BETTER CHOICES
better health®
GOOD&HEALTHY SOUTH DAKOTA COMMUNITIES

Better Choices, Better Health®
South Dakota
Work Plan
September 2015 - August 2017

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July 2015

Dear Fellow South Dakotans,

South Dakota State University Extension, the South Dakota Department of Health, and the South Dakota Department of Social Services, along with their partners, are pleased to present the Better Choices, Better Health® South Dakota (BCBH SD) Work Plan. The plan is the result of a collaboration of key stakeholders and partners.

Chronic disease continues to place a heavy burden on individuals, communities, and the economy. In light of the current challenges with chronic disease in our communities, there is an opportunity to implement and support an evidence-based approach to self-management of chronic disease in South Dakota. BCBH SD provides skills and strategies that individuals with chronic disease can use to make decisions and engage in behaviors that positively affect their health and improve quality of life (to live well despite their chronic health conditions).

This document details the two-year work plan for the BCBH SD program. The plan focuses on goals and objectives that can improve the self-management of chronic diseases in South Dakota.

STANFORD UNIVERSITY'S CHRONIC DISEASE SELF-MANAGEMENT PROGRAM (CDSMP) HAS THE POTENTIAL TO BECOME AN INTEGRAL COMPONENT IN A STRATEGIC APPROACH TO REDUCE PUBLIC AND PRIVATE COSTS ASSOCIATED WITH CHRONIC DISEASE. (Lorig, et al, 2001)

BETTER CHOICES... BETTER HEALTH... BETTER YOU! BETTER JOIN... YOU CAN DO THIS! LIVE BETTER... BE BETTER... BETTER CHOICES, BETTER HEALTH... TAKE BACK YOUR LIFE!

Sincerely,

Suzanne Stluka Kiley Hump Jamie Seiner

Better Choices, Better Health® South Dakota Workplan 1

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"BY ATTENDING THE WORKSHOP, I REALIZED THAT WE ALL HAVE PROBLEMS. WE ALL MAKE MISTAKES. BUT WE CAN MAKE IT. WE CAN FEEL BETTER. WE CAN DO THIS!"
2015 BCBH WORKSHOP PARTICIPANT

STATEMENT OF NEED

The 2012 Institute of Medicine report entitled "Living Well with Chronic Illness: A Call for Public Health Action" concludes that the prevalence of chronic disease is reaching a crisis phase and there is not enough being done to help people maintain or improve their quality of life.

"LONG-TERM CONDITIONS WILL BECOME THE LEADING CAUSE OF DISABILITY BY 2020 AND THE MOST EXPENSIVE PROBLEM FOR HEALTH CARE SYSTEMS IN BOTH DEVELOPED AND DEVELOPING COUNTRIES." WORLD HEALTH ORGANIZATION

Chronic disease accounts for about 70% of all deaths. According to the SD Department of Health's Health Data & Statistics website, chronic diseases including heart disease, cancer, chronic lower respiratory disease, Alzheimer's disease, and stroke were the top five causes of death among SD adults for 2012-2014. Over 36%, or one out of three residents, have two or more chronic conditions. Medical costs associated with chronic disease total about $1.5 trillion annually, or about 75% of overall U.S. health care spending. Chronic disease in SD remains a significant concern because of the negative economic impact, increased need for health care services, and can lead to decreased quality of life. Additionally, SD has a significant aging population and chronic disease tends to increase in prevalence with age.

Community-based health interventions are critical to improve the health and well-being of South Dakotans. The SD Department of Health convened a group of key stakeholders in the fall of 2012 to gain feedback regarding the current needs in their communities related to the support of chronic disease self-management. This group assessed the current status of self-management resources in the state, the level of coordination of these resources, and identified unmet needs. It was determined there was a need for chronic disease self-management resources and a coordinated approach to these efforts.

"I DIDN'T DESERVE TO GET THIS DISEASE… BUT I GOT IT. I HAVE TO ACCEPT IT AND USE THE SKILLS I LEARN TO MANAGE MY HEALTH." 2015 BCBH SD workshop participant

The Chronic Disease Self-Management Program (CDSMP) is a community-based workshop consisting of six weekly 2 ½ hour sessions. Individuals learn coping skills to actively manage or co-manage their disease and its impact on their lives. Since the content is not disease-specific, individuals with any chronic diseases (such as diabetes, arthritis, depression, anxiety, chronic pain, lung disease, high blood pressure, weight issues, heart disease, cancer, and any others) participate together. Sessions are typically led by trained lay facilitators who themselves have chronic conditions. Self-management skills covered in the CDSMP include goal setting, problem solving, relaxation/stress management skills, eating well, fitness/exercise, appropriate use of medications, and others. This workshop will also be available online for SD adults.

PURPOSE

The purpose of the BCBH SD Program, shared in this work plan, is to ensure all adults in SD with chronic conditions, including diverse and underserved populations, have access to regularly scheduled, high quality, sustainable programs.

Research studies have shown that participants who engage in CDSMPs tend to experience better health, spend less time in the hospital, and have a more active lifestyle. The program is helpful for people living with any chronic condition that affects their quality of life. Individuals who are caregivers for someone with a chronic condition can also benefit from self-management education.

Additionally, the program aligns with the SD Coordinated Chronic Disease State Plan, Goal #4 under the Strategic Direction: Clinical and Community Prevention Services. This objective references implementing evidence-based programs for individuals to prevent and manage their chronic diseases. There are several other goals from the state Coordinated Chronic Disease Plan that also align with the chronic disease self-management initiative.

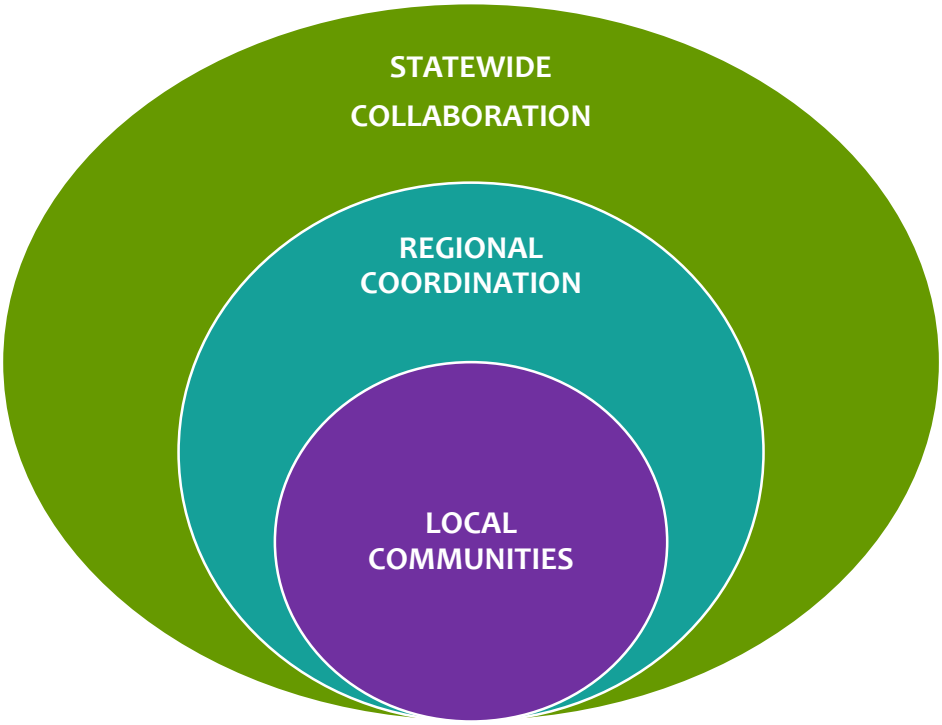
"AS SOMEONE WHO HAS LIVED WITH CHRONIC ILLNESS FOR MORE THAN 40 YEARS, THE TOOLS I LEARNED IN THE WORKSHOP TOOK ME FROM SURVIVING TO THRIVING!"
2015 BCBH SD workshop participant

Studies conducted by Stanford University and others have demonstrated that participants who have completed a CDSMP have improved self-efficacy, improved health status, reduced emergency room/doctor visits, and reduced length of hospitalizations. In addition, the CDSMP model has been shown to significantly improve patient and provider satisfaction.

INFRASTRUCTURE

Statewide Centralized Collaborative Model

The model was created to foster innovative state collaboration to ensure the evidence-based CDSMP reaches those affected by chronic disease and positively impacts quality of life, promotes access to care, and reduces health care costs.



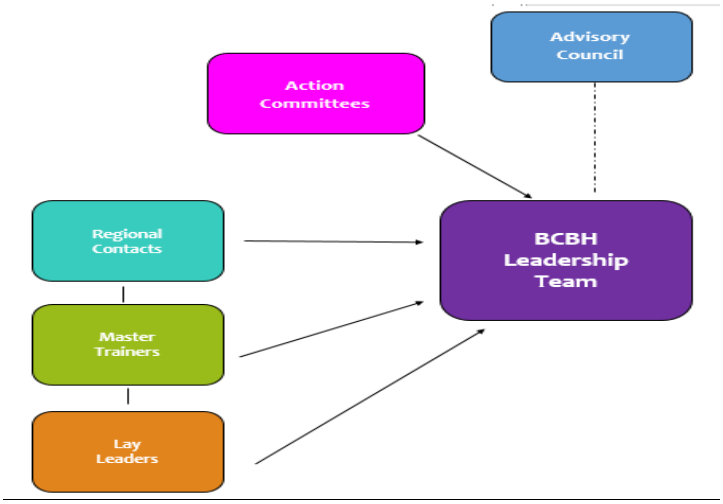
This model creates a structure in which there is coordination, support, and sharing of efficiencies on a state, regional, and local level. The advantages of this model utilized by BCBH SD include better coordination, sharing of resources, and readiness to maximize external funding opportunities through collaboration.

Initially, a steering committee guided the early process of designing and developing BCBH SD. Currently, the BCBH Network is led by SDSU Extension; as the license holder they provide project directive for BCBH SD. The SD Department of Health and Department of Social Services are the other main collaborative partners for BCBH SD and provide staff time, resources, support, and leadership.

BCBH Network

The BCBH Network is comprised of the *Leadership Team, Master Trainer Outreach Ambassadors, Regional Contacts, Lay Leaders, Master Trainers, Action Committee Members, and Advisory Council Members*. The BCBH Network is the primary mechanism by which future plans, activities, tools, and resources for BCBH SD are developed, discussed, and implemented.

- The *purpose* of the BCBH Network is for the common goals of implementing, scaling, embedding, and sustaining chronic disease self-management education.
- The *intention* is to collaboratively adopt best practices and standards that create a shared road map and opportunities toward reaching our common goals.
- The *mission* of the BCBH Network is to promote the expansion, implementation, coordination, and sustainability of a quality, statewide CDSMP.
- The *vision* of the BCBH Network is to improve the health of South Dakotans by positively impacting quality of life, promoting access to care, and reducing health care costs related to chronic disease.



Leadership Team- Consists of 2 project directors; 2 program coordinators/associates; DSS & DOH liaisons; 1 communications specialist; 4 master trainer outreach ambassadors; 1 expert consultant

Advisory Council – More than 25 unique members who provide non-binding strategic advice

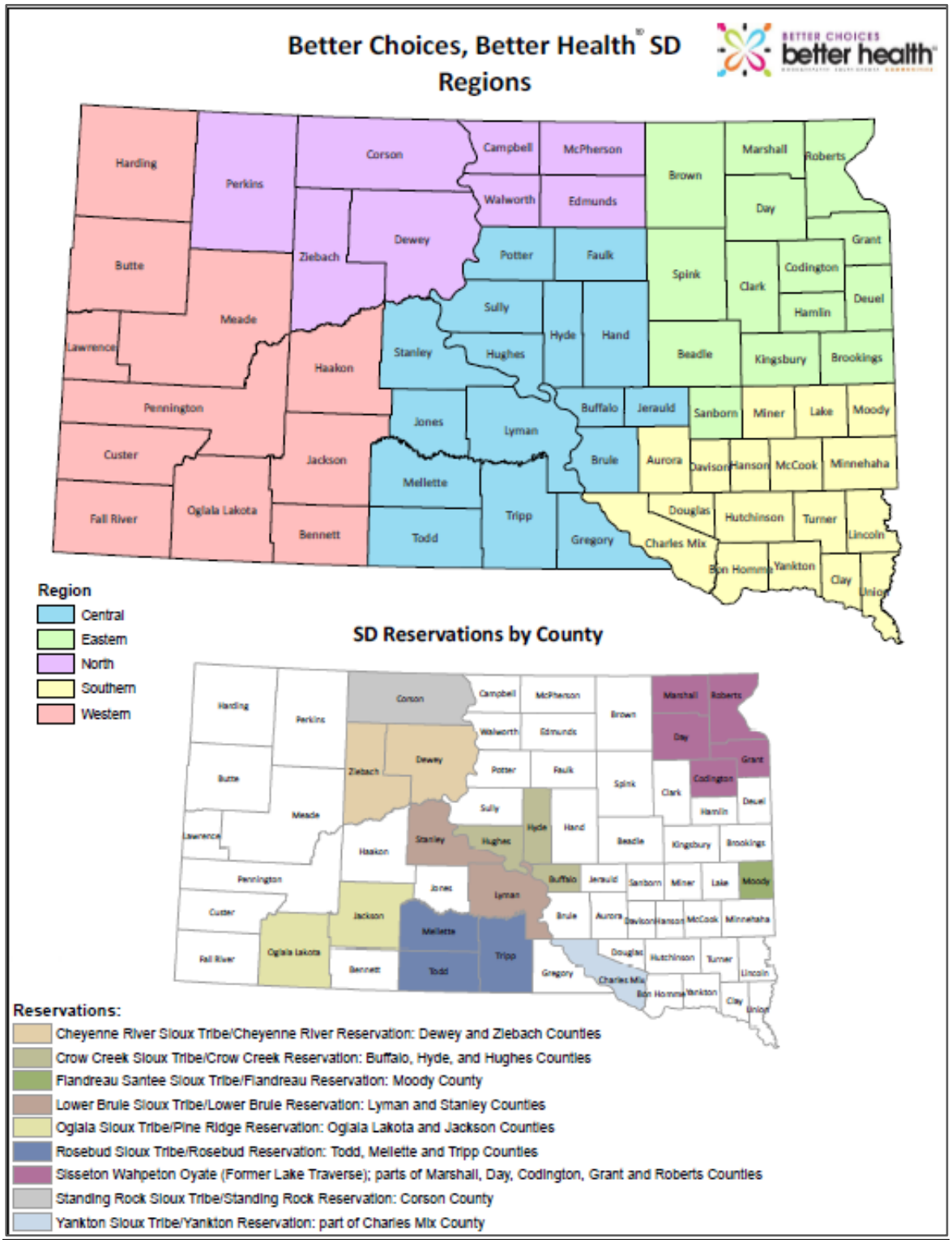
Action Committees – Six committees with 3-4 committee members who focus on a particular task/area of BCBH.

Regional Contacts – Eight recognized lead contacts in regions who streamline and coordinate BCBH SD activity.

Master Trainers – Individuals located statewide who facilitate BCBH workshops, Lay Leader trainings and mentor new leaders.

Lay Leaders –Volunteers located statewide who facilitate BCBH workshops.

Regional Contact Map



WORK PLAN

October 1, 2015 to September 30, 2017

Goals

1. *Enhance the newly established, collaborative Better Choices, Better Health® SD program to significantly increase and reach the number of older adults and adults with disabilities who participate, specifically those located in our rural and American Indian populations, in this CDSMP evidence-based program.*
2. *Focus on embedding innovative funding arrangements into the BCBH SD program in order to create an integrated, sustainable, evidence-based chronic disease prevention network in a rural state.*

Major Objectives

1. **Strengthen and increase the reach and/or access to the BCBH SD program to rural, American Indian adults, seniors, and adults with disabilities through traditional face-to-face and innovative online workshops.**
2. **Empower SD adults who are currently living with chronic conditions to better manage their chronic condition, by increasing their participation in and completion of the BCBH SD program.**
3. **Utilize federal grant funding to focus on further refining and developing the processes and infrastructure established by the BCBH SD steering committee and collaborating partners in order to make this a sustainable state-wide initiative in SD.**
4. **Seek out and develop partnerships with innovative funding and delivery systems, those of whom will help to support and create a sustainable BCBH SD program for SD residents.**

Measureable Outcomes

1. **Online program participation and completion will be similar or better than face-to-face program participation and completion.**
2. **Upon program completion, the majority of BCBH SD completers (>50%) will report: increased disease management self-efficacy, improved quality of life, being less affected by disease symptoms and increased physical activity.**

Key Activities

1. **Recruit and mentor a group of diverse group of Lay Leaders in order to keep them engaged in BCBH.** Develop a tracking system to monitor lay leader demographics; develop a communication plan for continuous engagement and support of Lay Leaders. Develop mentorship plan for sustainability of engagement of Lay Leaders. Determine training schedule for new Lay Leaders; host trainings as needed.

2. **Develop recruitment, retention, quality assurance, & sustainability protocols. I**dentify strategies for recruiting a diverse group of leaders. Create a Sustainability Manual.

3. **Engage Master Trainer Outreach Ambassadors for specific audience support and consultation.** Expand focus and engagement of diverse and outreach populations in BCBH programs (health systems, seniors, tribal populations, and adults with disabilities.)

4. **Engage up to two BCBH SD Master Trainers to become Stanford University T-Trainers.** Increase sustainability of providing trainings from trainers who understand SD needs. Connect with other states in order to re-assess and evaluate our implementation strategies.

5. **Establish specific types of participants to be reached in SD through participating communities. Identify and implement strategies and protocols to reach diverse participants.** Conduct focus groups to discover strategies for increasing the reach among seniors, adults with disabilities, and American Indian participants. Strengthen SD BCBH by adapting the program to ensure cultural competency for these participants.

6. **Integration of online CDSMP Classes into BCBH SD Program**. Integrate into Social Marketing and Business/Sustainability Plan. Explore interest and evaluate effectiveness and reach in rural and tribal populations. Explore innovative arrangements to help participants access online class (computers, internet, transportation, etc.).

7. **Collaboration and Integration of SD BCBH Programs into Worksites through SD DOH WorkWell Program.** Focus on worksite settings in rural locations and those with large numbers of male employees. Integrate the Stanford curriculum for implementation in worksites in SD; evaluate outcomes and employer satisfaction of return on investment.

8. **Work with healthcare organizations to implement a referral system for BCBH SD workshops**. Based off of the Quitline referral model, develop a BCBH referral system for providers using the Electronic Medical Record when a patient indicates they have a chronic condition. Evaluate participation effectiveness of BCBH referral system for providers using the Electronic Medical Record.

9. **Work with Quality Innovations Network (QIN)/Quality Improvement Organization (QIO).** In alignment with the mission of BCBH SD, and in following established Institutional Review Board (IRB) guidelines to protect BCBH participants, assist with diabetes data collection and sharing of BCBH available data that meets the requirements for CMS beneficiaries.

10. **Creation of Ambassador Toolkit.** Develop marketing toolkit. Utilize the toolkit to continually seek out sponsorships to increase BCBH sustainability. Update toolkit as needed.

11. **Create social marketing sustainability plan.** Use media channels to promote and increase awareness of BCBH. Develop standards to define types of partnerships (referral sources, coalitions, workgroups, etc.). Foster specific relationships (tribal organizations, health care systems, organizations that serve seniors and adults with disabilities, veterans, and prisons).

12. **Develop BCBH SD Implementation Manual**. Create job descriptions/scopes of work that support organizational chart structure. Develop cooperative agreement templates for partners (Memorandum of Agreement Develop centralized process to handle administration duties, leaders, workshop and training registration, tracking, and evaluation.

13. **Workforce and inter-professional development.** Partner with academic institutions to train students in the BCBH program. Examples might include nursing, pre-medicine, physician assistants, dietitians, pharmacists, etc. to provide BCBH in the communities where they conduct outreach, or as a part of their health curriculum.

14. **Creation of a webinar (series).** Use to inform potential partners, sponsoring organization, health care systems, and health care staff on benefits of offering BCBH. Offer CEU credit to health care providers to promote the integration of CDSMP into Care Transitions Programs.

15. **Offer mini-grants to various communities / host organizations to integrate BCBH into their programming efforts, especially in rural areas.** Establish contracts for a set time period and dollar amount along with all materials and supplies.

16. **Refine and develop an evaluation plan to fully utilize data and outcomes.** Create success stories. Develop impact report template that showcases data and can be utilized by partners to promote BCBH program outcomes. Determine logistics for collecting survey data. Review potential data to use for Return on Investment. Maintain IRB approval status at SDSU. Protect participant information and respect for participation.

17. **Develop a business & sustainability plan.** Use to diversify funding sources and support BCBH program sustainability. Finalize protocol for tracking in-kind donations.

PROGRAM PARTICIPANTS

It is expected that BCBH SD will reach 224 participants in Year 1 and 450 participants in Year 2 through regular face-to-face workshops (see table below). Additionally, another 150 are expected to be engaged through the online workshop.

The target completion rates for the proposed project are 68% by the end of Year 1 and 73% by the end of Year 2. This means that more than 180 individuals will complete the program in Year 1 and more than 400 individuals will complete the program in Year 2.

Year 1 (September 1, 2015-August 31, 2016)						
Regions	**Workshops**		**Workshop Participants (8 per)**	**Lay Leaders Trained**	**T- Trainers trained**	**Master Trainers trained**
	MT Led	**LL led**				
Southeastern (SE)	2	6	64	12		
Northeastern (NE)	2	5	56	10		
Central (C)	1	1	16	2		
Western (W)	2	6	64	12		
Tribal	1	2	24	4		
Totals	**8**	**20**	**224**	**40**	**0**	**0**
On-line CDSMP			**50**			

Year 2 (September 1, 2016-August 31, 2017)							
Regions	**Workshops**			**Workshop Participants (9 per)**	**Lay Leaders Trained**	**T- Trainers trained**	**Master Trainers trained**
	MT Led	**LL led**					
		Y1 LLs	**Y2 LLs**				
Southeastern (SE)	1	6	6	117	12		(Tribal, prisons, worksites, VA outreach etc.)
Northeastern (NE)	1	5	5	99	10		
Central (C)	1	1	1	27	2		
Western (W)	1	6	6	117	12		
Tribal	1	2	2	45	4		
Totals	**5**	**20**	**20**	**450**	**40**	**2**	**12**
On-line CDSMP				**100**			

*****_As noted on the map, the regions are now identified as Northern, Eastern, Southern, Western, and Central. This change has been to better align with Leader locations._

*MT = Master Trainer / LL = Lay Leader

PROGRAM EXPANSION

Geographic reach will increase from 9 counties to 23 counties (including 3 American Indian reservations) over the two-year course of the project, increasing the percentage of the SD population that has access to program workshops at least twice a year from just more than 50% to more than 75%. The proposed project will expand face-to-face workshop availability across SD, bringing BCBH workshops to an additional 12 cities and 3 reservations, ultimately providing 76.3% of the SD population with access to program workshops.

Current BCBH Reach	**Cities**	**Counties**	**Population**
Southeastern (SE)	Sioux Falls, Mitchell	Minnehaha, Lincoln, Davison	179640, 49858, 19823
Northeastern (NE)	Aberdeen, Huron, Sisseton	Brown, Beadle, Roberts	37907, 18080, 10251
Central (C)	Pierre	Hughes	17508
Western (W)	Rapid City, Custer	Pennington, Custer	105761, 8468
Tribal			
Current Totals	*8*	*9*	
Year 1 Workshop Expansion	**Cities**	**Counties**	**Population**
Southeastern (SE)	Brookings, Yankton	Brookings, Yankton	32968, 22696
Northeastern (NE)	Watertown	Codington	27853
Central (C)	Fort Pierre	Stanley	2981
Western (W)	Spearfish, Sturgis	Lawrence, Meade	24910, 27202
Tribal	Pine Ridge, Sisseton Wahpeton	Shannon, Roberts*	14118, *included above
Year 1 Additions	*6 cities, 2 reservations*	*7*	
Year 2 Workshop Expansion	**Cities**	**Counties**	**Population**
Southeastern (SE)	Parkston, Wagner	Hutchinson, Charles Mix	7145, 9241
Northeastern (NE)	Milbank, Miller	Grant, Hand	7281, 3391
Central (C)	Chamberlain	Brule	5366
Western (W)	Belle Fourche	Butte	10330
Tribal (reservation)	Lower Brule	Buffalo	2024
Year 2 Additions	*6 cities, 1 reservation*	*7*	
Overall Totals	**20 cities, 3 reservations**	**23 counties**	**644802**

**Roberts County is being included again here because of the expanded focus on its reservation cities.*

ACKNOWLEDGEMENTS

The BCBH SD Workplan is the result of statewide collaboration of the Better Choices, Better Health SD Network with key stakeholder and partners, including (but not limited to):

- SDSU Extension
- SD Departments of Health (DOH) & Social Services (DSS-Aging)
- Retired Senior Volunteers Program (RSVP)
- South Dakota State University
- South Dakota Health Systems (Sanford, Avera, Rapid City Regional)
- Diabetes & Cancer Prevention & Control Programs
- Health Connect
- SDSU Extension Tribal Programs
- Great Plains Tribal Chairmen's Health Board
- Veterans Affairs
- Indian Health Services (IHS)
- Area Health Education Centers (AHEC)
- SD Foundation for Medical Care (Medicare, QIN)

REFERENCES

Institute of Medicine, 2012 *"Living Well with Chronic Illness: A Call for Public Health Action"*, 2012

Lorig, et.al, 2011, *Chronic Disease Self-Management Program: 2 –Year Health Status and Health Care Utilization Outcomes*. Medical Care, 39(11), p. 1217-1223

The Health Behaviors of South Dakotans 2014. (n.d.). Retrieved July 13, 2016, from http://doh.sd.gov/statistics/2014BRFSS/default.aspx

Chronic Disease Self-Management Program (Better Choices, Better Health® Workshop). (n.d.). Retrieved July 13, 2016, from http://patienteducation.stanford.edu/programs/cdsmp.html

National Council on Aging (NCOA). (n.d.). Retrieved July 13, 2016, from https://www.ncoa.org/