Implementation Manual

Stanford
Self-Management Programs
*2008**

Please note that while this manual is written for the Chronic Disease Self-Management Program (CDSMP) it can also be used for any of the other Stanford small group programs (Diabetes Self-Management, Positive Self-Management Program, Pain Self-Management Program, or Arthritis Self-Management Program.)

Copyright © 2008 Stanford University
Stanford Patient Education Research Center

Table of Contents

I. Program Description

- Chronic Disease Self-Management Program
- Does the Program replace existing programs and treatments?
- How was the Program developed?
- How was the Program evaluated?
- What were the results?
- Why Programs Might be Implemented?
- What about Cost Savings?
- How do We Convince Health Professionals to Trust the Program?

II. What is Needed for Implementation

- A Consideration Before Implementation
- Program Coordinator
- Master Trainer
- Trained Leaders

III. Leaders

- How to Recruit Leaders?
- Leader Recruitment
- How are Leaders Trained?
- Something to think about BEFORE training
- What is needed for Training?
- How are Leaders Monitored?
- Are Leaders Paid?
- How to Retain Leaders

IV. Recruiting Participants

- Recruiting Systems
- Recruiting Tools

V. Scheduling

- Timing of programs
- Place
- Leader Availability

VI. Finding Participants

VII. Professional Backup

- You need to have someone to answer specific medical questions
- You need someone to call in an emergency
- How about an emergency during a workshop?

VIII. Community Sites

IX. Materials

- How do you assure participants have all needed materials?

X. Program License

XI. Special Considerations for Working with Different Cultures (even your own)

XII. Evaluation

- Reach
- Effectiveness
- Adoption
- Implementation
- Maintenance

XIII. Costs

XIV. What if my questions are still not answered?

I. Program Descriptions

Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries, clinics, and hospitals. The program was developed with for people with chronic health problems and their significant others. People with different problems attend the same workshop together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with at least one chronic condition. Please note that the program is written to be given in 2.5 hours time blocks and these blocks can not be shortened or divided.

Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health care professionals, 5) nutrition, and, 6) how to evaluate new treatments. There is also great emphasis on three process skills, action planning, disease related problem solving, and decision making.

Trained leaders follow a scripted Leaders Manual each time they lead the program. The course developers have scripted every minute of the course for content as well as the interactions of the Leaders with the workshop participants. Leaders must follow the script exactly except during the times that Stanford staff is in the process of updating the manual. Stanford staff members revise this manual approximately every 5 years. Their changes take into account suggestions from leaders, Master Trainers, Program Coordinators and, program participants.

Except at the time of updates, the program must be taught as scripted. Sometimes there are special reasons to change the program in small ways. Before these are undertaken permission must be granted by Stanford by emailing self-manage@stanford.edu.

Each participant in the workshop should receive a copy of the companion book, *Living a Healthy Life With Chronic Conditions, 3rd Edition*, and an audio relaxation CD, *Time for Healing.* These can be purchased from Bull Publishing.

It is the process in which the program is taught that makes it effective. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

Does the Program replace existing programs and treatments?

The Self-Management Program will not conflict with existing programs or treatment. It is designed to enhance regular treatment and disease-specific education such as Better Breathers, cardiac rehabilitation, or diabetes instruction. In addition, many people have more than one

chronic condition. The program is especially helpful for these people, as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives.

How was the Program developed?

The Division of Family and Community Medicine in the School of Medicine at Stanford University received a five year research grant from the federal Agency for Health Care Research and Policy and the State of California Tobacco-Related Diseases office. The purpose of the research was to develop and evaluate, through a randomized controlled trial, a community-based self-management program that assists people with chronic illness. The study was completed in 1996.

The content of the program was developed from holding focus groups with potential participants as well as having National and International experts (RDs, MDs, PTs, OTs, RNs and diabetes educators) assist us in developing key messages and being sure that the content was accurate, and evidenced based.

The process of the program was based on the experience of the investigators and others with self-efficacy, the confidence one has that he or she can master a new skill or affect one's own health. The content of the workshop was the result of focus groups with people with chronic disease, in which the participants discussed which content areas were the most important for them.

How was the Program evaluated?

Over 1,000 people with heart disease, lung disease, stroke or arthritis participated in a randomized, controlled test of the Program, and were followed for up to three years. We looked for changes in many areas: health status (disability, social/role limitations, pain and physical discomfort, energy/fatigue, shortness of breath, psychological well-being/distress, depression, health distress, self-rated general health), health care utilization (visits to physicians, visits to emergency department, hospital stays, and nights in hospital), self-efficacy (confidence to perform self-management behaviors, confidence to manage disease in general, confidence to achieve outcomes), and self-management behaviors (exercise, cognitive symptom management, mental stress management/relaxation, use of community resources, communication with physician, and advance directives). You can find references to our studies and those of others on our website, http://patienteducation.stanford.edu.

What were the results?

Subjects, who took the Program, when compared to those who did not, demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend

toward fewer outpatient visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:10. Many of these results persisted for as long as three years.

Why Programs Might be Implemented?

Program implementation should be based on the desire of the agency to offer evidenced base self-management education to their clients. We define evidenced based intervention as one that when evaluated in a randomized trials improved behaviors, and health status. The end outcome of such an implementation should be improved health behaviors and health status.

What About Cost Savings?

In 2008 The Centers for Disease Control & Prevention (CDC) in partnership with the National Council on Aging on the issue of financial sustainability for evidence-based health programs for older adults reviewed CDSMP studies. The authors, Catherine Gordon, RN, MBA a Senior Public Health Analyst in the Office of the Director, and Tracy Galloway, MPH, a Public Health Analyst in the National Center for Health Marketing at CDC made the following statement in their report.

There is evidence that CDSMP results in reductions in healthcare expenditures. There is a range in the amount of money saved and the healthcare settings in which these cost savings/utilization decreases occurred, but the research points to moderate expenditure reductions. The statement "CDSMP results in reductions in healthcare expenditures" is made with a reasonably high degree of confidence. This finding is consistent with the available evidence, but is limited by the fact that measurement approaches differ across studies and utilization decreases are not uniform. In four studies there were fewer emergency room (ER) visits, in three studies there were fewer hospitalizations, and in four studies there were fewer days in the hospital. In two studies there were reductions in outpatient visits. All of the preceding studies were able to demonstrate statistical significance. We found no studies in which costs were increased.

There is evidence to support the notion that CDSMP saves enough money in healthcare expenditures within the first year to pay for the program. This statement is made with a moderate degree of confidence. This degree of confidence reflects the range of cost estimates used for CDSMP and that there is no common cost accounting used to calculate program costs.

The available evidence also suggests that CDSMP results in more appropriate utilization of healthcare resources, addressing healthcare needs in outpatient settings rather than ER visits and hospitalizations. While CDSMP is not a cost-cutting strategy in and of it, it almost certainly results in improved health-related outcomes and reduced healthcare utilization sufficient to render the program cost neutral. Further work will be needed to more precisely calculate the CDSMP return on investment, using uniform cost methodologies and utilization metrics.

How do We Convince Health Professionals to Trust the Program?

The very easiest way to convince health professionals is to let them sit in on one or two session of the program.

Many health professionals like evidence so giving them the abstracts of the key program studies is useful. Health professionals usually to do not want to read long articles but you can have these available if they want to see them.

Have a trusted health professional talk about the program to his or her peers. Health professionals tend to trust their colleagues. Be sure the spokes person is someone that is mainstream and trusted, not the new fresh kid on the block or the one who always has crazy ideas.

Make it very easy for health professional to access the program.

II. What is Needed for Implementation

A Consideration Before Implementation

While the Stanford programs are relatively low cost, they are not cost free. If an organization intends to support a program coordinator and peer leaders, as well as materials it must be sure that it has enough long term funding to cover the costs. In addition the program must fit with the mission of the agency.

All of the following are needed for program implementation. Following this list is a discussion of each item.

Program Coordinator
Master Trainers
Trained Leaders
Systematic Participant Recruiting (marketing) Effort
Professional backup
Community Sites
Program Materials
Program License
Quality Assurance/ Fidelity Strategies (see evaluation section)

Program Coordinator

Every organization needs someone who is responsible for the program. This person, the coordinator, is sometimes a Master Trainer (see below). The program coordinator recruits leaders, supervises leaders, arranges for workshop sites, maintains program fidelity and may conduct program evaluation. This is also the person that leaders turn to in an emergency.

Depending on how many workshops your agency will offer each year this can be anything from a 25% time position to a full time position or more. This should not just be an add-on for an already busy person. It needs to part of a job description with specific time allocations. Over the years we have found that agencies with such a person tend to succeed and those without tend to have problems.

Master Trainers

1. Master Trainers are responsible for training leaders. Every organization does not need Master Trainers. In fact if you are planning on training leaders less than twice a year you are probably better off teaming with a near by organization and training your leaders together. However, all leaders must be trained by Master Trainers. For a leader training to take place you will need two (2) Master Trainers. These people may work for your agency or they may be affiliated with another agency in you area. At the present time there are over 1000 Master Trainers in the US. A list of all currently certified Master Trainers is on the Stanford Patient Education Research Center website's private Trainer section. If you need help finding Master trainers, please contact Stanford at self-management@stanford.edu or 1-800-366-2624.

All Master Trainers are certified. To become certified, a person must complete a 4 or 4.5 day Master Training conducted by two certified T-trainers. These can take place at Stanford University or can be arranged through Stanford to take place anywhere in the world. (Please note that in Canada, the Training Coordinating Center is at the University of Victoria in British Columbia headed by Dr. Patrick McGowan).

In addition to completing training, potential Master Trainers must lead two complete six-week courses for persons with chronic illness. These courses can be led with a trained leader, a potential Master Trainer, a certified Master Trainer or a T-trainer.

Once these requirements have been met, the potential Master Trainer notifies Stanford and they are sent a letter of certification.

Over the years we have learned that if an agency wants to have their own Master Trainers, it is best if they train more than two people, preferably three or four. In this way, if one person for whatever reason cannot or will not train, the agency will still have the capacity to conduct leaders' training.

Before sending someone to Master Training, it is best if the workshops they are to teach for certification are already planned with dates, sites, and recruitment. These workshops should take place within six months of initial training and never more than one year after training. If a potential Master Trainer has not taught one workshop within a year of their Master Training, or two workshops within 18 months, they are no longer eligible to become certified by Stanford as a Master Trainer.
When choosing people to become a Master trainer there are several considerations:

- It is best if the person has a chronic condition or has been a caregiver for someone with a chronic condition.

- The person should have experience and comfort with talking before groups.
- The person must be non judgmental.
- The person may or may not be a health professional or a retired health professional.
- It is best if the Master Trainer is of the same ethnic, racial group as the leaders he or she is going to train.
- If you want men to attend your program, it is important that one third to one half of your Master Trainers are men. It will be very hard to attract male leaders if the program does not have visible male role models.
- Leaders who have successfully taught several programs can make excellent Master Trainers.
- Master Trainers must have a work schedule that allows them to take four days two or three times a year to train leaders.

If Master Trainers do not conduct training as part of their work duties, then they should be paid for their training at the current rate for professional trainers in your area. The same rate should be paid to all Master Trainers, whether volunteer/peer or professional. While it is true that some Master Trainers may do training as volunteers, this should not be an expectation.

> Please note that training Master Trainers is a major program expense. To date it looks like only about half of the people trained as Master Trainers ever go on to certification. This is a large and expensive loss. Care should be taken in choosing Master Trainers and there should be plans for their immediate implementation of the program in place before they undertake training.

Trained Leaders

Implementation of the CDSMP requires **two (2)** trained leaders for each six week workshop. The leaders are usually non-professionals (peers) with one or more chronic conditions. In some cases they both are volunteers receiving no pay but it is suggested that leaders receive a small stipend (150 to 200 US dollars for teaching a six-week program).

The job of the leader is to teach a six-week class using a detailed scripted manual. It is not expected that leaders will find community sites, order materials, or recruit participants. They may do all of these things but if so they need additional training, and compensation. One of the real dangers of the CDSMP is that we will end up exploiting peer leaders. When this happens the leaders stop teaching and also through their communications and links in the community give the program a bad name.

III. Leaders

How to Recruit Leaders

There are many ways of recruiting leaders. Before you recruit you need to consider what characteristics you want in your leaders. We will discuss some of these.

- Leaders must be literate. They have to be able to read and follow the Leaders' Manual.

- Leaders should reflect the make-up of the community you are serving. Middle class areas should have middleclass leaders, Hispanic groups should have Hispanic leaders, rural farm groups should have rural farm leaders, etc. If you have mixed groups, then the leader pairing should be mixed.

  When we did a focus group with a group of Native Americans who took one of our workshops, we asked if the workshop was culturally appropriate. They answered that the workshop itself was neither culturally appropriate nor inappropriate. They added that what made the workshop appropriate and culturally relevant was having Native American leaders with Native American participants. The choice of leaders for any given population highly influences the cultural appropriateness of the CDSMP.

- If you want to serve men, then 30-40 percent of your leaders should be men. Women are generally happy to attend groups with any gender mix of leaders. Men will usually feel more comfortable in a group with one or two male leaders.

- The motivation of leaders to lead should come from wanting to serve others or even to help them but not to earn money. This is not a job. Having said this, for some leaders the little stipend they get is very important and can be the difference between their grandchildren getting Christmas gifts or not.

- Be a little cautious about having the following types of people lead.

  1. People whose main focus in life is their chronic condition.
  2. People who are super achievers despite their chronic condition. These are the people who have had an amputation and run marathons. They are to be greatly admired but their accomplishment is not something that the ordinary person with an amputation can strive for.
  3. People who are judgmental.
  4. People who have "found the answer" to their disease and want to share it with the world.
  5. People who are really sick. Sometimes a chronic condition can become all consuming and people are too sick to teach effectively. This is a hard one on which to make a judgment call. We have had leaders teach while in chemo therapy, while using supplemental oxygen and certainly in wheel chairs.

- The people you want to be leaders are those successfully living with a chronic condition. They have their good days and their bad days but in general get on with life and lead interesting and productive lives.

Leader Recruitment

Now that we have discussed what to look for in a potential leader we will discuss how to recruit them. Recruitment should be an ongoing effort using not one but many strategies simultaneously. For more than a quarter century we have recruited 20 to 50 new leaders a year.

First decide who you want to recruit. Leaders should be representative of the people in their groups. For example, if you want men to attend at least 30 to 40 percent of your leaders should be men. If you are serving an ethnic community, leaders should represent that ethnicity.

Remember that when you are recruiting, what you want is name and contact information. You might also ask in what areas they are willing to teach so that you will choose enough leaders to cover all the areas in which you want workshops. Thus, when you tell someone about the opportunity to become a leader or when you talk with a group, **do not ask people to call if they are interested.** Very few of them will ever call. Rather if they show even a little bit of interest, ask if you can take their name and contact information and get back to them with more information.

In a group **do not ask people to sign something at the door if they are interested.** Very few of them will do this. Rather as you are speaking pass a clip board with a sign up sheet among the group and then collect it after the meeting. If the gathering is large pass around several clip boards.

In both of the above cases give all those who are potentially interested a call within a few days. You can use this call both to inform people about the program but also to check the person out to be sure this is someone you might want as a leader. Some organizations even have a written job description for leaders.

However, there is one caution. Do not decide someone is not leader material just because they are not like you. If they meet the criteria above then they should be asked to come to training. This is where you really find out if someone can be a leader or not.

- Look around you. You probably know people who would make good leaders. Maybe they go to your church, are friends at work or neighbors.
- Post the opportunity to become a leader at your local volunteer bureau, senior center, and if available on-line at sites such as Craig's List.
- Talk with people in ongoing support groups
- Post a notice with your community volunteer center
- Post the opportunity on your agency website
- As you give talks in the community on any subject, mention this opportunity and take the names of people who might be interested

- Post a notice in the newsletters of voluntary health organizations such as the Arthritis Foundation, Heart Association, Diabetes Association, etc.
- Many local newspapers run free classified ads for volunteers.
- Ask health professionals to ask their favorite patients.
- Post notices in neighborhood newsletters and health clubs in the area that you wish to serve.
- If you live in a rural area see if you can get a public service announcement on the farm report or any other program that you know is listened to by the folks you want to recruit.
- After you have started offering programs ask you leaders to watch for people in their classes who they think might make good leaders. Once these folks are identified have the leader approach them with the idea and if they are call them up and ask if they would be interested.

It is also a good idea to have several staff people trained to offer programs. That way if you have to find a leader in a hurry you can send a staff person.

How are Leaders Trained?

Leaders are trained in groups of from 10 to 25 over 4 days by certified Master Trainers. The training should never have less or more people than the above numbers. Small trainings do not give a good opportunity for modeling and really learning how the workshop "feels'. Twelve to 20 is probably the ideal number. Skilled Master Trainers can handle up to 25 but this is the absolute maximum. `During the four days the Leader Trainees experience every activity in the workshop's six sessions, set and report success on their own action plans, practice teach two activities with a co-leader, and practice handling difficult people in groups.'
In addition they learn about licenses and also the process for becoming certified as a Master trainer.

The practice teaches are an especially important part of training. They serve to give the participants practice with the program and to gain confidence in delivering the program. In addition they serve as a fidelity check for the agency. If someone does not do an adequate practice teach the second time through, they should probably not be certified as a leader. If most potential leaders have major problems with the second practice teach there is probably a problem with the training.

Because the people coming to training usually have one or more chronic conditions it is best not to make the training days too long. It is for this reason that the training is designed to be offered over four-six hour days. These can be four consecutive days but it is probably best to offer the training two days one week and two days the next. Do not spread training out over more than two weeks. To become a leader someone must attend **ALL** of the training. It is surprising how many people will have an important appointment just when they are scheduled to do their practice teaching. In this case we offer them the opportunity to do their practice teaches in our office. This is usually declined. If someone really has to miss a half day of training you can go over this with them in an individual session. However if they miss more, they should start training again.

Something to Think About BEFORE Training

Once leaders are trained, the training will not do any good unless they actually teach within a couple of months. If they wait more than about 4 months to teach they will need to be retrained. Therefore, it is best if you have courses scheduled and **filled** before you ever start training. By asking potential leaders to commit to a class before they start training you are sure that they are really committed to teaching. Of course you can always have some folks who will never go on to train and you will have to scramble to find leaders. This is less of a problem than training lots of leaders you will never use. You should plan on have somewhere between 10% and 25% of the leaders you train never teach. It may be that they will not do well in training, decide that they do not want to teach or get sick. You can use this as a rough rule of thumb when deciding how many leaders to train.

What is Needed for Training?

- Two Master Trainers
- You will need a comfortable room where trainees can sit in a circle or opened square hopefully with tables in front of them. Be sure that the room is accessible as are the bathrooms and that the chairs are comfortable—people with chronic diseases will be using them all day for four day.

Equipment/Supplies

☐ A daily roster sheet—This way you can keep track of who is there each day.

☐ **Reusable** name tags for each trainee and trainer and black felt tip pen.

☐ During practice teaching on the 2nd and 4th days, one additional breakout room is needed with easel and chart pads (if you are training 12 people or less this is not necessary).

☐ A complete set of prepared charts plus duplicates of charts 5, 6, 7, and 8 for posting throughout training. The format for the charts is an appendix of the Leader's Manual that is received with your license. The charts should each be flip chart size and hand written.

☐ A whiteboard, chalkboard, or additional easel with blank flip charts for brainstorms.

☐ Whiteboard markers and eraser.

☐ Blank flip chart paper and markers for trainees to make their charts for Practice Teaching.

☐ An audio/CD player (boom box) for use for playing relaxation CD *"Time for Healing" (the classroom version).*

☐ Box of tissues.

☐ Water for trainees and trainers and you may want to consider having snacks.

Materials for Leader Trainees—1 of each of the following for each trainee

- ☐ Photocopy of Chart 2.
- ☐ Book: *Living a Healthy Life with Chronic Conditions.*
- ☐ CD: *Time for Healing* – classroom version and/ long version.
- ☐ *Leader's Manual* in a loose-leaf binder.

Materials for Trainees on last day of training

- ☐ Leader Evaluation forms—there is no set form and you can evaluate as you like.
- ☐ Leader certificate of completion—there is no set certificate but it is nice to make a certificate to give to each of your new Leaders.

Food

- ☐ Provision needs to be made for food including lunch and snacks.

How are Leaders Monitored?

Program fidelity is based largely on the ability of the leaders to deliver the program as designed. For this reason monitoring of the leaders is a key issue in program implementation.

1. Leaders always teach in pairs. This is true even if the leaders have a great deal of experience. There are several reasons for this.

    - This is a complex program and often requires two people to be sure that nothing is missed.
    - If there is a problem with one leader, they are late, not following protocol, you will often hear about it from the second leader.
    - The leaders act as models for the participants and two leaders provide a greater range of modeling.
    - Leaders support one another. This is especially true if a leader looses the train or thought, goes slightly off track, or there is a difficult participant.
    - By having two leaders, it is easier to deal with difficult workshop participants.

2. The first opportunity for monitoring leaders is during training. If someone is not appropriate during training, is judgmental, always comes late, talks too much, or is very critical of fellow leader trainees, this same behavior will be seen during actual workshops. Master Trainers should work with program coordinators to weed out potential problems during training.

    In addition, each potential leader takes part in two practice teaches during training. There are usually several problem during the first practice teach but by the second teach all trainees should be fairly comfortable with what they are suppose to be doing. If major problems still exist at the time of the second practice teach such as adding

material, not following the manual or being inappropriate with participants, then the person should not become a leader.

3. New leaders are best paired with experienced leaders. This is not always possible but should be done when possible.

4. Leaders sometimes like to teach with specific other leaders. This is OK and they should be given their choice if possible. Program needs do not always allow this so it should not be an expectation. It is important that leaders who do not like each other are not paired.

5. After the first session of each new class it is best to check in with each leader by telephone. In this way you can find out if there were any problems with the site, the participants or the co-leader. If any of these arise, they should be some followed-up.

6. Another call can be made to the leaders after the fourth or fifth class. Although, it may seen that these calls are unstructured, it is surprising the problems that can be uncovered and resolved.

7. Participants can rate the leaders. You will find a form "Leader in-class evaluation" in the Toolkit on the trainer site.
http://patienteducation.stanford.edu/trainers/tools/cdsmp_leader_eval.pdf

8. If at all possible, leaders should periodically be directly observed. This is best done at the second or third session so there will be time for leaders to utilize feedback. When observing leaders use fidelity check list such as the one found on the patienteducation.stanford.edu trainer website.
http://patienteducation.stanford.edu/trainers/tools/cdsmp_leader_eval.pdf

Are Leaders Paid?

Before talking about how leaders are paid it is important to discuss what they will be paid for. Leaders are expected to show up for classes on time, prepared and to teach throughout the full workshop. It is **not** the job of leaders to find sites, recruit or do publicity. It may be that they volunteer to do these things but this should not be an expectation. Whenever we ask leaders to do extra things such as give a community talk, we always give them a gift card or small stipend.

When using the Stanford Self-Management model there is a fine line between having happy volunteers and having exploited volunteers. The program was designed to include people with chronic conditions in every level of the program. What and how you pay leaders depends on your organization and its structure.

If they are truly volunteers training on their own time without pay of any kind, it is suggested that they receive a small stipend (e.g. 150 to 200 dollars) for teaching a six-week workshop,

or at a minimum, reimbursement for their travel expenses. The other advantage of this is that they do not get paid until they return any necessary paper work.

Some organizations just pay for expenses and travel.

Some organizations give the leaders gift cards or gifts. These can be instead or in addition to monetary compensation.

Some organizations find that there is a liability having volunteers or that there is a problem with Unions and thus they pay their leaders at a low hourly rate.

Other organizations, in fact most organizations do not pay leaders.

In all cases what is important is that the leaders are treated well, recognized at an annual event, and made to feel that they are key to the whole program. One of the most costly elements of the program is leader training, and thus it is important to limit leader wastage. We will discuss this in the next section.

How to Retain Leaders

The bottom line is to pay attention to them and be nice to them. Over the years here are some things we have learned.

- People decide to become leaders for their own unique reasons. The more you know about these reasons the more you are able to help them meet their expectations. If someone wants to help people like themselves, then they might be the right person to give talks to disease specific organizations. If they need social contact then they might want to teach more workshops or do some extra work recruiting. If they are a student who needs a project, then maybe you can have them evaluate some small part of your program.
- Leaders are special and need to feel special. Thus when they call you should talk with them or call back right away. When they come into the office stop and talk with them. Send thank you notes, birthday cards and/or holiday cards.
- Have a yearly or twice yearly Leader get together. You can use this for retraining but can also honor special leaders and give everyone a nice lunch and maybe a bag to carry their materials.
- If people decide they no longer wish to be leaders, find out why. Do not just accept the first answer such as “I am busy”. Probe a little to find out if there is something about the program which has made them decide that this is no longer worth doing. Here is an example of a probe. “I know that all of us are really busy, but I also know that sometimes leaders decide that they want to quit for other reasons such as it being too much work, not getting along with their co-leader or not being treated well by the staff. We really need to know these things so we can improve. Is there anything else you would like to tell us?”

IV. Recruiting Participants

Recruiting Systems

Before you start your publicity, be very clear about who you want to target. Do you want Spanish speakers, seniors, people living in a certain area, men, or people getting their health care from a specific health care location or system? Once you know who you want to attend, then everything else should be focused on getting your targeted folks to attend. This includes the time and place of the workshops as well as how and where you publicize them.
What often makes or breaks a program is participant recruitment. This is more difficult than you might suspect. Recruitment is a function of five factors: **time, systems, scheduling, names, and follow-up.** We will examine each of these.

Time. Successful recruiting (all scheduled courses start with 12-15 participants) takes advanced planning and it takes staff time. There needs to be a person whose job is to systematically recruit. Depending on how many people you want to reach this can be a day, a week, or a full time job. For example, if you want to recruit 500 or more people a year this is probably a full time task. This is another reason why you need a program coordinator.
From the start of recruiting to the start of a workshop also takes real time. You can not expect to put out publicity and have the workshops full in a week. At Stanford, we usually start publicity a full two months before the start of a workshop and this is an on-going effort.

Systems. One of the keys to successful recruiting is to streamline the process. Computers can be a great help. Think about keeping two different data bases, **Publicity Sources** and **Potential Participants.**

Recruiting Tools

Publicity Sources Data Base. Every community has hundreds of publicity sources. These include major media such as radio and TV as well as major and local newspapers. Then there are newsletters, church bulletins, advertising from realtors that contain community news, etc. There are so many that it is hard to keep track.

Do not forget websites and user groups. If your eyes glaze over when considering using the web, don't worry. This is not complicated and you can surely get someone who is web savvy. In large cities you might be able to use Craigslist, a hospital and/or city website. Voluntary health agencies also have local web sites as do such organizations as AARP. More and more neighborhoods have user groups and by contacting the group owner you can often post to these groups.

Every time you find a publicity source it should go in the data base. Be sure to note when they publish, who is the person to contact for public service announcements, the fax number and or email for that person, and how far in advance of publication do they need information. In some cases this may be days and in other cases weeks or even a month or two. You will also want to include in your data base what the coverage is for that media source. If you can enter this by ZIP code, neighborhood, or town, you can then sort your publicity sources when

we want to target a specific area. Every time you find a new source enter it. Thus the collective recruitment wisdom will not rest in the hands of one person who might not be around the next time you want to recruit.

The big advantage of this data base is that when you want to recruit in an area you can enter the ZIP or city and get all the collective knowledge about recruiting for that area. Of course you also have to continually add to and update this data base.

Potential Participants Data Base. Most organizations recruit on a workshop to workshop basis. It someone is not interested now or does not show up at class, they are lost as a potential future participant unless they call again. To avoid this problem and add efficiency to recruiting, we suggest that you set up a potential participant data base. The purpose of this data base is to keep track of all the people who may have indicated any interest at any time. This way they can be invited to each and every program in their area for two or three years. The important thing is to capture the contact information for as many potential participants as possible.

Once someone has given you their name, address, phone and hopefully email contact information, this should be entered into a data base. In the same data base you can keep information on whether the person actually registered for a program, showed up for a program and how many sessions he or she attended. You can also keep track of how many times the person was invited to attend a program before actually attending.

It has been our practice to keep people in the data base for two to three years and inviting them to every available program in their area before taking them out of the data base. Of course, we will immediately take out any person who requests it.

Scheduling. When and where programs are scheduled is very important to the success of your recruitment. For the purposes of recruitment, regularity is important so that if folks miss one program they will have a good idea when the next will occur. We will discuss three aspects of scheduling, **timing of programs, place of programs and leader availability.**

V. Scheduling

Timing of programs

1. Time of day/day of week

In scheduling your time you have to know your community and who you want to come. Older people will probably not come at night and working people will probably not come during the day. In our area we have found that Sat. mornings from 9:30 to 12 works very well for large segments of the community. For some communities, Sun. afternoon may work well and for workplaces times like 4:30 to 7 may work. The one thing that is important is to think outside of the normal Mon.-Fri. 9-5 box.

Older people generally do not like to attend classes that start too early in the day or last so late that they can not get home before dark.

Also be very aware of your competition. If a very popular activity such as BINGO is going on at the same site at the same time you probably will not get much attendance.

2. Time of year

It is best to schedule programs so that they will end by the second week in Dec. and not start again until the second week of Jan. Nothing happens in the health promotion world from about Dec. 10 to Jan. 10 or 15. There are also some other holidays that you need to watch for depending on where you live and who you are targeting. These include Thanksgiving, no programs on Wed. Thur. Fri. or Sat. of Thanksgiving week, and of course try to avoid programs that meet before long holiday weekends. If you have to skip a week to avoid a holiday it is not awful.

Then there are the holidays that are not date specific as they relate to different calendars. Some examples are Easter, the Jewish High Holidays, the first and second nights of Passover and some Muslim holidays. Jewish holidays always start at sundown. When you look at a calendar make sure you know which dates are affected. This website will help you avoid cultural misunderstandings-. This web site should help you avoid cultural misunderstandings.

http://www.interfaithcalendar.org/2008.htm

Weather can also be a problem and you have to be a judge about how much to consider this in your area. Our experience has been that folks of all ages are use to the weather where they live and that weather is less of a problem than one would imagine. That being said you need to have contingency plans in case you get snowed out.

In places where weather is really important then schedule the workshops at places that people go even in bad weather such as churches, retirement facilities, or meal sites.

Since strange things can always happen, from a snow storm to an earthquake to not having quite enough people to start a program when planned, we have found that when you ask for space you ask for seven weeks instead of six and thus have the option of starting a week late or skipping a week if the need arises.

Place

Once important consideration is to hold workshops where people usually go. Familiar sites are more successful than on familiar ones.

See community sites on pages 20 & 21.

Leader Availability

You cannot have programs without leaders so in planning you must have 2 leaders committed to teach for the full six weeks. If there are lots of leaders, for example in an urban area, you can schedule all your programs and then send a list to all your leaders asking them which they

want to teach. Then you have to do a fancy dance to see that leaders and programs match and also do a bit of begging to see that all are covered.

In rural areas or other areas where you may have only two or three leaders, you should first ask your leaders when they can/ or would teach and then schedule as best you can around them.

Sometimes, the best time for leaders is not the best for participants. In this case you may have to train new leaders because if the times are not good for participants they will not come. As you learn more about times for each of your communities you can talk with potential leaders about when they would be available to teach and train only those who meet the needs of their communities.

If you think that one or the other of the leaders might have a difficult time coming to all six sessions you might consider having three leaders.

Unfortunately, we are often told that no one wants to come to programs only to find they were scheduled to meet the needs of the leaders with very little attention to the needs of the participants.

VI. Finding Participants

You might wonder why it has taken us so long to actually talk about finding participants. The reason is that if you do not have personnel and systems in place, and if you have not done a careful scheduling of your classes, finding participants is much more difficult if not impossible. This section assumes that everything we have talked about so far in this section has happened.

Be sure that your publicity tells people what to expect. They tend to get upset when they think they are going to a lecture by a professional and end up in an interactive workshop.

The next thing many organizations like to do is put together a publicity kit. This should contain a simple fact sheet about the program along with as many of the following as you may use.

- Public service announcement print
- Public service announcement radio
- Public service announcement TV
- Flyer
- Letter to potential participants
- Website link
- Blog announcement
- User Group announcement
- Newsletter announcement

Again you want to think in terms of systems. All of the publicity should be the same color with the same logo and typeface so over time, those receiving it will think of your program. Produce all of these on-line so you only need to change name dates, and maybe the graphics as you publicize each site.

So now you have down all the ground work and you are ready to place your publicity. Go to the publicity data base and place the appropriate publicity with all the sources in your data base that reach your target participants.

Next be innovative. Here are some things that sometimes work, in some places.

- Anything you can do face to face is great. Talks to community groups, announcements made by leaders at church, talks at community lunch sites
- Use your sites to recruit. Many churches, Sr. centers etc. have their own newspapers and/or web sites. Be sure your publicity is included. Also get buy in from the staff at your sites. This may mean attending a staff meeting and telling them about your program and answering questions.
- Use of mass media such as newspapers, TV and radio—radio talk shows can be especially helpful in some areas.
- Flyers in grocery or pharmacy bags
- Information in utility bills
- Standing in front of big box stores like Wal-Mart and talking to people
- Announcements at senior lunch programs
- Emails to employees at their workplace
- Flyers under doors of housing projects or large apartment complexes
- Flyers in the windows of neighborhood stores
- Flyers on Community bulletin boards
- Letters with information about the program sent from the physician, health center or clinic. We have found that the uptake on a first letter is about 10% so you will need to send about 150 letters to fill a program.
- A reminder in the electronic medical record to health professionals to refer people to the program or better a link where they can download information and hand it to their patient.

- Past participants can also be a great recruiting resource. If you are giving a course in an area, you can use your data base to mail flyers to past participants in that area and ask that they post them or give them to friends.

Here are some rules of thumb.

- One of the things that we have found is that the more personal your publicity and contact, the more effective.
- Use multiple modes of publicity and usually the more the better. So what if you have too many people. You just give more programs and can show your funding source that you have a high demand.
- Be nice to responders. This sounds simple but what does it mean? Have your phone answered by a real person. When someone leaves a message call them back quickly.

Be sure that the person on the phone is well trained and can answer questions about the program. Again the more personal the better.

- Once you have someone's contact information, they should be invited multiple times to the program. This information can also be used when you almost have enough people for a program but not quite enough. Call up people who are on your data base and line in the area. Sometimes all it takes is a personal phone call to get someone to attend.

Here are some things that you can certainly try but usually do not work very well.

- Don't rely too heavily on newsletters. They may go to lots of people but never get read. Think about the newsletters you read and those you do not read.
- Do not rely on referrals from health professionals. They are extremely busy and it takes time to tell patients about your program. They may not remember even if they have the information right in the examining room. Remember a minute of professional time may be 10% of a clinic visit. In the past, giving physicians prescription pads was useful. However, today physicians for the most part do not use prescription pads and besides these pads are seldom exactly where the physician needs them unless someone in the office or clinic checks the supplies in each exam room every day.

VII. Professional Backup

This program deals with people who have multiple chronic conditions. Thus, it is not surprising that sometimes questions or situations arise that require help from health professionals. It should be emphasized that these do not occur very often but when they do you need to have health professionals on whom you can call for help. In reality there are two types of situations.

1. **You need to have someone to answer specific medical questions**.

   We teach our leaders that when someone asked a medical question that they be referred back to their health professional or told to find the answer and share it with the group the next week. This serves several purposes. First it supports self-management by making the individual responsible for using community resources and finding their own information. Second, it relieves leaders of being responsible for offering information they do not have. In fact, we do not want our leaders answering questions. Third, it assures health professionals and administrators that the program has health professional approval and backing.

   Sometimes a question arises from several people such as why blood glucose sometimes goes up in the morning when someone has been fasting and you would expect it to go down. In such cases, the leader should call the program coordinator who in turn will get the information from an appropriate professional; they will then pass the answer back to the leaders to share with the class.

2. You need someone to call in an emergency.

Emergencies do not happen often but when they do, they must be acted on quickly. Over the years we have had people who have talked about suicide, or talked about being abused or having children abused by a spouse. These are clearly situations outside of the ability of peer leaders. What we expect from them is to call the program coordinator immediately, who will in turn take over this situation. This is not a time to be coaching peers. The program coordinator will need expertise to which they can turn.

3. How about an emergency during a workshop?

These also occur but not often. This is usually a medical emergency and all that we ask our leaders to do is to call 911 or the relevant emergency number. They may want to dismiss the workshop until the next week. It is also important to let everyone know how the sick person is doing with their permission.

VIII. Community Sites

Program sites must meet several minimal criteria. They must be:

- Handicap accessible (this includes not requiring the use of stairs)
- Safe
- Be able to accommodate up to 20 people in a circle or U.
- Have parking if this is a consideration
- Be near public transportation if this is a consideration
- Have well lighted exteriors if the program is after dark
- Be opened to having anyone from the community attend
- Have a room that provides privacy and provides enough space for the leaders, participants, flip charts, white board and still moving around. Comfortable chairs help and remember you will need extra space if any of the participants or leaders uses a wheel chair or scooter.
- Have insurance

The site should also be in the same community you want to serve so that in most cases participants will need to travel a very few miles or sometimes blocks to reach the site.

Finally the site should be somewhere potential participants will feel comfortable. This is not always obvious. Sometimes, a church may be the perfect place to host the program and people from the community would also feel comfortable there. In other cases people would find a church other than their own uncomfortable. Oftentimes there is a very good site but the community sees it as serving another population such as youth and not someplace that they would typically go. To find out these things you have to talk to people in the community and find the natural meeting places for the people you are targeting. If such places do not exist, then look for neutral meeting places such as community rooms in shopping centers or training rooms in large department or warehouse stores. Also be aware that sometimes perception is more important than distance. You may have an excellent site near the community you want

to serve but people from that community may feel uncomfortable crossing the road or tracks to this site.

The following is a list of some sites that many groups have found useful.

- Senior centers
- Public libraries
- Churches
- Retirement communities
- Community centers
- Community rooms in apartment or condominium complexes
- Community rooms in banks
- Public schools after hours (be aware of small desks)
- Meeting rooms in the offices of voluntary organizations
- Union halls
- VFW halls

There are also some sites that may seem perfect but may also cause problems. You will have to make the decision for your own community.

- Hospitals—these may seem perfect but people usually do not like to go to places they find unpleasant and for most folks going to a hospital has bad memories.
- Clinics—these are less problematic than hospitals but may have some of the same problems as hospitals. Another problem is being sure that the reserved space will really be empty and available when promised. Unfortunately in health facilities, health professionals always seem to have first priority for meeting space and it is very easy to dump a community program.
- Mental health facilities, unless you are offering a program for people who use these facilities. The non-users of these facilities usually do not want to be associated with them.
- Perfect in every other way but the workshop is held in shared space. Unfortunately this will not do as workshop participants do not like to share the details of their lives with those not in the workshop. Even rooms with partitions can be a problem.

IX. Materials

The following discussion is the materials that are needed for each program participant. Materials needed for training are discussed in the training checklist on pages 10 & 11.
All program materials except charts are available from Bull Publisher
http://www.bullpub.com/
P.O. Box 1377, Boulder, Colorado 80306
800-676-2855

Each participant in the English program will need:

- A copy of *Living a Healthy Life with Chronic Conditions*. (please note that this is available in several languages and there are also English editions for the United States, Canada and the United Kingdom).
  For those that cannot read this is also available on CD.
- A relaxation CD (this is optional but many participants find it useful)

Each participant in the Spanish program (Tomando Control de Su Salud) will need:

- A copy of Tomando Control de Su Salud
- An exercise CD (audio)
- A booklet illustrating the exercises
- A relaxation CD (This is optional but many participants find it useful)

Every set of leaders (two per program) will need a set of charts for the Program.
These charts should be hand made and are usually made by the leaders. Directions for making charts are in the appendix of every Leader's Manual.

How do you assure participants have all needed materials?

Materials for the workshops are an important part of the program. Ideally, each participant is given a book and/or a CD to keep for on-going use.

This can be financially supported through the purchase of training materials by a sponsoring organization. Organizations, in turn, donate them to the program for use by participants.

Some areas charge the participant a small fee that covers the cost of the books or CDs and/or the cost of attending the workshop series.

Other areas establish a lending library that allows materials to be checked out and returned. Some places may also assure public libraries have several copies of the books which are then available to library patrons.

Some programs loan the books to participants for use during the workshops, giving them the option to purchase the book at the end of the series.

Other programs use the books as incentives, charging for them only if the participant does not complete at least four of six workshops.

Materials are much less expensive if bought in large quantities; Bull Publishing http://www.bullpub.com/ provides discount information.

X. Program License

Before an organization can offer programs it must have a license. The programs are all owned by Stanford University. There are at least four reasons for licensing.

1. The license establishes the legal obligations of the organizations offering the program.
2. The license protects Stanford's intellectual property.
3. The license lets Stanford keep track of who is offering the program and thus form a network of all licensed organizations.
4. The license allows Stanford to easily notify organizations when there are program changes.

The cost of a license is determined by how many programs your organization plans to offer each year. As of fall 2008 a basic license for 10 programs a year for three years costs $500. You can find full information about current license fees and a form to apply for a license at http://patienteducation.stanford.edu/licensing/

XI. Special Considerations for Working with Different Cultures (even your own)

The Stanford Self-Management Programs are designed to be as near as possible culturally neutral. This means that they are usually acceptable in any cultural setting as long as the leaders and participants are from the same culture (and sometimes socioeconomic status) and the workshops are offered in a site and at a time that is culturally acceptable for the population being served. Here are a few principles to think about when working in a culture with which you are unfamiliar.

1. Cultural competence is a developmental process. It is impossible for anyone to be aware of all facets of a culture—even in one's own culture. For this reason we prefer the concept of cultural humility. This means that we approach cultural issues from a humble position without making judgments. Being humble means that we realize that we do not know enough and want to find out more. Another way of saying this is to approach the culture with a curious mind and an open heart.

2. Don't assume (or believe those who say) that you can be effective working in a culture other than your own. Sometimes you can be MORE effective because you have no family affiliations (or conflicts) and bring a fresh perspective.

3. There is often as much diversity within a culture as there is between cultures. In fact sometimes more. People living in villages in Paraguay may have little in common with people living in villages in Spain or in New Mexico. The common link may be language and sometimes even that is different.

4. Since there is so much diversity within cultures one needs to be very careful about cultural stereotypes such as “all African Americans….” Or my people…” One size seldom fits all.

5. Be careful about advice from cultural experts. It has often been our experience that people come to training and immediately tell us how the program needs to be changed for “their” community. Often we are told XXX do not do this and if will be found to be offensive. Almost always when we look into this we find that some XXX do not do this and might find it offensive but that many other XXX have no problem. Sometimes we find that the expert has a problem with XXX but not the community they represent.

   Does this means you should not listen to experts? No. It just means that you need to listen to more than one expert and most importantly to the experts in the community.

6. Ask the people that know. These are the people you want to serve. We suggest that before you make any adaptations you find a group of people and offer the program as it is written. Then at the end of the program have a focus group and ask the participants what they would change. Every time we have done this we have found that the changes were not what we expected and were much more minor than we thought. Here are some examples.

   We have been surprised at how well some of the exercises worked with tribal people who I’d have thought would be reluctant.

   When we held a focus group with rural First Nations People in Canada they wanted longer sessions so that they would have time to sit around and talk before the program started. They quickly reminded us that their diet was mostly wild animals and berries. They wanted few other changes. When we did the same thing with urban Indians in the United States, they changed the symptom cycle to a Native symbol and added a short prayer.

   With Native American communities, either prayer or silent reflection is added to the beginning of most classes and more emphasis is placed on low fat low salt foods. In the Northwest, there might be more focus on a traditionally protein rich diet…fish, seal, deer, elk, and whale.

   In many cultures there is a focus on traditional foods and connecting the diet recommendations with the traditional diet will add cultural credibility to the presentation

   In some cases there is also a short section added on dealing with racism when receiving health care.

   Hispanic Seventh Day Adventists asked that we take out the relaxation exercises.

Hispanics (mostly those born in Mexico) did not like working in pairs and preferred small groups of three or four people. There also wanted a section on what the various health professionals did in the United States as they were usually saw only a physician in their native countries. Finally, because many people in our focus groups told us that they did not like exercising outdoors either because of safety, bad weather or embarrassment, we created an audio exercise CD that could be used at home.

7. Employ people from the community you want to serve. This does not mean that you should employee professionals from that community but just people with chronic conditions from that community who know the community and want to serve their community. This places an expert cultural guide in your organization and also sends a message to the community that you are serious about working with them. Do not worry about degrees. Instead hire someone who represents the population you want to serve, who lives in the community and has been active in the community. Nothing speaks of good intent more than putting money back into the community you want to serve.

8. Take some personal time to learn about and visit the community you want to serve. This is more than going to lunch at an ethnic restaurant. It means walking the streets, noticing the shops, going to festivals and see where people naturally gather. It is amazing how much you can learn about a community with "new eyes".

9. If you do not understand something, avoid the assumption that it is like something else you do understand. Instead, again ask the people who know the people from the community.

10. If you want to learn about someone else, share information about yourself.

11. Listen and then listen some more. Some people use silence to talk or are thoughtful before answering. Do not feel a need to fill in every silent space.

12. Plan for sustainability. Culturally diverse communities, more than most communities have been used by agencies and academic institutions to get grant. Programs are given for a short period of time, and even when very successful are discontinued when funding ends. It is very important when one works with a community that one has a commitment to that community beyond the end of a specific funding cycle or project. The best work is that which enables the community to continue the program.

XII. Evaluation

The RE-AIM (reach, efficacy, adoption implementation and maintenance) model provides one very useful way of considering how to evaluate the CDSMP. There is also an excellent website. http://www.re-aim.org/2003/researchers/defined_res.html

We will discuss possible evaluations you may want to consider for each element of the model. These are just examples, there are many other options.

Reach. You may want to find out who your program is reaching and how representative this is of your area or of who you are trying to reach. You may also want to know what proportion of a total population you are reaching.

1. The most basic reach question is how many people are attending your programs. Then you might want to know their characteristics such as gender, age, education, ethnicity, etc.

2. You might want to do a little more and compare your data with the data of the area. For example if 15% of your target population is African American are 15% of the CDSMP participants African American?

3. As your program grows you might have a goal of reaching 10% of the seniors in a specific ZIP code or who attend a specific Senior Center. Then at the end of the year you can check to see how you have done.

4. You may want to know which types of publicity bring in which kind of people?

Effectiveness. When people think about evaluation they usually think about evaluating the positive and negative impacts of the program on such things as behaviors, symptoms, health status and or health care utilization.

Effectiveness evaluations are usually done by getting information from participants (usually by questionnaire) before the program starts and again some time later. For CDSMP most effectiveness evaluations have been conducted four to six months after the beginning of the program. For more information about effectiveness studies and sample questionnaires you can go to the following websites.

http://patienteducation.stanford.edu/research/index.html

http://patienteducation.stanford.edu/research/primer.html

Adoption. Adoption evaluations look at the settings and or organizations that are offering a program and how successful each is. Unfortunately we do not do enough adoption studies. Here are some examples that you might consider.

1. You set off to target health plans in your area and talks to many people in many plans, how many plans offer the program and what are the characteristics of the plans that offer the program and those that don't.

2. You offer leader training to 20 community organizations and ten actually send people to training. How do those that send people differ from those that do not.
   After a year you find that 6 organizations have offered a program but four have not. It would be good to know what makes the difference. At the end of two years, there

are only 4 organizations offering programs. Two of these offer several programs a year while two only offer one program a year. Can you learn anything by talking to these programs and finding out what makes the difference?

3. You initially train 20 Master Trainers. Fourteen of these get certified and 10 actually train leaders. Since training Master Trainers is very expensive you might want to know why you had only a 50% success rate and how you can do a better job of selecting and supporting Master Trainers.

Implementation. At the agency level, fidelity refers to the how closely staff members follow the program that the developers provide. This includes consistency of delivery as intended and the time and cost of the program.

At the individual level, implementation refers to clients' use of the intervention strategies.

Checks on Program Fidelity

- Leaders should be observed or called during each workshop
- Monitor and follow up on drop outs
- Monitor effectiveness of recruiting strategies
- Offer refresher to leaders yearly

You can find more about more about maintaining leader fidelity on pages 11 & 12.

Maintenance. The extent to which a program or policy becomes institutionalized or part of the routine organizational practices and policies. Within the RE-AIM framework, maintenance also applies at the individual level. At the individual level, maintenance has been defined as the long-term effects of a program on outcomes after 6 or more months after the most recent intervention contact.

Beyond RE-AIM---You may want to examine how participants, leaders and or providers value the program and what it has meant to them. This will probably require a qualitative evaluation with open ended questions.

XIII. Costs

We can not tell you how much it will cost to implement the program. There are just too many factors that depend mostly on how many programs you will give. Here is a list of items to consider when thinking about costs.

- Program Coordinator (may be part-time or full-time)
- Master Trainers
- Training of Master Trainers if you do not have any available
- Leader's Training (food, room, materials, recruiting leaders, leaders' manuals)
- Publicity
- Participant Registration and support
- Leaders (may be volunteers or may receive a stipend)

- Sites for Programs (usually donated but you may have to pay rent)
- Materials for participants (should be factored in before implementation)
- Charts to be used by the leaders
- Evaluation
- License

XIV. What if my questions are still not answered?

Go to the Stanford Patient Education website
Patienteducation.stanford.edu
Email Stanford self-management@stanford.edu
Call Stanford 650-723-7935