Monitoring and Evaluating Evidence-Based Self-Management Programs (EBSMP)

NYS Prevention Agenda Webinar Series
December 15th, 2014

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- Today you will hear a presentation and have the opportunity to ask questions
- Find resources and materials at nyspreventschronicdisease.com
- Today’s session is being recorded

Webinar Guidelines

- Please designate one person at the computer
- Adobe Features you will use today:
  - Chat Box
  - Polls
Evaluations
Nursing Contact Hours, CME and CHES credits are available

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Today’s Objectives
- Describe evidence-based self-management programs for the prevention and management of chronic disease and be able to list examples;
- Define program evaluation and performance monitoring as it relates to evidence-based interventions and explain why they are important;
- Identify existing resources to evaluate and monitor three aspects of implementing evidence-based self-management programs; and
- Review an example of a local evaluation.
Today’s Speakers

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Bureau of Community Chronic Disease Prevention

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Bureau of Chronic Disease Evaluation & Research

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Glens Falls Hospital

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School of Public Health
University at Albany State University of New York

What are Evidence-Based Self-Management Programs?
**Research shows that patients are much more likely to attend these programs with a recommendation from their health care provider.**

**Program Description: EBSMPs**

**Evidence-based:** Programs based on sound, scientific research and have been rigorously tested for delivery in the community. Must be delivered as intended (with fidelity to original curriculum and delivery method).

**Self-management:** Programs that teach participants positive life skills to enhance well-being. These are delivered as a complement to clinical care and have been shown to significantly help people with chronic conditions.

**Components of EBSMP**
- Specific target population
- Specific, measurable goals
- Stated reasoning and proven benefits (research)
- Well-defined program structure and timeframe
- Specifies staffing needs/skills
- Specifies facility and equipment needs
- Builds in program evaluation to measure program quality and health outcomes

**Examples of EBSMP**
- Asthma Self-Management Training (ASMT)
- Diabetes Self-Management Education (DSME)
- Active Living Every Day (ALED)
- Arthritis Foundation Walk With Ease Program (WWE)
- National Diabetes Prevention Program (NDPP)
- Stanford Chronic Disease Self-Management Program (CDSMP)
- Stanford Diabetes Self-Management Program (DSMP)
- CDSMP Plus (Stanford Chronic Disease Self-Management Program plus hypertension module)
NYS Quality & Technical Assistance Center (QTAC NY)

- Works to build capacity for the high quality delivery of EBSMPs
- Functions as backbone organization to support statewide scaling up and sustainability of EBSMPs
- Assists partners through:
  - Dissemination of information, training and technical assistance, data management and reporting, program planning, implementation & sustainability support

Role of Prevention Agenda Partners in EBSMPs

DELIVERY  PROMOTION  REFERRAL

Prevention Agenda Track for EBSMPs

- Priority Area: Preventing Chronic Disease
  - Focus area: Increase access to high quality chronic disease preventative care and management in both clinical and community settings.
  - Goals: Promote culturally relevant chronic disease self-management education.

Objective: By 12/31/17, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.
How do we know if we are on the right path?

This was harder than we thought… (pant, pant)

HELP!!!! (where am I?)

Made it!

The mountain: a public health problem

Key Concepts

- **Performance Measurement**: The regular collection and reporting of data to track work produced and results achieved.
- **Performance Measure**: A quantifiable indicator of progress toward a defined goal or objective that captures incremental progress and enables informed course correction.
- **Program Evaluation**: The systematic investigation of the merit, worth, or significance of an organized public health action/activity to achieve a result.
- **Surveillance**: Ongoing, systematic collection, analysis, interpretation, and dissemination of health data.

Continuum of Data Collection and Use to Measure and Achieve Success

<table>
<thead>
<tr>
<th>What we do</th>
<th>What we are striving to accomplish</th>
<th>What we aim to achieve through individual accomplishments</th>
<th>What we aim to achieve through collective accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Measurement</td>
<td>Evaluation Of Local Interventions</td>
<td>Surveillance</td>
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Performance Measurement vs. Evaluation

- Performance measurement is an aspect of program evaluation
  - PM focuses on measuring what is occurring
  - Evaluation asks “why” or “how” it is occurring
- Program evaluation has several components, one of which can be performance measurement

Establishing Performance Measures and Standards

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Definition</th>
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<tr>
<td>Specific</td>
<td>Action oriented, clear direction, easily understood</td>
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<tr>
<td>Measurable</td>
<td>Quantifiable</td>
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<tr>
<td>Aggressive, but Attainable</td>
<td>Challenging yet realistic</td>
</tr>
<tr>
<td>Relevant</td>
<td>Focused on outcomes, not methods, results-oriented</td>
</tr>
<tr>
<td>Time bound</td>
<td>Based in a reasonable yet aggressive time frame</td>
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Adapted from: P. Lichiello & B. Turnock, Guidebook for Performance Measurement, Turning Point.

Why is program monitoring important?

- Ensures that you can monitor progress on your activities at the organizational level
- If you achieve these milestones, will result in improved health outcomes downstream
- Part of collective impact to move the dial on population health outcomes
- Partnership with QTAC allows for statewide snapshot of EBSMP capacity and reach
**EBSMP Logic Model**

*Increase availability, access to and use of EBSMP for chronic disease prevention & management*

- EBSMP are available in hospital or community settings
- Patients and providers are aware of EBSMP
- Health care providers screen and refer patients to EBSMP
- Patients participate in EBSMP for chronic disease

- Reduced prevalence of obesity, diabetes, CVD and other chronic diseases
- Improved control of risk factors and chronic diseases, including HBP and diabetes
- Reduced morbidity and mortality due to chronic diseases

**Delivery Activities**

- Assess organizational capacity
- Determine which programs to implement
- Determine population of focus
- Establish MOU with QTAC
- Recruit leaders/staff
- Train leaders/coaches
- Recruit participants
- Deliver program
- Monitor outcomes
- Evaluate and monitor progress

**Questions to Guide Measurement**

- What types of EBSMP fit with organizational capacity/mission?
- What gaps exist in current capacity to deliver EBSMP?
- Are we reaching our target populations?
Performance Measures
- # of MOUs established
- # of coaches/leaders trained
- # of program sites
- # and type of programs delivered
- # of participants and completers
  - And among target population (demographics)
- # participants achieving program outcomes

Data Sources & Collection Tools
- Capacity assessment tool
- QTAC MOU review
- Training logs
- List of programs delivered
- QTAC Partner Portal
- Participant data collection tools

Promotional Activities
- Determine objectives of marketing
- Identify program locations
- Determine which programs to promote
- Target specific providers or patients
- Develop and implement an outreach strategy
- Evaluate and monitor progress
Example Evaluation Qs: Promotion

- Are providers and patients aware of EBSMPs?
- What populations are reached by promotional materials and media?
- What forms of media and marketing are most effective?

Performance Measures

- # marketing materials distributed
- # providers/patients reached
- # of people who heard about EBSMP from hospital campaign
- # of clicks to EBSMP information on hospital website

Data Sources & Collection Tools

- Provider or patient outreach tracking spreadsheet
- Clinician awareness survey (ex: ASCP)
- QTAC Partner Portal
- “How Did You Hear” tracking sheet
- Page views based on promoted web link
Referral Activities

Obtain decision maker

Partner with community or hospital-based programs

Establish a referral policy

Put policies and systems in place to screen and refer patients

Identify and refer at-risk individuals to EBSPM

Establish mechanisms for patient feedback

Evaluate and monitor progress

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Example Evaluation Qs: Referral

- What community-based organizations are delivering EBSPM in the catchment area?
- What policies and systems are in place to refer patients to EBSPM?
- What processes exist for receiving feedback on EBSPM participants?

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Performance Measures

- # EBSPM sites in hospital or community setting
- # policies/systems in place to screen and refer patients
- # of patients screened
- # of patients eligible for EBSPM
- # of referrals made to EBSPM
- # of patients who were referred and attended
Data Sources & Collection Tools

- Community Service Plan or Partnership Assessment
- QTAC “Find a Workshop” Tool or Health Data NY
- Policy/protocol review
- Reports generated from EHRs
- Referral tracker

Data Use Opportunities

- Advocate for change
- Inform program planning
- Demonstrate progress
- Identify disparities

CDC Evaluation Framework

- Describe program
- Justify conclusions
- Gather credible evidence
- Utility feasibility propriety accuracy

http://www.cdc.gov/eval/framework
NYSDOH Evaluation Efforts around EBSMPs

- States are funded by CDC to evaluate efforts around actions to prevent and control obesity and chronic disease
- NYS evaluation project around EBSMPs focuses on four key drivers of the NDPP:
  - Availability of recognized programs, payers/payment mechanisms, referral policies, program attendance
  - What were major facilitator and barriers to implementing these drivers?
  - What were the key activities critical to addressing disparities in the four drivers?

EXAMPLE FROM THE FIELD:

GLEN FALLS HOSPITAL DIABETES PREVENTION PROGRAM

A conversation with Tracy Mills, MPP, CWPC
Director, Research and Planning

Q&A Session
Additional Resources

- NYS QTAC
- NYS Prevents Chronic Disease Webinar Library
- AHRQ Clinical Community Relationship Materials:
  - Evaluating Clinical-Community Linkages Road Map
  - Measures Atlas
  - Potential Measures
- The 1-2-3 Approach to Provider Outreach
- CDC Marketing Resources for the DPP

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