Healthy Living Program
Workshop Survey Packets

Thank you for leading this Workshop! Your help in collecting information using the forms described below will enable us to learn about the people who are taking this workshop, so that we can determine how best to serve all members of the community. We appreciate your help. For more detailed information please see our Workshop and Survey Packet Guide.

Form Name	Description	Purpose	How to Use
Facilitator Non-Disclosure Agreement	1 page document, 1 for each facilitator (including any substitutes)	To ensure facilitators will not share participant's identifiable information and will follow all safeguards for protecting this information	Each facilitator, including substitute facilitators, must sign and submit to AZLWI for every workshop they facilitate
Pre- Program Leader Script	1 page document, 1 for each workshop	To explain the importance of the Authorization for Use and Disclosure of Health Information form	Facilitators read this script BEFORE participants complete the Authorization form and the Pre-Survey
Authorization for Use and Disclosure of Health Information	2 page document, 1 for each participant	To inform participants that their information will only be shared with AZLWI and will not be identifiable	Distribute to participants at the beginning of the workshop and have them complete after the Pre-Program Leader Script has been read but before the Pre- Survey
Registration Form and Pre-Survey	3 page document, 1 for each participant	To collect demographic and baseline data on each participant	Facilitators distribute to participants to complete after they have completed the Authorization form
Attendance Log	1 page document, 1 for each workshop	To record attendance of participants for each session	Facilitators will write the name of each participant legibly. The names should match what the participants have indicated on the Authorization and Pre- Survey. This form is only to be completed by the facilitators.
Post Program Leader Script	1 page document, 1 for each workshop	To explain how to complete the Post- Survey to the participants and describe the value of collecting the Post-Survey data to compare to the Pre- Survey	Facilitators read the document before participants complete the Post- Survey
Post- Survey	2 page document, 1 for each participant	To obtain feedback on the workshop and facilitators and collect data on each participant to compare to the Pre- Survey	Facilitators distribute to each participant at the end of session 6
Workshop Cover Sheet	2 page document, 1 for each workshop	To record workshop details about the date, location, facilitators, and participants	Completed the requested information about the workshop and include in Survey Packet that is sent to AZLWI. Keep a copy for your records

Healthy Living: Self-Management Education Programs

Non-Disclosure Agreement for Administration for Community Living Chronic Disease Self-Management Education Program Data Collection and Data Entry Personnel

Workshop Facilitators: Please carefully read and sign this non-disclosure agreement prior to facilitating your Healthy Living workshop. If you have any questions, please contact the Survey Coordinator at the AZLWI.

I will not disclose any personally identifiable information provided by Chronic Disease Self-Management Education Program (CDSME) workshop participants. More specifically I will not disclose any data provided in the Participant Information Survey and will follow all standard safeguards for protecting this information, including transmitting the forms in sealed envelopes and storing them in secure, locked locations. If involved in data entry, I will only share the data via the designated, encrypted, password protected database authorized by the Administration for Community Living. After the data is entered, I will destroy the forms.

I understand that unauthorized disclosure of any sensitive CDSME participant data may subject me to disciplinary and adverse administrative action.

Name	Signature
Position/ Title	Date
Organization	

If you have any questions about these forms, please contact AZLWI:

Attn: Survey Coordinator
Arizona Living Well Institute
2066 West Apache Trail, Suite 116
Apache Junction, AZ 85120
Support@azlwi.org

HEALTHY LIVING Pre-Program: Leader Script

Workshop leader: Read the following welcome message and instructions to workshop participants BEFORE they fill out the Authorization for Use form and Pre- Survey.

Welcome to the Healthy Living Workshop. Healthy Living is a self-management program, originally developed at Stanford University, to help participants learn to manage their on-going chronic health conditions through group learning and sharing. This is achieved by learning tools and techniques to deal with problems such as frustration, fatigue, pain, depression and isolation. The workshop meets one (1) day per week for six (6) weeks. Each session is two and a half (2.5) hours in length. Two trained facilitators guide the group discussions.

We would like you to complete a Registration Form and Pre- Survey, and an Authorization for Use and Disclosure of Health Information form today.

The purpose of the registration and survey is to understand who is being served by this program, and to measure the quality and impact of the workshop. We will also ask you to complete a Post- Survey at the end of the sixth session to learn how you feel about the workshop and your health then. Please write your name in the box on each page, so we can match your ending survey with today's survey.

The purpose of the Authorization form is to allow us to collect and use the information you provide on the registration and surveys. We keep your information private and secure, following strict rules of the Health Information Portability and Accountability Act, or HIPAA. Please sign two Authorization forms if you would like to keep one for your records.

We cannot use the survey without also receiving an Authorization form from you, so we hope you complete both.

You can participate in the workshop even if you decide not to sign the Authorization form or complete the Survey.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the use and disclosure of personal and health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Participant: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the release of information listed below to the Arizona Living Well Institute, 2066 W. Apache Trail, Suite 116, Apache Junction, AZ 85120:

All personal information, including my name, race and ethnicity, and birthdate, and health information pertaining to medical history, mental or physical condition, and treatment received that I provide during and after participating in the program.

PURPOSE

The purpose of the requested use and disclosure is to permit us to share information with Arizona Living Well Institute, to evaluate and improve the effectiveness of Self-Management Resource Center (SMRC) programs.

Participants in SMRC programs are requested to provide information about themselves on written forms and by telephone. This includes information about you (e.g., name, race and ethnicity, birth date), your health, and your knowledge, activities and clinical information regarding health conditions.

List limitations on sharing information, if any: _____

_____

Please turn over for additional questions

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to participate in the program.
- I may inspect or obtain a copy of the information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Arizona Living Well Institute, 2066 W. Apache Trail, Suite 116, Apache Junction, AZ 85120. Notice must mention Self-Management Resource Center programs and include: participant's name, date of service, and location of service. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by state law and may no longer be protected by federal confidentiality law (HIPAA).

EXPIRATION

This authorization expires one year from the date written below.

SIGNATURE

Date:_____(month) _____(day) _____(year)

Participant Signature: _____

Participant Name (*printed)*:_____

If signed by a person other than the participant, indicate relationship: _____

_____

HEALTHY LIVING
Registration Form and Pre- Survey

Today's Date: ____/____/_____ **Name:**_____

Month Day Year

Thank you for taking a few minutes to answer some brief questions on this registration form and survey. The information you provide helps us demonstrate who we are serving and the benefits of the program. It also helps us improve our services. Completing the survey is entirely voluntary, and you may skip any questions that you do not want to answer. If you decide not to complete the survey, you can still participate in this program.

First Name:_____ **Last Name:**_____

Date of Birth:____/____/_____ **Sex:** ☐ Male ☐ Female

Address:_____

City:_____ **State:**____ **Zip Code:**_____

Phone Number: (__) _____ **E-mail:**_____

Program Name: *(Check appropriate box)*

☐ Chronic Disease Self-Management	☐ Tomando Control de su Salud
☐ Diabetes Self-Management	☐ Programa de Manejo Personal de le Diabetes
☐ Positive Self-Management (HIV)	☐ Building Better Caregivers
☐ Cancer Thriving and Surviving	☐ Chronic Pain Self-Management

How did you learn about this workshop? *(Add name where appropriate)*

Community organization:	Print material (magazine, flyer):
Social media/ internet:	Friend or family member:
Health professional:	Health plan:
Hospital or clinic:	Employer:
Building where I live:	Other:

Please turn over for additional questions

HEALTHY LIVING
Registration Form and Pre- Survey

Name:_____

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

What is your race? *(Check all that apply)*

☐ American Indian or Alaskan Native	☐ Asian
☐ Black or African American	☐ Native Hawaiian or other Pacific
☐ White or Caucasian	☐ Other (please specify)

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

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

Has a health care provider ever told you that you have any of the following chronic condition? *(Check all that apply)*

☐ Alzheimer's or Related Dementia	☐ High Cholesterol
☐ Arthritis / Rheumatic Disease	☐ Hypertension (High Blood
☐ Breathing (Asthma, COPD,	☐ Kidney Disease
☐ Cancer or Cancer Survivor	☐ Osteoporosis (Low Bone
☐ Chronic Pain	☐ Obesity
☐ Depression or Anxiety Disorder	☐ Multiple Sclerosis
☐ Diabetes	☐ Schizophrenia/Psychotic
☐ Pre-Diabetes	☐ Stroke
☐ Heart Disease	Other:
☐ HIV Positive	☐ None (No Known Chronic

In the past three months, how many times did you go to a hospital emergency room for your own care related to a chronic condition? _____ times

In the past three months, how many times did you stay in a hospital overnight or longer related to a chronic condition? _____ times

What is your health insurance coverage?

☐ Medicaid (AHCCCS)	☐ SSI (Federal disability benefits)	☐ Don't know
☐ Medicare	☐ Veterans Administration	☐ Not insured
☐ Private or Commercial	Other: _____	

Please turn over for additional questions

HEALTHY LIVING
Registration Form and Pre- Survey

Name:_____

1. In general, would you say that your health is**:** *(Please circle **one** number)*

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

2. What is your level of confidence in managing your chronic condition(s)? *(Please circle **one** number)*

Not at all confident										Totally confident
	1	2	3	4	5	6	7	8	9	10

3. In the **past week**, did you ever forget to take your medicine?

No ☐ Yes ☐ I do not take prescription medicine ☐

4. In the **past week,** how many days did you exercise for at least 30 minutes?
*(Please circle **one** number)*

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

5. How often do you examine Nutrition Facts labels to aid in making food choices?
*(Please circle **one** number)*

Never	Occasionally	About Half the Time	Usually	Always
1	2	3	4	5

6. When you visit your doctor, nurse or other health care provider, how often do you prepare a list of questions? *(Please circle **one** number)*

Never	Occasionally	About Half the Time	Usually	Always
1	2	3	4	5

7. Do you know the following numbers? *(Circle yes or no for each one)*

Weight	Yes	No
Blood pressure	Yes	No
Cholesterol	Yes	No
Hemoglobin A1C *(for Healthy Living with Diabetes workshop)*	Yes	No

Please return the completed survey to your workshop leader

HEALTHY LIVING: Attendance Log

LEADERS: Please clearly print the Workshop Information and the Participant Names below. Write participants' names as they appear on their *Surveys and Consents.*

Mark each session that the participant ATTENDS like this: X
Mark each session that the participant is ABSENT like this: A

****Do NOT allow participants to complete the attendance log. Leaders should take attendance each session.*

Workshop Information

Site Name:_____

Start Date: ____/_____/_____ **End Date:** ____/_____/_____

Participant Name (as written on Authorization and Surveys)	**Session Number** 1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						

HEALTHY LIVING Post- Program: Leader Script

Workshop Leader: Read the following closing message to workshop participants at the conclusion of the workshop **BEFORE** they fill out the feedback and **Post-Survey.**

Thank you for attending the Healthy Living workshop.

Please take a moment to give feedback on the program and us, your facilitators. [Leaders – Identify who will be leader **Leader A** and who will be **Leader B** then write names on board. First names only.]

We would also like you to complete a brief Post- Survey. The purpose of this survey is to measure the quality and impact of the workshop. Write your name in the box on each page and return to us when you are done.

As a reminder, we will not use this survey if you did not fill out the Authorization form at Session 1.

HEALTHY LIVING
Post- Survey

Today's Date: ____/____/_____ **Name:_____**

Month Day Year

Thank you for participating in the workshop.

Please take a few minutes to give us feedback about the program and answer some questions about your health. The information you provide helps us demonstrate the benefits of the program and improve our services. Completing the survey is entirely voluntary, and you may skip any questions that you do not want to answer. Please place an **X** in the corresponding box.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Overall, I am satisfied with this workshop.					
I would recommend this workshop to others.					
Please share any additional comments about this workshop.					

Leader A:_____	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Leader was well prepared for each session.					
Leader treated participants respectfully.					
Please share any additional comments about this leader.					
Leader B:_____	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Leader was well prepared for each session.					
Leader treated participants respectfully.					
Please share any additional comments about this leader.					

Please turn over for additional questions

HEALTHY LVING
Post- Survey

Name:_____

1. In general, would you say that your health is**:** *(Please circle **one** number)*

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

2. What is your level of confidence in managing your chronic condition(s)? *(Please circle **one** number)*

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

3. In the **past week**, did you ever forget to take your medicine?

No ☐ Yes ☐ I do not take prescription medicine ☐

4. In the **past week,** how many days did you exercise for at least 30 minutes?
*(Please circle **one** number)*

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

5. How often do you examine Nutrition Facts labels to aid in making food choices?
*(Please circle **one** number)*

Never	Occasionally	About Half the Time	Usually	Always
1	2	3	4	5

6. When you visit your doctor, nurse or other health care provider, how often do you prepare a list of questions? *(Please circle **one** number)*

Never	Occasionally	About Half the Time	Usually	Always
1	2	3	4	5

7. Do you know the following numbers? *(Circle yes or no for each one)*

Weight	Yes	No
Blood pressure	Yes	No
Cholesterol	Yes	No
Hemoglobin A1C *(for Healthy Living with Diabetes workshop)*	Yes	No

Please return the completed survey to your workshop leader.

ARIZONA LIVING WELL INSTITUTE
AT EMPOWERMENT SYSTEMS, INC

Healthy Living Workshop Cover Sheet

Instructions to the Group Facilitators:

Please provide the requested details about this Workshop. Please print clearly. Use this as a cover sheet for the completed data collection forms to return to the survey coordinator.

1. Site Name:_____
   Address: _____
   City: _____ State: _____ Zip: _____

2. Workshop Leaders' Names (please provide full first and last names). If we may contact you with questions about these forms, please provide your daytime phone number as well.

   _____ _____ ☐ Staff or ☐ Volunteer? Ph: (_____) _____-_____
   First Name Last Name

   _____ _____ ☐ Staff or ☐ Volunteer? Ph: (_____) _____-_____
   First Name Last Name

3. Was there a substitute Workshop Leader during this workshop?

   □ Yes Which session? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
   Name: _____ Ph: (_____) _____-_____
   □ No

4. Workshop Start Date (mm/dd/yyyy): ___/_____/_____ (not the Session 0 date)
   End Date (mm/dd/yyyy): ___/_____/_____

5. Did you offer a "Session 0" with this workshop? ("Session 0" is an optional pre-workshop information session. Not all workshops offer a "Session 0".)

   □ Yes
   □ No

6. What type of workshop is this? (Mark only one.)

   □ **Healthy Living: Chronic Disease Self-Management Program (CDSMP)**
   □ Healthy Living with Chronic Pain (CPSMP)
   □ Healthy Living with Diabetes (DSMP)
   □ Cancer Thriving and Surviving (CTS)

Please turn over

7. Please circle which language you used when leading this workshop:
English Spanish Other: _____

8. Number of participants *enrolled*, attending at least 1 session *: ____ * *Excluding "Session 0"*

9. Number of participants who *completed at least 4 sessions* *: _____ * *Excluding "Session 0"*

10. Number of ***PRE*** *Participant Information Surveys* included in the returned packet: _____
If the number of forms is fewer than the number of participants noted in #7 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.):
_____
_____

10a. Number of ***POST*** *Participant Information Surveys* included in the returned packet: ____
If the number of forms is fewer than the number of participants noted in #7 above, please provide a brief explanation (e.g., illness, refusal, loss or destruction of forms, etc.): _____
_____

11. If you charged the participants a fee to attend this workshop, please indicate the amount:
$_____ per participant.

Forms Checklist:

Please return the following forms to the Survey Coordinator (contact information below) within **2 weeks after the 6th (final) session**:

- ☐ *Non-Disclosure Agreement* for Facilitators *(**one** for each facilitator)*
- ☐ *Workshop Cover Sheet* (**one** for each workshop)
- ☐ *Attendance Log* (**one** for each workshop)
- ☐ All signed *Authorization for Use and Disclosure of Health Information* (**one** for each participant)
- ☐ All completed *Participant Information Surveys* (**two** for each participant – one pre and one post workshop)

Please mail all the documents within 2 weeks of workshop close to:

Attn: Survey Coordinator
Arizona Living Well Institute
2066 West Apache Trail, Suite 116
Apache Junction, AZ 85120

If you have any questions about these forms, please contact AZLWI at (480)-367-6937 or email: support@azlwi.org

www.azlwi.org