Moderator: Hello and welcome to Public Health Live, the third Thursday breakfast broadcast. I’m Joyelle Ray Alexander and I’ll be your moderator today. Before we get started I would ask you to please fill out your online examination at the end of the web cast. Continuing education credits are available after you take our short posttest. Your feedback is helpful in planning future programs. We encourage you to let us know what topics are of interest to you and how we can best serve your needs.

As for today's program we will be taking your questions throughout the hour by phone. The toll free number is 800-452-0662, or you may send your written questions by fax. The fax number is 518-426-0696. We will also be taking questions by email. Please email us at any time throughout the hour at ph.live.new york@gmail.com.

Moderator: Today's program is Engaging and Activating Patients for Better Health, The Power of the Chronic Disease Self-Management Program. Our guest is Lisa Feretti, a Social Director at The Center for Aging and Community Wellness. Thank you very much for being here.

Lisa Feretti: Thank you, I am thrilled and honored to be here today.

Moderator: This is an exciting topic and we're going to get right into it. We're here to talk about the chronic disease and self-management program but before we do that, can you talk about what self-management is?

Lisa Feretti: Sure! Self-management really focuses on the patient and what the patient believes is happening with their health care and their chronic condition. So it really focuses to help people to understand how to build confidence that they can better manage their chronic health condition by realizing the patient's central role, we really approach this differently. So rather than prescribing things for people, necessarily, we focus on getting people to think about what's important to them and how they can make changes and how to make decisions about how to implement the changes that they want to make in their lives. So it really builds people to develop proactive strategies and adaptive strategies so they can manage the day-to-day management of their chronic health condition, whatever that may be.

It also employs kind of a team-based effort so we look at it as a kind of holistic health approach so it's not just the doctors and the nurses and the patient but also family members, friends, coworkers and the community that really support the person as they manage day-to-day their chronic health care.

Moderator: A truly comprehensive effort.

Lisa Feretti: Yeah, it definitely is.

Moderator: It sounds a little bit like patient health education. How is self-management different from patient health education?

Lisa Feretti: I think the main difference between patient self-management and patient health education is that self-management seeks to help people build the skills they want to make to make changes in their life related to their health. Patient education helps people learn about their condition, what to expect, what will happen and that's important, but you also need to know how to apply that in your life so how will you make changes you need to make. Knowledge informs change but knowing something doesn't necessarily mean that you are going to do it.

Moderator: Absolutely.
Lisa Feretti: An example is that most people know that getting more physical activity will help them improve their life.

Moderator: Absolutely, but knowing it and doing it are two different things.

Lisa Feretti: You know that, but sometimes you still don't do it, but why? Why don't you do things you know are good for you?

Moderator: I don't know, Lisa.

Lisa Feretti: Probably for the same reasons other people don't. Maybe you don't have the time; you are having pain that day, all these other things going on in your life. Self-management education really seeks to give people the skills and the tools they need to be able to do those things on a regular basis so you know something that you learn from patient health education and self-management education helps you to do it, so it's really about the application of that knowledge. These two things are complementary and we can't do one well without the other, so we need to find ways to make those things work better together.

Moderator: I agree. I agree.

Lisa Feretti: The chronic disease self-management program has been around for a while, but there seems to be a lot of interest in the program recently.

Moderator: Next we're going to hear from Phillip McCallion, Director of the Center for Aging and Community Wellness. He will set some context into the center for chronic disease and self-management program, so let's take a look.

Philip McCallion: Hi, I'm Phillip McCallion, I'm with the Center for Aging and Center for Community Health. There are a lot of good programs out there. One of the things that distinguishes CDSMP is that there has been a concerted effort by multiple funders to develop infrastructure across the country. Certainly here in New York there has been efforts by the Department of Health, by the State Office for the Aging and then on a more local level by hospitals, by county offices for the aging, by the faith community, a whole variety of partners.

But what all of that really means is that we're starting to see an infrastructure really starting to develop and take hold in communities across the state and across the country, that it becomes possible that having been convinced that something like CDSMP might be very helpful for patients that physicians and other health providers can say, you know what, I'm going to refer you to a class and there will be a class that a person can be referred to. It's going to be happening within a time frame that makes sense and it's likely to be happening in a place that the person can access. And that's what infrastructure really is about; it's building something that someone can benefit from a program it's actually available to them to be able to participate in it.

Moderator: So it's a very important part of what CDSMP has to offer today, is that this infrastructure has been built and continues to be built.

Philip McCallion: There's an awful lot going on in the health care environment at the moment, a lot of new initiatives, a lot of considerations around cost controls, a lot of considerations around better management of care happening certainly within Medicaid and Medicare, happening more generally as we look at the redesign
of some of our health care system. Some of it clearly is being influenced as well by our considerations around the multiple chronic conditions framework so we’re really trying to understand -- I’ll step back a little bit.

One of the things that's very striking to me is that we talk about the size of the chronic disease, the population with chronic conditions and chronic diseases and one of the factors in that is that for so many people there's more than one chronic condition. So we really are looking within the different reform efforts within health care at how do we grasp that, how do we redesign our systems to better support the whole person? And so we're seeing initiatives like certainly health homes, medical homes, we're seeing initiatives that again focus much more upon self-management and the linkage in community supports and resources.

CDSMP clearly offers an opportunity to be able to advance some of those things. Within one of them, if you like, the stability of CDSMP programs, the diabetes program, we're looking into making that reimbursable under Medicare. We're looking at where this fits within a constellation of services, if they are not able to be e reimbursed directly what part of the package can be reimbursed.

Moderator: I think under the idea of medical homes this becomes a program that could be used to advance those types of ideas.

Philip McCallion: There are programs that have evidence to support them as well. The attraction here is to think about this is a program that's likely to have infrastructure. That's likely to be something that can be more universally available and I think we also have to think about this in terms of what's the potential to impact upon large numbers of people, whole communities, potentially, as well as addressing individual needs. And I think that that's the promise that CDSMP offers in the midst of all of these reform efforts.

Moderator: Well, that was some great information that Phillip covered. There's obviously increased interest in self-management education and the chronic disease self-management program. Lisa, what do you think is behind this? What do you think is moving the interest?

Lisa Feretti: I think there are many things moving the interest. I'll talk about maybe about just a few.

First, the national data is pretty compelling when you consider that over the past 10 years we have seen a steady increase of the numbers of people with chronic conditions and we're projected by 2030 to have about 170 million Americans who are living with chronic conditions, so that's an increase of about 37 percent. There's certainly interest in how we're going to better manage this as we move forward because we know we're going to have people living longer with more chronic conditions.

The second thing I think is that we also recognize that people with chronic conditions represent a lot of cost to the health care system. So I don't want to overplay the concerns everyone has about costs, but certainly health care costs are rising and a lot of the health care costs that are rising are related to these chronic health care conditions. It's not so much the on-going care but more the acute events that can happen for people who have more chronic health care conditions. The more events someone has, the more likely they are to have an in-patient hospital stay. This also increases the chance their hospital stay will be longer. There's going to focus interest as well.

Beyond the cost piece, the fact that we have people living with multiple chronic conditions is of great interest to everybody at this point because we have to figure out a way to help manage this. Our health care system was used to manage acute care. People get sick, they go to the doctor and they get better. That's not what
happens with chronic health conditions. You get sick, you get better but you have to figure out how to manage this for the rest of your life. There's a lot of interest looking at this at the national level.

The third piece that's really important is what we've seen in the advent of technology. With technology, particularly things like electronic health reports and other types of interactions, we now have patients in an on-going way. This presents an opportunity, if you will, to figure out how we can really work with people with their self-care because if we think about it, really, care that we get from our physicians when we have a chronic health-care condition probably is about 5 percent of the time. You know, out of the whole piece of this, 95 percent of the care that we do is self-care; it's what we do at home. It's the decisions we make about what we're going to eat and when we're going to exercise and how we're going to take our medications and all those things. Technology represents a way for us to influence that with people and really be more of a team. You know, on a more day-to-day basis, so I think all those things and many other things are moving that interest.

Moderator: Well, many other things, as you said, so maybe you could tell us in a bit more detail, if you would, Lisa, about the chronic disease self-management program. How was it developed and how do we know that it works?

Lisa Feretti: Okay, well, I'd be happy to tell you more about that. The first thing I'm going to tell you is that we don't call it the Chronic Disease Self-Management Program. That's actually because a lot of people living with chronic health care conditions don't identify with that language. One of the very few things you can change about the program is the name. Here in New York State, we call it the Living Healthy New York Program but it's known by many other names across the country and really around the world.

What you need to know that's important about the chronic disease self-management program, or I might call it the CDSMP for short, is that it's an evidence-based program. It was developed with a randomized control trial and through that randomized control trial a number of individuals saw significant changes in self-management, in health status, in simple actual management and other things for the folks who took the program. Unlike many other programs, the CDSMP has a large amount of evidence behind it.

In addition to that, the chronic disease self-management program addresses the concerns and problems that are really common for people who have any type of health condition. It's not just a class for people with diabetes but people with diabetes are in the same class as people with arthritis, osteoporosis, et cetera. Because of that you have these incredible interactions between the participants that help people support one another and to learn strategies from one another in a very encouraging and interactive environment so it's a really dynamic program as well. I think that attracts a lot of people to it.

It's also a program that's really appropriate for care givers. People who take care of other people often times really are more focused on the person they are taking care of than themselves and they may very well have chronic health conditions of their own; so the program helps care givers see how to better manage their own condition and deal with the problems they are having and try to deal with someone else who is also a self-manage. So it has a lot of pieces of that as well. It gives people an opportunity to figure this stuff out, practice the skills and learn how to apply it to them and get feedback from their peers as they work through how they are going to manage the day-to-day management of their chronic health care.

Moderator: Would a care giver be at one of those sessions with their patient or independent of their patient or a combination of both?
Lisa Feretti: Actually, it could be both. They’re very dynamic when you have care givers and the people you care for in the same workshop because, you know, a lot of light bulbs go off for people as you go through these things.

One of the things that's interesting for care givers is that care givers want to make goals that are really the goals of the people they are caring for. While sometimes we see some tension, there’s an opportunity to bridge some of that and help everybody to have better interaction.

Moderator: Now, Lisa, you touched upon the self-management techniques. How do they work?

Lisa Feretti: Self-management techniques are the things we teach people in the workshop that help people learn how to apply these things. One of the things we do is have people set short-term goals, a weekly action plan. They implement the plan knowing they are going to come back next week and talk to the people in their workshop, so there's a little built of accountability and gentle persuasion that happens but it's also a way for people to taste success. If they pick something they are successful with they get a lot of positive reinforcement from the group.

If they are not successful what they also get is an opportunity to help figure out why, so some of those problem solving, to develop those problem-solving skills that will help them on an on-going basis to manage things outside of the workshop.

We also have a lot of cognitive symptoms management, like distraction, positive thinking, progressive muscle relaxation, those types of things and other types of strategies, we have this whole self-management toolbox that teaches people multiple tools but beyond just the multiple techniques or tools is that we teach people most of those tools can be used to address many of the symptoms, whether they are physical symptoms or emotional symptoms or whatever. That gives people a real arsenal so they can go after the problems they are experiencing so it's very powerful.

Moderator: Powerful and interesting. Is there research to support what you are telling us about?

Lisa Feretti: Yeah, there is. As I mentioned earlier it's an evidence-based program so with randomized trials, the original work was done by Dr. Kate Laurig at the Stanford Patient Education Center. They did a randomized trial with a thousand people, some in the randomized group and some in the control group and also reductions in E.R. visits and physician visits.

The other real interesting piece, we talk about is increasing your confidence. The higher the increase in confidence or self-efficacy at the 6 month follow-up for these patients, the lower their health care utilization for a year. So we see that when we increase people's confidence in the short term, in the long-term we can benefit from that. Many of these cost savings held for 6, 12, 18 and even 24 months for some people.

The last thing I will mention about that is the CDC arthritis program did a study of the CDSMP. Whether it was for different target populations or different settings, et cetera, and the studies actually showed that on many of the same variables that we looked at, we saw small to moderate changes or effects which means that there’s also a possibility for a public health intervention for this as well. It’s not that it’s just in particular settings but we've seen those things hold across settings and across populations.

Moderator: In addition to benefits to the participants, are there financial benefits as well?
Lisa Feretti: Yeah, there are. Part of the Stanford Study was also to do a cost effectiveness study.

Moderator: Is this going to save money? We did see in the original study cost savings for patients somewhere between four and five hundred dollars per patient and at the same time we saw reductions in hospital in-patient stays which we all know can be very expensive. All these point to the opportunity for potential savings for the CDSMP for patients but also for systems. Another piece of the work that they did out at Stanford was looking at a health care system. In this case it was northern California Kaiser Permanente, they found that for just slightly under 500 patients the system saved $400,000. So it’s easy to see how the financial benefits can really add up quickly.

Moderator: Lisa, I understand that the CDSMP also has several associated programs. Can you tell us about the other versions of the program?

Lisa Feretti: Yeah, absolutely! You know that’s been kind of an interesting thing that’s developed as well. The chronic disease self-management program is what we think of as the flagship program. It catches everybody no matter what kind of chronic health-care condition you have; but there were also several other iterations of the program that have been developed. One that I want to talk about particularly is the Spanish language version of the CDSMP which is called the Tonando Program. This was studied in another way. It had additional studies with it to provide a cultural program. It's not a direct translation from English to Spanish but it was studied whether the program itself made more sense to people of Spanish language cultures. It still has the same core tenets but it also has other things that are specific to this target population.

In addition to that, I think they are listed on the screen right there. There’s a number of other programs. I’ll just mention one of the more condition-specific programs— that’s the diabetes self-management program that’s also available in English and Spanish. That program has a 50 to 60 percent of the same things we see in the CDSMP, the same core tenets, but in addition, it has some other guidance to help people who are living specifically with diabetes. So it really provides additional information on things like managing your blood sugars and planning meals and planning for sick days. All of the other disease-specific programs do similar things.

Moderator: Thank you, Lisa. It certainly sounds like there is a lot of evidence to support using the chronic disease self-management program to help people engage more fully in their health care. This might be a great time to hear about the benefits of the program from someone who has taken the workshop. Let’s take a look.

[Video]: Hello, my name is Norma Pettit and I'm a member of the Program Healthy Living. Healthy living, to me is believing; believing in myself. You know, even when you go to the doctor you don't tell him everything and some doctors don't care about whether you bring notes or not. “Oh, put them away, they will say.” But when you go to the doctor you can’t remember everything and you only have a few minutes but then you get back home and it's, now I don't know what to do for myself. But by talking with each other, we maybe have the same experience. So sometimes we get more help from each other.

Since I started the healthy workshop six months ago, I discipline myself. I really do my walking, I really do the walking on the stairs, I have a pump bicycle and I have it right in front of my couch and I use it several times a day, maybe only a couple minutes, maybe 10 minutes, maybe 20 minutes, but it's there for me when I want it, when I need it. I might sit down for a few minutes and I'm always thinking of something to do. That's probably one of the best things for me because if I don't do it, no one else is there to do it. If I drop something on the floor, if I don't pick it up, there's nobody behind me to pick it up.
I enjoyed it. We looked forward to it. We made sure; I think everybody that signed up for it was there every meeting. We visit and we joke and we laugh and laughing is also good medicine. I think the more people we can get to come to these things, the better their chances are for a better life.

Moderator: Well, you know it’s easy to see why people like the workshops and the personal benefits but I’m also wondering if there are benefits to health care providers as well. You talked about health care of care providers or caretakers. I’m wondering if health care providers also reap benefits from the program.

Lisa Feretti: Absolutely they do. The first and most obvious one is the potential for cost savings that we talked about. Cost savings, not just about health care dollars that people spend but also the resources available in health care systems and health care provider offices, et cetera. That’s one potential benefit that’s pretty obvious but I work with a lot of health care providers in the field, many who I’ve trained to be leaders or trainers for this program. You know, what you hear all the time really is that health care providers are just as frustrated as patients are when things are not going the way they should be going. People get into the health care system because they want to help people have better outcomes, not necessarily to worry about the business aspects of this. What I learn from that is that there’s an opportunity and potentially a benefit for health care providers to build better interactions with their patients, which hopefully leads to better health outcomes for everybody. I think a good example of this is what we see in the chronic care model, which is kind of a road map, if you will, for effective management of chronic health conditions. Remember that we said earlier that acute conditions are sort of what our system is set up for. Well, the chronic care model actually helps us look at this system together where it’s not just about what patients do and it’s not just about what the system can do, but it’s how those things interact to create those good interactions between patients and their providers.

Moderator: Well, tell us a little bit more. How exactly does it work?

Lisa Feretti: Sure. I think there’s a graphic up there that gives you, this is the graphic representation of the chronic care model. On your screen what you can see is that the overall goals of course which is at the bottom here are improved outcomes. It doesn’t say improved outcomes just for patients but improved outcomes. Everybody wants to benefit.

The key to this is improved interaction between providers and the system, not just communication but actually interactions that are helping to improve these outcomes.

You also see, and I don’t know if maybe they can circle that, but there’s a bullet there on self-management support. So we have the health-care system side, we have the community health care side and then within the community health care side, self-management support. Self-management support is what activates patients to get engaged in this interaction and take advantage of both community resources but also to work better with the health-care system.

So the CDSMP, which is a self-management program, obviously is a really good fit. It fits into that niche really well because it’s a community-based program. The intervention meets people where they live and where they live with their chronic health care conditions and where they manage that 95 percent of self-care. Hopefully, you know, what we see from all of this improved interaction is that we have patients who are more informed and more activated, better able to influence their own health care outcomes and hopefully health care systems that really feel that they can meet the needs of their patients as well.

Moderator: Lisa, take us through that. What do informed and activated patients do?
Well, they do lots, actually. Informed activated patients are people who are engaged in their health care. They both seek knowledge about their condition but also seek to make changes in their behavior that will help them to have better health outcomes and have better personal wellness. There’s another graphic up here that describes something called a patient-activation measure. This is a measure that kind of sets people on a continuum from 1 to 4 with 1 being sort of the least active, although not active at all, and 4 being folks who are really active in their engagement around their health care condition.

Obviously we like to see everybody be a 4, but not everybody is there. It’s important to remember, though, at every level even if you are in that level 4 where you are maintaining largely your health care behavior changes, et cetera. Even folks that level can still benefit from self-management education because if an adverse event happens or if something, some crisis happens and they falter, they may now be sort of set back or relapse a little bit in terms of their level of activation. They may become a little disillusioned that the things they were doing didn't make a difference. So there's an opportunity always for us to be moving people along this scale.

Here in New York State we surveyed about 500 people who were folks coming to our chronic disease self-management program and we took a look at where they were at base line on this scale. We saw about 65 percent. So 2/3 of the people coming to these programs were in the stage 1, 2 or 3, so really had a significant opportunity to progress along this scale and hopefully could take great advantage of the self-management education through the CDSMP.

We don't know yet because we don't have all the data for whether or not it moved people along that scale. But, we're sort of speculating that that's what happens, that people who engage in a program like the CDSMP will become more activated patients and will move a little bit on that scale because they will now have some of these tools and strategies that they need to be successful and build confidence and we're hoping that when we have all the data that that's exactly what it will show.

In addition to that, we collected a lot of other data so the measure can help us understand not just who took the program but who benefited the most from the program because when we couple that with the other information we have about outcomes and ratio, we can find who the program is the best fit for which can also help us understand who it's not a good fit for, the CDSMP, and what do we need to do to get folks ready for self-management education.

Moderator: My understanding is there are other programs out there, why would health care providers choose this program over others?

Lisa Feretti: Hopefully take my word for it, but if they won't, don't take my word for it. One of the reasons you would pick this over other programs is because it has been around for so long, because it has been tested in so many ways with so many different populations and we know it works. It works in community-based settings. It works in community settings, and we know it works for everybody. We've got all this evidence that shows that people can take these changes and these changes stick. They stick for 6 months, 12 months, 18 months, 24 months and even 36 months in some cases so why not choose the CDSMP?

I think one of the other reasons is there has been a tremendous amount of effort in the last couple years to disseminate this program really widely. The federal government through some of the American reinvestment and recovery act funds provided funding to the U.S. Administration on Aging who then disseminated that through 45 states and two territories to actually build an infrastructure to deliver this program. So while some of us were working on this, this allowed us an opportunity to ramp up the effort to the point where we have a
lot of New York State covered and this program can be available to people everywhere. If you are a clinical provider and you are trying to figure out how I can get people self-management education, it might be as close as the next community center or someone right outside your door.

In addition to the great evidence, we know it's readily available in most places and it's also a low-cost model. It relies largely on peers who are volunteers and so while staff resources are used typically as trainers, peers who are volunteers deliver the program and by doing that we can keep the cost of the program down so it's something that can become part of regular clinical care without increasing the cost of the program.

Moderator: So cost benefits, evidence, access, research, deliverables, outcomes, you certainly have made a solid case. I think this would be a great time to hear from Bonnie, a Nurse and Health Educator who has been working with the chronic self-management education program for several years. Let's take a look.

[Video]: Probably learning about self-management programs did change how I look at educating people in the community. Rather than just standing and giving out the facts, that you have them work with goals and action plans and problem solving and brainstorming. By individuals working through those methods, it does put them in the mode of thinking about their own care and self-management and putting them more in the driver's seat instead of just rote learning.

Project healthy life is important because it is evidence-based, but it's also important because it includes everyone with chronic disease, whether you have diabetes, heart disease, lung disease or arthritis, all those people have the same concerns, the same fears, the same problems. So when you put them all in a room together and have the class, they interact together and can help each other.

The very first course that we taught was to a senior complex. We had about 15 people in the class. They went through the class doing very well, doing all of the activities, the action plans and the brain storming. When we got to the very last class, a man who had come to the first 5 classes in a motorized scooter came on a walker. A lady who had always come to class with oxygen that she used 24 hours a day, 7 days a week, came without her oxygen, which really scared me, and then a man whose blood sugars had run constantly for several years in the 300's and who has had, he said, for the last 3 weeks in the course, nothing over 115, which was really good for somebody who has diabetes.

I really do believe these things were able to happen to these 3 people because of taking the 6-week Project Healthy Life Course.

Moderator: Lisa, you were here to talk about chronic disease self-management programs in New York State. Several years ago I recall when things were just getting started, in just the last two years as part of the national effort to build infrastructure to deliver chronic disease self-management program, your center, partnering with the New York State Center for Aging and Department of Health, have expanded access to the program to much of the state through some of the innovative partnerships that we referred to earlier in the program. Can you describe how that's been done?

Lisa Feretti: Yeah, that was a big effort.

We are one of the initiatives through the U.S. Administration on Aging, but we do have a really long history with the CDSMP here in New York State. While those funds helped us expand the work we were doing, a lot of this work was being done already and really provided a lot of opportunity to link that together. I'll talk more about that in just a minute.
The focus here in New York State was largely on working with older adults with multiple chronic conditions so even though many of our partners serve many other people, and that was absolutely perfectly fine through all this, our purpose was to work with older adults with multiple chronic conditions largely because of the things we mentioned earlier but there's also some other data we can talk about related to that.

Some of our decisions on that were because of the funding and through our partnerships but at the same time we have to recognize that folks who are older who have multiple chronic conditions are actually, you know, impacting the health care system and are actually experiencing a lot of adverse effects from not maybe having the good care they need and self-management can really help with that.

Also I think there's a graphic up about Medicare spending. Medicare is the public funding that funds health care for people over the age of 65 and also for people with disabilities. When we really look at that, this graphic represents that, we see that the spending for people with chronic conditions is higher the higher the number of chronic conditions. People with 5 or more chronic conditions are using I think it's 59 percent of the health care resources in Medicare, so we wanted to disseminate the program in a way that we could reach targets who could potentially benefit health wise from the program; 2, maybe slow their progress, the progressiveness of some of their chronic conditions but, 3, could also potentially represent a cost savings or a cost avoidance for Medicare and other health care systems. So there's a lot of thought that went into that and why we would do it that way.

Now, the way we did it, here in New York State was we broke the state into 6 regions. So the regions are not sort of equal geographically because we have really some regions that have only a few counties and some that have up to 17, but what we tried to do was by looking at that population say to ourselves, within these regions who are the people who are at risk, the people who are 60-plus and have more than one chronic condition. So, we tried to break it up population wise so there was an opportunity for each of the regions to reach similar numbers of people.

Now, as I said, we have had a really long history with the CDSMP here in New York State. And so we also worked really hard to link in organizations that were already delivering the CDSM PCHL because there's been many organizations delivering this apart from any effort the state has made, so we really wanted to find those folks and link them into this state effort so that together we could work to more broadly disseminate the program, we could link those partners with our new regional partners to an area that could become much more accessible much more quickly.

We did all that realizing we had to pay close attention to the quality assurance and the quality improvement part of the program. We know if people are going to fund the program we have to be sure we are delivering them the way they were intended to be delivered and that's consistent. So, if you go into a program in Broom County and you walk SBA a program in New York City or the Walk SBA a program in Saint Lawrence Program, it's the same program.

Moderator: That must have been incredibly challenging because the state is so diverse geographically, you have suburbs and rural communities large and small. How did you go about zeroing in and kind of tailoring the program for those areas in diverse regions?

Chris Feretti: That wasn't easy. That's a big question. It wasn't that easy but it was something that we really did and did achieve.
What we did was we named like a regional lead, so in all our regions we worked with one particular partner who would serve as the representative for that region to help disseminate information, to help to get training capacity built and to link in partners.

Chris Feretti: That's easy in some of the regions that are pretty small, but in the Western New York Region, which is 17 counties, that's a little more challenging. So what it became about was linking those partnerships together.

Moderator: How do we find folks who are doing this and interested? Can we bring them to a central location and can we make them work well together and help them work well together?

Chris Feretti: We did that with technology. Remember I mentioned technology. We used an online learning community. So we developed this learning community as a way to disseminate information. It helped people with logistical support. So, if they needed help with licensure, if they needed help with bulk purchasing, if they needed information about recruitment or training or quality assurance, whatever the case. We used this online learning community to run monthly webinars, we used it to disseminate information, we have forums on it and blogs, there's a shared calendar so you could find out where there's training near your location and we also have like a shared learning tool file cabinet so all these kind of things that not just we developed but were developed by many of our partners are housed there. So as a member to the online learning community you can guess get access to all these things quickly and easily which really helped. A lot of fun. I like technology so I was happy to see that be a good vehicle to really do this. As you said, New York State is a big state.

In any case, we also collected a lot of data on all the work we did, so we learned a lot about our partners, we learned a lot about the programs and the delivery sites, we learned a lot about the participants and how satisfied they were with the program, we worked a lot with leaders to understand their delivery and how they were doing with that and to support them, you know, in their on-going development as leaders of the program. We collected a lot of data related to outcomes for patients as well as some of the other things we mentioned--the patient activation program, et cetera. So hopefully all this comes together to tell the story of what we achieved. I think it will also tell us what we didn't achieve and what we will do next.

I can't talk to that right now because we don't have all the data, but in May of this year, May 7 and 8, we are going to be holding a summit where we will disseminate all the information on the program and bring multiple partners together to start working on sustainability plan for the program in all the different regions in New York State.

Moderator: If you are in New York State, please stay tuned and tune in for that. I think that, you know, all of this presented a great opportunity to disseminate the program and maybe we want to talk. I know we have some maps so maybe show people a little bit of what we did by looking at the maps.

Chris Feretti: The first map we have, hopefully you can see that on your screen. We can see the outline of the 6 regions so each of the regions is kind of outlined in black. Within that hopefully you can find your county and see which region you are. That will help you again if you go to the web site. If you are interested in learning about your region, you can find out who your regional contact is, et cetera, so if you want to learn more that way, that's one thing.

The next map I will have put up, shows all these shaded gray areas on the map. The shaded gray areas represent counties that have the capacity to deliver the program. So by capacity, what we mean is that we
have trained master trainers or trained leaders in those communities who are ready to deliver the program. So either they are delivering the program on their own or they are potentially available to train people in your organization to deliver the program for you.

Roughly 50 percent of the state, maybe even a little bit more. More than 50 percent of the population of the state has capacity or has access to the program because a lot of our population center is down state. I know we have a lot of really robust areas in the New York City area but you can see from the map that even Erie and Chautauqua counties are included.

The next map will put some hash marks on there. In those counties we have access to some of the additional programs; things I mentioned earlier, Tomando Program, the diabetes self-management program, the positive self-management program, et cetera, et cetera, those are all available in those places as well and we can bring the other programs to the other counties but this is where we have the capacity currently built from the two-year project.

The last map I'm going to show you is where we delivered programs. Obviously a lot of concentration on programs is in the down-state area where we have a lot of population, but we've spread the program across the state fairly well. The different colored dots represent the different programs. Most of the work done is CDSMP but a fair amount of work on the Spanish language versions of the program and the diabetes program as well.

It's been a long road, this is something we could have done only with all these innovative partnerships, with various centers on aging, federally qualified health centers, community networks and community care networks, just anybody and everybody, faith-based organizations, anybody who would hear us -- we brought the program to. So it's been a tremendous effort by everyone in the state and there's still work to do, as you see from the map, you know, but at least, you know, we feel that we really made a really good start on trying to reach people everywhere in the state.

Moderator: Well, let's talk about those people. Okay, what can you tell us about the people that you have reached through this particular effort, Lisa?

Lisa Feretti: We reached a lot of people, although I will say we didn't really scratch the surface of the numbers of people who can benefit from the program, but in New York State in about 18 months, it's been a two-year project and it took us a while to get ramped up. In 18 months we reached 4700 people, not a small amount but not what we could do if we could move the program a little bit more. That happened in about 400 workshops; a little less than 400 workshops. We reached people from age 18 to 100. Even though our target was largely older adults and you can see the mean age we had was just slightly under 70, so obviously we reached mostly older adults but in addition to that we really did reach people across the board age-wise.

We also reached people who did not report having really good health. So remember we talked about the patient activation measure earlier, typically people who are more activated perceive themselves as having better health, not always but often. 25 percent of the people we reached really didn't feel that they had good health or felt they had poor health, which also presents to us some information that we have reached beyond what we call the low-hanging fruit or the people who normally join these programs and we found people who really have an opportunity to engage in their own self-management, maybe in a different way than they ever have before. Since we know CDSMP really moves status for people, we are excited to look at our data and find out what happened with that.
Lisa Feretti: In addition to that, we reached a diverse group of New Yorkers and I think there's a pie chart on that that reflects people of all races and ethnicities. We delivered a lot of programs in other languages other than Spanish, we did a lot of work with Russian programs, Chinese programs, Korean, Japanese, so we had a lot of opportunity to reach a very diverse group of people in New York. I don't have a chart for this but we did reach both men and women. We reached more women than men, which is pretty typical because women, I think two reasons, one, women are typically the joiners of these type of groups but women also are living longer. When we see our group is on the higher end, I think that says we need to do more work to reach men. I don't want to down play that like good for us, I think we need to reach more men. We reached men and women but with some opportunities.

And we reached folks with multiple chronic conditions, which was the other target. We wanted to meet folks who had one or more chronic conditions. Again there’s a chart for this but if you look at the overall effort, here is by region and you can look where you are if you are interested in your region. If you draw your focus to the New York State total, about 50 percent of the people we reached had two or more chronic conditions so we definitely found the people who could benefit from it, not that everybody couldn't, but in terms of our own target.

So I think we reached our target but we also developed really great partnerships that I think will be long-lasting and can help us reach out to many more people than we have had an opportunity to reach before. Good job, but there’s more to do.

Moderator: You have made significant inroads. We have some questions that have come in and let’s get to this. This comes from the University of Connecticut. How can I support this kind of program if a specific chronic deals with a small underserved population with unique needs? Are there funding sources to demonstrate the feasibility and efficacy of a program with this small population?

Chris Ferretti: In terms of funding for the program, in terms of long-term, we have certainly looked at and it is being looked at, at the national level. In terms of the program, you need to identify the target population. There’s a lot of work being done in Connecticut. I have worked with folks there, so there are CDSMP programs in Connecticut. One way would be to link up with those programs and find out if there’s a way for you to link up and build capacity and also if it’s a particular target population that’s underserved. Certainly if there’s a university-based question, there’s a research opportunity to look at these things. I’d be happy to talk with that person more at length about some of those things and to connect them with the people in Connecticut that are doing a program if they are interested.

Moderator: Is there a web site or contact information or you or telephone number?

Chris Ferretti: There’s a slide. I don’t know when they are going to put it up. I’ll read it to you -- they have it, okay. Well, that’s helpful resources. There are other helpful resources on your screen right now. The first one is the Stanford Education Research Center, you can certainly contact them as well, but in addition here’s our contact information here. We have an 800 number you can call us at. We also have an email that’s easily accessible and we have staff there that can connect you directly with me if your questions are more specific to some of these efforts or if you just want to learn more about the program in your area you can do that.

Moderator: Has cancer or cancer screening ever been included in this program to reduce risk factors for cancer or to increase cancer screening?
Chris Feretti: So certainly any screening of any type is something that we would hope when people are good self-managers and are activated patients that they are engaging in those types of behaviors. We don't add things to the program so we wouldn't add in any type of screening to the program because the program itself again, is evidence-based and exists, kind of, on its own.

That said, we have had many many cancer patients in our programs. There's certainly, again, a lot more information about that out there, but it certainly is a good fit for that, yes.

Moderator: And how do you go about attracting and retaining participants.

Chris Feretti: I think the most important piece of recruitment is helping people understand what the program really is and what it isn't. Remember we talked earlier it really isn't patient health information so if someone thinks they are going to come and sit and bring their pill bottles and get a medication reconciliation, that's not what happens. We developed here in New York our version of what we call a session zero, to help people understand what the program is, how interactive it is, and to recruit people into the program. That's available on the web site.

Moderator: Are there lay leaders, do you pay lay leaders or are they volunteers?

Chris Feretti: We have had both models. We have many, many volunteer lay leaders and usually it's the role of the master trainer who trains lay leaders for an organization to try to mentor those people.

We do have dropout rates of lay leaders. Lay leaders are people who have chronic conditions and sometimes they have to take care of their own health. Sometimes they can leave programs but the retention rate is about 70 percent or so.

Moderator: Do you use community-health workers?

Chris Feretti: We are getting more into community-health workers and they are, again, great folks to be lay leaders for this program.

Moderator: When we looked at the map of New York State, the map shows that the workshops, someone indicates it doesn't show that the program exists in their area. Does this mean that a participant or a provider, even, could not participate if it's not specifically in their area?

Chris Feretti: No, absolutely not. Again, this is why we've been able to develop so far. In fact the last couple months of the training, of the grant, we have been doing a tremendous amount of training to try to expand our reach. The Quality and Technical Assistance center hopefully is here to stay so if you are interested in training you can contact us and we can partner with you to figure out how do we get the program into your community?

Moderator: That's exciting. You described how health-care providers can benefit from their patients participating in the CDSMP. Can you give some examples how a provider might recommend the program to patients?

Chris Feretti: I mentioned technology earlier so an electronic health record is potentially a way this can be built into that for anybody who has a chronic health condition can be recommended.
I think beyond that one of the things that's happening right now that representing a real opportunity are the medical homes and the patient centered medical homes. We have done some work with patient centered medical homes, trained some of the staff and that links the clinical piece and we're seeing out in Western New York. There's a whole effort to bring the CDSMP to physician practices. Some of that is just making physicians aware of the fact these things are happening in their community but it also is about working with them to understand how they can most quickly and easily recommend the program to people.

One thing I will say about this is we all want to link doctors into this and other health-care providers but we have to make sure we have programs and other things available that are on-going. One of the challenges of these things is to keep the program available for those who need it.

Moderator: This has been a wonderful program. You and Phillip are doing a wonderful job, you certainly provided us with great contact information, background information, evidence this program works and your passion is infectious so we appreciate you being here today.

Chris Feretti: Thank you so much, it was a real pleasure being here today.

Moderator: Thank you so much for being here today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. An archive of this web cast will be on our web site within two weeks. Visit www.phlive.org and complete an evaluation and the post test for today's offering. Please join us on March 15th for the next broadcast of public health live on teen pregnancy prevention, lessons learned from New York State. I'm Joyelle Ray Alexander, thank you for joining us on Public Health Live.