

**NWX-CNCS**

**Moderator: Jill Sears  
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12:00pm CT**

Coordinator: Welcome and thank you for standing by. At this time, all participants' lines will remain on a listen-only mode. During the question and answer session, please press \*1 on your touchtone telephone.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would like to turn today's call over to Jill Sears. You may begin.

Jill Sears: Thanks, (Sandy). Hi everyone. This is Jill Sears. I am a Program Officer with Senior Corps. Thanks for joining us today as we are going to take some time today to explore a couple of evidence-based programs that have been designed out of Stanford University.

Both programs appear on the federal registries or reports within Appendix C in the table in Appendix C, for those of you who are making your applications right now. And today we are going to hear from Dr. Kate Lorig, who's kindly agreed to speak with you directly today about the program.

(Sandy), it sounds like we're going to do Q&A throughout the presentation, just as a heads up, and with that I will turn it over to Dr. Lorig.

Kate Lorig: Hello all. I'm really, really pleased to be with you today. I've been a great fan of Senior Corps for a very long time, mainly because I've known many people that have been involved in some of your programs. So it's good to be able to talk to you today about the Stanford Program.

The way I'm going to do this - and by the way, who I am is I'm the Director of the Patient Education Research Center at Stanford. And along with my team, we have developed these programs and done most of the research that has made them evidence-based.

So what I'm going to do is I'm going to present for a few minutes and then I'll ask for questions and then we'll present a little bit more and we'll just see how it goes. So if I could have the first slide, please. Jill, can you change slides?

Jill Sears: I changed slides. Can everyone see slide number two or no?

Kate Lorig: No, I can't.

Jill Sears: So this is our new system, our new Skype for Business system, and it sound like - participants on the phone, can anyone see slide number two?

Coordinator: If anyone would like to respond, please press \*1 on your touchtone telephone. Once again, please press \*1. One moment. Go ahead. Your line is open.

Woman: I said I'm on the 1(800) number. I called in and I cannot see any slides.

Kate Lorig: Ok. So why don't I just - what I'm going to do, because we seem not to have a functional system and as long as everybody can hear me, life is fine.

Jill Sears: Great.

Kate Lorig: I'm going to kind of read and tell you what's on the slides. And if anybody wants them afterwards, I'm sure Jill will be able to get them to you. How's that?

So, why should we even care about self-management? And the reason we should care is that these programs focus on the 99% of the time people with chronic conditions are outside of the healthcare system. And what they do in this time greatly affects both their quality of life as well as the cost to the system.

Now, you might say who cares about chronic illness? Well, when we talk about seniors -- actually just people over 60 -- people on average have two and a half chronic conditions. And chronic conditions are also the largest driver of health care costs in the country.

So what is the Chronic Disease Self-Management Program? Let me talk to you a little bit about it. We talked about why we should care. First, the Chronic Disease Self-Management Program is a program which is - I'm sorry. I just need to look at something myself here. Dear. Good.

The Chronic Disease Self-Management Program is a program which is offered - all of the disease programs at Stanford are offered as programs that are offered two and a half hours a week for six weeks. They're offered in community settings and they're taught by peers. So I'm going to talk about

two programs today. There are actually more programs than that. But all of the programs follow that same format.

The kind of gold standard program or premiere program is the Chronic Disease Self-Management Program. It's designed for anyone who has one or more chronic conditions, and those chronic conditions can be physical conditions like diabetes or arthritis. They can also be mental health conditions such as schizophrenia and bipolar.

We actually have research that shows that the program seems to be about equally effective for both types of people. And in fact, no matter what you decide to do, you're going to have people with mental health conditions. And the reason we know that is because from all of our studies we know that about a third of the people that come to our programs with physical chronic conditions are also clinically depressed. So you can't not mix the two.

In the Chronic Disease Self-Management Program, people with all kinds of conditions attend the program together. So in the program you can have one person that has heart disease and diabetes and another person that has multiple sclerosis and another person that has arthritis and heart disease, another person that has Parkinson's and depression, and on and on and on.

There are somewhere between 10 and 15 people in a group, and each group is taught by two peer leaders. There is no disease-specific content.

So what do we actually teach? Well, we deal with managing symptoms -- pain, fatigue, depression, shortness of breath, disability. These are the things that people tell us are the problems of living with chronic conditions.

We also - so we teach management of those symptoms. We teach exercise, and we help each person design their own exercise program. We teach relaxation techniques, healthy eating, communicating with family and friends and communicating with the healthcare system. We don't teach anything about specific medications, but we do talk about medication management.

And then we have three very core skills, and those are problem solving, action planning, and decision making. And we use these very systematically throughout the program.

Now, what I've talked to you about so far has been the Chronic Disease Self-Management Program. Again, a program for people with all kinds of conditions all together at the same time.

We also have a Diabetes Self-Management Program. And that program is specifically designed for people with Type Two Diabetes. It meets all the American Diabetes Association standards for advice on diabetes care, and it also meets all of the American Association of Diabetes Educators standards for diabetes self-management. So it's right in the mainstream of diabetes programs and that program, the content is specific.

And so the types of things that we teach in addition to again action planning, problem solving, decision making, we also teach healthy eating, exercise, how to prevent hypoglycemia, monitoring glucose, we do some stuff on stress and depression, again some things on medication management, how to prevent the complications of diabetes, and what to do during sick days when you have diabetes.

So the content of the two programs are different; the format is pretty much the same. And I should also mention that both of these programs are available in

English and Spanish, and they also are available in several other languages. So if you actually have a language need outside of English and Spanish, we may have a program that - we may have manuals that would be useful for you. We may not, but we may.

So, let's continue a little bit and talk about why are these community based and why do they really fit in the programs, such as the programs you all are doing. They're community-based because, believe it or not, people don't like going to hospitals and clinics. They'd much rather go to a senior center, a church, or a public library.

Secondly, people are always more comfortable in their own neighborhoods. And so these programs are given in people's neighborhoods. The example that I sometimes give -- which is an extreme example but it works really well -- is George's Garage.

In San Diego, (Jorge) lived in the Hispanic area and they didn't have a good meeting place, but he had a pretty empty garage. So he actually held classes at this garage in his neighborhood. And while most classes are not given in garages, it basically shows that they can be given anywhere.

Also in a community, you don't have very many transportation problems. And you give them where people naturally gather rather than making people uncomfortable by going to some place other than where they would normally go.

And another question that we get very often asked is how about - why do you have peers teaching? Why don't you have professionals? Wouldn't professionals be better? Well, we have peers teach them, and we have patients

teaching patients. There are two leaders for every class. They really act as models to the community because our peers come from the community.

They are easily trained. They use standardized curriculum. We probably have 10,000 leaders in the United States today. Peers pretty much do what you ask them to do. There's lots of them. They're also less expensive and more flexible than health professionals.

And then you're going to say yes, but wouldn't health professionals still be better? And I can tell you that we've done a few studies and in some of the studies, the peers actually have better outcomes in their participants than the health professionals, and then sometimes it's about the same. But we don't have any studies that show that health professionals have superior outcomes to peers.

I'm going to stop at this point because I kind of described the program. And I understand if you hit \*1, you can talk to me. And so let's ask some questions and then after you've asked the questions, I'll go on and I'll talk a little bit about what the requirements are if you all decide that you want to do one of these programs.

Coordinator: Once again, if they'd like to respond to ask a question or make a comment, please press \* and 1. One moment.

(Lori Brinksmeyer), your line is open.

Jill Sears: Thank you.

(Lori Brinksmeyer): How are the peer leaders trained?

Kate Lorig: Ok. I was going to get to that, but I'll be happy to answer it now. The peer leaders are trained - we actually have four levels of trainers. We have leaders. Those are the peer leaders. They are trained by master trainers. And master trainers are trained by T-trainers. And I'll talk to you a little bit more about that in a minute. But the training for peers is four six-hour days. And usually the way that training is given is two days one week and two days the next week.

(Lori Brinksmeyer): And those trainings then are on site at Stanford?

Kate Lorig: No. What we would do is they would be in your community.

(Lori Brinksmeyer): Ok.

Kate Lorig: You'd have - we'd either train some master trainers for your community or we'd help you find master trainers in your community that already exist. And they would do the training for you.

(Lori Brinksmeyer): I see. Thank you.

Kate Lorig: We're much too expensive.

(Lori Brinksmeyer): Ok.

Kate Lorig: I mean, if you want to send them here, we'll be happy to train them but you wouldn't want to pay us for what it would cost.

(Lori Brinksmeyer): No, but I'm thinking yes, I'm thinking, you know, we're pretty far away so that would be a cost that we might not have to (unintelligible).

Kate Lorig: No. Where are you?

(Lori Brinksmeyer): On the central coast of California. We're about halfway between LA and San Francisco.

Kate Lorig: Ok. Well I mean, we'd figure out a way. But this is true. What I'm asking for you, I'm saying to the whole country because right now, we actually have master trainers in every state in the country except Wyoming, and we will have people in Wyoming in six weeks.

(Lori Brinksmeyer): Ok. Thank you.

Coordinator: Our next question will come from (Eden Slater). Your line is open.

(Eden Slater): Hi. I was just wondering about follow-ups. I help coordinate volunteers and we have some that do the lay leaders for Living Well and Diabetes. But I was wondering when you mentioned earlier the proof of the lay leader/peer leaders versus health care professionals. Do you ever follow up with folks who go through the class to see if they've stuck with it? Or how do you measure that?

Kate Lorig: Yes. We've actually done - the reason that I think that you all are even looking at this program is because we are probably one of the better known evidence-based programs in the country. And that means that for this program, we have done randomized control trials.

The original trial was about 500-600 people. We just did an 1,100-person longitudinal trial. And then we actually go back to people six months and a year -- and in one case, two years -- later to see how well they're doing.

And in the latest study, which was a 22 site study, in the United States with 1,100 people, what we found was that after one year, people continued to have improved symptoms -- that is, they had less pain, they had less shortness of breath, et cetera.

They had better behaviors, especially exercise, and adherence to medications. And they also had lower costs. And that was mostly fewer emergency room visits and fewer hospital days. So the program met the triple aims of health care, which is kind of what the whole Accountable Care Act is based upon.

Now, that's just one study. But altogether for the chronic disease program, there's probably been 30 or 40 studies. For the diabetes program, there's been fewer studies but in the diabetes programs we've done studies in both English and Spanish. In both cases hemoglobin A1c has been lowered, symptoms of hypoglycemia have been lowered, behaviors have been improved.

So that again is why these are evidence-based programs. And anybody that really wants to read any of the things about these programs, if you go to our Web site -- and our Web site is really easy to remember. It's [patienteducation.stanford.edu](http://patienteducation.stanford.edu).

And you can get that. Just put "patient education" and "Stanford" and you will probably find everything that you want to know. Under Bibliography, you'll find all the citations for the major studies.

(Eden Slater): Thank you.

Coordinator: Once again if you would like to ask a question, please press \*1 on your touchtone telephones. Once again, that is \* and 1. Please stand by for any questions.

Kate Lorig: Ok. If we do not have more questions, I can continue on and we'll give a chance a little bit later. How's that?

Coordinator: I do have one question. One moment.

Kate Lorig: Ok. And this will be the last one. Then we'll go on.

Coordinator: Our question is from (Jackie Bishop). Your line is open.

(Jackie Bishop): Hi. This is (Jackie Bishop) in Alabama Corporation State Hospice. It's not a question but I just wanted to let everyone know that we currently have an RSVP project in Alabama with the Department of Senior Services, who is licensed to offer the Chronic Disease Self-Management Program. The name of their program is Living Well Alabama.

And so what they are doing, they have trained their RSVP volunteers to conduct workshops, two and a half hours a day once a week for six weeks in community settings such as senior centers, churches, libraries, and hospitals.

And the participants are people with different chronic health problems. They all attend together in one setting. The workshops are facilitated by two trained leaders -- one of both of whom are non-health professionals with chronic diseases themselves.

And during those workshops, they cover such topics such as techniques to deal with problems such as frustration, fatigue, pain, isolation. They also engage in appropriate exercise for maintaining and improving strength and endurance.

So we're really pleased with what they've been able to do at this point. But I wanted to bring that to the floor as well.

Kate Loring: That's terrific. Ok. Thank you very much. That's a good testimonial from the field, and that's exactly what we like. And I know that Alabama's been doing a terrific job.

(Jackie Bishop): Great.

Kate Loring: So let's talk a little bit about the nuts and bolts. One thing I forgot to tell you before is when do you give classes. You can give classes at any time that is good for people in your community. It doesn't have to be nine to five. It can be Sunday afternoon. Around here -- at least in the Spanish-speaking community -- Saturday morning seems to be a really good time. So you give the classes when people can come and it's good for them.

Let's talk a little bit about the training. For leaders, I've already told you it's six hours a day for four days. During that training - and the training is all done using a very detailed manual. So what we're doing is we're teaching people to use the manual that they're going to use to teach with. They don't have to come with any knowledge about anything.

What we're teaching them how to do is to follow the manual, and that manual has in it both the content of the program, exactly what people should say, but also all the processes. So for this exercise you do it this way, and this exercise you do it that way. And by the end of four days, they will have seen every exercise. They will have seen practice teaches of every exercise. And they're really ready to go.

Now, these people are trained by master trainers. Master trainers are people that have taken a four-and-a-half-day master training program. Those programs are given here at Stanford. They can also be given at other places in the country.

And then once people have gone through the four-and-a-half-day program, they go back and they teach two programs. They teach two different workshops to participants. And after they've taught the workshops to participants, then they can teach a leader's training. They can begin to train leaders.

At the present time, we probably have about maybe a thousand master trainers in the United States. So that's why I can say pretty surely that there's some master trainers near you so if you wanted to do a local training, you'd have to arrange with the master trainers around you. Now, that's probably going to cost you something, because, you know, these people are working and they have to get off work. They're probably not going to do this as volunteers.

On the other hand, you may want to train some of your own staff to be master trainers. So then somebody says well how? T trainers. T trainers are the people that train master trainers. And the way people become a T trainer is they come here to Stanford when we're doing a master training and they do a master training with Stanford staff. So it's an apprenticeship program. It's a little bit different than for the other two.

Let's talk a little bit about why this program tends to work kind of all over the world. And one reason is, is we really insist on fidelity. We're sometimes known as the fidelity police, although I can assure you that Stanford actually does not have any fidelity police. The world seems to think that we do.

And the reason that fidelity's so important is that it really preserves the integrity of the program. We don't let you change it. Everybody that ever sees the program thinks they can change this or that, and if we did, we'd have a mess really soon. And so you really can't change the program.

Now, once in a while somebody will call us and say, "We need to do this or that for this reason," and we'll say that's fine. But generally you don't change it.

Fidelity's also important because it indicates quality to potential users. So if you go to your local hospital or you go to a local clinic or, you know, you kind of link up with a medical home, you're talking about an evidence-based program and something that has a lot of evidence and that you are going to give the way it's given everywhere else.

Probably one of the most important reason for fidelity is you avoid harm to participants. We've put about a million people through the program so far. And as far as we know, there has been no major harm to everybody. I always knock on wood when I say that. But we're pretty sure the programs are safe. And the second that you start fiddling with them, they might not be safe anymore.

And finally, it's an effective use of resources. For example, one of our fidelity standards is that you can't give classes for less than eight people. And number one, you don't have the critical mass for the interaction to occur. That's one of the reasons for that. And the other reason is it just becomes exceedingly expensive.

And so a lot of our fidelity standards have to do with efficient use of resources. And if you want to kind of see those fidelity standards, you can

again look at our Web site. And I should tell you on our Web site, on the home page, there is both a fidelity manual and an implementation manual.

I'm actually currently rewriting both of those. But you can get a pretty good idea what you need to do from what's written there. They're not going to change that much.

Now, to give a program, you must have a license. There's no getting around this. No one can give a program without having a license. And the major reason for a license is so that it is very clear who has responsibility for the program. And the responsibility always goes to the organization offering the program. And so that's one of the reasons for the license. You also agree to keep fidelity and to make a report every year.

And there are different types of licenses. There are licenses - the simplest license is to give the program. You can give 30 courses over three years in any one program. And the cost is \$500. And then in many states and in many other places, there are what we call multi-course licenses and multi-site licenses. These licenses usually cost \$8000 and you can give as many of the different Stanford programs as you have people trained to offer, and you can give 600 courses in three years. And then there's all kinds of licenses in between those two.

So again, if you look at our Web site, there's all kinds of things about licensing requirements. But the thing that you really must know is that every organization offering the program must be covered by a license. You may not have your own license. You may be covered by a state license, because in some places, there are state licenses. But you must be covered formally by a license.

Secondly, every trainer and every leader must teach only for a licensed agency. So when somebody comes to leader's training, they have to be attached to a licensed agency before they ever come to training. Same thing with a master trainer. Before anybody comes here for master training, they must be attached to a licensed agency. And we keep pretty good track of these sorts of things. So there are licensing requirements.

And maybe what I should do is stop here and again ask if there are any questions about licensing requirements.

Coordinator: Once again if you would like to ask a question, please press \*1. I think we have a question from before. (Amy), your line is open.

(Amy): Can you hear me?

Kate Lorig: Yes, I can. Go ahead, Amy.

(Amy): Well, I'm from the great state of Wyoming and we're just starting, as you mentioned.

Kate Lorig: And I'm so excited. You have no idea how excited I am.

(Amy): The training is coming up next week and we're getting all the stuff. And we do have two licensees in the state of Wyoming and they are also coming to our master training and they're bringing their licenses.

The number one question from volunteers is kind of some of the things you've already mentioned. Well, can, you know, can we change it? Can I - and I tell them, because we're with the RSVP Program here, and I say, "No you can't change it. You will teach it the way it is in the manual." So it is a question that

does come up. So, any suggestions on how to maybe word that better?  
Because I just say, "No you can't change anything."

Kate Lorig: What we say - well number one, especially for people that have never taught, everybody that's never seen it has no idea what it is. And we say teach it exactly the way it is right now. And then, if you think that it needs to have changes, what you do is you write those things, you send them to us at Stanford...

(Amy): Yes.

Kate Lorig: ...and it depends. I mean, once in a while there will be something that really needs to be changed right away. I can't think of the last time we did that, but once in a while, there is. I know -- in the south, some folks wrote and said, "You know, we're always in African American communities and they pray before classes. Can we have prayers before classes?" And we'll say sure, have prayers before the class.

(Amy): Yes.

Kate Lorig: You know, are we ready to do that everywhere in the country? No. But if that works for you in your community, who am I to tell you whether you can pray or not?

(Amy): All right. We do have a significant number of retired teachers coming to the training, which I really like. And those are the ones that generally ask.

Kate Lorig: Well number one, they're retired teachers from teaching kids, and teaching behavior change to an adult is very, very different technique. Because we're not teaching people for knowledge.

(Amy): Yes.

Kate Lorig: We're teaching people for skills and competence. But...

(Amy): It has been my approach. You're not teaching little kids. You're teaching grown-ups.

Kate Lorig: Yes.

(Amy): And grown-ups who have significant issues. And some of the people that are coming have mentioned that some of the things you talked about that can happen to people are happening to them -- you know, the depression, the withdraw.

Kate Lorig: Sure.

(Amy): I'm glad that we're getting people that are able to articulate that as well.

Kate Lorig: That's terrific. And as I say, once the training is over, if people have really concerns and stuff, please write me and I'll be happy to, you know, correspond with you back and forth.

(Amy): Ok.

Kate Lorig: But I can tell you, we've had enough experience with you now that we're probably going to be very, very hesitant to change things.

(Amy): We're really excited and as I said, there's another licensee which is the University. We're really excited to have it here.

Kate Lorig: Well I've gone through like for the last ten years saying the program is offered in every state in the country except Wyoming.

(Amy): Not anymore. Now you can say it's offered in all 50 states.

Kate Lorig: And I can say it's offered in all 50 states. And by the way, I love Wyoming. I'm a Coloradoan.

(Amy): Ok. Well, one of our trainers is from Denver, which makes it very easy.

Kate Lorig: Terrific. Yay. All right. So, any other questions about licenses or anything else? And if not, we can kind of continue.

Coordinator: I'm showing no further questions.

Kate Lorig: My goodness, am I really that clear? All right. I'm going to talk a little bit - I've already talked about the three levels of training -- that leaders facilitate workshops, master trainers train leaders, and T trainers train master trainers.

A leader training has to be given by two master trainers. Everything in our entire system is done in twos. You can kind of think of Noah's ark. It takes two leaders to do a program. It takes two master trainers to train leaders. It takes two T trainers to train master trainers. And when you do a leader training, there's no payment to Stanford, outside of the fact that you must be licensed.

And it's up to your master trainers whether people are certified as leaders at the end of training. Not everybody that comes to training actually becomes a leader. Most people do, but some people don't. And it's not just on a whim

that the master trainers make this. They actually have specific criteria that they're looking for during training, such as is the person always judgmental?

So the first day, somebody says, "Well you really should teach it like this because this is the way my Aunt Minnie did it," or, "This is what my doctor said." And the master trainer will say, you know, "There's lots of different ways of doing things, and one of the things we try to do is not be judgmental." If that same person on the last day is still saying, "Well, you should. You should. You should," that person probably will not become a leader. That's a sign of judgment that people should not be doing - cannot be doing in this program.

We (unintelligible) how they do their practice teaching. If by the second practice teach, they don't understand or they need to be following the manual, and they're still making up stuff on their own, then they can't be a leader.

If they haven't learned the basic processes of doing brainstorming and problem solving and action planning and can follow those, then they cannot be a leader.

So there's very, very specific criteria that we're looking for.

I will tell you all that anybody that you invite to leader's training must be literate in the language of the training. And we've actually had that problem where I did a training many years ago where I learned this. It never occurred to me to ask whether people were literate and I was about halfway through the training and realized that people could not read the manual.

People that cannot read the manual cannot be a leader. They can certainly attend the course. There's nothing with literacy about attending it. But they cannot be a leader.

So that tells you a little bit about leader training. Let me see if there's more that you need to know here. Sorry, I have a recalcitrant mouse here.

Let's talk a little bit about master training. Master trainings can be 12 to 20 participants. And again, when people come to master training, not everybody always passes. Basically for the same reasons -- that they can't follow the manual, they're judgmental, they really don't like the program. And not everybody does, and that's fine. It's pretty hard to teach somebody if you don't like the program.

And master training can be done one of two ways. You can get your own master trainer's training and then you can give as much master training as you want. We do ask that a fee does come to Stanford every time you do a master training.

And the reason for that is because number one, we keep track of all the master trainers in the country. We also have a listserv of all the master trainers in the country. If you've been hearing pings in the background today, it's because I'm getting emails. And most of those actually come from the listserv.

We usually have anywhere from five to ten posts a day on the listserv. And it's a way for people all over the country to share experiences, to learn things. We tend to have discussion threads. Right now, there's a discussion thread about what are some good points for advertising the program. But the listserv actually ends up taking about an hour and a half or two hours of personnel

time here each day just to maintain. And so some of those fees go for things like that, and keeping up the manuals for coordinating the training, et cetera.

And then the other way you can do master training -- and I think this is what's happening in Wyoming -- Wyoming really didn't have the infrastructure to do its own training. And so they called us -- and I'm not actually sure this is true.

So Wyoming, if what I'm telling you is not true, forget it because we do do it someplace else, other places -- that somebody says, "You know, we just want Stanford to do everything."

And we can do that for you. We can find your master trainers. We can kind of walk you through the process. That's pretty intense from our point of view. And when that's happened, then again there's a fee to Stanford but it's a larger fee.

So there's two different ways of doing the master training.

And then as far as T training is concerned, to be a T trainer, somebody has to have conducted at least three leader's trainings. They must be an active master trainer. They must be recommended by their organization. And then they come to Stanford for a week. We actually don't charge anything for that. They have to pay their own way here, but we don't charge anything for the training. And they train with us for a week.

There's some other pieces here that might be interesting. If you're just starting the program, you may not be terribly interested in these right now, but we do have some other pieces. We have recertification so that - to remain active as a leader, you have to teach every year. To remain active as a master trainer, you either have to do a training every year, or you have to teach a workshop every

year and you have to do a training every two years. So there's very, again, fidelity standards for maintain certification.

And we're just now completing a program where we're going to be able to actually update and certify leaders that have fallen behind.

Just so that you know, because some of you may be interested, today I've talked about the Chronic Disease Program and the Diabetes Program. But we also have some other programs. We have a Pain Self-Management Program, an HIV Program, a Cancer Thriving and Surviving Program for cancer survivors. So there are other programs.

Now, every time you do a new program, you don't have to go through four-and-a-half days of training or four days of training. What we tend to do is we tend to train everybody in the Chronic Disease Self-Management Program using the standards which I told you today, and then if people want to - let's say they want to do Diabetes. Then what we do is we do cross training.

And cross trainings are done by a series of having people watch a bunch of videos and then attend a webinar online. And usually we cross train master trainers who then cross train leaders in a one or two-day session to cross train them into the new course.

So the thing just to remember is get everybody trained in Chronic Disease and then let's worry about some of these others and how to cross train them.

Now, the one exception to that would be if all you ever want to do is Diabetes, and you know you never want to do anything else but Diabetes. Then we can do a four-and-a-half-day training or a four-day training in Diabetes. But you

cannot be cross trained from Diabetes to any of the other courses. So you're kind of stuck with Diabetes once you're there.

I think I am about finished. For those of you, if you can see any slides, I just put up a slide to show you where I'm at, the slide of Stanford, just in case you happen to want to come here. And I'd be happy to answer any more questions. We still have maybe 10-15 minutes.

Coordinator: At this time if you would like to ask a question or make a comment, please press \*1 on your touchtone telephone. Once again, that is \* and 1. Please stand by for any questions or comments.

Jill Sears: Well I can tell you that was new information for me. I took some notes on the cross training. I think that's very interesting. So thank you for sharing that.

Coordinator: And at this time, I'm showing no questions or - one moment. The person did not record their name. Go ahead if you pressed \*1 for a question. Go ahead. Your line is open. Please check your mute button.

(Caroline): (Caroline).

Coordinator: Your line is open. Go ahead with your question.

(Caroline): What are some of the examples of licensed organizations?

Kate Lorig: Dear. Well the first thing I'm going to tell you again is to go to the Web site, [patienteducation.stanford.edu](http://patienteducation.stanford.edu) and look under organizations offering our program. They're organized by state. And you can see everybody in your state that's licensed.

(Caroline): Ok. Thank you.

Kate Lorig: But, what kinds of organizations are licensed? Senior centers, area agencies on aging, hospitals, clinics, YMCAs, (unintelligible) hospital systems like Kaiser Permanente.

(Caroline): Ok. Thank you.

Kate Lorig: Parks and Rec departments.

(Caroline): Parks and Recreation?

Kate Lorig: (Unintelligible) department, senior centers. I think you'll be - there's huge numbers of licensed organizations and they go all the way from the National Health Services of England -- which is our single biggest licensee -- to Winning Turtles . Winning Turtles are two disabled women in Washington who give about two courses a year and have been doing it for years and years and years. And so - and almost anything in between.

So they're very varied. I can tell you that RSVP really sits kind of, you know, right in the middle of our licensed organizations. We certainly have some Catholic charities that are licensed. We have some Jewish family services that are licensed. We have some churches that are licensed. The state prison system in Oklahoma. So very varied.

(Caroline): Thank you.

Coordinator: Our next question will come from (Jamie). Your line is open.

(Jamie): Thank you. If you were an RSVP Program and looking for this, what kind of outcome-based materials does this program offer?

Kate Lorig: Again, if you look at the bibliography on our Web site, you will see all the publications. But are you asking - maybe I'm not understanding. Are you asking if you want to collect your own data? Or are you asking what evidence do we have?

(Jamie): Well, I guess that if you did it as an RSVP program, you'd have to collect your own data, right?

Kate Lorig: You know, I think you have to ask your system about that. I would strongly urge to say no, that you don't.

(Jamie): Ok.

Kate Lorig: And the reason I would say that -- and Jill may come and chop off my head at this point -- the reason I'd say that is collecting data is expensive. To really collect it well is expensive. And there's really no need to do that, because we've done it enough already that we pretty well know what you're going to find out if you do it well.

(Jamie): Ok.

Kate Lorig: So it's not a brand new program. If RSVP insists that you collect data, then what I'm really happy to do is to work with Jill and to put together a really simple form so that you don't spend all your money on collecting data as opposed to collecting outcome data.

Of course, what you do want to collect is you want to collect how many people attend, how many sessions so they attend. We usually consider somebody a completer if they've done four sessions out of six.

(Jamie): Ok.

Kate Lorig: And the reason - and so people say, "Why don't you just give four sessions?" Well, it's because our evidence shows us that people that complete four out of six actually do well in the long term. They do well at one year, and they do well at two years. And about 70% of the people that start the program complete four out of six.

We also know that people that only do three don't do nearly as well. So if you only offer four weeks, people being what they are, most people would not come to all four weeks. They'd only come to three and you'd lose you effectiveness.

So we pretty well decided that four out of six works pretty well. It gives people a little slippage. At the same time, we certainly don't want to tell people, "You only have to come to four out of six."

(Jamie): Right. Are you familiar with the Matter of Balance Program?

Kate Lorig: I am.

(Jamie): It sounds like they modeled a lot out of - I don't know which one is older, but they sound very similar.

Kate Lorig: Well, in many ways we are. We're both members of the Evidence-Based Leadership Console. We're both considered among the, you know, better evidence-based programs in the country today for older people.

(Jamie): Ok.

Kate Lorig: And yes, the fact that we look a little bit alike is not coincidental.

(Jamie): Ok. That's, you know, that's what I was hearing as I was listening. But I guess bottom line is I just wanted to know what is being used for documentation if RSVP programs are using this? Because - or are they being required to have outcomes?

Kate Lorig: Ok. That's not a question for me. It's going to have to be a question for RSVP. I'm sorry.

Jill Sears: This is Jill. I'll give a quick answer to this. There, in the application instructions, there is an output measure that's specifically designated for health education programs. And this falls into that.

(Jamie): Ok.

Jill Sears: So in our framework, you don't necessarily have to reach an outcome. This falls into that bucket that it's health education programming.

(Jamie): Ok.

Jill Sears: And the thing that I'll say about documentation and data collection is that there is always a requirement for some sort of documentation. And one of the things that we will likely need to do is prove fidelity to the model that you're

implementing. But how we get that done, like Dr. Lorig is saying, hopefully we can find a way to accomplish that where we're not reinventing the wheel or creating a lot of extra work, so.

(Jamie): Ok. Well I mean you guys have pulled our programs into this information, so we're just trying to see how we can, you know, fit together.

Jill Sears: Yes. And then the other thing that I'll mention is that, you know, part of this proposal for RSVP includes requesting a higher level of funding. And that's an allowable expense and that framework has to do with, you know, licensing fees or material fees or possibly evaluation, the extra additional expense that comes with evaluation. So all things to kind of keep in mind.

(Jamie): That's fabulous. Thank you.

Jill Sears: You're welcome.

Kate Lorig: By the way, I'm happy to talk to any of you at any time about evaluation. I need to understand a little bit more about what's totally required. But I haven't even talked about evaluation today but it's something obviously I know a great deal about.

Jill Sears: Great.

(Jamie): Excellent. Thank you.

Coordinator: Our next question will come from (Eden Slater): Your line is open.

(Eden Slater): First, if it's all right, I can shed a little light on at least what we're doing here in Knoxville with RSVP. I think our licensed program is through the Health

Department. But our RSVP sponsors bring in a lot of lay leaders. So for my personal RSVP outcomes, I have to have at least 10 leaders that go through training. And then we have to have an output target of 60 participants, and our output measure is just the sign-in sheet.

I know we fill out post and pre surveys as well. And I usually do a chart and collect that data and record it and we send that with the grant also. But I think the main reason we do the surveys is for the Health Department, because we send all those back to them as well.

I don't know if that helps you, but that's sort of the model we've been following here in Knoxville.

But my question was, one thing that has been brought up to me from the ladies from the Health Department is do you ever do these sort of trainings for doctors' offices? Because a lot of the folks that of course attend the program find out they have a chronic condition like Type Two Diabetes and the doctor says, take this pill. I mean hopefully they maybe hear about this and end up at one of the trainings, but if they don't, do the doctors know to refer people to chronic conditions classes?

Kate Lorig: Ok you're asking a very thorny question, which could be a whole webinar.

(Eden Slater): Ok.

Kate Lorig: Basically, doctors don't refer to community classes. You need to understand that. And the reason they don't is because they don't quite trust you. And plus, which they don't know quite when they're going to be or where they're going to be.

And so the systems in the country that have worked best for getting physician referrals is something like Massachusetts.

(Eden Slater): Ok.

Kate Lorig: Massachusetts can guarantee a class to anybody anywhere in the state within two to three weeks of calling. They have a state-wide system. Every doctor in the state knows there is one number that people should call in the entire state. And in fact, they're getting a lot of referrals.

But it's a matter of setting up the system so that A, the doctors know, you know, you know, I told Mary to call and she couldn't get into a class in nine months. Or the class was cancelled. Or there wasn't one. Once that happens to a doctor, they're never going to refer again.

So if you're going to do referrals from docs, you have to do it with a system. Now here at Stanford, we have a couple clinics -- the Pain Clinic and also one of the Primary Care Practices runs their own classes. They have staff and patients that run the classes -- and by the way, their staff are not health professional staff. They're office staff. And so they can fill them and they can run them as they wish.

But remember, people don't like coming to the doctor's office. So it's much better to give these classes in the community. So as I said, we could do a whole webinar on this. But if you are going to depend on your programs for doctors without having a really good system in place, I can promise you it's going to be a failure.

(Eden Slater): Yes. We don't. I just...

Kate Lorig: Yes.

(Eden Slater): ...was curious if they were aware of the resources.

Kate Lorig: Yes. Are doctors aware? Some are, some aren't. But making them aware doesn't do any good unless you have a system in place that guarantees that people are going to get into classes and they don't have to remember it starts at this senior center on Monday at 3:00 and at that senior center on Thursday at 2:00. Forget it.

You might also look at - I mean, there's an organization in San Jose that's done an incredible job with a Web site. They give about 100 diabetes classes a year. You go to their Web site, you put in your zip code, and it tells you the next class that's nearest to you and where. And you can really register online.

(Eden Slater): Wow.

Kate Lorig: So there are beginning to be systems in place.

(Eden Slater): Thank you.

Kate Lorig: But, yes. Other questions?

Coordinator: At this time, I'm showing no further questions. Once again, if you'd like to ask a question, please press \* and 1.

Kate Lorig: And in the meantime, I'm going to just tell you that I've said my Web site enough so that you can find it. If you have questions for me, my email is very easy. Again, it's Lorig -- L-O-R-I-G -- at Stanford -- S-T-A-N-F-O-R-D -- dot

edu. And I'm perfectly happy to answer questions if you want to write to me as well.

Coordinator: We do have another question. (Amy), your line is open.

(Amy): It's not a question, but since we're so new here in Wyoming, we actually have a doctor on the advisory council who is a member of the hospital, you know, working group. And we've also him to come to the master training to observe what we do so that he can spread the word to his colleagues.

That's pretty much - we're so new. But that's pretty much the only way we could figure out how to do it, because the doctors in Wyoming are few and far between.

Kate Lorig: Yes. I think that's an excellent, excellent thing. I mean, I can see already that Wyoming's going to be a big success. And I'll add to you something that we did in Humble County in Northern California, a very rural county. Doctors are few and far between.

And what we did is they meet periodically and at one of their meetings, we talked to them a little bit about the program and we said, "How many of you think that you could refer two people in the next month?" And most of them said they could. We said, "Fine. On your table, you will find fax forms. Take these fax forms and when you have somebody that you'd like to have a program, you just fax them to a central place.

We will call them. And by the way, this meets all HIPPA requirements. And we'll get them into a class. Not only that -- at the end of the month, we're going to send all of you a list of how many each of you has referred," so that every doctor in the whole county got to see how many people other doctors

had referred. And they upped their physician referral by huge, huge amounts. They went like from something like 30 a month to 200 a month.

So that sort of thing might work for Wyoming.

(Amy): Sure it would.

Coordinator: And at this time, I'm showing no further questions. Once again, if you would like to ask a question or make a comment, please press \* and 1.

Kate Lorig: I think our time is about up.

Jill Sears: It is. I'm seeing we're at 2:00.

Kate Lorig: Then I will say to all of you what I always say at the end of training -- go forth, do good, and multiply.

Jill Sears: Well, thank you so much. Thank you for engaging with us and helping us really take a look at how our programs can think about both sort of best serving their communities and incorporating some of your programs that have been proven to work.

I'm sure that some of our folks will follow up with you individually, since you've given your email out. And I will certainly follow up with you and hope that we can kind of be as successful as possible. So thanks.

And anyone, if you have questions for Senior Corps, please feel free to email us at [2016SeniorCorpsStaff@cncs.gov](mailto:2016SeniorCorpsStaff@cncs.gov). And we'll talk to you soon.

Coordinator: Thank you. That does conclude today's conference call. Thank you for participating. And you may disconnect your lines at this time.

END