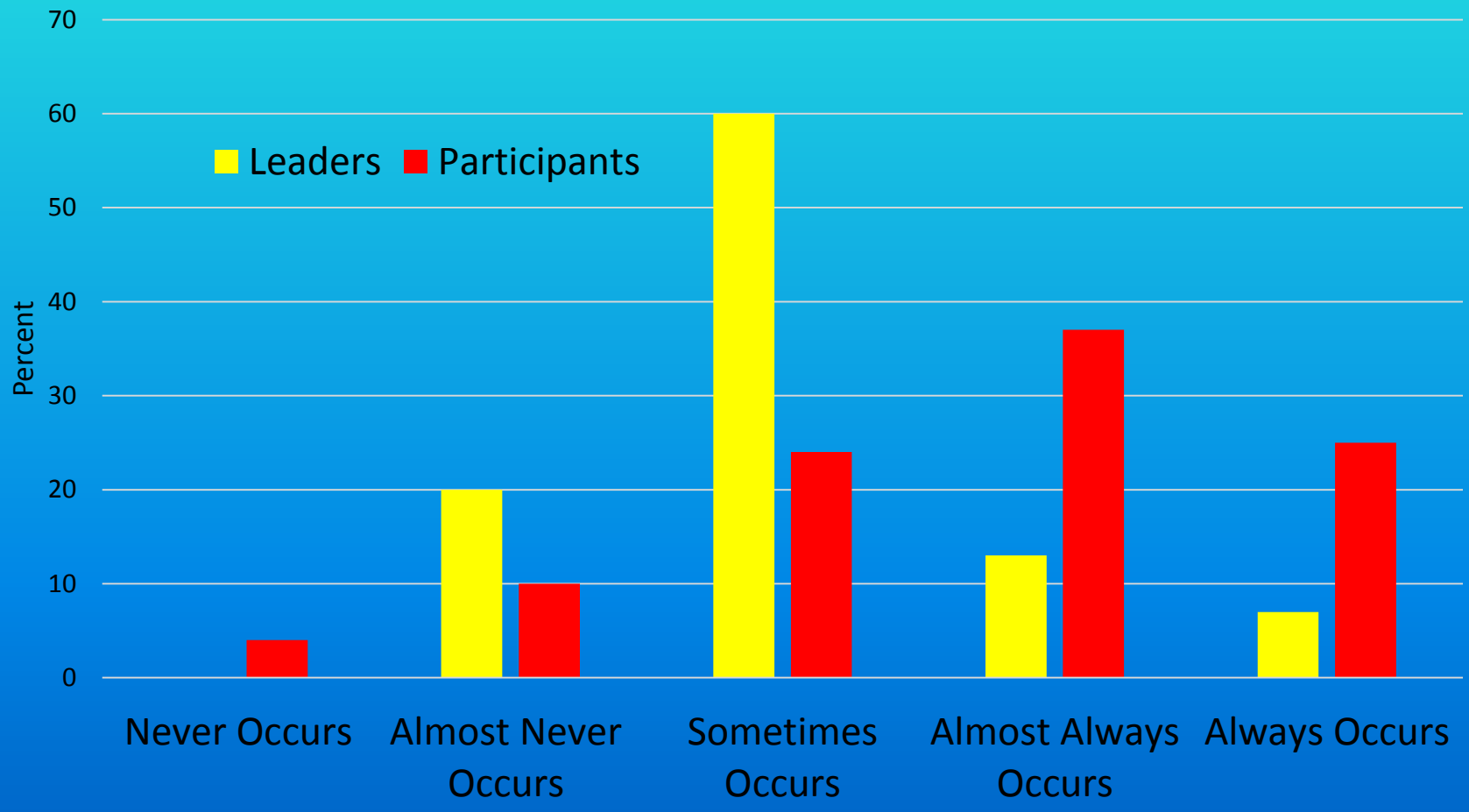
PACIC: Patient Activation

Over the past six months, I (the typical client) was	Never, Almost Never Occurs	Sometimes Occurs	Almost Always, Always Occurs	Mean (SD) (5 point scale)
…asked for ideas when treatment plans are developed.	L: 8% P: 15%	L: 41% P: 26%	L: 51% P: 59%	L: 3.6 (.74) P: 3.7 (1.2)
…given choices about treatment options.	L: 3% P: 18%	L: 41% P: 27%	L: 56% P: 55%	L: 3.7 (.76) P: 3.6 (1.3)
…asked to talk about problems with medicines or their side effects.	L: -- P: 12%	L: 37% P: 21%	L: 63% P: 67%	L: 3.7 (.64) P: 3.7 (1.2)

[1] Four-point response scale: 1=Disagree Strongly, 2=Disagree, 3=Agree, 4=Agree Strongly

PACIC: Delivery System

"I was satisfied that services were well-organized."



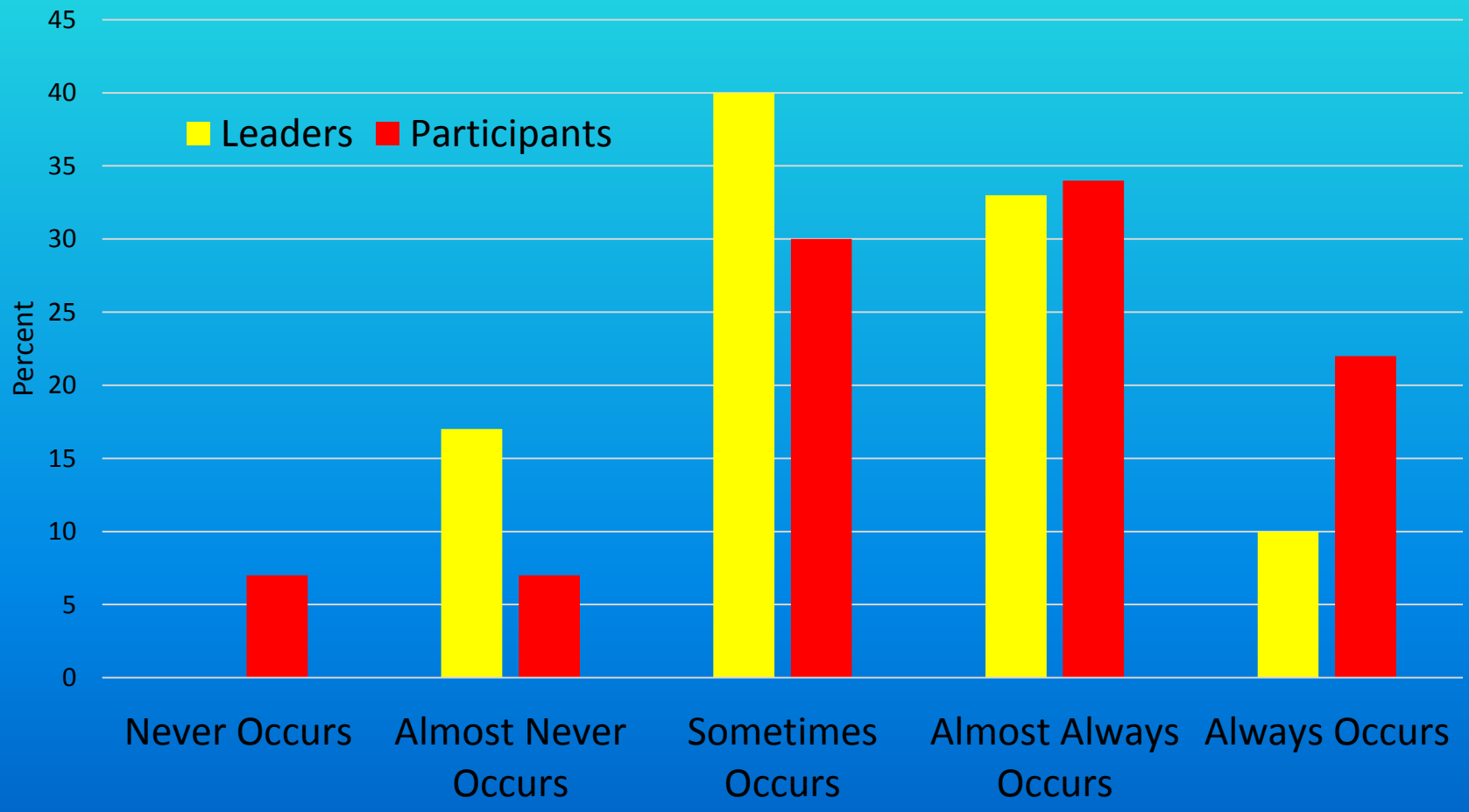
PACIC: Delivery System*

Over the past six months, I (the typical client) was…	Never, Almost Never Occurs	Sometimes Occurs	Almost Always, Always Occurs	Mean (SD) (5 point scale)
…given a written list of things to do to improve my/their health.	L: 47% P: 30%	L: 33% P: 30%	L: 20% P: 40%	L: 2.80 (.99) P: 3.13 (1.61)
…satisfied that the services received were well-organized.	L: 10% P: 10%	L: 55% P: 27%	L: 35% P: 63%	L: 3.23 (.65) P: 3.91 (1.18)
…shown how what I/they did to take care of themselves influenced my/their condition.	L: 23% P: 24%	L: 49% P: 20%	L: 28% P: 56%	L: 3.06 (.94) P: 3.40 (1.61)

*5-item response scale: 1=Never Occurs, 2=Almost Never Occurs, 3=Sometimes Occurs, 4=Almost Always Occurs, 5=Always Occurs

PACIC: Tailoring/Patient-Centered

Over the past six months, clients were typically helped to set specific goals in order to care for their health condition(s).

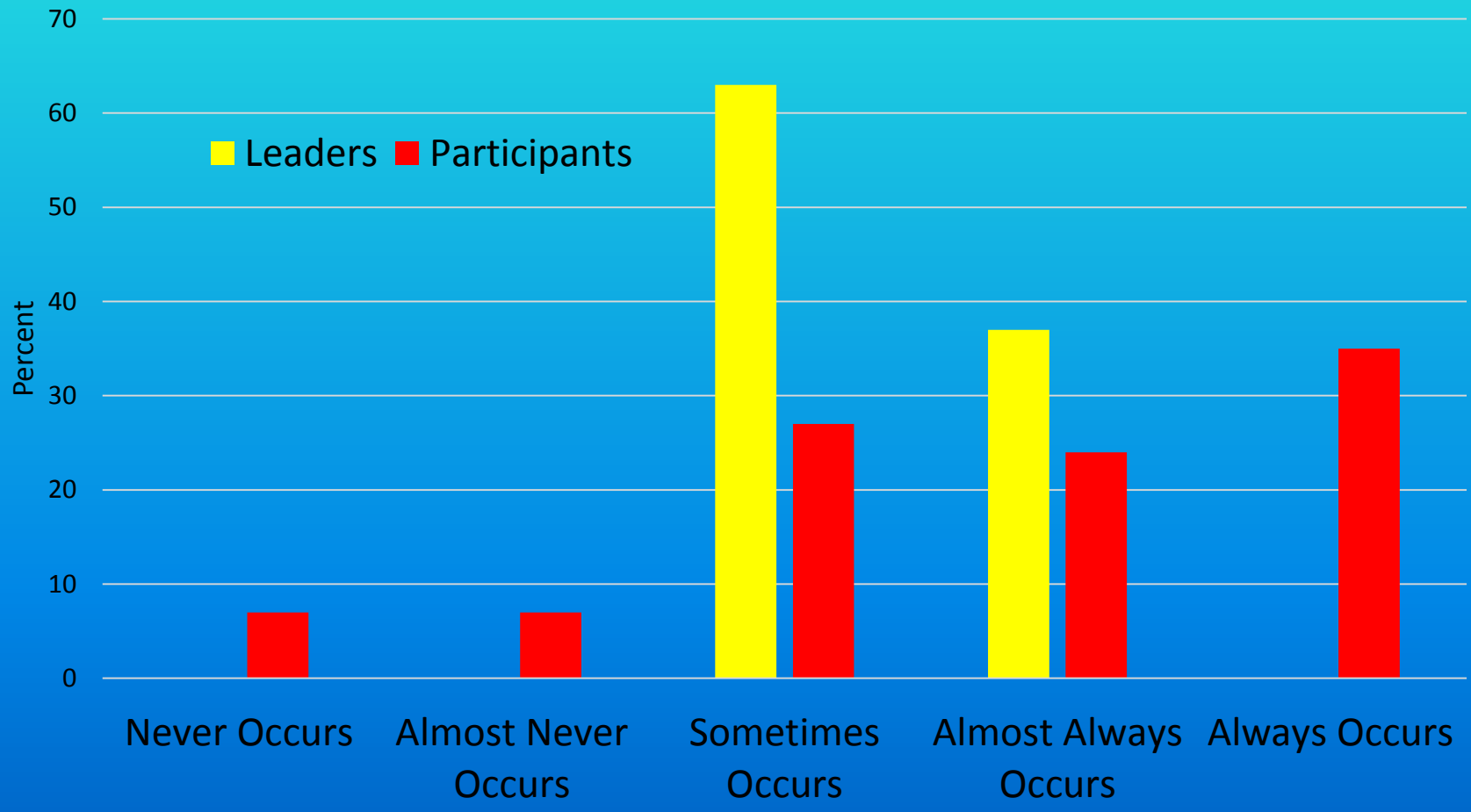


PACIC: Tailoring/Patient-Centered

Over the past six months, I (the typical client) was…	Never, Almost Never Occurs	Sometimes Occurs	Almost Always, Always Occurs	Mean (SD) (5 point scale)
…asked to talk about their goals for caring for their health condition(s).	L: 25% P: 22%	L: 30% P: 25%	L: 45% P: 53%	L: 3.3 (.99) P: 3.5 (1.4)
…helped to set specific goals in order to care for their health condition(s).	L: 20% P: 15%	L: 31% P: 37%	L: 49% P: 48%	L: 3.4 (.97) P: 3.5 (1.3)
…given a copy of their treatment plan.	L: 43% P: 32%	L: 24% P: 12%	L: 33% P: 56%	L: 3.0 (1.3) P: 3.5 (1.7)
…encouraged to go to specific groups or classes to help them cope or deal with their chronic health condition(s).	L: 18% P: 20%	L: 37% P: 24%	L: 45% P: 56%	L: 3.3 (.93) P: 3.5 (1.4)
…asked questions, either directly or on a survey, about their health habits.	L: 25% P: 21%	L: 45% P: 33%	L: 30% P: 46%	L: 3.1 (.79) P: 3.4 (1.4)

PACIC: Problem Solving

"I was helped to plan ahead so I could take care of my chronic health condition(s), even in hard times."

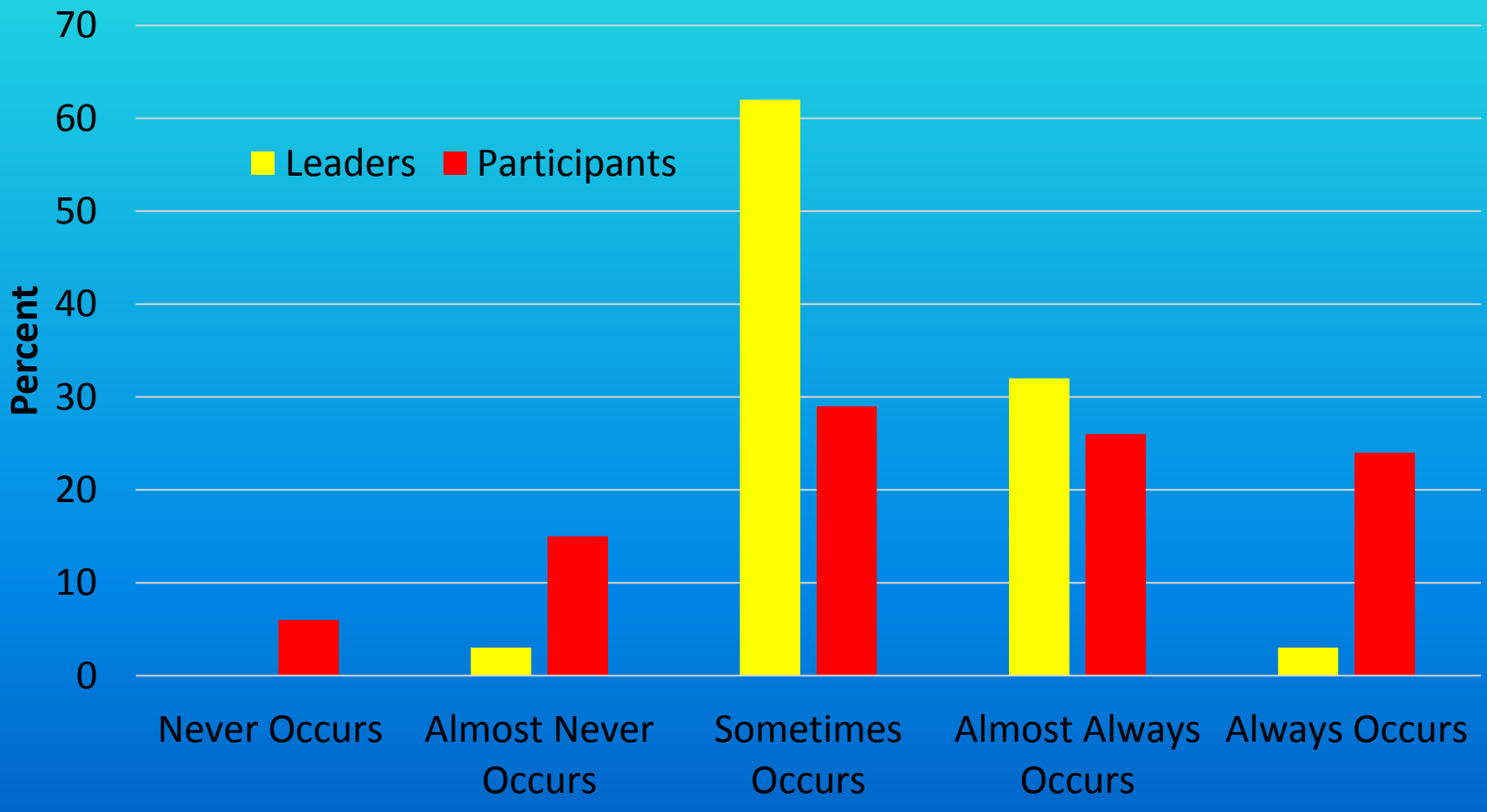


PACIC: Problem Solving

Over the past six months, I (the typical client) was…	Never, Almost Never Occurs	Sometimes Occurs	Almost Always, Always Occurs	Mean (SD) (5 point scale)
…satisfied my/their service provider considered their values, beliefs, and traditions when recommending treatments.	L: -- P: 18%	L: 64% P: 21%	L: 36% P: 61%	L: 3.37 (.55) P: 3.70 (1.31)
…helped to make treatment plans I/they can carry out in their daily life.	L: 13% P: 15%	L: 45% P: 18%	L: 42% P: 67%	L: 3.43 (.78) P: 3.73 (1.34)
…helped to plan ahead so I/they can take care of my/their chronic health condition(s) even in hard times.	L: 23% P: 25%	L: 54% P: 13%	L: 23% P: 62%	L: 3.00 (.81) P: 3.58 (1.44)
…asked how my/their chronic health condition(s) are affecting their life.	L: 15% P: 23%	L: 36% P: 20%	L: 49% P: 57%	L: 3.40 (.81) P: 3.65 (1.60)

PACIC: Follow-Up

"I was contacted after my visit to see how things are going."



PACIC: Follow-Up*

Over the past six months, I (the typical client) was…	Never, Almost Never Occurs	Sometimes Occurs	Almost Always, Always Occurs	Mean (SD) (5 point scale)
…contacted after a visit to see how things are going.	L: 13% P: 25%	L: 51% P: 32%	L: 36% P: 43%	L: 3.23 (.77) P: 3.24 (1.39)
…encouraged to attend programs in the community that may help me/them manage my/their chronic health conditions.	L: 13% P: 17%	L: 51% P: 24%	L: 36% P: 59%	L: 3.23 (.73) P: 3.59 (1.30)
…referred to other specialists to improve my/their overall health.	L: 12% P: 17%	L: 48% P: 25%	L: 40% P: 58%	L: 3.26 (.70) P: 3.67 (1.40)
…asked whether visits with other types of doctors, like an eye doctor or other specialist were helpful to me/them.	L: 5% P: 24%	L: 67% P: 16%	L: 28% P: 60%	L: 3.23 (.60) P: 3.40 (1.58)
…asked how my/ their visits with other doctors are going.	L: 8% P: 23%	L: 51% P: 29%	L: 41% P: 48%	L: 3.29 (.62) P: 3.45 (1.30)

*5-item response scale: 1=Never Occurs, 2=Almost Never Occurs, 3=Sometimes Occurs, 4=Almost Always Occurs, 5=Always Occurs

Health Outcome Scales:

Client Survey ONLY

Stanford Symptoms Scale*

Over the past 30 days, about how often did you…	Never, Almost Never	Sometimes	Almost Always, Always	Mean (SD) (5 point scale)
Feel tired or fatigued?	12%	42%	46%	3.4 (.95)
Feel stressed out?	9%	42%	49%	3.3 (1.2)
Experience shortness of breath or difficulty breathing?	33%	50%	17%	2.6 (1.1)
Experience a level of pain that interfered with regular daily activities?	17%	41%	42%	3.2 (1.2)
Have trouble sleeping?	17%	39%	44%	3.3 (1.3)

*5-item response scale: 1=Never, 2=Almost Never, 3=Sometimes, 4=Almost Always, 5=Always

Psych Distress Scale*

(National Outcomes Measure)

Over the past 30 days, about how often did you…	Never, Almost Never	Sometimes	Almost Always, Always	Mean (SD) (5 point scale)
Feel nervous?	14%	50%	36%	3.2 (1.0)
Feel hopeless?	22%	61%	17%	2.9 (.93)
Feel restless or fidgety?	20%	56%	24%	3.3 (1.5)
Feel so depressed that nothing could cheer you up?	30%	55%	15%	2.7 (1.2)
Feel like everything was an effort?	15%	56%	29%	3.2 (.77)
Feel worthless?	26%	51%	23%	2.9 (.98)

*5-item response scale: 1=Never, 2=Almost Never, 3=Sometimes, 4=Almost Always, 5=Always

Positive Affect*

Over the past 30 days, about how often did you…	Never, Almost Never	Sometimes	Almost Always, Always	Mean (SD) (5 point scale)
Feel energetic?	29%	53%	18%	2.9 (.88)
Feel capable?	12%	58%	30%	3.3 (.85)
Feel good about yourself?	27%	50%	23%	2.9 (.93)
Feel relaxed?	23%	61%	16%	2.9 (.77)
Feel hopeful?	13%	56%	31%	3.1 (.90)
Feel happy?	17%	61%	22%	2.9 (.69)
Feel calm?	20%	58%	22%	3.0 (.75)
Feel that life is good?	23%	44%	33%	3.1 (.97)

*5-item response scale: 1=Never, 2=Almost Never, 3=Sometimes, 4=Almost Always, 5=Always; developed for pilot

Next Steps

- Continue implementation until Pilot Sites implement ≥ 2 Workshops
- Insure that all Leader Trainees get opportunity to get certified (facilitate 1 group with fidelity within 12 months post training)
- Conduct cross site focus group in spring 2015
- Produce findings report and recommendation by 9/2015
- Seek opportunities to disseminate findings more widely in Ohio and beyond

Thank You!

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5 See last slide: Recognition Tools

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