Integration of Self-Management Programs into Clinical Settings

14th Annual Summer Institute

Change the Conversation: Maximizing Opportunities in the Emerging Healthcare Landscape

Melanie Mitros, PhD, CES
Executive Director
WWW.AZLWI.ORG
Agenda

1. Why Evidence-Based Programs are needed?
2. History of Evidence-based Programs in AZ
3. Learn of the background, structure and purpose of Healthy Living
4. AZ Data to Date
5. Behavioral Health Programs
- **U.S. Administration on Aging funded Initiative 2006**
  - To transform Aging Services Network to health impacting sites
  - Brings evidence-based programming to community-based organizations
    - Stanford University’s CDSMP is the core program
- **2010 American Recovery and Reinvestement Act (ARRA)**
  - Communities Putting Prevention to Work: Chronic Disease Self-Management Program initiative - $27 million (45 states, District of Columbia and Puerto Rico)
- **2011 NASMHPD Peer Support Specialist Workforce Development Grant**
- **2012 ACL-AoA 3rd Round of Self-Management Funding**
  - 22 States to continue to increase reach of EBP to ethnic minority groups and expand programs available
The Business Case for this Work

- Booming Generation (1946-1964)
- Chronic conditions account for:
  - 76% of inpatient hospitalizations*
  - 88% of all prescriptions filled*
  - 72% of all physician visits*
  - 7 out of 10 deaths each year in the US**
- 99% of Medicare spending is on behalf of beneficiaries with at least one chronic condition***

*Johns Hopkins University, 2003
**Centers for Disease Control and Prevention, 2009
***Thorpe & Walker, 2010
What Can be Done?

- Increase skills to manage conditions and symptoms
- Learn techniques to help cope with conditions
- Gain insights and wisdom from others
- Being with others who have similar challenges can be a powerful motivator
Evidence-Based Programs

- A process of planning, implementing, and evaluating programs adapted from tested models or interventions in order to address health issues at an individual level and at a community level

The History

WHAT ARE WE PREPARING FOR?

LIVING WELL

ARIZONA LIVING WELL INSTITUTE

HEALTHY LIVING
In Arizona

- From 2000-2010 population grew by 24.6% to 6.4 million
  - US growth was 9.7%
- With a 14% of those over 65 years (882,098)
- And 31.7% over 50 years (~2 million)

- Aging baby boomers drove Arizona’s median age up by 1.7 years over the last decade, to 35.9 years old in 2010, according to U.S. Census Bureau data.

- Yet ... Active-Adult Lifestyle state
A Different Aging Population

- Active aging, resilience, productivity, and aging in a healthy manner
- Voluntarism, voting, and community groups
- More likely to vote in national elections
- Redefining voluntarism

Healthy Living (CDSMP)

Enhance Fitness

Arizona Living Well Institute
Statewide Work

- **Arizona Department of Health Services**
  - Bureau of Tobacco and Chronic Disease
    - Healthy Aging
    - Diabetes Coalition
  - Division of Behavioral Health Services

- **Department of Economic Security**
  - Division of Aging & Adult Services

- **Arizona Living Well Institute**
  - Support dissemination of evidence-based programs:
    - Healthy Living (CDSMP)
  - Integration & collaboration with other EBPs
    - EnhanceFitness
    - A Matter of Balance
Why the Arizona Living Well Institute?

✓ A need for greater coordination and leveraging of resources to create greater impact
✓ A systematic approach to data collection and management
✓ Coordination of training opportunities throughout the state, including coordination of self-management workshops
✓ Educate employers, health care providers and community services organizations about the benefits of self-management programs and evidence-based health promotion programs
THE MISSION:
TO ADVANCE EVIDENCE-BASED PROGRAMS
FOR ARIZONA COMMUNITIES THROUGH
STRUCTURED COMMUNICATION, MULTI-LEVEL
COORDINATION AND FACILITATOR COACHING.
Funds to launch the Arizona Living Well Institute were made available by grant funds from St. Luke’s Health Initiatives and the Arizona Department of Health Services through a grant from the Administration on Aging.
Evolution of the Living Well Institute

1. **Coordination**
   - Master & Lay Leader Trainings
   - Strategic Planning Meetings

2. **Communication**
   - Statewide to Next door
   - Regional Collaboratives

3. **Coaching**
   - Assessing Agency Readiness
   - Implementation Coaching
   - Workshop Fidelity
   - Follow-up & Continued Mentoring

The 3 C’s
EBHPP’s for Older Adults

In Arizona ...
- Chronic Disease Self-Management Program*
  - In-person in English & Spanish Online, By Mail
- Diabetes Self-Management Program*
  - English & Spanish
- A Matter of Balance*
- Enhance Wellness/Enhance Fitness*

Others to Consider...
- AF Exercise Program
- Active Living Every Day
- Care Transitions
- Fit and Strong!
- Healthy IDEAS
- Healthy Moves for Aging Well
- HomeMeds
- PEARLS
- Stepping On
- Tai Chi: Moving for Better Balance
- WRAP

www.ncoa.org/improve-health/center-for-healthy-aging/where-to-find-evidence-based.html
Healthy Living
Stanford University’s CDSMP

http://med.stanford.edu/patienteducation/
Symptom Cycle

Disease
- Fatigue
- Tense Muscles
- Pain
- Stress/Anxiety

- Shortness of Breath

- Depression

- Difficult Emotions
Workshop Design

- 6 weekly sessions that meet 1 day per week for 2.5 hours each
- Introduces tools needed in day-by-day life with chronic conditions
- Practices using self-management skills
- Highly interactive
- Focuses on goal setting
- Shared experiences, emphasizes mutual support
Topics Covered

- Action Plans
- Feedback/Problem Solving
- Getting a Good Night’s Sleep
- Managing difficult emotions
- Falls Prevention
- Physical Activity/Exercise
- Nutrition & Food Labels
- Weight Management
- Mind-Body Connection
- Informed Treatment Decisions
- Working with Health Care
### Stanford University
- $500.00 for offering 30 or fewer workshops and 6 Leader trainings
- $1000 for offering 90 or fewer workshops and 12 Leader trainers
- Multiple Program License

### Partnership with a licensed agency
- Directly with AZLWI
- MOU Required/Recommended
- Licensed agency is responsible for fidelity
Healthy Living (CDSMP) Facilitators

**T-Trainer**
- Mentored by Stanford
- Train Master Trainers

**Master Trainers**
- 4 ½ day training led by 2 T-Trainers
- Certified through Stanford after facilitating 2 workshops
- Train Leaders – 1 training per year
  - May facilitate workshops
  - May assist in fidelity monitoring

**Lay Leaders**
- 4 day training led by 2 Master Trainers
- Facilitate workshops
- Preferably peers with chronic conditions
  - May be volunteers or staff, usually not health professionals
Self-Management NOT Health Education

Purpose of self-management is to help people gain self confidence in their ability to:

- control their symptoms
- control how their health problems affect their lives

5 year randomized study, 1000 people

Outcomes?

Outcomes

- Increased physical activity
- Improved health-status
- Improved social/role activities
- Better psychological well-being
- Decreased days in hospital
- Improved self-reported general health
- Enhanced partnerships with physicians
- Increased energy/reduced fatigue
- Reduced health care expenditures

National Study of CDSMP (2010-2012)

- How does CDSMP affect the lives of participants and society as a whole?
  - What are the impacts on:
    - Symptom management and lifestyle behaviors?
    - Better care?
    - Improved health?
    - Reduced health care costs?

- Study Participants
  - Baseline (n=1,170)
  - 12 month (n=825)

- Measures
  - Symptom management and lifestyle behaviors
  - Better Care
  - Better Health
  - Lower Health Care Cost

Does CDSMP Facilitate the IHI Triple Aim Goals?

- The best care for the whole population at the lowest cost.

1. **Better Care:**
   - improving the experience of care

2. **Better Health:**
   - improving population health

3. **Lower Cost:**
   - reducing per capita health care costs

### CDSMP: Better Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Mean</th>
<th>12-Month Mean</th>
<th>% Improvement  †</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with MD (0-5) ↑</td>
<td>2.6</td>
<td>2.9</td>
<td>9%**</td>
</tr>
<tr>
<td>Medication Compliance (0-1) ↓</td>
<td>0.25</td>
<td>0.21</td>
<td>12%**</td>
</tr>
<tr>
<td>Health Literacy (Confidence filling out medical forms) (0-4) ↑</td>
<td>3</td>
<td>3.1</td>
<td>4%**</td>
</tr>
</tbody>
</table>

**Notes.**  † These statistics control for covariates gender, age, race/ethnicity, education, number of chronic conditions.
- ↑ Indicates that larger scores are better for this measure
- ↓ Indicates that smaller scores are better for this measure.
- **p<0.01, *p<.05**
## CDSMP: Better Health

<table>
<thead>
<tr>
<th></th>
<th>Baseline Mean</th>
<th>12-Month Mean</th>
<th>% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-assessed Health (1-5)  ↓</td>
<td>3.2</td>
<td>3</td>
<td>5% **</td>
</tr>
<tr>
<td>PHQ Depression (0-3)  ↓</td>
<td>6.6</td>
<td>5.1</td>
<td>21% **</td>
</tr>
<tr>
<td>Quality of Life (0-10)  ↑</td>
<td>6.5</td>
<td>7</td>
<td>6% **</td>
</tr>
<tr>
<td>Unhealthy Physical Days (0-30)  ↓</td>
<td>8.7</td>
<td>7.2</td>
<td>15% **</td>
</tr>
<tr>
<td>Unhealthy Mental Days (0-30)  ↓</td>
<td>6.7</td>
<td>5.6</td>
<td>12% **</td>
</tr>
</tbody>
</table>

**Notes.** † These statistics control for covariates gender, age, race/ethnicity, education, number of chronic conditions.
- ↑ Indicates that larger scores are better for this measure
- ↓ Indicates that smaller scores are better for this measure.
- **p<0.01, *p<.05**
### CDSMP: Lower Health Care Cost

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>12-Month</th>
<th>Adjusted Ratios †</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage with ER Visit in Past 6 Months ▼</td>
<td>18%</td>
<td>13%</td>
<td>0.68**</td>
</tr>
<tr>
<td>Number of ER Visits among those with any ER Visit</td>
<td>1.5</td>
<td>1.4</td>
<td>1.00</td>
</tr>
<tr>
<td>Percentage Hospitalized in the Past 6 Months ▼</td>
<td>14%</td>
<td>14%</td>
<td>1.01</td>
</tr>
<tr>
<td>Number of Hospitalizations among those with any Hospitalization</td>
<td>1.4</td>
<td>1.4</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Notes.** † Odds Ratio or Mean Ratio after controlling for covariates gender, age, race/ethnicity, education, number of chronic conditions
- ▼ Indicates that larger scores are better for this measure
- ▼ Indicates that smaller scores are better for this measure.
- **p<0.01, *p<.05**
Estimated Cost Savings Related to Reduced ER Visits & Hospitalization

- Preliminary Results:
  - ~$740 per person savings in ER and hospital utilization
  - ~$390 per person net savings after considering program costs at $350 per participant

- Reaching even 10% of Americans with one or more chronic conditions would save ~$4.2 billion!
What Else Do I Need to Know?

• Healthy Living will NOT interfere with other programs - it will complement other programs!

• Healthy Living is not a support group.
  o Even though participants share experiences and support each other, it is a workshop where you learn and try new skills, and increase your ability to manage your health.

• To be most effective, it is important for participants to be present and contribute in all sessions.
Evaluation Tools

WORKSHOP

PARTICIPANT

FEEDBACK
## Evaluation Tools

<table>
<thead>
<tr>
<th>Workshop &amp; Training Registration</th>
<th>Participant Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.azlwi.org">www.azlwi.org</a></td>
<td>Pre</td>
</tr>
<tr>
<td>Mentoring Process</td>
<td>Post</td>
</tr>
</tbody>
</table>

### Workshop Cover Sheet
- Date
- Time
- Location
- Facilitators
- Substitutes
- Session Zero

### Feedback Questionnaire
- Program
- Facilitators
- Meeting Space

### Fidelity Process
- Workshops
- Trainings
Participant Level Data

2007 - 2013
Workshop Participants

- Number of Participants and Completers ↑ over last 6 years
- Completion rate ↑ from 50% in 2007 to average of 71% since 2010
  - Completers defined as attending at least 4 of 6 workshop sessions
# Summary by Year for Arizona

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (% female)</td>
<td>78%</td>
<td>76%</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>Age (years)</td>
<td>70</td>
<td>62</td>
<td>60</td>
<td>59</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>89%</td>
<td>84%</td>
<td>76%</td>
<td>83%</td>
</tr>
<tr>
<td>African American</td>
<td>3%</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>11%</td>
<td>16%</td>
<td>24%</td>
<td>17%</td>
</tr>
<tr>
<td>Asian/Pacific islander</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>1%</td>
<td>2%</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>2+ Chronic Conditions</td>
<td>69%</td>
<td>70%</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td>Number of Workshops</td>
<td>23</td>
<td>72</td>
<td>120</td>
<td>56</td>
</tr>
<tr>
<td>Workshop Participants</td>
<td>320</td>
<td>882</td>
<td>1317</td>
<td>555</td>
</tr>
<tr>
<td>Workshop Completion Rate (4+ sessions)</td>
<td>67%</td>
<td>76%</td>
<td>71%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Age Demographics by Year

Arizona Living Well Institute
Organizational Level Data

FACILITATORS

WORKSHOPS
Facilitator Growth

April 1, 2010

June 30, 2013
## Host Organization Growth

### 2007-2010

- **3 Counties**
- **3 Host Organizations**
  - Community Health Center
    - Mariposa Community Health Center, Inc.
  - Area Agency on Aging
    - Pima Council on Aging
  - Local Health Department
    - Yavapai County Community Health Services

### 2013

- **15 Counties**
- **48 Host Organizations with over 110 Partners**
  - Area Agencies on Aging
  - Behavioral Health
  - Health Insurance Plans
  - Community Health Centers
  - Local Health Departments
  - Non-Profits
  - Veterans Administration
## Workshop Growth by County

<table>
<thead>
<tr>
<th>County</th>
<th>2007-2009</th>
<th>2010-2011</th>
<th>2012</th>
<th>2013 (TD)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apache</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Cochise</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Coconino</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Graham</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Greenlee</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>La Paz</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Maricopa</td>
<td>34</td>
<td>50*</td>
<td>20*</td>
<td></td>
<td>99</td>
</tr>
<tr>
<td>Mohave</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Navajo</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Pima</td>
<td>11</td>
<td>17</td>
<td>30</td>
<td>16</td>
<td>74</td>
</tr>
<tr>
<td>Pinal</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>7</td>
<td>1</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Yavapai</td>
<td>6</td>
<td>15</td>
<td>12</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Yuma</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Total in AZ</strong></td>
<td>24</td>
<td>92</td>
<td>120</td>
<td>56</td>
<td>292</td>
</tr>
</tbody>
</table>
Programs in Behavioral Health
Where it’s Happening

- Stanford
  - HARP Program
- New Zealand
- Oregon
- Michigan
- Arizona!
  - RBHA
  - Provider Organizations
  - VA Health Care System
Behavioral Health Outcomes

Jackson Co. MH Project

- **Demographics**
  - 27 Participants
  - Age range 21-62
  - Average of 3 chronic conditions per participant
  - Retention rate 40%

- **Outcomes**
  - 19% drop in fatigue
  - 35% drop in shortness of breath
  - 18% drop in pain levels
  - Number of doctor visits dropped by 26%

- **Limitations**

For more information: Arlene Logan, LCSW, Regional Coordinator for Living Well, alogan@rvcog.org
Structure of Behavioral Health

ADHS

DBHS

RBHAs

NARBHA

Magellan

Cenpatico

CPSA

Gila River

Navajo

Pascua Yaqui

White Mountain

Colorado River

TRBHAs

RAs

NPOs

Provider Org.

Provider Org.

Arizona Living Well Institute
Implementation Models

- **Target Participants**
  - SMI, Behavioral Health, Combination
- **Partnerships with other clinics or county health departments**
- **Facilitators**
  - Peers
  - Other behavioral health Professionals
  - Combination
- **Evaluation**
Behavioral Health Workshops

- 40 workshops hosted since 2011
- 371 participants
  - 283 completers
  - 76% completion rate
- Reported Depression Rate of 67%
- NARBHA RA’s (Sept 2011-Dec 2012)
  - Increased confidence in doing things
  - Decreased interference in daily activities
  - Decreased health distress
  - Increased physical activity
### Workshops Held at NARBHA’s RAs
**September 2011 - December 2012**

<table>
<thead>
<tr>
<th></th>
<th>Stanford</th>
<th>NARBHA Pre-Workshop</th>
<th>NARBHA Post-Workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence Managing Chronic Disease (6 Items) 10 is &quot;Totally Confident&quot;</td>
<td>5.17</td>
<td>5.52</td>
<td>6.45</td>
</tr>
<tr>
<td>Symptoms - Health Distress (4 Items) 0 is &quot;none of the time&quot;</td>
<td>2.04</td>
<td>2.50</td>
<td>2.37</td>
</tr>
<tr>
<td>Symptoms - Fatigue (1 Item) 0 is &quot;no fatigue&quot;</td>
<td>4.89</td>
<td>5.65</td>
<td>5.55</td>
</tr>
<tr>
<td>Symptoms - Pain (1 Item) 0 is &quot;no pain&quot;</td>
<td>4.36</td>
<td>6.04</td>
<td>5.75</td>
</tr>
</tbody>
</table>

From NARBHA, V. Wilson 2/8/2013

NARBHA CDSMP Outcome Measures ~ Veronica Wilson, Master Trainer
Feedback from Facilitators

- Focus on Behavioral health or Physical health
- Time frames
  - 2 ½ hours, 6 consecutive weeks
- Triggers
  - Small Workshops
- Attrition rates
  - 2 ½ hours, 6 consecutive weeks
- Facilitator Turnover

Arizona Living Well Institute
Possible Solutions and Adaptions

- Collaboration
- Follow-up (for recruitment issues)
- Facilitator “Refreshers” prior to workshop
- Careful Consideration when choosing facilitators
- Extra “Support” person

Consult with Stanford prior:
- Support groups
  - Oregon
- Longer breaks
The Benefits
Benefits Beyond the Program

- **Strategic Growth**
  - Technical Assistance
  - Regional Collaboratives
  - County Coalitions
- **Improved Retention**
  - Facilitators
  - Participants
- **Stay up to Date**
  - Updates
  - Meet & Retreats
  - Refresher Trainings

- **Improved Problem Solving**
  - Local Mentors
  - Statewide Webinars

- **Leverage Funding Opportunities**
  - Partners supporting Partners
Empowerment Systems, Inc. (EmSys) proposes to enhance the AZ Healthy Living Initiative

- a comprehensive membership system of evidence-based wellness programs that are promoted, paid and integrated with primary and behavioral health outpatient providers of service for enrolled Medicaid and Medicare patients living with or at risk of developing chronic conditions.

- In order to sustain and expand impact, AZLWI will further develop, support and promote a structured provider membership system to ensure quality evidence-based wellness services are provided at affordable prices.
Integrated Closed Loop Referral Process

**Referrals**
- Community Navigators
- Medical/Behavioral Health Providers
- Self-Referral

**Services**
- Integrated, Point of Care Screening for Chronic Disease Risk Factors
- Evidence-based Self-Management Workshops
- Assistance completing health & human service applications (e.g. AHCCCS)
- Referral to potential Medical Home
- Referral to other needed services (e.g. ASHLine, etc.)

**Outcomes**
- Response to referral source of services provided to include:
  - Participation in Self-Management Workshop
  - Other completed referrals/services
Moving Forward with Action
What is your Action Plan?

Things to Consider:

- What is your agency’s plan for programs in 2013?
- Number of workshops
- Target population
- Will you train facilitators?
  - Leaders or Master Trainers?
- What is your target completer/retention rate?
  - Facilitators
  - Participants
- Potential partners
Find out who your friends are...
• Making a Difference in the lives of adults with ongoing health conditions and individuals with disabilities
  o Changing the course of chronic conditions & injury
  o Changing systems “The way we do business.”

• Working from an Evidence-based Perspective
  o Drawing from the evidence
  o Contributing to new evidence

• Working Collaboratively to “Move the Dial”
  o Creating an inclusive, far reaching agenda for healthy living for all ages in all communities
  o Creating conditions for sustained improvement in health in caregivers and care recipients
So how do we get to “Healthy Aging”?

- **Develop a Mantra:**
  - It’s never too late to start & it’s always too early to quit!

- **Invest in health**
  - Regular Exercise
  - Good Nutrition
  - Self Management of Stress & Chronic Conditions
  - Engagement in family and community, volunteering

- **Protect health**
  - Immunizations
  - Early detection of health conditions
  - Fall Prevention

Arizona Living Well Institute
Participant Comments

- I feel that this class has been of great benefit to me which will stay with me in times of difficulty or when I feel myself slipping back toward depression or isolation from people. I will put forth an extra positive effort to continue the breathing techniques and especially the exercises learned or reinforced in a continued plan to control my painful condition in the best possible way without being dependent upon prescription drugs. *Rebecca – Arizona City*

- We had experienced, or learned different parts of this program before, but no part alone was life changing. But with this program structure, I am a different person than I was just six-weeks ago and hope to stay motivated! *MDC - Goodyear*
Questions?

Melanie Mitros, PhD
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mmitros@azlwi.org

(480) 982-3118 or (877) 982-3118
www.azlwi.org

Arizona Living Well Institute
Advancing Evidence-Based Programs for Arizona