

**Health Homes Webinar Series:
Health Promotion
May 27, 2014**

Presenters: Becky Ross, KDHE Division of Health Care Finance and Virginia Barnes, KDHE Bureau of Health Promotion Community-Clinical Linkages

Moderator: Sonja Armbruster – Public Health Initiatives Coordinator, WSU Center for Community Support & Research

Sonja: Welcome to the Health Homes series. This series is presented to highlight tools and resources available to potential Health Homes Partners. This webinar and all of the Health Home Webinar presentations are recorded for future viewing from the KanCare website. The slides for today are already posted. For each webinar, answers to questions raised during the presentation have been answered and posted. In a moment, Becky will give you a quick tour about how to locate the materials on the KanCare website.

Just a few quick housekeeping items, all of your lines have been muted and will remain so for the entirety of the presentation. You will receive a thank you email after the webinar that includes a short survey to provide an evaluation. Feedback is important so that we may improve the experience for future meetings. You should all have a question box that appears on your desktop as part of the GoToWebinar Layout. This will be the method for asking questions during the presentation. You may type your question related to today's discussion at any time and our staff will theme these and ask them of the panelists at the end of the presentation. Because of the large number of people participating, we will not be taking questions via telephone. Again, please limit your questions to the topic of today's webinar. Any other questions will be referred to Becky Ross and her email address will appear toward the end of the presentation. My name is Sonja Armbruster and I am facilitating this call from Wichita State Center for Community Support and Research. We welcome you all.

Our panelists for today are Becky Ross from the Kansas Department of Health and Environment: Division of Health Care Finance and Virginia Barnes of the Kansas Department of Health and Environment: Bureau of Health Promotion. Today, our purposes are related to defining Health Promotion as a service provided by Health Home Partners and then some resources within the KDHE Bureau of Health Promotion that will assist you all in providing those Health Promotion services. Becky, I will turn things over to you.

Becky: Thank you Sonja. What you are seeing on the screen right now is the page on the KanCare website that shows you how to get to the Health Homes website. So you click there where the red box is highlighting Health Homes and KanCare and that will take you to the Health Homes front page and you're going to want to click on the "Providers" box which will then take you to this area where you get a lot of information about Health Homes, program manuals, and other tools for providers. You see there that the Health Homes webinar series is listed on the left-hand side of the screen and that's where you can find the slides for today and all of the other webinars that we have done. As soon as we are finished with this one, there will be questions and answers and a transcript posted as well.

So, today we are going to talk about Health Promotion and Health Homes. Listed there are the six core services that Health Homes must provide and you see Health Promotion there highlighted...not all of it are we going to talk about today, because it's a typical service for Health Homes. It's really about helping people participate in managing their own chronic condition.

We have defined Health Promotion pretty robustly within Health Homes. It's really engaging the member in a variety of ways, using a variety of tools to help them understand their condition. In addition to assessing their level of understanding and trying to move that level of understanding, working with the member wherever they are, meet them where they are to help them understand their condition and what they can do to help improve their condition. So you see a lot of different things listed there that are included in the definition of Health Promotion. All of these are critical to helping people with chronic conditions participate in the management of those conditions and make changes in their behaviors to help them improve their conditions.

These are some Health Promotion activities that Health Home Partners can participate in or can engage in to help the member become more engaged themselves. Health Homes are going to be working with a wide variety of folks, many of whom may have cognitive issues or issues with participation or compliance and it's important for the Health Home Partner to know where the person is starting from to know how best to engage them, but there is a strong emphasis on including the member, their family, significant others, anyone who can be helpful with them in understanding their condition.

Part of Health Promotion is helping the individual set some health goals. That occurs in the Care Management activity, but those goals then are managed through, in part, Health Promotion. So an individual might have a goal that involves them either learning more about managing their condition or setting a goal around weight loss, exercise, or some other form of activity - appropriate eating, learning more about their diet, a variety of things to meet Health Action goals that would engage the individual in Health Promotion and managing their condition and learning some behavior or changing some behavior that would help improve that condition.

Virginia Barnes: This is Virginia Barnes and I am the Community-Clinical Linkages Section Director for the Bureau of Health Promotion at KDHE. Thank you for having me today and I am excited to tell you about our programs. I wanted to start off today with some definitions of Health Promotion from the National Center for Chronic Disease Prevention and Health Promotion. There are public health books and power of prevention documents. So chronic conditions prevention, to be most effective, must occur in multiple sectors and across an individual's entire lifespan. Health Promotion, as Becky really said it nicely, encompasses activities and encourages healthy limits and healthy living that limit the initial onset of the chronic disease. So there is a lot that goes into Health Promotion, not just a simple activity of...kind of education – there is quite a bit to it.

Additionally, the NCCDPHP as the acronym is, funds most of the Bureau of Health Promotion's activities currently for diabetes, heart disease, obesity and risk factors that are associated with those diseases, as well as school health. The current approach takes that...that encompassing approach and looks at epidemiology and surveillance, environmental approaches to public health, health system interventions and community health...Community-Clinical Linkages.

I wanted to also show you this slide, which is the framework that the CDC has put out to emphasize that prevention and Health Promotion must be addressed through a number of ways, including lifespan settings, worksites, schools and communities, underlying risk factors, as well as the conditions. So again, it's not just about focusing on one thing; there is a number of approaches and it's critical to have that coordination for Health Promotion to make a difference.

OK, and so the other piece that I want to touch on today is evidence-based public health. So the CDC has made a strong effort to prioritize evidence-based public health, which is the practice of integration of science-based intervention with community preferences for improving population health. This is about linking public health and clinical practices to the underlying scientific evidence and encouraging evaluation of program options in connection with information that is relative to what we do. I think traditional public health messages have often been considered just choosing a design, going for it and not necessarily doing these key components and so there has been a strong push recently to really make sure that we look at those programs or practices that include the decisions that can really make changes and that we know is based on the science and we know work. So that's a strong piece of what the Bureau of Health Promotion does, is really looking at the evidence that is out there and incorporating that into our programs that we promote.

So this diagram is also just another way of looking at...where we are taking those pieces that go together, looking at the resources, including what the practitioners have out there and taking a look at the best available research and then additionally, looking at the population characteristics and who needs the approaches and what their preferences and values are. So taking all of those things and incorporating them into the design of the programs that we promote and how we approach public health in general for Health Promotion.

This next slide is an introduction to the Bureau of Health Promotion. We are currently set up in the following sections with the Community-Clinical Linkages, which is my section; Community Health Promotion which is headed by Jennifer Church; Health Systems, and the Director for Health Systems is Julie Sergeant; and Injury Prevention and Laura Haskett is our Section Director for Injury Prevention.

I wanted to go into a little bit more detail as we move through these. The Community-Clinical Linkages section includes the Kansas Arthritis Program. We have our main programs through the Kansas Optimizing Health Program or KOHP, which includes the Chronic Disease Self-Management Program, Diabetes Self-Management Program, Diabetes Primary Prevention, and a couple of others that I will touch on in a moment. Then we also have a Worksite Wellness, as Health Educators, which is included in our section to

help promote, as I mentioned earlier with that framework, help specifically in the worksite. Then we also work directly with the Chronic Disease Alliance of Kansas to help engage additional partners to look at how we can address chronic disease in Kansas through that Alliance.

So Community-Clinical Linkages and Health Homes, I wanted to point out that that connection is very specific to that population that is defined for Health Home Partners as the people who have asthma or diabetes, including pre-diabetes, and are also at risk for developing hypertension, coronary artery disease, depression, substance abuse disorder or those who are overweight or obese. So it fits in very nicely, again, with what we do with our focus in our section on diabetes, heart disease, and stroke.

This slide here is just to show that the Kansas Optimizing Health Program is an umbrella for all of our prevention and self-management programs that we offer through the Bureau. So again, Chronic Disease Self-Management Program, Diabetes Self-Management Program, the Tomando Control is the Spanish version of the Chronic Disease Self-Management Program. We also offer a walking program...Walk with Ease and Stepping On which is in Injury Prevention Program. There's also the Diabetes Prevention Program, which you see is kind of in dashes, and I'm going to tell you more about that today. It's one that we are just in the process of setting up, so it's not widely available, but I will give you more information as we go on with the webinar.

I'll just start with giving some information on the Walk with Ease Program. This is a program that has been supported through the Kansas Arthritis Program and the Arthritis Foundation, mainly within our section. It is a walking program that encourages people with and without arthritis to start walking and then to stay motivated to keep walking. It's a six week program and it encourages people to walk three times a week for about 30 minutes. The nice thing about the Walk with Ease program is that it's something that is available as a self-led program or it can be done in groups, so it's available in a number of situations or settings; it's not particularly limited to how people can approach it.

Currently, when you do Walk with Ease, we offer a bag, a pedometer and a guide book. It includes information about stretching and strengthening activities, self-monitoring for physical problems while walking, motivation to keep exercising, as well as developing a walking plan for participants. So some of the benefits that we have seen through the Walk with Ease program are a reduction of pain and discomfort, increase in strength and walking pace and additionally, just improved overall health in terms of being physically active.

The next piece I want to cover is the Chronic Disease Self-Management, Diabetes Self-Management Program, the Tomando Control workshops. These are six week workshops that are offered once a week for 2 1/2 hours. They were first developed through a collaboration with the research project between Stanford University and the Northern California Kaiser Permanente Medical Care Program. What these programs do is they offer assistance with issues for individuals who have a variety of chronic diseases that they face issues on a daily basis. The nice thing about these programs is they don't specifically focus in on one chronic disease or one specific bit of information. They actually offer a

curriculum that addresses a lot of practical ways to deal with a variety of symptoms, such as pain management, fatigue, they offer information on better nutrition and exercise choices, new treatment choices, and ways to talk to your healthcare provider. So they really...these programs fit in very nicely with what the Health Homes are actually designed to do. They are working with the same definition that Becky talked about for us earlier.

So the Diabetes Self-Management program is similar...is exactly the same curriculum, if you will, as the Chronic Disease Self-Management, but then it actually goes into a little bit additional detail for Diabetes Self-Management such as counting carbs and remembering to take your socks and shoes off so the doctor can check your feet if you are at an appointment. So these programs help people to create Health Action Plans around particular items as they go through the program across the six weeks.

And so, KDHE has been offering Chronic Disease Self-Management since 2008 when we obtained our license from Stanford and currently we have programs in at least 42 counties across Kansas and we have 20 Master Trainers for Chronic Disease Self-Management and Diabetes Self-Management and about 120 Leaders and, Leaders are the people who actually teach the workshops, so we have quite a bit of...a fairly large network of resources across the state and we are growing that network as we move through this year. In fact, the Diabetes Self-Management is something that we actually just brought on in 2014, so we are pretty excited about the ability to expand this resource to Kansas.

This slide is a little bit more information on why people should be interested in doing self-management. Again, increasing exercise, helping cope with strategies and symptoms, having more energy, being able to really manage any distress or disability that your patient may be having. Various aspects of this program have been studied over the past several years and they have shown that participants who were followed up with on a six month, one year, and two year intervals showed an improvement across time, and once again, this is very much an evidence-based program. Additionally, there has been an occasion that there is cost savings involved from participants with fewer hospital stays and fewer outpatient visits.

This is just a workshop overview to give you a little bit better understanding of what is offered during the six-week program. It covers a lot of materials, quite a bit of information on action planning and problem solving, done each week. Action planning on this level can be very simple; they could say that they would eat one more piece of fruit or one more vegetable every day for three days this week and I'm confident that I can do this. My confidence level is an 8 out of 10. It really just helps participants kind of get an understanding of making small goals – setting small goals and keeping themselves motivated across the six weeks. These workshops come with a *Living A Healthy Life With Chronic Conditions* book and a relaxation CD. The books offer a lot more in-depth information than what is covered specifically in the workshop, so it offers additional resources to those who participate.

This is our KOHP Workshop Calendar. This can be found on the KDHE website under the Arthritis Program. I put that address on the slide so that people are able to find it a little bit more easily than if I tried to walk you through all the details getting to it from our website.

The nice thing about this is that you can see it shows all of our KOHP Programs and they are color-coordinated so that you can see that Tomando Control is blue, the Chronic Disease Self-Management is in red, Diabetes Self-Management is green, so it makes it a little bit more easy to pick out and we try to schedule those out as far in advance as possible, so as soon as we have a Leader say they want to put on a program, even if it's in December, we get it on the calendar and it will give you...if you click on one of those links, it will give you additional information about where it's located, the address and the Leaders who are putting on that program so we try to include as much information on the calendar as possible. We don't currently have any type of map, specifically, that shows where things are in the state, but we are working on that resource. To give you an idea, in the fiscal year 2013, we had 370 Chronic Disease Self-Management program participants and we had 232 Tomando Control. Keep in mind we haven't tracked our Diabetes Self-Management yet because we just started that this year, so we are just getting up and running. The nice thing we found out as we've gone through evaluations is that 94% learned what they expected, 99% of participants would recommend the program and 99% of the participants also thought the Leader did a nice job of putting together a program with a supporting environment. So we've had very positive results with this particular program.

Now just to give you a little bit more about what is coming up with the Chronic Disease Self-Management...we are working with our Chronic Disease Risk Reduction coalitions and lead grantees. We are expanding...currently we have provided support to Johnson County, Sedgwick County and Wyandotte County to increase participation in those areas and we hope to continue to expand the Chronic Disease Risk Reduction grantees over the coming years. We are also working with the Robert Dole VA Medical Center in Wichita to try and expand workshops within the VA. We are also working with the Chronic Disease Alliance of Kansas. So again, more ways to bring these resources to people across Kansas. We are also in the process of developing a Provider Referral Toolkit to help the coalitions who are working with Chronic Disease Self-Management to be able to actually have a fax form or something so that Providers can recommend the courses to their patients and then fax in their referral to us to help us then hook up that patient with the local workshop that's going on and then make it a little bit easier to connect. Again, the Community-Clinical Linkage piece for these programs. So I'm very excited about that piece.

Moving on, this is the Diabetes Prevention Program...we are just starting to bring this to Kansas and we are very excited about being able to offer this resource. About 26 million US adults are living with diabetes and one out of every three US adults have pre-diabetes, so this is a big issue. Seventy-nine million Americans aged 20 years or older are thought to have pre-diabetes and of those, they are likely...people with pre-diabetes, are likely to develop type II diabetes within 10 years if we don't take action to begin preventing or delaying this. Some of the information on pre-diabetes from the 2011 Kansas Behavioral Risk Factors Surveillance System... just to give you a little bit more information – 9.4% of Kansans reported being diagnosed with diabetes and 9.8% male and 9.1% females and then 19.9% are living with a disability, 20.1% also have arthritis and we know that chronic conditions are often a contributing factor, and then 17.9% are obese and 7.8 % are overweight, so risk factors are there and we really do need to concentrate on this particular issue.

So the CDC has put together the Diabetes Prevention Program at the national level to increase workforce, to make sure that there are quality evidence-based programs, and to increase the networks across the United States. So we are working on bringing more of the National Diabetes Prevention Program workshops to Kansas to actually help delay and prevent type II diabetes. These are done usually in group settings; there are 16 core sessions and there are usually about one a week for those 16 core sessions and then six post-core sessions over the course of a year.

Currently in Kansas, we do have the Greater YMCA of Wichita has started offering this program through their facilities. They are in the process of getting CDC recognition; this is a two-year process, so you start offering the programs and they then come through and aggressively make sure that you are meeting the standards of the program before offering full certification. So we are very excited that they began that process in January. As you can see, the program goal is really about reducing body weight by 7% and increasing physical activity. Those two things make a huge difference as far as being able to...have people who are pre-diabetic, again, either prevent diabetes or even not be pre-diabetic anymore. Additionally, we have been working with the Y and other stakeholders...we had a meeting in October and we are also working with the Chronic Disease Alliance of Kansas to increase availability of these programs. Like I said, currently the Greater Wichita area, you are able to find that resource there.

Moving on to some other programs that we offer through other sections in the Bureau, would be in the Health Systems section...I wanted to highlight our tobacco cessation program specifically, but I also wanted to show you the other programs that are available in Health Systems there with cancer. The Kansas Tobacco Quitline is a program that helps Kansans quit smoking. It offers one-on-one coaching for tobacco users and it's available 24/7, 7 days a week, which is great because you never know when you need help on that one. So some of the health costs of smoking...tobacco use is the leading cause of preventable deaths in the state of Kansas and every year approximately 3900 Kansans die from direct...diseases directly linked to smoking. I like this last fact, particularly, that it causes more deaths than HIV, illegal drug use, alcohol use, car wrecks, suicides and murders combined.

Just to show some of the effectiveness of the Quitline, 31% were quit within seven months after treatment and 94% were satisfied with the program. It is a program that is designed, they think to help encourage...even, you know, as we know, tobacco use...most people don't quit on the first try so it's designed to be available and continue offering that resource and encouraging people to continue trying, even if they don't manage to quit the first time.

Another nice thing about the Quitline is that it does have highly trained coaches. The Coaches are professionals who do a lot of ongoing quality training to really know their stuff. They are very highly trained and are not the main resource on the Quitline, but I'm very impressed with what I've heard. They do a lot to make sure that they are kept up-to-date with the most recent information on tobacco cessation and are available, so a very, very good resource too.

Text2Quit is one way that the Quitline is offered and that way people are able to receive texts to help manage urges, to help them meet their goals and receive ongoing encouragement from the Quit Coach. So the Text2Quit Program is one thing that is offered.

Additionally, there is a mobile app that can be downloaded from the App Store and it is also designed to help smokers quit. They offer prompt and help with setting a quit date, as well as once somebody has quit, helping to actively support them. It is a free app and the next couple of slides I just wanted to show some of the screenshots of the app so you can see it has “Welcome”, “Helping Set a Quit Date”, and some of those things that might be motivating factors, so how much money you might spend, so people can really see the benefit of quitting as they go through. The next slide as well, again, helping people list their reasons for quitting, and helping them develop a plan and then offer tips and resources as well through the app. So a very comprehensive mobile app.

Then the third way it can be accessed is through the KanQuit! Website, so again, you can access the Coaches through the website. You can do the same thing that is on the mobile app and then there's, I believe, some chat rooms and some additional resources to help you get connected to other people that are going through the same thing. So a good resource for people who are looking as maybe part of their Health Action Plan to quit smoking; this is an excellent way to encourage them to do that.

So I just want to reiterate again that it is free, it is interactive, there's a lot of support for decision-making with the quitting process and just again to reiterate some things that the Web Coach can do.

Another important piece is the fax referrals. So on the website you can find the fax referral forms whereas Providers, if someone who might be referring to the Quitline, that is available to help connect patients to the Quitline and once the referral is made, the Kansas Tobacco Quitline will work through contacting the patient until they either say that they are not interested or begin working with the Quitline Coaches or after five contacts, they will let you know that they had no success.

One last section I want to go through is the Community Health Promotion Section just to let you know that is another area that has some additional resources such as the Tobacco Use Prevention and the Farmers' Market Program. So this isn't so much on the evidence-based programming, but again it's addresses a lot of that environmental approach that we talked about earlier by providing direct technical assistance to communities, helping with policies to make streets safer for Farmers' Markets...to make environmental changes such as community gardens and just a lot of work around increasing physical activity in communities. They also are over the Senior Farmers' Market Nutrition Program, so again perhaps one of the Health Action Plans is you could refer patients to find ways to eat fresher fruit and vegetables. This may offer some assistance in locating a Farmers' Market in their area and hooking them up with trails in their communities and other things that could promote healthy, nutrition and physical activity. I wanted to make sure I included this slide is well.

Here at the end, I also have some additional resources. Again, you will see a link to the Kansas Optimizing Health Program, as well as the information for Ariel Capes, who is our Health Educator who does most of the work in helping set up workshops with Leaders. She's a very good resource to try to find out if this is available in your area. Matthew Schrock is the expert for the Kansas Tobacco Quitline, so if I butchered any of that information, he can set you straight. Then Anthony Randles is our Physical Activity Nutrition and Obesity Program Manager.

Now I'm going to go on to some additional resources that are not KDHE resources, but that offer a lot of great information on evidence-based programs and things that might be available in your area. The Community Guide actually goes through and sorts specific diseases, looks at evidence-based programs that are available and give people an understanding of what meets the guidelines and in what setting. So perhaps for instance, Chronic Disease Self-Management is great in some settings but Worksite hasn't shown as much of an advantage, but it is absolutely wonderful and other communities. So just to give people an idea of how to implement the evidence-based programs. The Million Hearts concentrates efforts around reducing blood pressure and other risk factors for heart disease and stroke. There are a lot of very excellent resources on this particular website, so I certainly encourage you to check it out. The YMCA Diabetes Prevention Program gives you more information for the DPP in the Wichita area and then Chronic Disease Prevention and Health Promotion through the CDC.

Sonja: OK, thank you again, Virginia, for the overview of the many programs that KDHE provides support and funding for. Thank you, Becky, for the overview of what exactly is required in the Health Promotion portion of the Health Homes six core services. Now it is time for us to receive some answers to questions that have been posted. If you have a question, you are encouraged to type that into your question chat box now and we will work to get those answered. The first question we got was whether or not the links to these workshops and the information about these workshops was going to be provided on the Health Homes website? So we can see from just the last couple of slides that we had links to the KOHP Program and others that Virginia mentioned here in these slides and these slides are available on the Health Homes site now, but the question is really to Becky, are these resources going to be linked in a different way or in another resource place on the Health Homes website?

Becky: We have a Health Promotion link on our Health Homes site so we can certainly add them under there.

Sonja: Excellent, thank you. A second question and this one is probably more for Virginia was related to how the workshops are paid for...are they free to participants in Health Homes to just sign up and attend a workshop?

Virginia: Yes, and I am embarrassed that I left that out. Chronic Disease Self-Management Workshops and Diabetes Self-Management are all free workshops that are available, yes.

Sonja: Excellent, thank you. A related question and it may be a combination of the both of you answering this is related to...as Health Home Partners, will our staff be trained to provide these prevention programs like the KOHP, various Chronic Disease Self-Management Programs, or will our staff be referring members to these programs and the community? The concern is that they live in a frontier county and these programs might not already be happening among those 120 Leaders in the state.

Becky: Well, I'll take a stab first and then let Virginia step in. I think it could be either way. Obviously, if you have that resource in your community, it's a great resource to refer people to; if you don't have it, I'm sure Virginia would love to have more people trained.

Virginia: Yeah, so as Becky's saying, we're certainly interested in being able to offer this resource across Kansas. One of those things we are actually working on is really mapping out where we currently have Leaders and where we have a large burden that is not being addressed and trying to target those areas whether it be through the Chronic Disease Risk Reduction grantees or through other means. We certainly...if you find that you do not have this resource in your area, the best way would be to contact either myself or Ariel Capes and we can work with you to see...it could certainly be that your organization is the best organization to offer these programs and we could get a Leader trained through your organization or we could look at the resources available in the area and see where we might be able to pull in additional resources to get Leaders trained and make classes available. So we are absolutely interested in helping get the workshops to where they need to be.

Sonja: Excellent, thank you both. We have at least a couple more questions and you're all invited to send more our direction. There's a couple of interesting questions here – do you have any programs that have been developed specifically for individuals with developmental or intellectual disabilities?

Virginia: We do not specifically target those individuals with our particular programs. I think that what you might find is if you use that Community Guide resource, then that may be a place where you can find some additional resources I will say that with the Chronic Disease Self-Management, like I said, they don't specifically target, but they do offer some information that is very easily understood and broadly available. I think they are still a good resource for people with disabilities, as well as any other piece of the population with a chronic disease.

Sonja: Thank you and the last question in the queue is related to whether or not these Chronic Disease Self-Management Workshops are in person? Is that correct? Are they in person?

Virginia: Yes, they are in person; six weeks 2 1/2 hours in person. There are some resources that are available across the nation that we don't specifically have in Kansas, but do offer some online versions of both the Diabetes Prevention Program and the Chronic Disease Self-Management Workshops. Currently, again like I said, we actually do offer some of the Diabetes Prevention Program type online resources through a particular pilot, but they are less available so they are through specific clinics. Chronic Disease Self-

Management and Diabetes Self-Management, we aren't currently offering online, but it is a possibility in the future. We're kind of keeping an eye on how those pilots are going.

Sonja: Thank you, that was helpful. We have a few more questions and I just wanted to make everyone on the call aware that we do have representatives from all three MCOs available and they might be able to take a question if you have one specific to them related to Health Promotion. The question about the face-to-face workshops, I believe was related to, again distance for travel for folks that are further away from places where those courses are being provided and the statewide coverage for that. So I think we have addressed the fact that that could be addressed in a number of ways, including training staff to deliver those programs. Are there any of these Chronic Disease classes that are specific to children? That's to Virginia.

Virginia: No, these are classes that are promoted specifically to adults. And I realized I made maybe not a clear answer earlier with the cost. The Chronic Disease Self-Management and the Diabetes Self-Management courses are free. The Diabetes Prevention Programs - those courses are not free, but currently with the YMCA they do offer a sliding scale for cost for participants. You need to contact the YMCA to get a better understanding of how that might be offered.

Sonja: Thank you for that clarification. So the six week 2 1/2 hour courses that you mentioned, one was Chronic Disease Self-Management and one was Diabetes Self-Management...those are free courses but the Diabetes Prevention Program offered by the Y that is the 16 week, may have a cost associated with it and they would have the answer, is that correct Virginia?

Virginia: Yes, that's correct.

Sonja: OK, I think that concludes all of the questions that we have. Wait, we have one more - if a client has a learning disability, would they be able to have their family member or caregiver attend with them so that they could get more from the programs? Would that be a potential for...

Virginia: Yes, absolutely. So again, with the Chronic Disease Self-Management and the Diabetes Self-Management programs, and actually, the Tomando Control version specifically is actually set up to be particularly family-friendly due to addressing the Hispanic population and their culture, but the Chronic Disease Self-Management and the Diabetes Self-Management are also set up so that caregivers are welcome to attend because really, as the target group, the courses offer a lot of information to those folks as well in understanding how to help the person with the chronic disease really manage their care. So they are very beneficial to those caregivers and the person who's dealing with the chronic disease so they are encouraged to attend. They are fairly kid-friendly to be quite honest. I actually attended one myself and there were a couple of lovely children there who were able to keep themselves entertained while their mother went through the course. It worked out just fine; it was very relaxed and easy to get through the information.

Sonja: Excellent. I just want to thank you again Becky and Virginia, for those presentations related to Health Homes. I am reminding everyone that the webinar is being recorded and will be posted in the next few days for future viewing on the KanCare website. The final public webinar is scheduled for June 17 on your screen there and will focus specifically on Targeted Case Management. Again, you all will receive a thank you email shortly after the webinar asking for some feedback. We thank you all for participating and hope you have a great day and a short week.