CA HEALTHIER LIVING COALITION

WEDNESDAY, APRIL 30, 2014

1:00 PM – 4:00 PM

Welcome

Thank you for joining us today.

We appreciate your patience as we wait for others to join the webinar.

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CALIFORNIA HEALTHIER LIVING COALITION

In-Person Meeting

WEDNESDAY, APRIL 30, 2014

1:00 PM – 4:00 PM

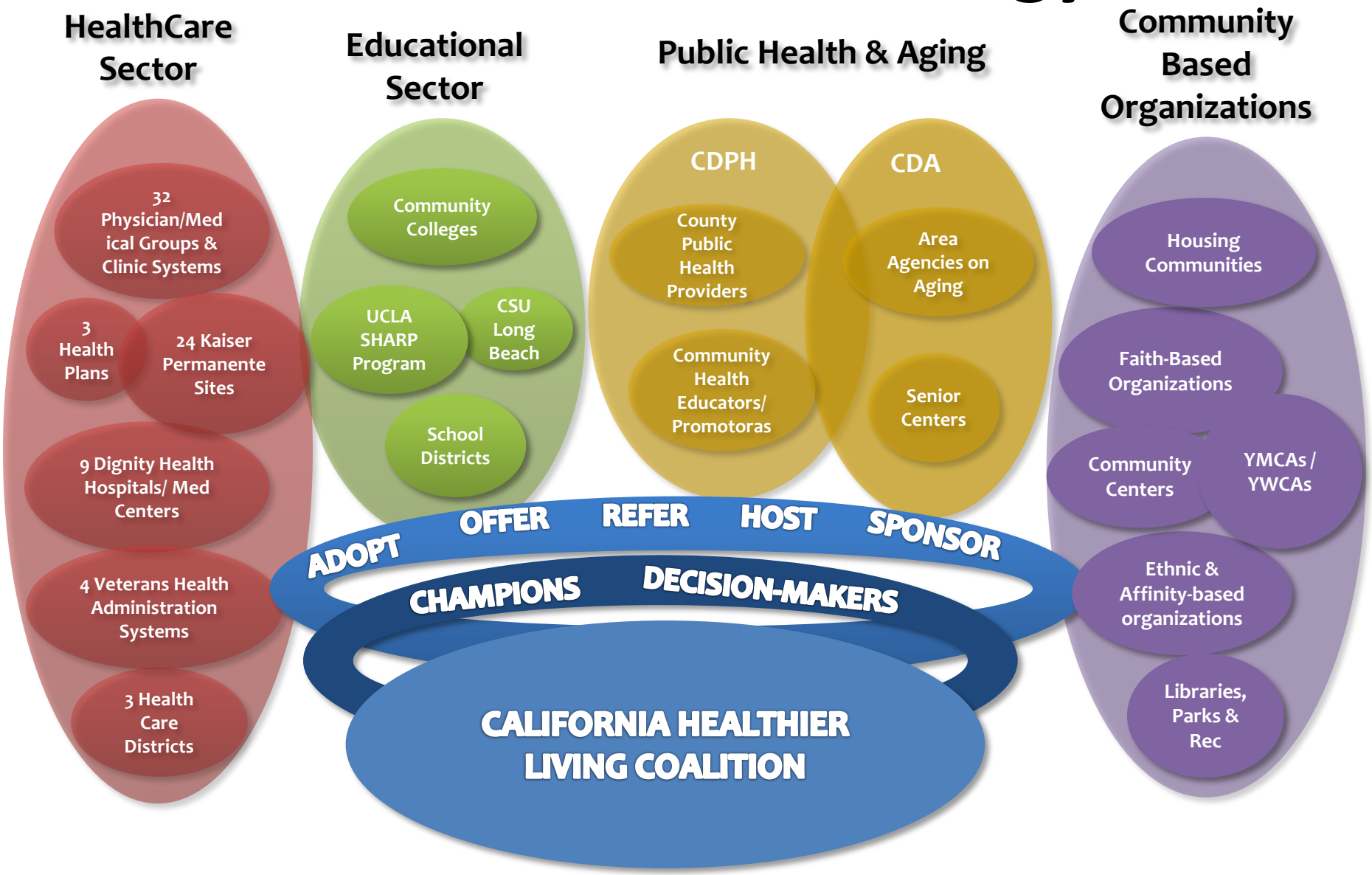
C A L I F O R N I A

HEALTHIER LIVING

Living Your
Best Life…

CALIFORNIA DEPARTMENT OF AGING
1300 NATIONAL DRIVE
SACRAMENTO, CA 95834
CONFERENCE ROOM 1A

Dissemination Strategy

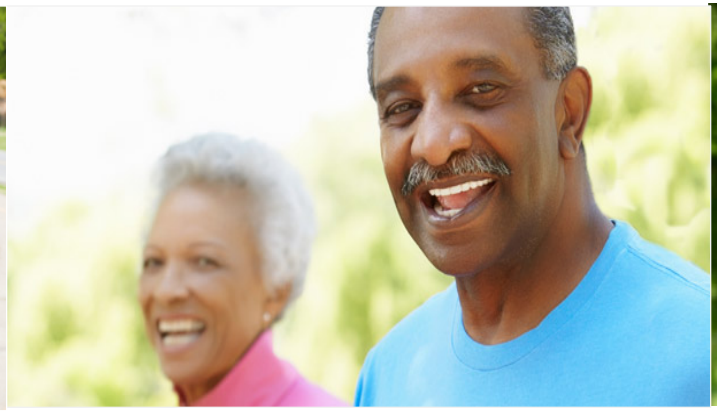


MAKING THE CASE FOR CDSME WITH KEY DECISION MAKERS

Eileen Barsi

Senior Director, Community Benefit

Dignity Health



Making the Business Case for Chronic Disease Self-Management Education

Eileen Barsi
Senior Director, Community Benefits
April 30, 2014

Dignity Health™

DIGNITY HEALTH – ABOUT US

- **OUR MISSION**
  - We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:
  - Delivering compassionate, high-quality, affordable health services;
  - Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
  - Partnering with others in the community to improve the quality of life.

- **OUR VISON**
  - A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served.

Looking Back and Looking Forward

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In the Beginning…

The Community Need Index

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The Community Need Index

- The Community Need Index (CNI)
  - *Qualitative* means of defining community "Need" at a local level
  - *Standardized* mechanism for identifying variation in local need
  - Tool to help *Justify* and *Prioritize Resource Allocation* at a local level
  - Baseline against which to *Measure Performance Over Time* toward meeting community need

CNI Scoring Comparison

		Green Valley, AZ 85614		Compton, CA 90220	
Barrier	Indicator	Indicator %	Barrier Score	Indicator %	Barrier Score
Income	Elderly Poverty Child Poverty Single Parent Poverty	3% 8% 32%	3	17% 27% 40%	4
Cultural	Minority Population Limited English	8% 1%	2	97% 16%	5
Education	Without HS Diploma	9%	1	45%	5
Insurance	Unemployed Uninsured	4% 13%	2	15% 32%	5
Housing	Renting %	12%	1	38%	4
Final CNI Score			1.8 (Low Need)		4.6 (High Need)

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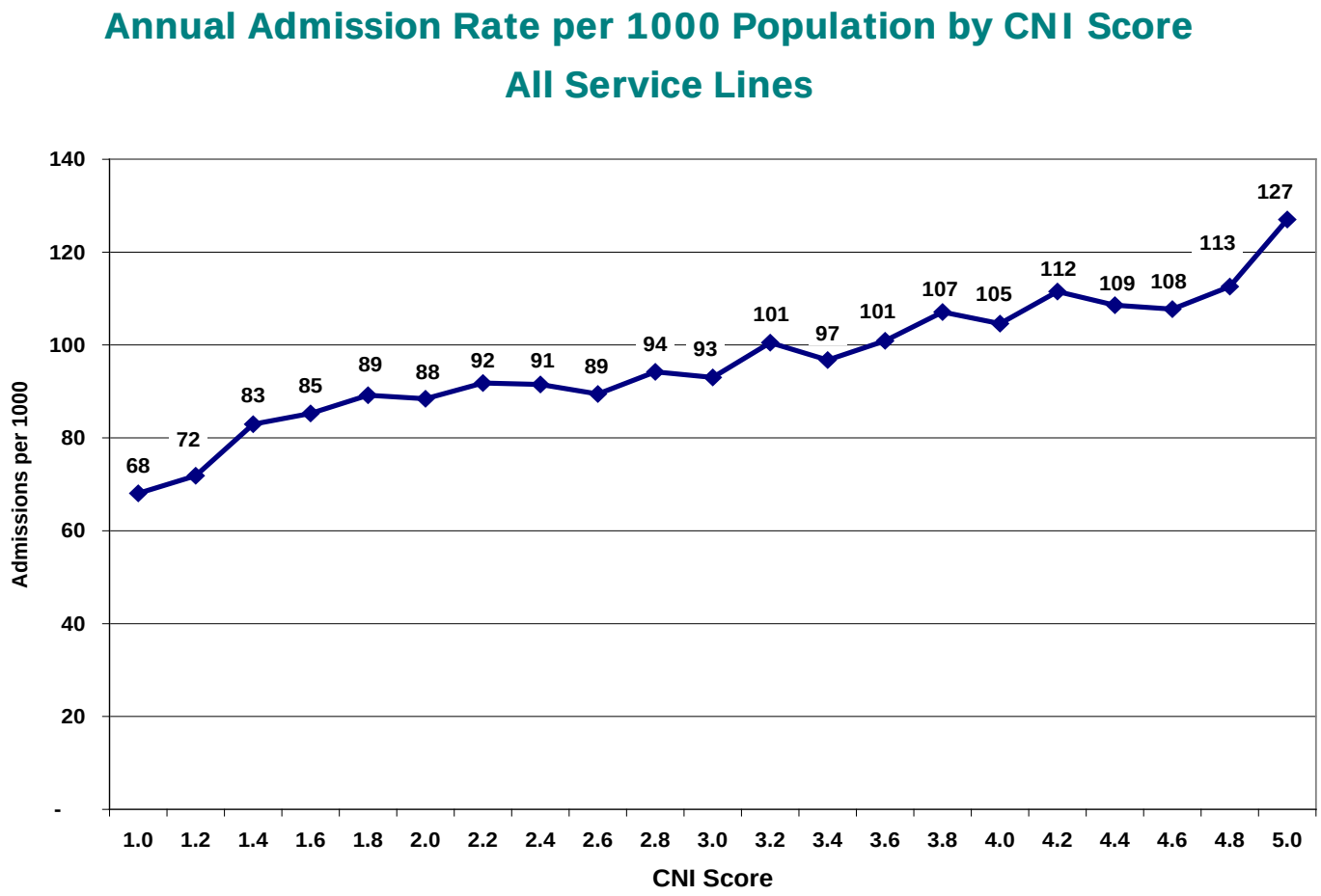
Strong Correlation with Discharge Rates



Admission Rates in High Need Areas Twice Those of Less Need

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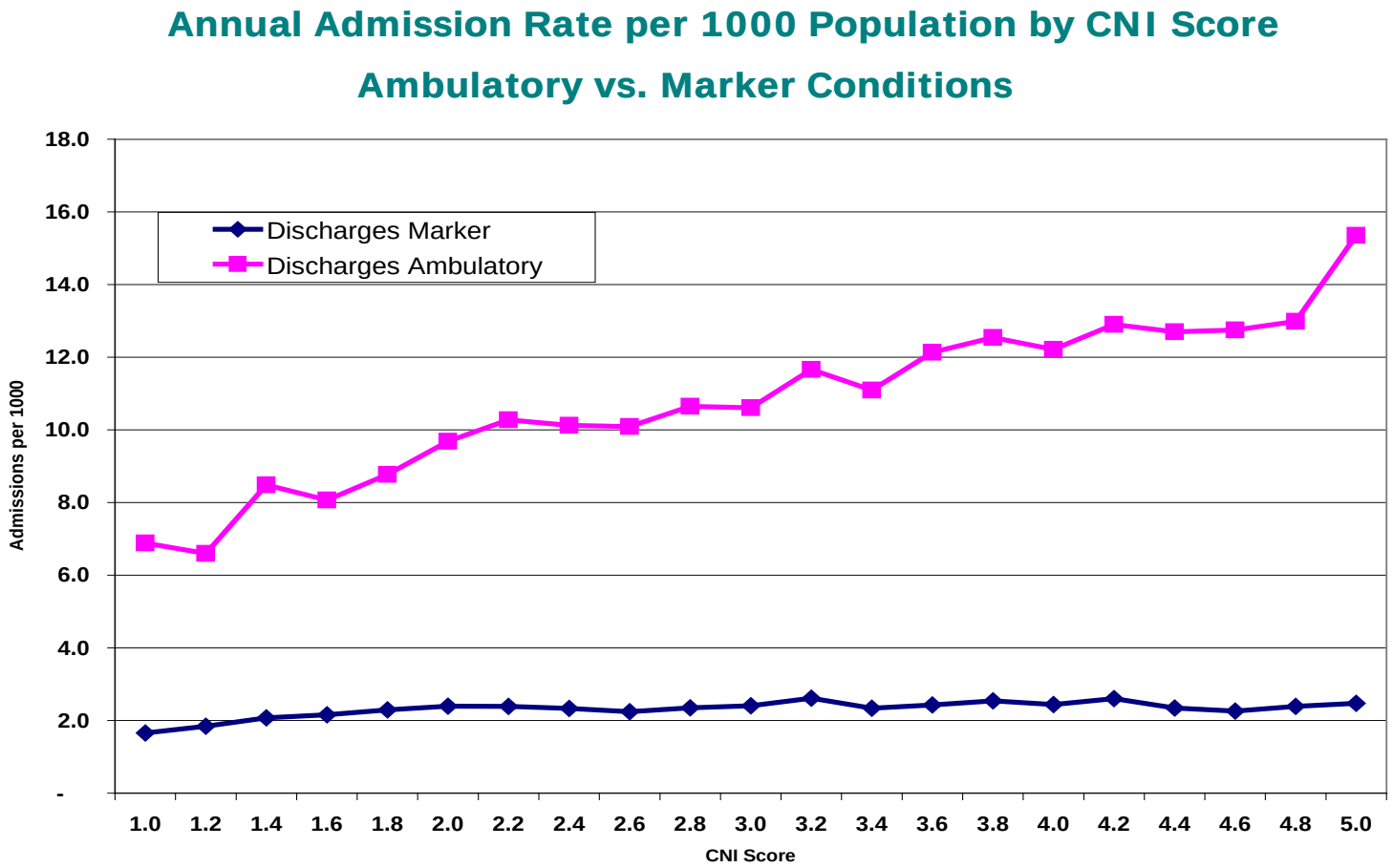
Strong Correlation with Avoidable Admissions



Preventable Admissions More Than Twice As Likely To Occur In High Need Areas; While Marker Conditions Occur At The Same Frequency

Note: *Ambulatory Sensitive Conditions if treated properly in an OP setting, do not generally require an acute care admission*

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Ambulatory Care Sensitive Conditions - Defined

- Medical conditions for which hospital use might be reduced by timely and effective outpatient care prior to the need for hospitalization (hence, the terms "avoidable" or "preventable" hospital use).
- Appropriate prior ambulatory care could
  - prevent the onset of an illness or condition;
  - control an acute episodic illness or condition;
  - or manage a chronic disease or condition.

A New and Expanded View

- Residents of high risk areas are *more than twice as likely* to be hospitalized for ambulatory care sensitive conditions.
- The Community Need Index has put a face on the poor unlike any we have seen before.
  - Carol Bayley, VP Ethics and Justice Education

No Data: No Problem

How was this impacting us?

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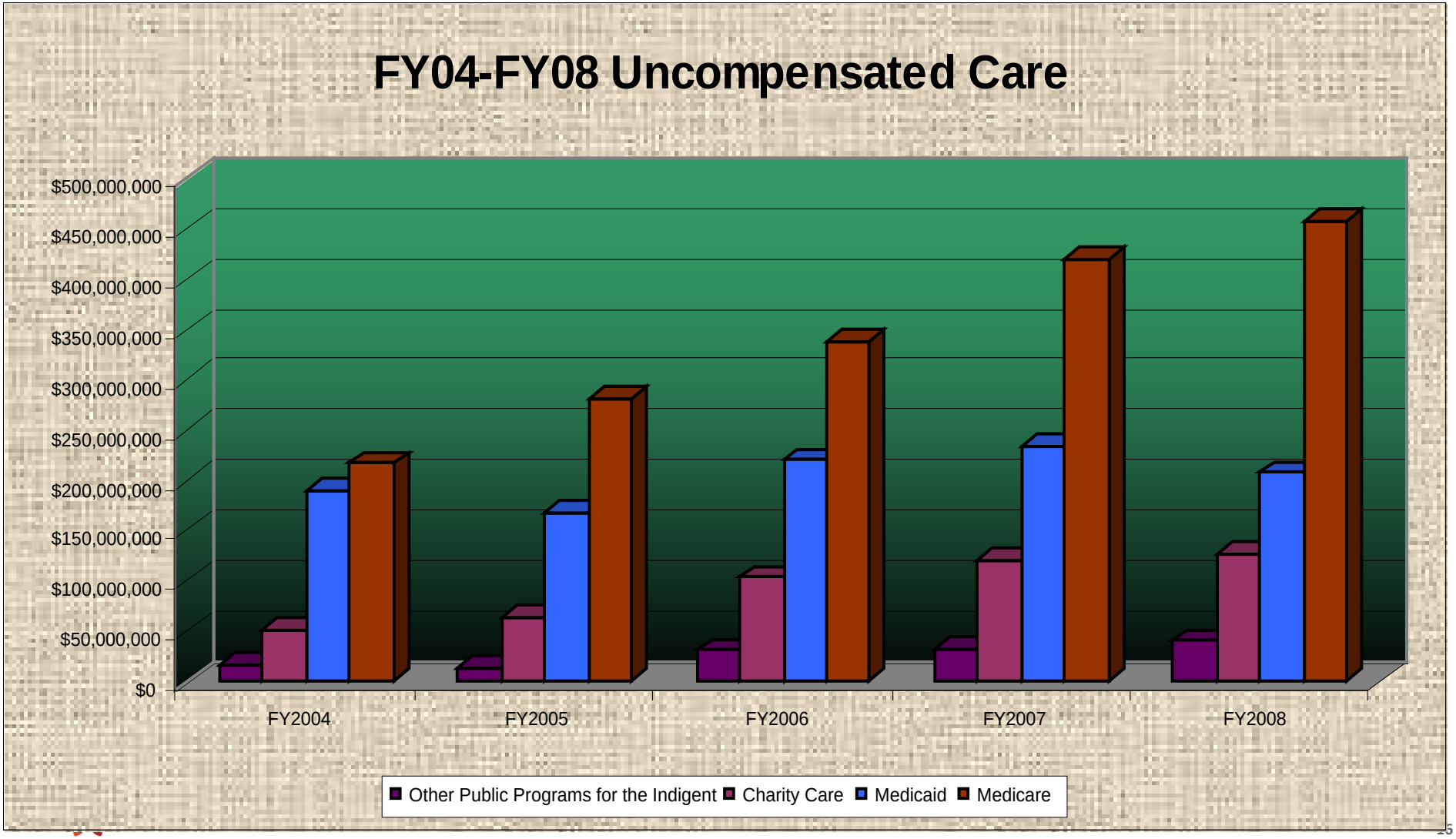
CHW Trended Uncompensated Care



Chronic Disease: A National Crisis

- Chronic diseases are the No. 1 cause of death and disability in the U.S.
- Treating patients with chronic diseases accounts for 75% of nation's health care spending
- Two thirds of the increase in health care spending is due to increased prevalence of treated chronic disease
- The vast majority of cases of chronic disease could be prevented or managed.

www.fightchronicdisease.org

Chronic Disease: A Local Crisis

- 100% of the current Community Health Needs Assessments conducted by Dignity Health facilities cited chronic disease management for diabetes, asthma, heart disease and/or cancer as a priority unmet need.

Can We Make a Difference?

Three Pilots Launched

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Can We Make a Difference?

- Saint Francis Memorial Hospital, San Francisco
  - McMillan Stabilization Project
- St. John's Regional Medical Center, Oxnard/Camarillo
  - Diabetes Initiative
    - Educated health professionals about current treatment of diabetes.
    - Launched community wide education/support.
    - Received federal funding for improvement in Latino health
- California Hospital Medical Center, Los Angeles
  - Chronic Disease Self-Management Program

We CAN Make a Difference!

Next Step: Toolkits

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The Business Case

- Disease self-management plays an integral part in managing the risk and health of populations.
  - Fewer readmissions
  - Decreased utilization (free bed capacity for more appropriate inpatient admissions)
  - Decreased costs
  - Improved quality
  - Increased health/quality of life for patients living with chronic conditions

Educational Materials Prepared

Catholic Healthcare West
CHW

APPLYING THE SCIENCE OF COMMUNITY BENEFIT

AMBULATORY CARE SENSITIVE CONDITIONS

"Knowing is not enough; we must apply.
Willing is not enough; we must do."

J.W. von Goethe

CHW HORIZON 2010 SYSTEM-WIDE 5-YEAR GOAL IN COMMUNITY BENEFIT

- CHW will expand and/or enhance services for persons with disproportionate unmet health needs resulting in care delivery in settings most appropriate to meet their needs.
- Ensure appropriate access to care for the poor and disenfranchised, which is evidenced by a 5% reduction in hospital admissions for ambulatory sensitive conditions.

Ambulatory sensitive conditions (ASC) are conditions that, if treated properly in an outpatient setting, do not generally require an acute admission.

EXECUTIVE SUMMARY

Residents of communities with multiple socioeconomic barriers *are more than twice as likely* to be hospitalized for ambulatory sensitive conditions (ASC), conditions that if treated in the community may not require acute care admissions. Appropriate prior ambulatory care might prevent the onset of an illness, control an acute condition, or help to manage a chronic disease.

In response to this compelling information, which correlated with our hospital utilization data, we have developed a strategic initiative to reduce the number of inpatient hospital admissions for ambulatory sensitive conditions by 5% over the next five years.

We believe that by applying the science of community benefit, with a focus on disease management programs in our communities with greatest need, we have a unique opportunity to reduce health disparities. The goal is to improve health status and quality of life in a sustainable manner and reduce the demand for high cost medical care to treat preventable conditions.

This report has been developed to help enhance or develop community health initiatives that will help *CHW Hospital* achieve the community benefit objectives outlined in Horizon 2010. It is intended that programs will focus on the areas where fulfillment of the mission imperative to serve and advocate for our brothers and sisters who are poor and disenfranchised can be best realized. The report includes:

- the demographics of the community served by your facility, which gives insight to the socioeconomic status of neighborhoods and barriers to access;
- the Community Need Index (CNI) ranking by zip code of each neighborhood in your service area, which will help pinpoint populations who are likely to have the most unmet health needs;
- a summary of current community benefit expense and an assessment of FY04 utilization of hospital services that included ambulatory sensitive conditions
- an overview of the funds channeled through the CHW Community Grants and Community Investments programs which may reveal opportunities for additional investment; and
- resource information on programs that addresses ambulatory care sensitive conditions from the Centers for Disease Control, the Joint Commission on Accreditation of Hospital Organizations (JCAHO) and a list of effective disease management strategies currently offered at CHW facilities.

We will work together over the next year to review this information and to plan a strategy of intervention to address these community health issues and their underlying causes. It is expected that an intervention strategy will be implemented in FY07 and the objectives achieved by 2010.

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Hospital-Specific Data Provided

What are the current Issues?

- Increasing costs of insurance are unsustainable.
- Solutions at the federal level are unlikely, given budget constraints and a lack of support for systemic change in health care financing.
- Cost shifting from employers to employees is resulting in higher out of pocket expenses, which are adversely impacting lower income population.
- Chronically ill are more likely to defer care due to cost.
- Reimbursement to cover the cost of care for ASC conditions, regardless of payer, is not adequate.

How does this Affect *CHW Hospital*?

By focusing our community benefit efforts on reducing utlization for ASCs, CHW hospitals will generally benefit as follows:

1. CHW hospitals, in general, have a negative operating performance associated with these admissions.
2. Patients presenting with underlying conditions related to selected ASCs (Diabetes, COPD, etc) are largely responsible for this performance. Reducing their associated complications should improve patient outcomes and reduce costs in subsequent admissions.
3. Focusing on reducing admissions from this population frees capacity for those patients in greatest need for acute care serivces.

Utilization for Inpatient Ambulatory Sensitive Conditions at *CHW Hospital*

This utilization data reflects all inpatient admissions that included an ASC DRG diagnosis.

DRG	ASC Description	Cases	Net Margin (Loss)*
89/90	Simple Pneumonia	273	(640,341)
127	Congestive Heart Failure	255	(629,336)
88	Chronic Obstructive Pulmonary Disease (COPD)	95	(275,635)
143	Chest Pain	145	(165,698)
96	Asthma	39	(109,424)
79/80	Respiratory Infection	95	(94,929)
179	Inflammatory Bowel Disease	8	(49,582)
294/295	Diabetes	62**	(34,482)
All other ASC		59	(79,712)
	Total	1023	(2,079,139)

* Includes fixed and variable cost and contribution margin
** Considered grossly under-reported

Payer Group	Net Margin (Loss)*
Medicare	(1,829,062)
Medicaid/MediCal	(379,534)
Commercial	(1,861)
Self-Pay/Charity Care/Bad Debt	58,940
Other	72,378
Total	(2,079,139)

Pneumonia, heart disease, chest pain and chronic obstructive pulmonary disease are the top ASCs at *CHW Hospital*. Prevention programs that manage the incidence of these conditions may improve the health status and quality of life for individuals and lower hospital admissions and expenses. Measures to prevent or manage diabetes, a known contributor to the other diseases, are of great importance, particularly in this service area where community demographics indicate a high risk for and incidence of this disease among Hispanic/Latino residents. Because of the decreased responsiveness of the immune system during older adulthood, a common cold may become complicated by bronchitis and pneumonia before it runs its course. For this reason, and the greater susceptibility of older adults to lower respiratory tract infections in particular, it is advisable for all individuals who are 65 or older to be immunized with pneumococcal vaccine once and with influenza vaccine every year.

What is currently being done to address unmet health needs at *CHW Hospital*?

What is already known about the community?

2003 Needs Assessment Survey Priorities	2004 Top Four ASC from Utilization Data	Community Demographics	
• Access to Primary Care	• Pneumonia	• Population	– 223,194
– Primary Care Physicians	• Heart Disease	• Area 1	– 66% Hispanic
– Specialty Care Physicians	• Chest Pain	• Area 2	– 73% Caucasian
– Bilingual/bicultural clinic services	• COPD	• Average Income	– 63,000
• Bilingual/bicultural mental health services		• Uninsured	– 13%
		• Unemployed	– 7%
		• No HS Diploma	– 35%
		• Renters	– 42%

Community Need Index – Socioeconomic assessment of health services utilization risk

Zip Code	Score	Population	Zip Code	Score	Population
93030	4.2	49,966	93010	2.2	44,591
93033	4.0	81,439	93035	2.6	26,756
93041	3.6	20,442			

FY05 Community Benefit Expenses

96% of *CHW Hospital* Community Benefit Expense, highlighted on the adjacent chart, is in "reaction" to the demand for healthcare services, as evidenced by the expenses associated with government funded insurance program shortfalls in reimbursement at cost, and in response to the community's need for charity care. The remaining 4% represents the proactive investment of the hospital to promote the health of the community.

Benefits for the Poor	
Traditional Charity Care	$2,241,342
Unpaid Cost of Medicaid	4,139,100
Other Public Programs	64,362
Community Services	257,403
Benefits for the Broader Community	
Unpaid Cost of Medicare	16,164,253
Community Services	631,523
Total	$23,497,983

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Evidence-Based Examples and Best Practices Provided

Resource Information – Who to talk to about Programs that work.

I. Chronic Disease Management

Five chronic diseases - heart disease, cancers, stroke, chronic obstructive pulmonary disease, and diabetes - account for more than two-thirds of all deaths in the US and 75% of the nation's total health care costs[1]. Tertiary prevention programs designed to stabilize health status, control pain, restore function, increase personal autonomy, and prevent disability in persons who have serious chronic illness and continuing functional limitations are recommended.

a) Chronic Disease Self-Management Program

California Hospital Medical Center Los Angeles, CA

Self-Management program designed by KR Lorig et al of the Stanford Patient Education Research Center aims to help patients with medical management, maintaining life roles, and managing negative emotions as well as provide patients with the necessary knowledge, skills, and confidence to deal with disease-related problems and collaborate with their health care providers.

Resource Information
Margaret Lynn Yonekura, M.D.
Director of Community Benefits
(213) 742-5974

Outcome: A 1996 randomized controlled trial of the program revealed that program participants demonstrated significant improvements in overall health, spent fewer days in the hospital yielding a cost to savings ratio of approximately 1:10. Many of the results persisted for as long as 3 years.

II. Chronic Obstructive Pulmonary Disease (COPD)

COPD refers to a number of lung diseases characterized by obstruction to airflow that disrupts normal breathing. It is the fourth leading cause of death in America claiming 120,000 lives in 2002. Smoking is the primary risk factor for COPD.[2] Secondary prevention programs including measures to halt, reverse or retard the progress of a condition and prevent disability or the development of a secondary condition; prevention of disability and additional incidents of disease, are recommended.

a) Freedom from Smoking Class

Mercy Medical Center Mt. Shasta, Mt. Shasta, CA

Two "Freedom from Smoking Clinics" per year are provided to promote healthy lifestyles and behaviors, as well as educate the communities served about the health issues smoking and chewing tobacco can cause.

Resource Information
Janyth Bolden, RRT
Freedom from Smoking
(530) 926-6111

Outcome: Since the clinic began, 63 out of 68 attendees quit smoking/chewing tobacco and 47 sustained maintain tobacco-free lifestyles.

III. Congestive Heart Failure

Heart disease and stroke count for nearly 40% of all deaths in the United States and cause 6 million hospitalizations each year. Research shows that the secondary prevention programs to reduce risk factors such as high blood pressure, high cholesterol, tobacco use, diabetes, physical inactivity and poor nutrition can result in a 7% to 11% decrease in cost for heart disease.[3]

a) Joint Commission Core Measure Set - Congestive Heart Failure

Resource Information
JCAHO
http://www.jcaho.org/pms/core+measures/hf_overview.htm

HF-1 Discharge Instructions
Educating patients with heart failure and their families is critical. Patient non-compliance with physician's instructions is often a cause of re-hospitalization.

HF-2 LVF Assessment
Measurement of left ventricular performance is a critical step in the evaluation and management of almost all patients with suspected or clinically evident heart failure.

HF-3 ACEI for LVSD
Clinical trials have established that the using ACEI for patients diagnosed with HF can alleviate symptoms, improve clinical status, enhance overall sense of well-being, and can reduce the risk of death and hospitalization.

HF-4 Adult smoking cessation advice/counseling.

[1] Centers for Disease Control, The Burden of Chronic Diseases and their Risk Factors
[2] www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=35020
[3] Centers for Disease Control, http://www.cdc.gov/diabetes

b) Congestive Heart Failure (CHF) Care Management Program

Marian Medical Center, Marian HomeCare and Hospice

At Marian Medical Center, patients are consistently monitored through bi-monthly phone calls from a home care nurse. When symptoms present an earlier intervention at an appropriate level of care occurs.

Resource Information
Kathi Farrell, RN, BSN
CHF Program
(805) 739-3830

Outcome: Only 16 of 100 program participants were admitted to the hospital during second year of the program.

c) Congestive Heart Failure Active Management Program (CHAMP®)

Mercy General Hospital, Mercy Heart Institute

The Congestive Heart Active Management Program (CHAMP®) staff at Mercy General Hospital educates, monitors, and treats, patients to avert exacerbation and repeated hospitalizations.

Resource Information
Joyce Higley, Manager
Mercy Heart Institute
(916) 564-2880

Outcome: 80% decrease in number of inpatient episodes, 85% reduction in cost of inpatient episodes, 86% reduction in readmits/patient day per patient pre- and post-CHAMP®.

d) Cardiac Risk Assessment

Mercy Clinic Norwood, Mercy General Hospital, Sacramento

Low-income patients at Mercy Clinic Norwood are screened using the "Framingham Criteria" to determine coronary heart disease risk and are treated based on clinical indicators.

Resource Information
Patricia Samuelson, M.D.
Medical Director
Mercy Clinic Norwood
Sacramento, CA
(916) 929-8575

Outcome: Standardized approach to cardiac risk assessment provides continuity for patients when more than one provider in the clinic sees them. Quarterly audits show 80-90% of audited charts meet expectations.

IV. Diabetes

People with diabetes have a shortage of insulin or a decreased ability to use insulin, a hormone that allows glucose (sugar) to enter cells and be converted to energy. When diabetes is not controlled glucose and fats remain in the blood and, over time, damage vital organs. Diabetes can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, lower-extremity amputations, and deaths related to flu and pneumonia. Heart disease is the leading cause of diabetes-related deaths, and death rates are about 2-4 times higher for adults with diabetes than for those without the disease.[4]

Diabetes Is Preventable and Controllable

Although the increasing burden of diabetes and its complications is alarming, much of this burden could be prevented with early detection, improved delivery of care, and better education on diabetes self-management. Possible complications include the following:

- **Cardiovascular disease.** Heart disease and stroke cause about 65% of deaths among people with diabetes. These deaths could be reduced by 30% with improved care to control blood pressure, blood glucose, and blood cholesterol levels.
- **Pregnancy complications.** About 18,000 women with preexisting diabetes and about 135,000 with gestational diabetes give birth each year. These women and their babies are at higher risk for serious complications such as stillbirths, congenital malformations, and cesarean sections. These risks can be reduced with screenings and diabetes care before, during, and after pregnancy.
- **Flu- and pneumonia-related deaths.** Each year, 10,000–30,000 people with diabetes die of complications from flu or pneumonia. Although they are about three times more likely to die of these complications than people without diabetes, only 55% get an annual flu shot.[5]

a) St. John's Diabetes Academy

St. John's Pleasant Valley/CHW Hospital, Ventura County, CA

Increase knowledge and expertise of health care providers in Ventura County regarding the diagnosis and management of Diabetes Mellitus.

Resource Information
Eugene Fussell, MD, VPMA

Outcome: 460% more providers enrolled than expected; reported 26% increase in knowledge post symposia.

b) Gestational Diabetes Mellitus Management Program

St. John's Pleasant Valley/CHW Hospital, Ventura County, CA

Provide support and education to pregnant women, with particular concern for Latinas, with a diagnosis of gestational diabetes (GDM), to enhance the

Resource Information

[4] Centers for Disease Control, http://www.cdc.gov/diabetes
[5] Centers for Disease Control, http://www.cdc.gov/diabetes

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Report Outcomes – Population Health

- In the last year alone (FY2013), outcomes reveal that more than $2.7 million was invested in these programs by our hospitals, which served 13,764 individuals.
- Six months following participation in the programs only 5% of the participants were seen in either the hospital or emergency department.
- The average variable cost per inpatient case for all chronic PQI conditions was about $10,450 for fiscal year 2013.
- Not only does the intervention reduce the burden of cost on healthcare systems, more importantly it also empowers people living with chronic conditions to better self care and improved quality of life.
- With a primary focus on vulnerable communities, this intervention effort also helps to reduce health inequity.

Next Steps

Continue to Provide Data, Education and Support

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In Patient Hospitalizations for Prevention Quality Indicators (PQI)

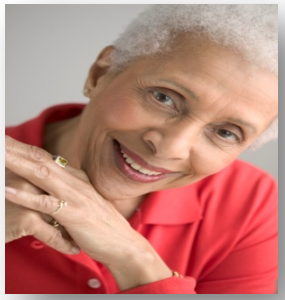
July 1, 2012 – June 30, 2013

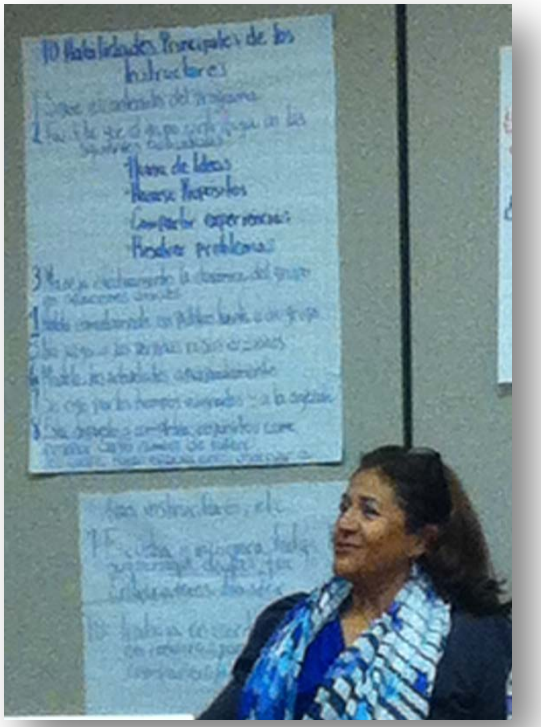
PQI Condition	Sum of Cases	Sum of Days	Sum of Net Margin (Non Commercial)
Angina Without Procedure	109	221	($307,375)
Asthma in Younger Adults	1,051	2,332	($2,292,116)
Bacterial Pneumonia	2,366	14,168	($11,536,838)
Congestive Heart Failure	3,207	16,664	($13,097,824)
COPD or Asthma in Older Adults	5,740	20,495	($14,135,244)
Diabetes Long Term Complications	2,328	11,619	($7,236,198)
Diabetes Short Term Complications	1,828	6,145	($7,569,097)
Hypertension	7	62	($53,482)
Low Birth Weight	2,178	42,852	($29,167,310)
Lower Extremity Amputation Among Diabetes Patients	223	2,876	($2,167,008)
Muliple Conditions	195	1,935	($975,537)
Perforated Appendix	750	4,225	($4,474,184)
Uncontrolled Diabetes	247	597	($255,145)
Urinary Tract Infection	3,556	12,101	($5,191,525)
	23,785	136,292	($98,458,883)

Evidence-Based Programming – CDSME

"I am ninety years old and this program has been very helpful in my way of life… the importance of daily exercise and less worry over my health problems… I am much more relaxed than I have been in a long time."

"We learned to deal more effectively with anxiety, anger, pain, depression and emotions. I now have more confidence in myself…"





To Ensure Continuing Success

- The Board and System Leadership need to believe in and support the effort.
  - It was elevated to a system wide goal and continues to be the primary system initiative in Community Benefit
- Integrate community benefit into the overall strategy of the organization.
  - Ensure that all stakeholders realize the value of this focused effort
- No data, no problem.
- Share best and promising practices.
- Let your in-reach be as important as your outreach.
- Support the facilities with funding or in kind support.

Questions

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WORKGROUP DISCUSSION

Making the Case for CDSME



MAKING THE CASE FOR CDSME

Participants break up and **identify the top 5 things** to get across in conversations to different categories of leadership/partners:

Group A - Physician Groups

- In-Person

Group B – Health Plans

- In-Person & Phone-in

Group C - Clinic/Office Manager & Staff

- Phone-in

Group A

Physician Groups

In-Person only

- Jackie Tompkins
- Arline Delacruz
- Barbara Estrada
- Charlotte Tenney
- La Roux Pendleton
- Linda Lau
- Melissa Mallory
- Raymond Grimm
- Sydni Aguirre

Group B

Health Plans

In-person **& *Phone-in**

For those of you on the phone

- ***Please hang up and call (832) 551 – 5100***
- ***Passcode 293269#***

- Lora Connolly
- ***Cheri Hoolihan****
- Eileen Barsi
- Karen Grimsich
- Majel Arnold
- ***Muriel Guzzi****
- Pam Ford-Keach
- ***Ricardo Lopez****
- ***Sue Lachenamyr****
- ***Dianne Davis****

Group C

Clinic/Office Manager & Staff

Phone-in* only

For those of you on the phone

- ***Please hang up and Call (832) 551 – 5100***
- ***Passcode 293275#***

- ***Natalie Zappella****
- ***Bertha Sandoval****
- ***Deb Harris****
- ***Erin Ulibarri****
- ***Jean Grady****
- ***Karol Matson****
- ***Lindsey Nibecker****
- ***Melisa Acoba****
- ***Sonali Parnami****
- ***Stephanie Nathan****
- ***Tracy Repp****
- ***Javier Carillo****

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WORKGROUP REPORT OUT

Making the Case for CDSME



QUESTIONS?
COMMENTS?
DISCUSSION?

ALUMNI PROJECT

Linda Lau

Nutritionist

San Francisco Department of Aging and Adult Services



Click on the link below to access the presentation

http://bit.ly/hl-presentation

QUESTIONS?
COMMENTS?
DISCUSSION?

PEER ACTION TOWARD HEALTH (PATH)

Sydni Aguirre
Program Manager
Dignity Health

Jacqueline S. Tompkins
Program Coordinator
California Arthritis Partnership Program



Peer Action Toward Health - PATH

PATH Meeting Characteristics

Agenda Development

- Meet 1x each quarter; 2 ½ hours
- Two Master Trainers or Leaders
- Modeling, role-play, and practice
- Brainstorming, problem-solving
- Action-planning
- Break for networking
- Leader feedback and evaluations

PATH Meeting Agenda #1

Friday, January 10, 2014 | 1:00pm – 3:30pm

- **Welcome and Introductions** (15 min.)
- **New Workshop Forms and Privacy/Security Training** (50 min.)
- **2014 Workshop Schedule/Calendar – Leader Sign-Ups** (5 min.)
- **BREAK/NETWORKING** (20 min.)
- **Problem-Solve/Brainstorming Activity** (35 min.)
- **Action Plans** (15 min.)
- **Closing/Evaluation** (10 min.)

CDPH California Department of PublicHealth

CAPP California Arthritis Partnership Program

Dignity Health

PATH Meeting Agenda #2

Friday, April 10, 2014 | 1:00pm – 3:30pm

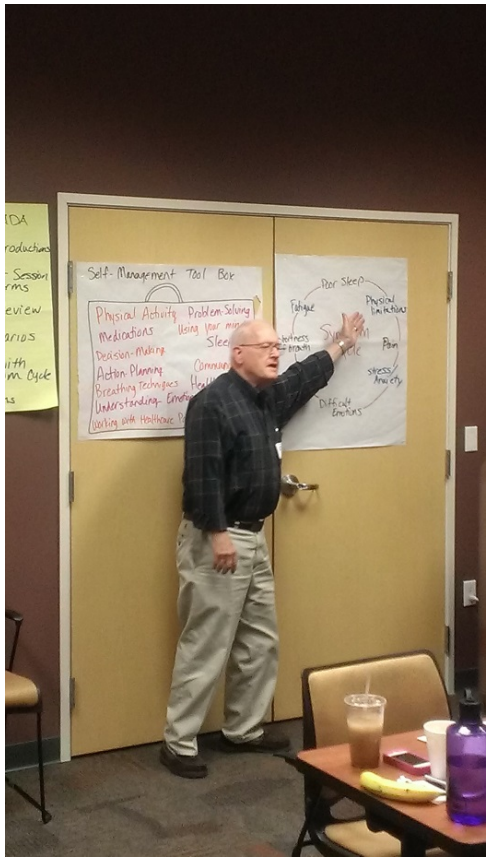
- **Welcome and Introductions** (15 min.)
- **Q & A on Workshop Forms** (10 min.)
- **Problem-Solving Review** (45 min.)
- **BREAK/NETWORKING** (15 min.)
- **What-If Scenarios** (35 min.)
- **Linking the Self-Management Toolbox with the Symptom Cycle** (15 min.)
- **Closing/Evaluation** (10 min.)

Most valuable to me

PATH Leaders Say…

Networking

- "It was good to be with leaders I have met as well as other leaders."
- "Getting feedback from other leaders."
- "Collaborating and connecting with other leaders."
- "Rapport-building."

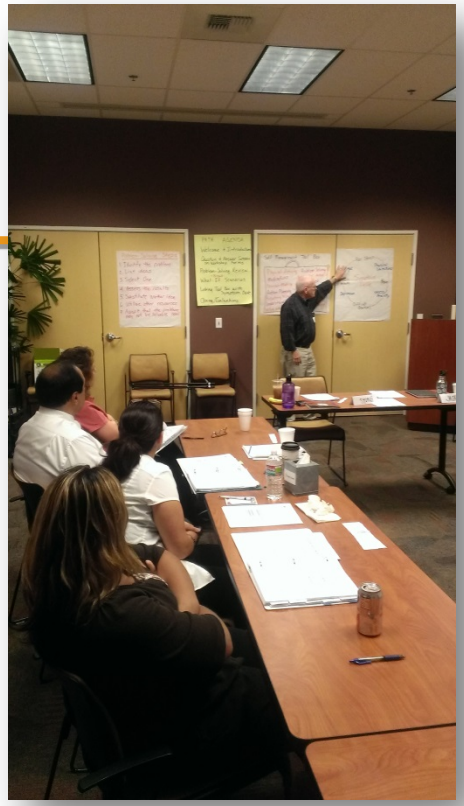


Learning & Skill Development

- "Learning that other leaders have similar issues."
- "Refreshing my knowledge."
- "Group problem-solving."
- "Familiarizing myself with the new forms."
- "Seeing the diversity of the population being served."

CDPH California Department of PublicHealth
CAPP California Arthritis Partnership Program
Dignity Health

PATH in Action!



CDPH California Department of PublicHealth

CAPP California Arthritis Partnership Program

Dignity Health

PATH

Meeting Agenda

CDPH California Department of PublicHealth

Peer Action Toward Health (PATH) - Meeting Agenda

PATH Meeting #1

Friday, January 10, 2014 | 1:00pm – 3:30pm

1. Welcome and Introductions (15 minutes)
   - *State your name and one reason why you to like to facilitate workshops*

2. New Workshop Forms and Privacy/Security Training (50 minutes)
   - *Introduce new forms and data collection processes*

3. 2014 Workshop Schedule/Calendar – Leader Sign-Ups (5 minutes)

4. BREAK/NETWORKING (20 minutes)

5. Problem-Solve and Brainstorming Activity (35 minutes)
   - *Ask leaders "What problems have you experience in facilitating the workshops?"*
   - *As a group select a few to brainstorm solutions*
   - *Pair and Share – additional problems identified by leaders in pre-work*
   - *Handout "What-if" scenarios from Master Trainer manual*

6. Action Plans (15 minutes)
   - *Ask leaders "what would you like to accomplish between now and the next time we meet in three months?" Share.*

7. Closing/Evaluation (10 minutes)

PATH

Meeting Agenda

CDPH California Department of PublicHealth

Peer Action Toward Health (PATH) - Meeting Agenda

PATH Meeting #2

Thursday, April 10, 2014 | 1:00pm – 3:30pm

1. Welcome and Introductions (15 minutes)
    - *State your name and your favorite season and why*

2. Question and Answer Session on Workshop Forms (10 minutes)
    - *Quick review of forms*
    - *Field leader and coordinator questions*

3. Problem-Solving Review (45 minutes)
    - *Pair and Share. Distribute problem-steps and put in order*
    - *Describe the types of problem-solving activities in the workshop setting*

4. BREAK/NETWORKING (15 minutes)

5. What-If Scenarios (35 minutes)
    - *Scenarios dealing with difficult people, time-management, additional facilitation skills, and diverse communities.*
    - *As a group select a few to brainstorm solutions to What-If scenarios*

6. Linking Self-Management Took Box with Symptom Cycle (20 minutes)
    - *Ask for volunteers and have pairs demonstrate/paraphrase the relationship*
    - *Group discussion as needed*

7. Closing/Evaluations (10 minutes)

PATH

Meeting Evaluation

California Department of PublicHealth

PATH Meeting
Evaluation – January 10, 2014
Sacramento, CA

Please help us ensure PATH meeting content and format are valuable to you by completing this evaluation.
Return the completed form to Jackie Tompkins or Sydni Aguirre before you leave today.
Thank you for taking the time to complete this evaluation.

Please select a response for each statement.

		Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Comments
1	I feel more confident in my abilities to facilitate Healthier Living/Tomando Control workshops in my community.						
2	I have increased knowledge of the statewide data forms and collection processes.						
3	I feel more confident in my abilities to utilize and administer the data collection forms.						
4	The format of the PATH meeting was appropriate.						
5	Overall, I am satisfied with the PATH meeting and I feel my time has been well spent.						
6	I will attend and participate in future PATH meetings.						

Two things that were most valuable to me were:
1.

2.

Two suggestions I have for improvement are:
1.

2.

Complete the following sentences:
1. More meeting time could have been spent on _____

2. Less meeting time could have been spent on _____

What is one thing NEW that you learned as a result of attending this PATH meeting? _____

What additional tools/resources/program and facilitation topics would you like discussed/presented at future PATH meetings?

_____

_____

PATH

Meeting Evaluation

CDPH California Department of PublicHealth

PATH Meeting
Evaluation – April 10, 2014
Sacramento, CA

Please help us ensure PATH meeting content and format are valuable to you by completing this evaluation.
Return the completed form to Jackie Tompkins or Sydni Aguirre before you leave today.
Thank you for taking the time to complete this evaluation.

Please select a response for each statement.

		Strongly Agree	*Agree*	*Undecided*	*Disagree*	*Strongly Disagree*	*Comments*
1	As a leader, I feel more confident in my ability to manage challenging/difficult workshop situations.						
2	As a leader, I feel more confident in my ability to manage challenging/difficult workshop participants						
3	As a leader, I have an increased understanding of the workshop's problem-solving activities.						
4	As a leader, I feel more confident in describing the relationship between the Symptom Cycle and Self-Management Tool box.						
5	The format of the PATH meeting was appropriate.						
6	Overall, I am satisfied with the PATH meeting and I feel my time has been well spent.						
7	I will attend and participate in future PATH meetings.						

Name the most valuable part of today's PATH meeting: _____

Name one NEW thing you learned as a result of attending this PATH meeting? _____

Complete the following sentences:

1. **More at the meeting could have been spent on** _____
2. **Less time at the meeting time could have been spent on** _____

What additional tools/resources/program and facilitation topics would you like discussed/presented at future PATH meetings?

_____

Are you interested in sharing and presenting at an upcoming PATH meeting? If yes, please describe the activity and/or resource. Include your name and organization in your response. Thank you.

_____

PATH Questions & Comments

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CA4HEALTH: WHAT'S IN THE FUTURE?

Pam Ford-Keach

CA4Health

QUESTIONS?
COMMENTS?
DISCUSSION?

CLOSURE AND EVALUATION



California Healthier Living Coalition Meeting

November 2014
Los Angeles

Join

Share

Brainstorm

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