Planning and Implementing Chronic Disease Self-Management Workshops

A Guide for Program Coordinators and Facilitators

Background

Chronic Disease Self-Management Education (CDSME) is a suite of programs including, but not limited to:

- Chronic Disease Self-Management Program (CDSMP)
- Diabetes Self-Management Program (DSMP)
- Chronic Pain Self-Management Program (CPSMP)
- Tomando Control de su Salud

These programs are designed to help participants develop tools to manage their chronic conditions on a daily basis. Coordinating a workshop for the first time can be challenging, so this guide will help by providing some useful information.

Materials

There are a number of things you will need for your workshop before you can begin!

- Charts
    - Workshop charts can be handwritten or printed, but they must be large enough to post up so that the group of participants can read them. They are not given as handouts. To assemble charts, you can:
        - Buy poster-sized paper and write them out by hand
        - Type them up and print them through a company such as Staples
    - We recommend you are very careful with your charts so that you can reuse them as many times as possible before they wear out.
    - The information for each chart can be found in the appendix of the facilitator's manual.
- *Living a Healthy Life with Chronic Conditions* Books
    - These books are supplementary reading for workshop participants and are occasionally referenced during the workshop. You can either purchase books to give to participants or you can purchase books to lend to participants.
    - Books can be purchased at www.bullpub.com. Books typically cost between $17 and $22, but please note that shipping for large quantities is quite expensive.
    - Be sure you are purchasing the correct (most recent) edition.
- Relaxation CD
    - Like the books, CDs can either be given to participants or lent to participants.
    - CDs can also be purchased at www.bullpub.com.
- Blank flip charts – 1 pad
    - A white board at the location can be a substitute for flip charts
- Pens/pencils – enough for all workshop participants

- Extra paper – enough for 2-3 pages for each participant
- Large floor easel to hang up charts – 1 if using a white board or 2 if using a blank flip chart
- Binder clips – 2-4
- Markers – regular for flip charts or dry-erase for white boards, 2-3 in different colors
- Rolling cart - 1
    - Workshop facilitators often find a rolling cart helpful to carry materials to and from workshops. This may not be necessary if you can store all of your materials at the workshop location.
- Secure boxes with lock for sensitive data – 1
    - If you are facilitating workshops in a location where you have HIPPA-compliant file cabinets or other storage units, you may use those instead of a secure box.
- Painter's tape – this can be helpful in hanging charts on walls without disturbing paint, 1 roll
- Copies – the documents below can be found in the appendix of this guide
    - Workshop information handout – enough copies for all participants
    - Session 1 Survey – enough copies for all participants
    - Session 6 Survey – enough copies for all participants
    - Attendance log – 2 copies for facilitators
    - Cover sheet – 1 copy for data packet

Coordinating a Workshop

You may have experience coordinating programs already, but whether or not you do these guidelines and tips will prove useful.

- Plan workshops 4-6 weeks in advance when possible.
- Distribute flyers with logistics included (see Appendix for a sample flyer).
- Collect sign-ups (see Appendix for a sample sign-up sheet).
    - It's best to have between 15 and 20 people sign up, since not everyone who signs up will show up.
- Call before the workshop begins.
    - It's best to call at least once before a workshop begins, within 1 week of the start date.
    - This is a good opportunity to make sure that everyone has the correct information and understands what to expect.
- Set up the room.
    - Use a private space. Confidential information is shared during the workshop, so it's best not to have interruptions or eavesdroppers.
    - Make sure the space is large enough to comfortably and safely accommodate all participants and the two facilitators. Everyone should be able to sit around a table or set of tables facing each other (nobody's back should be toward anyone else). It's important that everyone have table space in front of them so that they can write comfortably when needed and place their name card in front of them.
    - The space should be large enough to safely stand easels away from walking paths.
    - The space should have windows or walls where wall charts can be posted.

- Make sure both facilitators are available for every session, including half an hour beforehand to set up the materials and half an hour after to tear down materials and speak with participants.
    - If only one facilitator is available, you cannot hold the workshop.
- Do not begin the workshop if there are fewer than 8 people present.
    - If there are fewer than 8 people at the beginning of the first session, cancel or postpone the workshop.
- Do not have an interpreter present.
    - There just isn't enough time to interpret everything being said in a workshop into another language. It can be disruptive, and participants will not be able to engage fully.
    - The exceptions are a sign-language interpreter or headphone interpreters, as hose interpreters can work at the same time as the facilitators and participants are speaking.

A few notes for facilitators

You have responsibilities as a facilitator aside from facilitating!

- Keep complete and accurate data forms
    - Double check that participant IDs are accurate, and that the participant ID on the Session 1 Survey matches the participant ID on Session 6 Survey.
    - Encourage workshop participants to complete as many questions as they're comfortable answering.
    - Be sure that all forms are legible.
    - Complete the cover sheet in its entirety.
    - Turn in completed data packets to your program administrator in a timely manner (within 1 week of workshop completion).
- Maintain your certification
    - To keep your CDSMP facilitator certification you must facilitate at least 1 workshop per year starting at the conclusion of your training.
    - You may need to undergo mandatory update training, which occurs every few years or so as the program developers determine necessary.
- Only facilitate CDSMP under a current license.
    - If you move to another organization, your ability to facilitate will not follow you. You must be sure that your new organization works under a current CDSMP license from the Self-Management Resource Center in order to facilitate for that organization.
    - Organizational licenses must be renewed on a regular basis, so check with your program administrator annually to make sure you're still working under a current license.
- Make sure you're using the most updated forms.
    - The forms do occasionally change, so please check with your program administrator on an annual basis to be sure you are using the correct forms: Session 1 Survey, Session 6 Survey, Attendance Log, and Cover Sheet

Appendices

- Workshop information handout (CDSMP)
- Workshop information handout (Tomando Control)
- Group Leader Script (English)
- Group Leader Script (Spanish)
- Session 1 Survey (English)
- Session 1 Survey (Spanish)
- Session 6 Survey (English)
- Session 6 Survey (Spanish)
- Attendance Log (CDSMP)
- Attendance Log (Tomando Control)
- Cover Sheet
- Sample flyer
- Sample sign-up sheet

For Chronic Pain or Diabetes forms, contact your program administrator

Workshop Overview

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Overview of self-management and chronic health conditions	●					
Fatigue and Getting a good night's sleep	●					
Using your mind to manage symptoms	●				●	●
Making an action plan	●	●	●	●	●	
Feedback		●	●	●	●	●
Problem-Solving		●		●		
Dealing with difficult emotions		●				
Physical activity and exercise		●	●	●		
Preventing falls		●				
Making decisions			●			
Pain management			●			
Healthy eating			●	●	●	
Better breathing				●		
Communication skills				●	●	
Medication usage					●	
Dealing with depression					●	
Making Informed treatment decisions						●
Working with your health care team						●
Future plans						●

Homework by Session

Session 1:

- Reading covered this session: Chapters 1 & 2, pages 90-92, 106-110 & 148-149
- Practice using distraction.

Session 2:

- Reading covered this session: pages 25-26, 87-90, 110-123, Chapters 7, 8 & 9
- Think about how you would like to start an exercise program or increase the program that you are now doing.
- You may want to keep a journal of your feelings.
- In Session 3, we will be taking about making decisions. Please think of something in your life for which you need to make a decision and have it ready for next week's activity.

Session 3:

- Reading covered this session: pages 27-28, 92-98, 129-133, Chapters 7 and 10
- Choose one of the methods of monitoring exertion and check your exertion level during different activities and exercises.
- **In Session 4, we will look at what we eat for at least 2 days during this week.**
  - We suggest using one day during the week and one day on the weekend because our eating habits are often different on the weekends.
  - We will share what we learned. This information will be useful when we talk about healthy eating next week.

Session 4:

- Reading covered this session: pages 25-26, 69-71, 98-106, Chapters 10 and 11
- Keep the food diary again for one weekday and one weekend day. Look at your portions and the number of calories, and grams of fat and sodium you are eating, especially saturated and trans fats.

Session 5:

- Reading covered this session: pages 110-116, 137-143, 150-159, Chapters 10 and 13
- Make a personal medication list, with names of all your medications, the provider who prescribed it, dosage, date started, reason for taking it, and any drug allergies.
- We invite you to call, email or write a letter to your provider about what you have accomplished during this workshop. If you are not pleased with your progress over the past 6 weeks, please write a letter or email the developers of this workshop explaining your reasons. The address is: Self-Management Resource Center • 711 Colorado Ave • Palo Alto CA 94303 USA • or email: SMRC@SelfManagementResource.com. You don't have to mail or show these letters, but please bring them with you next week to use during the sharing activity. If you mail the letter to your provider, though, it would help to spread the word. Also, we would like your permission to share your letters with SMRC and your Congress representatives to gain support for funding these programs.

Session 6:

- Reading covered this session: pages 143-148, 289-297, Chapter 13

NOTE: If you are interested in other self-management programs like this, please check out the Evidence-Bases Leadership Council's (EBLC) website for programs in your area: **http://www.eblcprograms.org/evidence-based/map-of-programs**

RESUMEN DEL TALLER						
Temas	**1**	**2**	**3**	**4**	**5**	**6**
Manejando sus síntomas (Técnicas Cognitivas)	●					
Durmiendo bien toda la noche	●					
Alimentación saludable	●	●	●	●		
Ejercicio	●	●		●	●	
Formular planes de acción/metas	●	●	●	●	●	●
Compartir experiencias/resolución de problemas		●	●	●	●	●
Evitando caídas y mejorando el equilibrio		●				
Tomando decisiones			●			
Mejorando la respiración			●			
Trabajando con su proveedor de salud y decidiendo su tratamiento médico			●		●	
Manejando la depresión				●		
Pensamientos positivamente				●		
Mejorando la comunicación					●	
Medicinas					●	
Saber es Poder					●	
Evaluando tratamientos alternativos					●	
Planeando para el futuro						●
Celebración de los logros						●

Tareas por Sesión

Sesión 1:

- Lectura cubierta en esta sesión: Libro Edición 2013: páginas 210, Capitulo 10; páginas 59-63, Capitulo 4; páginas 108-111, Capitulo 6; páginas 5-18, Capitulo 1; página 31, Capitulo 2.
- Recuerde anotar los alimentos que comen y las actividades que hacen y traer el diario de estilo de vida. También llevar un control de su plan de acción.

Sesión 2:

- Lectura cubierta en esta sesión: Libro Edición 2013: páginas 20-21, Capitulo 2; páginas 107-111,Capitulo 6; 121-142, Capitulo 7; páginas 181-188, 190-191,Capitulo 9;
- Piense un poco en si le gustaría empezar un programa de ejercicio o incrementar el que está haciendo ahora.
- En la Sesión 3 hablaremos acerca de tomar decisiones. Por favor piense en alguna decisión que necesiten tomar y téngala la lista para la próxima semana.

Sesión 3:

- Lectura cubierta en esta sesión: Libro Edición 2013: páginas 25-31; Capitulo 2; páginas 54-58, Capitulo 4; páginas 85-90, Capitulo 5; páginas 181-188, 202, Capitulo 9; páginas 271-274, Capitulo 14.
- Traer 2 o 3 etiquetas de nutrición de sus productos preferidos para la sesión de la próxima semana.

Sesión 4:

- Lectura cubierta para esta sesión: Libro Edición 2013: páginas 144-148, Capitulo 8; páginas 178, Capitulo 9; páginas 356-357,366-369, Capitulo 19.
- Recuerde llevar un control de su plan de acción y el diario de estilo de vida.

Sesión 5:

- Lectura cubierta para esta sesión: Libro Edición 2013: páginas 33-44, Capitulo 3; páginas 203, 217-218, Capitulo 10; páginas 221-243, Capitulo 11; páginas 255-256, 260-263, Capitulo13; páginas 271-274, Capitulo 14.
- Haga un lista personal con los nombres de sus medicinas, nombre del doctor que se las receto, dosis, fechas que comenzó a tomarlas, razón del porque las toma, y alergias a las medicinas.
- Recuerde que la próxima semana es la última sesión. Si todos están de acuerdo pueden traer un bocadillo o platillo saludable. Además pueden traer recetas de sus platillos.

Sesión 6:

- Lectura cubierta en esta sesión: Libro Edición 2013: páginas 233-243, Capitulo 11.

Chronic Disease Self-Management Education Program Group Leader Script

Read the following statement to participants prior to their completion of the Participant Information Survey

- This workshop is made possible by a grant from the U.S. Administration for Community Living (ACL) [and support from X funding agencies/sponsors].
- We would like to give you a two-page Participant Information Survey (Survey).
- Before we can share your information with ACL and its database contractor, the National Council on Aging [and X funding agencies or sponsors], we want to explain how your information will be used and protected.
- Completing the Survey is entirely voluntary. You can skip certain questions or choose not to complete the Survey at all. If you decide not to complete the Survey you can still participate in this program.
- However, please know that your information is very valuable to us. We use it to learn who is being reached by this program and to improve our services for others like yourselves. It also helps our funding agencies show that they are spending their money wisely.
- At the top of the Survey, we ask for a participant ID. We will use this ID to match your information to an Attendance Log to track how many times you attend a class. We do not share your participant ID with anyone else.
- We follow very strict rules to protect all of your information and to keep it private. We will maintain these paper forms securely following standard practices for protecting private data. After a trained person enters your information into a secure online database, we will destroy the paper forms.
- Please take time now to read the Survey.
- You may ask us to explain any questions that you find confusing.

Texto del líder de grupo del Programa educativo de autogestión de enfermedades crónicas

Lea las siguientes palabras a los participantes antes de que completen la encuesta de información del participante

- Este taller es posible gracias a la Administración para la Vida Comunitaria (ACL, por sus siglas en inglés) de los EE. UU, El Consejo Nacional del Envejecimiento (NCOA, por sus siglas en inglés) / [y otras organizaciones de financiamiento o patrocinadores].
- Nos gustaría pedirles que completen una encuesta de dos páginas.
- Antes de que podamos compartir su información con ACL o [otros organizaciones de financiamiento o patrocinadores], nos gustaría explicarle cómo se utilizará y protegerá su información.
- Completar la encuesta es totalmente voluntario. Pueden saltar cualquier pregunta que no deséen contester o no completer la encuesta. Si deciden no completar la encuesta, pueden seguir participando en el programa.
- Sin embargo, su información es muy importante para nosotros. La usamos para saber a quiénes alcanza este programa y para mejorar nuestros servicios para otras personas como usted. También sirve para mostrarle a nuestras organizaciones de financiamiento que estamos invertiendo el dinero con sensatez.
- En la encuesta, solicitamos un número de identificación. Usaremos esté número para igualar con un registro de asistencia y hacer un seguimiento de cuántas veces asisten a clase. No compartiremos su información con cualquier otra persona.
- En la encuesta, también solicitamos que proporcione su edad. Puede pedirnos que le expliquemos cualquier pregunta que le parezca confusa.
- Seguiremos reglas muy estrictas para proteger su información y mantenerla confidencial. Conservaremos estos formularios en papel de forma segura, siguiendo prácticas establecidas para la protección de datos privados. Después de que una persona encargada ingrese su información a una computadora segura, destruiremos los formularios en papel.
- Tómen unos minutos para leer la encuesta y háganos saber si tienen alguna pregunta.

OMB Control No. 0985-0036
Exp. Date 11/22/2022

Chronic Disease Self-Management Education

Participant Information Survey

Admin Use Only: The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

Participant I.D.: | C | A | | | | | | | | | | | | |

(1) State abbreviation: C A *(2) First four letters of site name:* __ __ __ __

(3) Start date of program: __ __ /__ __ /__ __ *(4) Participant number:* __ __

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1. Did your doctor or other health care provider suggest that you attend this program? ☐ Yes ☐ No

2. How old are you today? _____ years

3. Are you: ☐ Male or ☐ Female?

4. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

5. What is your race? Mark all that apply.

   ☐ American Indian or Alaska Native
   ☐ Asian
   ☐ Black or African American
   ☐ Native Hawaiian or other Pacific Islander
   ☐ White

6. Are you deaf or do you have serious difficulty hearing? ☐ Yes ☐ No

7. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

   ☐ Yes ☐ No

8. Do you live alone? ☐ Yes ☐ No

9. What is the highest grade or year of school you completed?

   ☐ Some elementary, middle, or high school
   ☐ High school graduate or GED
   ☐ Some college or technical school
   ☐ College 4 years or more

10. Have you ever served in the military? ☐ Yes ☐ No

11. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? ☐ Yes ☐ No

12. In general, would you say that your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

13. Has a health care provider ever told you that you have any of the following chronic conditions?

	YES	NO		YES	NO
Anxiety Disorder	☐	☐	Chronic Pain	☐	☐
High Cholesterol	☐	☐	Kidney Disease	☐	☐
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	☐	☐	Osteoporosis (Low Bone Density)	☐	☐
Cancer or Cancer Survivor	☐	☐	Obesity	☐	☐
Hypertension (High Blood Pressure)	☐	☐	Schizophrenia or other psychotic disorder	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes (High Blood Sugar)	☐	☐	Arthritis/Rheumatic Disease	☐	☐
Heart Disease	☐	☐	Other Chronic Condition	☐	☐

14. Because of a physical, mental, or emotional condition, do you:

- Have serious difficulty concentrating, remembering, or making decisions?
  ☐ Yes ☐ No
- Have difficulty doing errands alone such as visiting a doctor's office or shopping?
  ☐ Yes ☐ No

15. Do you have serious difficulty walking or climbing stairs? ☐ Yes ☐ No

16. Do you have difficulty dressing or bathing? ☐ Yes ☐ No

17. How often do you feel lonely or isolated from those around you?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

18. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure	1	2	3	4	5	6	7	8	9	10	Totally sure

19. Are you on Medi-Cal? ☐ Yes ☐ No ☐ I don't know

20. During the past week, how much has your health interfered with your normal activities with family, friends, neighbors or groups?

☐ Always ☐ Usually ☐ Half of the time ☐ Occasionally ☐ Never

21. In the past week, how many days did you exercise for at least 30 minutes?

☐ 0 days ☐ 1 day ☐ 2 days ☐ 3 days
☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days

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Fecha de Vencimiento 11/22/2022

Tomando Control de su Salud

Encuesta de información del participante

Para uso exclusivo del administrador: El facilitador o el personal del programa deben completar esta parte del formulario y marcar el número secuencial del participante con el nombre en el formulario de asistencia.

Identificación del participante: | ***C*** | ***A*** | | | | | | | | | | | | |

Abreviatura del estado: C A (por ejemplo, NY, VA, etc.)

Primeras cuatro letras del nombre del sitio: __ __ __ __

Fecha de inicio del programa: __ __ / __ __ / __ __ (por ejemplo, 01/12/19)

Numero de participante: __ __ (por ejemplo, 01, 02, 03, etc.)

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1. ¿Su médico u otro proveedor de atención médica le sugirió que participara en esté programa?

   ☐ Sí ☐ No

2. ¿Cuántos años tiene hoy? _____ años

3. Usted es: ☐ ¿Hombre o ☐ Mujer?

4. ¿Es de origen Hispano/a, Latino/a o Español? ☐ Sí ☐ No

5. ¿Cuál es su raza? Marque todo lo que corresponda.

   ☐ Indígena de las Americas o Nativo de Alaska
   ☐ Asiático
   ☐ Negro o Afroamericano
   ☐ Nativo de Hawái o de otra Isla del Pacífico
   ☐ Blanco

6. ¿Es sordo o tiene serias dificultades para oír? ☐ Sí ☐ No

7. ¿Es ciego o tiene una dificultad seria para ver, incluso cuando usa lentes? ☐ Sí ☐ No

8. ¿Vive solo? ☐ Sí ☐ No

9. ¿Cuál es el grado o año escolar más alto que ha completado?

   ☐ Parte de la escuela primaria, intermedia o secundaria (preparatoria)
   ☐ Graduado de la escuela secundaria o el GED
   ☐ Parte de la universidad o escuela técnica
   ☐ 4 años o más de la universidad

10. ¿Alguna vez ha servido en el ejército de los Estados Unidos? ☐ Sí ☐ No

11. Durante el año pasado, ¿proporcionó atención o asistencia regularmente a un amigo o familiar que tiene un problema de salud a largo plazo o discapacidad? ☐ Sí ☐ No

12. En general, usted diría que su salud es:

☐ Excelente ☐ Muy buena ☐ Buena ☐ Regular ☐ Mala

13. ¿Alguna vez un proveedor de atención médica le ha dicho que tiene alguna de las siguientes condiciones crónicas?

	SÍ	NO		SÍ	NO
Ansiedad	☐	☐	Dolor crónico	☐	☐
Colesterol alto	☐	☐	Enfermedad renal	☐	☐
Asma/enfisema/otro problema crónico respiratorio o pulmonar	☐	☐	Osteoporosis (baja densidad ósea)	☐	☐
Cáncer o sobreviviente de cáncer	☐	☐	Obesidad	☐	☐
Hipertensión (Presión alta)	☐	☐	Esquizofrenia u otro trastorno psicótico	☐	☐
Depresión	☐	☐	Derrame cerebral	☐	☐
Diabetes (azúcar alta en la sangre)	☐	☐	Artritis/enfermedad reumática	☐	☐
Enfermedad del corazón	☐	☐	Otra condición crónica	☐	☐

14. Debido a una condición física, mental o emocional, usted:

- ¿Tiene dificultad seria para concentrarse, recordar o tomar decisiones?
  ☐ Sí ☐ No

- ¿Tiene dificultad seria para hacer mandados solo/a, como ir al consultorio de un médico o ir de compras?
  ☐ Sí ☐ No

15. ¿Tiene dificultad seria para caminar o subir las escaleras? ☐ Sí ☐ No

16. ¿Tiene dificultad para vestirse o bañarse? ☐ Sí ☐ No

17. ¿Con qué frecuencia se siente solo o aislado de quienes lo rodean?

☐ Siempre ☐ Seguido ☐ A veces ☐ Raramente ☐ Nunca

18. ¿Qué tan seguro está de que puede controlar su condición para que pueda hacer las cosas que necesita y desea hacer? Marque con un circulo su respuesta.

Totalmente inseguro 1 2 3 4 5 6 7 8 9 10 Totalmente seguro

19. ¿Tiene usted Medi-Cal? ☐ Si ☐ No ☐ No estoy seguro/a

20. Durante la última semana, ¿como ha interferido su salud en sus actividades normales con su familia, amigos, vecino o grupos?

☐ Siempre ☐ Seguido ☐ A veces ☐ Raramente ☐ Nunca

21. En la última semana, ¿cuántos días hizo ejercicio por al menos por 30 minutos?

☐ 0 días ☐ 1 día ☐ 2 días ☐ 3 días ☐ 4 días ☐ 5 días ☐ 6 días ☐ 7 días

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Chronic Disease Self-Management Education

Participant Session 6 Survey

Admin Use Only: The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

Participant I.D.: | C | A | | | | | | | | | | | | |

State abbreviation: C A *First four letters of the site name:* _ _ _ _

Start date of program: _ _ / _ _ / _ _ *Participant number:* _ _

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1. In general, would you say that your health is:

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. How sure are you that you can manage your condition so you can do the things you need and want to do?

   Totally unsure 1 2 3 4 5 6 7 8 9 10 Totally sure

3. How often do you feel lonely or isolated from those around you?

   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

4. How did you learn about this workshop?

   ☐ Doctor or healthcare professional ☐ Pharmacist or pharmacy employee

   ☐ Employer ☐ Health insurance provider

   ☐ Flyer or poster (where did you see it) ☐ Internet or website

   ☐ Family member or friend ☐ Other: _____

5. During the past week, how much has your health interfered with your normal activities with family, friends, neighbors or groups?

   ☐ Always ☐ Usually ☐ Half of the time ☐ Occasionally ☐ Never

6. In the past week, how many days did you exercise for at least 30 minutes?

☐ 0 days ☐ 1 day ☐ 2 days ☐ 3 days

☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days

7. Overall, how satisfied are you with this Healthier Living workshop?

☐ Extremely dissatisfied
☐ Very dissatisfied
☐ Satisfied
☐ Very satisfied
☐ Extremely satisfied

8. Please rate your level of satisfaction with your Workshop Leaders.

☐ Extremely dissatisfied
☐ Very dissatisfied
☐ Satisfied
☐ Very satisfied
☐ Extremely satisfied

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Tomando Control de su Salud

Encuesta de sesión 6 del participante

Para uso exclusivo del administrador: El facilitador o el personal del programa deben completar esta parte del formulario y marcar el número secuencial del participante con el nombre en el formulario de asistencia.

Identificación del participante: | ***C*** | ***A*** | | | | | | | | | | | | |

Abreviatura del estado: C A (por ejemplo, NY, VA, etc.)

Primeras cuatro letras del nombre del sitio: __ __ __ __

Fecha de inicio del programa: __ __ / __ __ / __ __ (por ejemplo, 01/12/19)

Numero de participante: __ __ (por ejemplo, 01, 02, 03, etc.)

1. ¿En general, diría que su salud es:

   ☐ Excelente ☐ Muy buena ☐ Buena ☐ Regular ☐ Mala

2. ¿Qué tan seguro está de que puede controlar su condición para que pueda hacer las cosas que necesita y desea hacer? Marque con un circulo su respuesta.

   Totalmente inseguro 1 2 3 4 5 6 7 8 9 10 Totalmente seguro

3. ¿Con qué frecuencia se siente solo o aislado de quienes lo rodean?

   ☐ Siempre ☐ Seguido ☐ A veces ☐ Raramente ☐ Nunca

4. ¿Cómo se enteró usted de este taller?

   ☐ Doctor, u otro profesional de la salud
   ☐ Empleador
   ☐ Folleto o póster (donde lo viste)
   ☐ Miembro de la familia o un amigo
   ☐ Farmacéutico u otro empleado de farmacia
   ☐ Proveedor de seguro de salud
   ☐ Internet o sitio web
   ☐ Otro: _____

5. ¿Durante la última semana, ¿cuánto ha interferido su salud con sus actividades normales con su familia, amigos, vecino o grupos?

   ☐ Siempre ☐ Seguido ☐ A veces ☐ Raramente ☐ Nunca

6. En la última semana, ¿cuántos días hizo ejercicio por al menos 30 minutos?

   ☐ 0 días ☐ 1 día ☐ 2 días ☐ 3 días ☐ 4 días ☐ 5 días ☐ 6 días ☐ 7 días

7. En general, ¿qué tan satisfecho está con este taller para una vida más saludable?

- ☐ Extremadamente insatisfecho
- ☐ Muy insatisfecho
- ☐ Satisfecho
- ☐ Muy satisfecho
- ☐ Extremadamente satisfecho

8. Califique su nivel de satisfacción con los líderes de este taller.

- ☐ Extremadamente insatisfecho
- ☐ Muy insatisfecho
- ☐ Satisfecho
- ☐ Muy satisfecho
- ☐ Extremadamente satisfecho

OMB Control No. 0985-0036
Exp. Date 11/22/2022

Chronic Disease Self-Management Program

Attendance Log

Instructions to Program Facilitators*: Please clearly print the Program Information and the Participant IDs below. Write participants' IDs as they appear on their *Participant Information Surveys.

Mark each session that the participant attends like this: ☑

Implementation Site Name: _____

Start Date (mm/dd/yyyy): __ __/__ __/__ __ __ __ **End Date** (mm/dd/yyyy): __ __/__ __/__ __ __ __

Participant ID	Session Number*						Notes
	1	2	3	4	5	6	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

Participant ID	Session Number*						Notes
	1	2	3	4	5	6	
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

OMB Control No. 0985-0036
Exp. Date 11/22/2022

Tomando Control de su Salud

Attendance Log

Instructions to Program Facilitators*: Please clearly print the Program Information and the Participant IDs below. Write participants' IDs as they appear on their *Participant Information Surveys.

Mark each session that the participant attends like this: ☑

Implementation Site Name: _____

Start Date (mm/dd/yyyy): __ __/__ __/__ __ __ __ **End Date** (mm/dd/yyyy): __ __/__ __/__ __ __ __

Participant ID	Session Number*						Notes
	1	2	3	4	5	6	
1.							
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Participant ID	Session Number*						Notes
	1	2	3	4	5	6	
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Chronic Disease Self-Management Education

Program Information Cover Sheet

Instructions to Program Facilitator(s): Please provide the requested details about this program. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the Survey Coordinator.

1. License Holder/ Org:_____

   Site Name:_____

   Address:_____

   City: _____State: _____ Zip: _____

2. Program Facilitator Names (please provide full first and last names and provide the daytime phone number and/or email of the best person to contact about any questions on the forms)

First Name Last Name Phone Email

Would you like to receive program information from the National CDSME Resource Center?
☐Yes ☐No

First Name Last Name Phone Email

Would you like to receive program information from the National CDSME Resource Center?
☐Yes ☐No

3. Program Start Date (mm/dd/yyyy): __ __/__ __/__ __ __ __

   Program End Date (mm/dd/yyyy): __ __/__ __/__ __ __ __

4. Did you offer a "Session 0" with this program? (*Session 0 is an optional pre-program session. Not all programs offer a Session 0.*)
   ☐ Yes ☐ No ☐ I don't know

5. What type of program is this? (Mark only one.)

   ☐Chronic Disease Self-Management Program (CDSMP)
   ☐Chronic Pain Self-Management Program (CPSMP)
   ☐Diabetes Self-Management Program (DSMP)
   ☐Programa de Manejo Personal de la Diabetes (Spanish DSMP)
   ☐Tomando Control de su Salud (Spanish CDSMP)
   ☐Workplace Chronic Disease Self-Management Program (wCDSMP)

6. Please check which language you used when offering this program:

☐English ☐Spanish ☐Other: _____

7. What funding source(s) were used in direct support of this program? (Check all that apply.)

☐ ACL CDSME Grant
☐ Older Americans Act (Title III-D, Title III-E, etc.)
☐ Centers for Disease Control and Prevention
☐ Other Federal Funding
☐ Medicaid/Medicaid Waiver
☐ Medicare/Medicare Advantage
☐ Other Health Care Payer
☐ Foundation Funding
☐ Corporate Sponsor
☐ I Don't Know
☐ Other: _____

Live Your Best Life!

Healthier Living Workshop

About Healthier Living Workshops

- Free on-site workshops
- Meets for 2 1/2 hours each week for six weeks
- Trained peer leaders
- Meet new people and gain social support
- Gives you tools to live a healthier life

Supports self-management of ongoing health conditions such as arthritis, heart disease, diabetes, high blood pressure, lung disease, and cancer.

Workshop activities and their benefits:

Activity	Benefit
Goal setting and problem solving	Helps you feel well and be well
Reading food labels and meal planning	Learn about healthy eating
Learning easy ways to increase physical activity	Become more active and increase energy
Learning different ways to cope with difficult emotions	Live happier and calmer
Meditation, visualization, and positive thinking	Improve relaxation and sleep
Managing medications	Reduce missed medication doses
Improving communication about your health	Better relationships with health care providers and loved ones

"It gave me the courage to get my life back on track..." *Workshop participant*

Sign up NOW for six 2 ½ hour sessions.

Location:

Dates:

Time:

Contact:

CALIFORNIA HEALTHIER LIVING

www.cahealthierliving.org

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SMRC Self-Management Resource Center

An SMRC Evidence-Based Self-Management Program originally developed at Stanford University.

CALIFORNIA

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Living Your Best Life…

www.cahealthierliving.org

INTERESTED IN JOINING?

SIGN UP HERE!

NAME	PHONE NUMBER
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By providing this information, I hereby give consent to receive information or be contact by a representative from Partners in Care.