PATIENT CENTERED MEDICAL HOMES & CHRONIC DISEASE SELF MANAGEMENT

Two Innovations in Health Care Delivery
Currently at the Forefront of National and State Healthcare Policy.

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OBJECTIVES FOR THIS TALK

- Review the emerging construct of Patient Centered Medical Homes
- Examine the Stanford Chronic Disease Self Management Program
What is a medical home?

“In broad terms, the patient centered medical home (PCMH) provides care that is “accessible, continuous, comprehensive, and coordinated and delivered in the context of family and community (AAFP, AAP, ACP, AOA)

See joint principles of the patient-centered medical homes, at: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.
Background

• Importance: What is the problem?
  • U.S. healthcare is programmed to respond to, and pay for acute, episodic problems.
  • Care has been reactive, not proactive.
  • Poor performance in controlling chronic illnesses.
  • Rapid growth in chronic illness - numbers and costs
  • Poor communication exists between HC providers.
  • Patients are not taught to take ownership of their own health through education & self-management.
What is known?

- Many models of medical homes and care coordination
- We have a mixed record of success – clinically and in ROI

What is unknown?

- How can a model that fits all or most of the design features attain clinical and financial success?
- How do specific elements of the model contribute to such success?
- What incentives are needed for patients, providers and organizations to participate?
What is unknown?

- Can we agree upon a set of metrics that accurately measure the success or failure of PCMH implementation? (The impact of the MH model on patient and provider experiences is not well known).
- How do practices successfully evolve and overcome challenges posed by the MH model? (This needs to be described).
<table>
<thead>
<tr>
<th>Factor/Principle</th>
<th>PCMH</th>
<th>Non-integrated managed care*</th>
<th>Pay for performance</th>
<th>Disease management</th>
<th>Chronic care model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose/focus</td>
<td>Facilitate partnership between PCP and patient</td>
<td>Ideally: cost, quality; Actually: control utilization</td>
<td>Meet operational goals with financial incentives</td>
<td>Meet specific management targets for chronic disease</td>
<td>Org. framework for chronic care mgt and practice improvement</td>
</tr>
<tr>
<td>Patient centric/personal PCP</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Maybe, often led by actors independent of primary care</td>
<td>Yes, for chronic illness</td>
</tr>
<tr>
<td>PCP directed medical “team”</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Whole person orientation</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Care is coordinated and/or integrated</td>
<td>Yes</td>
<td>No incentive for coordination</td>
<td>No incentive for coordination</td>
<td>Maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Emphasis on quality and safety</td>
<td>Yes, evidence-based and best practice; improved outcomes rewarded</td>
<td>No, reduced utilization rewarded</td>
<td>Indirectly; process targets rather than outcome ones</td>
<td>Yes, particularly for diseases</td>
<td>Yes, for chronic illnesses</td>
</tr>
<tr>
<td>Enhanced access</td>
<td>Yes</td>
<td>No, reduced access</td>
<td>No</td>
<td>Maybe</td>
<td>No</td>
</tr>
<tr>
<td>Appropriate reimbursement</td>
<td>Yes for PCPs, unclear for others</td>
<td>Potential conflict in motivation</td>
<td>No, still volume driven</td>
<td>Partially, if evidence-based used</td>
<td>No</td>
</tr>
</tbody>
</table>

Alignment with PCMH principle:  
- **Aligned**  
- **Mixed alignment**  
- **Not aligned**

*Note: By “non-integrated managed care,” we refer to the form of managed care practiced in the 1980s and early 1990s that emphasized a “gatekeeper model” with cost controls, rather than a more patient-centered focus on primary care. Most surviving forms of managed care are more integrated and incorporate more elements of the PCMH model.*

Source: IBM Global Business Services and IBM Institute for Business Value.
Goals of PCMH Study

- **Goal #1** – to identify PCMH attributes and components
  - in early stages of development in different settings
  - analyze initial features and status of the evolving model
- **Goal #2** – track changes and intermediate outcomes
  - in progress toward becoming a model PCMH-CC, tier 1, tier 2
  - in improving clinical and financial outcomes
- **Goal #3** – analyze the medical home transformation
  - identify key “drivers” in attaining such transformation
  - progression toward adoption of critical medical home features
  - contributions of feature to clinical and financial outcomes
- **Goal #4** – Publish findings that can guide system change
Description of Project and Importance to the Policy of U.S. Healthcare System:

- A medical home is a place where people can access high quality care, for most types of conditions in a coordinated manner.
- Right now both the federal government and the state of Texas are very interested in improving healthcare by making sure all adults and children have a medical home.
Interview Format

• We will give you a set of cards listing 11 factors that CMS and other official groups have suggested are necessary for insuring a “medical home”.
• We would like your feedback and opinions about LONE STAR’s performance with respect to each of the factors.
• There are probably few health organizations that score high on all of these factors.
• We will ask you to indicate whether Lone Star “fully meets”, “partially meets”, “doesn’t meet” or “I don’t know” each of these items.
Medical Homes include...
a PCP-led health care team

(for example)
1. oversight & guidance provided by PCP
2. qualified HC team with needed skills
3. trained to provide coordinated care
Medical Homes include...

Assessment & Care Plans for Care Coordination

(for example)

1. Written health assessment
2. prepare documented care plans and modifications
3. use health assessment and plans to coordinate care
Medical Homes include...

**Broad access to care**

(for example)

1. Clinic “walk-in” availability
2. On-call coverage nights and weekends
3. Seven days/week, 24 hour access to phone triage
Medical Homes include...

**Medication safety coordination**

(for example)

1. Track and approve medication changes from health benefit plans or pharmacy benefit plans.
2. Conduct medication reconciliation to avoid interactions or duplications
3. Document with patients the medications they are currently receiving
Medical Homes include...

Reviewing and tracking all patient hand-offs

(for example)

1. Lab and test results,
2. Treatment referrals,
3. Hospitalizations and discharges,
4. Medication changes
5. Referral results, prescriptions, and related communication with other physicians and health care professionals.
Medical Homes ...

Ensure quality care

(for example)

1. Measure clinical quality performance against benchmarks and best practices
2. Take action to improve care and care processes
3. Use patient registries, or EMR, to monitor and track patient health status or generate clinical reminders
Medical Homes include...

Information system support

(for example)

1. electronic scheduling system
2. electronic medical record system
3. electronic prescribing system
4. electronic health information exchange with other providers
Medical Homes include...

Appropriate communication with patients, families and caregivers

(for example)

1. Phone calls to patients for follow-up or reminders
2. Email communication with patients
3. Letters to patients
Medical Homes include...

Self-management and prevention education for...

(for example)

1. wellness & prevention
2. chronic disease management
3. end-of-life planning
4. home monitoring
Medical Homes include...

Community Linking Services

(for example)

1. Continuously monitoring patients’ eligibility for services such as WIC, Medicaid, CHIP.
2. Facilitate linking through appropriate referrals to other needed health and human services.
Medical Homes include...

Full scope of care for most kinds of medical conditions

(for example)

1. Strive to be a single source of primary care and treatment to avoid fragmented care.
2. Maintain well-managed relationships to needed specialists and hospitals.
3. Care provided across the life-span or disease spectrum.
Medical Homes include...

**Payment Recognition**

refers to providers receiving adequate payment or appropriate reimbursement for MEDICAL HOME types of services provided.

- Health care reimbursement should include reimbursement to providers for providing a “medical home”.
- Basic policy shift for the government/state recognize providers for medical home services.
Our Evaluation

- Select medical home models deployed in one or more health systems – with tier 1 and/or tier 2 elements.
- Identify organizational structures, processes in model.
  - examine prior changes and changes during study
  - examine current professional assessments and expectations
- Identify key metrics, including, clinical and financial outcome measures.
  - associated with one or more conditions target
  - measured across units and organizations doing medical home
  - compared retrospectively and prospectively during the study
  - explained by analysis of medical home features

Center for Health Organization Transformation
OUTCOMES?

- Lone Star Circle of Care’s data and information.
- They are on the forefront of the Medical Homes initiative in the Austin, Round Rock, & Georgetown area.
SELECTED QUOTES FROM KEY PERSONNEL

[Tracking patient hand-offs]:
“We have a good system in place for follow-up with patients. We can generate letters using our EMR system, for labs or anything else. Our front desk staff calls patients to remind them about their appointments. So our communication is pretty good.”
SELECTED QUOTES FROM KEY PERSONNEL

Ensuring quality care
“I would say without a doubt, we fully meet [quality of care]. We have benchmarks in place and we’re taking action to improve care and care processes.”
SELECTED QUOTES FROM KEY PERSONNEL

[Patient and family communication] “I think our staff members do a really great job at getting lab results and talking to the patients about their results and sending out referral letters. Each clinic dedicates one person to referrals, making sure the patient gets a specialist and we receive all the hospitalizations and discharge notes from the hospitals and our nurses are really good about working with the providers on this. And we chart everything in the chart, like tasking and telephone calls.”
SELECTED QUOTES FROM KEY PERSONNEL

“Our [information] system is very robust and it meets all of our needs quite well. We keep find better ways to improve the system and use it in different ways that improve and meet all of our needs. It’s very impressive because it is so flexible, and the extent to which it can be modified to meet all of our needs. It’s very dynamic.”
Challenges & opportunities

- Challenges (Provider time to participate—busy family centered practices, busy waiting rooms)
- Opportunities
  - Grant on transforming primary care practices into medical homes
  - Behavioral/Psychiatric care health evaluation collaboration
PART II:

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM
STANFORD MODEL
Texas Healthy Lifestyles:
Chronic Disease Self-Management Program

An evidence-based approach to improving health outcomes in a senior population

June 16, 2010
Chronic Disease Self-Management Program (CDSMP)

Bexar AAA
-San Antonio Area

Brazos Valley AAA
-7 counties
Why are we doing so poorly?

The IOM Quality Chasm report says:

- “The current care systems cannot do the job.”
- “Trying harder will not work.”
- “Changing care systems will.”
Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health System
- Health Care Organization
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Outcomes
- Improved Outcomes
Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Outcomes

Improved Outcomes

Community
- Resources and Policies
- Self-Management Support

Health System
- Health Care Organization
- Delivery System Design
- Decision Support
- Clinical Information Systems

Chronic Care Model
Essential Element of Good Chronic Illness Care

- Informed, Activated Patient
- Informed, Activated Caregivers
- Prepared Practice Team
- Senior Resources

Productive Interactions
Chronic Disease Self-Management Program

Intervention Approach

Reduce Impact of Chronic Disease Burden

Aims to help people gain self-confidence in their ability to control their symptoms

Understand how their health problems affect their lives and how to manage them

http://patienteducation.stanford.edu/programs/cdsmp.html
RE-AIM Framework

- Maintenance
- Reach
- Implementation
- Effectiveness
- Adoption

Texas Healthy Lifestyles
Based on all data processed as of October 1, 2009
CDSMP REACH

The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative.

Texas Healthy Lifestyles

STATE-WIDE

Total = 634

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period
The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative.

**CDSMP REACH**

**Texas Healthy Lifestyles**

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period.*
CDSMP REACH

The absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period
ADOPTION
The absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program

<table>
<thead>
<tr>
<th>CDSMP</th>
<th>Bexar</th>
<th>Brazos Valley</th>
<th>STATE-WIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>464</td>
<td>170</td>
<td>634</td>
</tr>
<tr>
<td># of Unique Implementation Sites</td>
<td>24</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td># of Classes</td>
<td>33</td>
<td>16</td>
<td>49</td>
</tr>
</tbody>
</table>

Based on data processed as of October 1, 2009
ADOPTION - Implementation Site Types for CDSMP classes taught

Based on all data processed as of October 1, 2009

- Senior Center/AAA: 9
- Recreation Facility: 7
- Faith-based Organization: 5
- Residential Facility: 4
- Health Care Organization: 4
- Workplace: 3
- Community Center: 2
- Other: 1

STATE-WIDE (n=36)
Bexar (n=24)
Brazos Valley (n=12)

Texas Healthy Lifestyles
CDSMP IMPLEMENTATION
Number of Classes by Program by Year

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period

State-wide:
- Year 1: 26 classes
- Year 2: 23 classes

Total: 49 classes
CDSMP IMPLEMENTATION
Number of Classes by Program by Year

Classes

<table>
<thead>
<tr>
<th>Program</th>
<th>YR 1</th>
<th>YR 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE-WIDE</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Total= 49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexar</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Total= 33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazos Valley</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Total= 16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period.
CDSMP IMPLEMENTATION

CDSMP Classes in Texas

Year 1: classes held between May 1, 2007 and August 31, 2008
Year 2: classes held between September 1, 2008 and September 30, 2009

*Cumulative data based on reported data from all sites. Some data still being received for the Year 2 time period
CDSMP IMPLEMENTATION - Program Capacity

Master Trainers and Lay Leaders

Active

<table>
<thead>
<tr>
<th>State-wide</th>
<th>Bexar</th>
<th>Brazos Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master Trainers</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Lay Leaders</td>
<td>44</td>
<td>20</td>
</tr>
</tbody>
</table>

Not Active

<table>
<thead>
<tr>
<th>State-wide</th>
<th>Bexar</th>
<th>Brazos Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master Trainers</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Lay Leaders</td>
<td>12</td>
<td>5</td>
</tr>
</tbody>
</table>

Based on all data processed as of October 1, 2009
CDSMP IMPLEMENTATION

At the setting level, fidelity to the various elements of an intervention's protocol including:

- Consistency of delivery as intended, and
- Time and cost of the intervention

Based on attendance data processed as of October 1, 2009
Total Enrolled = 634 participants (only 483 had attendance information)
Average Age = 74 years

*Cumulative: Includes all data reported as of October 1, 2009 from baseline pre-assessment forms completed by consenting participants.
Who is in CDSMP?

Participant Characteristics by %

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-Wide (N=601)</td>
<td>82.5%</td>
<td>84.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexar (N=457)</td>
<td>77.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazos Valley (N=144)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Living Alone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-Wide (N=601)</td>
<td>42.8%</td>
<td>46.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexar (N=457)</td>
<td>31.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazos Valley (N=144)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Minority**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-Wide (N=601)</td>
<td>56.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexar (N=457)</td>
<td>62.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazos Valley (N=144)</td>
<td>36.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Cumulative: Includes all data reported as of October 1, 2009 from 601 baseline pre-assessment forms completed by consenting participants. Missing/refused data not included in analysis.

**Minority includes all reported race/ethnicity other than Caucasian/White non-Hispanic.
Who is in CDSMP?

% Did not graduate from High School
- STATE-WIDE (N=601) 22.4%
- Bexar (N=457) 25.7%
- Brazos Valley (N=144) 10.9%

% Income less than $15,000/yr
- STATE-WIDE (N=601) 37.5%
- Bexar (N=457) 41.5%
- Brazos Valley (N=144) 28.6%

*Cumulative: Includes all data reported as of October 1, 2009 from 601 baseline pre-assessment forms completed by consenting participants. Missing/refused data not included in analysis.
CDSMP: Reported Chronic Diseases

*Includes all data reported as of October 1, 2009 from 605 baseline pre-assessment forms completed by consenting participants. Missing/refused data not included in analysis.

Average # of Chronic Disease Per Person=2.3

- **Hypertension**: 439
- **Arthritis/Rheumatic Disease**: 423
- **Diabetes**: 402
- **Heart Disease**: 386
- **Lung Disease**: 352
- **Cancer**: 341
- **Other**: 375

- **STATE-WIDE (N=601)**
- **Bexar (N=457)**
- **Brazos Valley (N=144)**
Includes all data reported as of October 1, 2009 from baseline pre-assessment forms completed by consenting participants (n=601). Numbers vary slightly due to missing data.
Demonstrated Program Effectiveness for CDSMP*

**Significant Improvement in:**
- Feeling less pain
- Feeling less fatigue
- Improved self-efficacy to reduce or prevent falls
- Less days kept from normal social activities
- Less visits to the physician/health care provider

**Adverse Effects:**
- At this point, no negative consequences reported with being an CDSMP participant

*Paired t-test Analyses: Significant if P value =< .05 (n=ranging from 173 to 341)
### Significant Improvements*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Pre Course Mean</th>
<th>Post Course Mean</th>
<th>P-value</th>
<th>Improved*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived Pain (past 2 weeks)</td>
<td>311</td>
<td>4.31</td>
<td>4.25</td>
<td>.003</td>
<td>X</td>
</tr>
<tr>
<td>Perceived Fatigue (past 2 weeks)</td>
<td>317</td>
<td>3.97</td>
<td>3.90</td>
<td>.028</td>
<td>X</td>
</tr>
<tr>
<td>Falls Efficacy (confidence to prevent and manage falls)</td>
<td>198</td>
<td>14.83</td>
<td>14.93</td>
<td>.016</td>
<td>X</td>
</tr>
<tr>
<td>Health interference with normal social activities (past 4 weeks)</td>
<td>173</td>
<td>1.83</td>
<td>1.79</td>
<td>.019</td>
<td>X</td>
</tr>
<tr>
<td># visits to physician or health care provider (past 6 months)</td>
<td>317</td>
<td>3.89</td>
<td>3.82</td>
<td>.001</td>
<td>X</td>
</tr>
<tr>
<td>#times visited hospital ER</td>
<td>317</td>
<td>1.40</td>
<td>1.29</td>
<td>.013</td>
<td>X</td>
</tr>
</tbody>
</table>

*Paired t-test Analyses: Significant if P value =<.05
Program Effectiveness for CDSMP*

Promising Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Pre Course Mean</th>
<th>Post Course Mean</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participates in physical activity</td>
<td>202</td>
<td>1.24</td>
<td>1.23</td>
<td>.083</td>
</tr>
<tr>
<td># Days physically active during week</td>
<td>197</td>
<td>3.76</td>
<td>3.80</td>
<td>.088</td>
</tr>
<tr>
<td># Self-reported falls (past month)</td>
<td>198</td>
<td>.32</td>
<td>.29</td>
<td>.058</td>
</tr>
<tr>
<td>Health interference with normal daily activities (past 4 weeks)</td>
<td>142</td>
<td>8.05</td>
<td>7.99</td>
<td>.229</td>
</tr>
<tr>
<td># Nights hospitalized (past 6 months)</td>
<td>317</td>
<td>7.29</td>
<td>5.23</td>
<td>.199</td>
</tr>
<tr>
<td>General Health Status</td>
<td>345</td>
<td>3.13</td>
<td>3.12</td>
<td>.180</td>
</tr>
</tbody>
</table>

*Paired t-test Analyses: In correct direction but not Significant at P value =<.05
CDSMP Helps Meet National PA Guidelines

Physical activity participation 5 days a week or more

Paired t-test Analysis: $P-value = 0.088$ (n= 197)

*Includes all data reported as of October 1, 2009 from 133 baseline pre-assessment forms and 77 post-assessment forms completed by consenting participants. Missing/refused data not included in analysis.
CDSMP Helps Reduce Pain

% Reduction of pain reported by participants

Significant Improvement
Paired t-test Analysis: $P-value = 0.003$ (n = 311)

*Includes all data reported as of October 1, 2009 from 311 participants with both pre and post assessment data on pain. Missing/refused data not included in analysis.
CDSMP Helps Reduce Fatigue

Percent Reduction of perceived fatigue reported by participants

Significant Improvement
Paired t-test Analysis: *P*-value = 0.028 (n= 317)

*Includes all data reported as of October 1, 2009 from 317 participants with both pre and post assessment data on fatigue. Missing/refused data not included in analysis.
CDSMP Decreases Health Care Utilization

*Includes all data reported as of October 1, 2009. Missing/refused data not included in analysis.
CDSMP Improves How Health Impacts on Normal Daily Activities

% Reported health interfering slightly or not at all

Paired T-Test Analyses: Overall P-value = .229 (n=142)

[Social Activities = .019 (n=173), Hobbies/Recreation=.319 (n=187), Household Chores= 1.00 (n=205), Errands/Shopping=.656 (n=177)]

*Includes all data reported as of October 1, 2009.
Missing/refused data not included in analysis.
Why Participants are taking the course?

“A desire to help my health situation”

“Interest in what might be available to help deal with pain/discomfort”

“Awareness and better understanding of illness. Learn coping methods and other aids.”

“Because I had fallen and broke my wrist. Did not want to fall again and learned to better manage my health problems, doctor visits, exercise and food.”

“A desire to help my health situation”
What Participants Had to Say About the CDSMP Classes?

“I want to stay as healthy and active as possible. The textbook and relaxation tape provided were excellent. Thanks! ”

Helped me with setting up future strategies to deal with the physical, mental and emotional processes of living a full and rewarding and mindful life!

“I wanted to learn about diabetes. I really enjoyed the class. I have had diabetes for 40 years. I need to learn as much as I can about it.
Success with RE-AIM Elements

**REACH**
Able to recruit and retain a diverse population (n>600)

**EFFECTIVENESS**
Improvements in health and health care

**ADOPTION**
Over 35 implementation sites across Texas

**IMPLEMENTATION**
Self assessment coach feedback form to ensure program fidelity

**MAINTENANCE**
Sustainability plans in place
Sustainability

Bexar County
- Now part of AoA Oasis
- Expanding opportunities for implementation in senior health centers
- Will be complemented by Diabetes Self Management program

Brazos Valley
- Now getting picked up by Scott & White
- Being considered by VA
- Will pair with AMOB delivery channels
Next Steps

Disseminate programs
• Continuing to disseminate the programs throughout the State

Recruitment and Reach
• Continue to monitor participant recruitment to ensure participant reach

Evaluation and Data Collection
• Continue monitoring evaluation and data collection activities

Sustainability
• Identify and secure supplemental/sustainability funding sources

Advocate for Texas Healthy Lifestyles
• Advocate at the State policy level to continue supporting THL dissemination and sustainability
Questions?

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