

Chronic Disease Self-Management Education Success Stories

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Chronic Disease Self-Management Education Success Story

*Living Well Alabama:
Closing the Gap*



Contact Name: Jabari Sullen

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Background

According to a 2006 report from the National Association of State Mental Health Program Directors, people with serious mental illnesses (SMI) die, on average, 25 years earlier than the general population. More recent studies report a continued gap between the general population and those living with SMI. A study conducted at the University of Oxford in the United Kingdom tells us that people living with SMI experience a health risk, “as great as that associated with smoking 20 or more cigarettes a day.”

Time Period of Achievement

Ongoing

Location of the Story

Jefferson, Blount, and St. Clair counties in Alabama

Key Organizations Involved

Alabama Department of Senior Services, Alabama Department of Public Health, JBS Mental Health Authority

Population Served

Individuals with persistent mental health issues and chronic conditions

Intervention

Many health programs have been developed to combat this unfortunate disparity that affects so many lives. In Alabama, the Certified Peer Specialists of Jefferson, Blount, St. Clair County Mental Health Authority (JBS) are trying to narrow the gap by serving as facilitators for Living Well Alabama (LWA). Evaluations of the program show that participants have significant improvements in exercise, self-reported general health, cognitive symptom management, fewer number of days spent in the hospital, and fewer outpatient visits compared to non-participants.

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Funded through a grant from the Alabama Department of Senior Services, most of the current Certified Peer Specialists were trained in 2014 to be LWA program facilitators. Also in 2014, approximately 15 Certified Peer Specialists facilitated five LWA workshops at local community-based service sites for consumers across Jefferson County. This year, 10 more Certified Peer Specialists have been trained, leaving JBS with a total of 18 facilitators (some of the original facilitators have left the program). In 2015, eight more community-based sites are scheduled to host workshops to reach approximately 110 consumer participants.

Results and Impact

This could be the beginning of a 'Whole Health' collaboration effort between the Alabama Department of Mental Health and ADPH, which could prove significant for future funding that may support Medicaid policy changes in the near future as well as attract other grants to improve the health and quality of life for Alabama consumers in mental health recovery.

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Chronic Disease Self-Management Education Success Story

*Creating a Workforce:
AmeriCorps Members Embody Self-Management*



Contact Name: Jenna Burke

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Background

The identified community need is the expansion of a volunteer, peer-to-peer, chronic disease self-management program with a focus in Maricopa County, Arizona's largest and most densely populated county. Many of Arizona's 15 counties have strong leadership organizations that have served as the hub for Chronic Disease Self-Management Program delivery within their counties; however, the expanse of Maricopa County presented challenges during the American Recovery and Reinvestment Act (ARRA) grant from 2010-2012.

Time Period of Achievement

September 2012 to August 2015

Location of the Story

Maricopa County, Arizona

Key Organizations Involved

The Department of Health's Chronic Care and Disease Management Team, Health Promotion and Wellness Team, Office of Special Healthcare Needs, and external stakeholders collaborated in the creation of the Community Health Network. The following programs and agencies were part of the collaborative:

- Technical Assistance Partnership
- St. Luke's Health Initiatives
- Arizona Living Well Institute
- Asian Pacific Community in Action
- Creciendo Unidos – Growing Together
- Maricopa Integrated Health Systems
- Orchard Community Learning Center
- Scottsdale Prevention Institute
- Tanner Community Development Corporation

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Population Served

The focus was on serving adults age 50+, including those in underserved communities, who are low income, and members of ethnic populations experiencing health disparities. This population was selected because, according to the Arizona Health Survey, 71% of Arizonans age 65+ reported having at least one chronic condition in 2008. Twenty percent of this population reported having three or more chronic diseases, with minority populations bearing the greatest chronic disease burden. The need for chronic disease self-management is widespread. According to the National Patient Safety Foundation's Partnership for Clear Communication, two out of three US adults age 60+ have low literacy skills, pointing to the need for health promotion materials that require minimal reading. People with low health literacy and chronic diseases have less knowledge of their disease and its treatment and fewer self-management skills.

Intervention

During the course of the ARRA funding awarded to the Arizona Department of Health Services (ADHS), there was a clear realization that there were strong partners in northern and southern Arizona to manage a network of volunteers to provide Chronic Disease Self-Management Education (CDSME) throughout their regions. But, there was a problem in Central Arizona. We identified a lack of leadership at the ground level in Arizona's largest county. The Arizona Living Well Institute (AZLWI) discussed this barrier with St. Luke's Health Initiatives (SLHI). SLHI suggested workforce development and expansion by applying for an AmeriCorps grant. The Technical Assistance Partnership (TAP) offered to be the fiscal sponsor to maximize the capacity of AZLWI to run the project without having to manage the money.

Once awarded the AmeriCorps State Formula Grant in September 2012, AZLWI and SLHI, in partnership, began interviewing key stakeholder organizations in Maricopa County who were interested in hosting AmeriCorps members at their sites. These organizations had been connected to AZLWI for a minimum of one year prior to joining the AmeriCorps project. In late October 2012, AZLWI and SLHI hosted the first orientation for AmeriCorps, and the Living Well CommunityCorps was formed. Year 1 (2012-2013) was purely a learning year. We assembled the team of host organizations and created our policies and procedures, but we lost AmeriCorps members due to poor communication.

During Year 2 (2013-2014), we took our lessons learned and contracted with Saguaro Evaluation Group to support independent site visits and qualitative evaluation of our project. The key lessons learned were 1) host sites wanted to learn about one another and the work they were doing and 2) members and managers wanted to meet and network face-to-face. We implemented monthly conference calls and twice a year face-to-face meetings.

Year 3 (2014-2015) has brought with it terrific communication, even with extensive staffing changes. We sustained the monthly calls but increased face-to-face calls to four times per year. The face-to-face meetings have served as training opportunities as well as networking chances for members and site managers. We still retained Saguaro Evaluation Group to facilitate these quarterly meetings as well as the once per year site visit and follow-up phone calls.

Challenges/Barriers to Success

It was difficult for our sites to understand how important communication was with their members and with us as the project management.

Some host organizations were unfamiliar with volunteer management practices including the project management organization, Arizona Living Well Institute. This was not realized until mid-year during the second year, and training on these practices was not implemented until the third year.

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Results and Impact

We now have a core of seven stable host sites that house 31 AmeriCorps members who are trained in multiple CDSME programs (chronic disease, diabetes, chronic pain, and cancer) in both English and Spanish. Fifteen of our AmeriCorps members are in their third year of service which has created a stable pool of leaders who continue to expand their skills while learning more and more about their community.

These AmeriCorps members truly serve as community health workers as they are a part of the communities that they are serving. Many were actually were already volunteering for the organizations before the AmeriCorps opportunity arose.

Implications

Think creatively about your needs/barriers. Sometimes the needs are more than money. Yes, we needed money to create a workforce, but we decided to address the need in a different way.

As a next step, the project team will re-apply for another three years of funding to continue the Living Well CommunityCorps.

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Chronic Disease Self-Management Education Success Story

*Stretching Existing Resources to
Maintain CDSMP in Rural Counties*



Contact Name: Lora Connolly

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Background

The California Public Health Institute (PHI) applies for and administers federal public health grant funding on behalf of the 12 most rural counties in the state. Under the Institute's Community Transformation Grant (CTG), several of these counties had been providing the Chronic Disease Self-Management Program (CDSMP) through a group license with Stanford and with technical assistance from the Institute's staff.

For many years, the California Department of Aging (CDA) and the California Department of Public Health (CDPH) have actively collaborated with PHI to incorporate all of the counties involved in offering CDSMP in the California Healthier Living Coalition. The Coalition provides technical assistance via webinars, in-person meetings, and online resources; and members share challenges and best practices.

When the CTG program was terminated in September 2014, PHI lost their staff position, and the public health agencies offering CDSMP workshops lost their funding. In some counties, the key staff person who had been involved transitioned to another position or left the agency.

Time Period of Achievement

CDA and CDPH became aware that the Stanford license for these rural counties had been "maxed out" in January 2015 and inclusion of these eight public health agencies in the California Healthier Living Coalition is underway (March 2015).

Location of the Story

The eight rural counties involved include: Calaveras, Imperial, Madera, Mendocino, Merced, Shasta, Solano, and Tulare.

Key Organizations Involved

CDA, CDPH, Partners in Care Foundation (as technical assistance center) and the eight rural county public health agencies listed above.

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Population Served

Adults with chronic health conditions in these eight rural counties with high poverty rates and very limited health care infrastructure.

Intervention

After one of the rural counties contacted Partners in Care Foundation in January 2015 seeking information about whether they could be included in Partners' Stanford group license, we became aware that the rural counties' license with Stanford had been fully used. We (CDA and CDPH) wanted to reach out to these counties to identify whether they had and planned to continue offering CDSMP workshops and had purchased their own Stanford license and what training and technical assistance (TA) they needed to continue offering the Stanford program.

The public health agencies had already dedicated resources and developed alliances to make CDSMP workshops available in their communities. We did not want to see this investment lost if modest support could help maintain the needed program infrastructure.

CDA, CDPH, and Partners in Care quickly developed and sent a survey to the public health agencies to identify specific support needs. Based on the responses, all of the counties that plan to continue offering CDSMP have been invited to join the California Healthier Living Coalition (if they do not already belong). Their specific training, licensing, and other TA needs will be incorporated in CDA's current federal grant funding, and the CDPH may also be able to provide resources to address these needs.

Challenges/Barriers to Success

CDA and CDPH have collaborated in supporting expanded access to the CDSMP since California's first grant in 2006. We have been "braiding" our federal funding to leverage these resources and have invested time in creating common data collection processes, a shared website, and strong ongoing communications to support collaboration at the county level between the aging and public health networks. The loss of the CTG funding was a setback of these efforts. However, it was an opportunity to identify what could be done to preserve CDSMP and DSMP workshops in these counties. The challenge is that CDA is in the third and final year of its federal CDSME grant; therefore, the support we are able to offer these rural counties is limited to the current project year.

Results and Impact

Providing support to these eight rural public health agencies will assist them in being able to make the CDSMP and DSMP available to adults with chronic health conditions in their counties.

Implications

This situation underscores the importance of collaboration and that shared commitment at all levels—from the local community up to the state level—can make all the difference in whether a situation becomes a setback or an opportunity to start something new. While our collaboration in California will not replace the lost CTG funding, it will help to maintain the availability of CDSMP in these rural areas in the coming year.

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Chronic Disease Self-Management Education Success Story

*Health Systems, Networks,
Contracts, and CDSME*



Contact Name: Dianne Davis
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Background

As funding streams continue to decrease, organizations that offer chronic disease self-management education (CDSME) need to find additional ways of supporting and sustaining self-management programs. One pathway is to begin partnering with at-risk organizations (accountable care organizations, health systems, and managed care organizations) that are moving toward population health.

Time Period of Achievement

From the start of conversations with Blue Shield of California to the implementation of the Contact Center was eight months. This involved negotiating contracts, building a CDSME workshop network, and establishing a Contact Center.

Location of the Story

This initiative/contract covers the state of California starting with six southern California counties.

Key Organizations Involved

Blue Shield of California, Partners in Care Foundation, and 14 network partners

Population Served

Blue Shield members enrolled in their Disease Management program, (member has asthma, chronic heart failure, chronic obstructive pulmonary disease (COPD), coronary heart disease, or diabetes), 18 years of age or older.

Intervention

Partners in Care's Goal:

1. Develop a network of aging services agencies, public health, and community-based organizations to enhance the spread and sustainability of the chronic disease management programs.
2. Develop contracts with at-risk organizations to foster additional funding streams for these programs.

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Blue Shield of California's Goal:

1. Launch pilot program to compare outcomes of health plan members participating in either:
 - a. Health plan's current outsourced disease management program, or
 - b. Health plan's current outsourced disease management program and CDSME programs in English and Spanish.

Impetus for a managed care organization to develop a pilot program focused on CDSME, Institute of Health Improvement's Triple Aim:

- Move to new payment structures from units of care (lab tests, doctor visits, MRIs) to reimbursements for keeping a population healthy;
- Increase in providers/at-risk organizations' incentive to refer their patients to self-management programs. As patients become better able to self-manage their chronic conditions, this should decrease the need clinical services; and
- Reduce the number of emergency department visits, hospitalizations, less invasive treatments;
- Resulting in the reduction in per capita cost; and
- Patients maintain their health, increase their quality of life, and slow the progression of their chronic condition.

Criteria for organizations that will provide self-management services:

- Meet quality, volume, confidentiality, geographic area, and IT needs of the large managed care/health care organizations;
- Demonstrate their value in terms of the Triple Aim.

Steps to develop and implement a contract with a managed care organization:

- Secure health plan contract
- Develop pricing structure for two components of the program
 - Outreach and engagement
 - CDSME program delivery
- Negotiate contract language and price
 - Vetting of IT HIPAA/HITECH compliance for Partners in Care and all subcontractors (very time consuming and highly detailed)

2. Develop network – single point of entry for health plan and member assessment and referral to services
 - a. Assess reach and capacity of partnering community-based organizations with providing programs and services;
 - b. Execute nondisclosure agreements and business associate agreements with all network subcontractors;
 - c. Execute network subcontractor partner agreements;
 - d. Develop and provide network training concerning contract requirements with managed care organization; and
 - e. Use a mapping function to overlay the sites where CDSME programming is provided with disease management enrollees.

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3. Develop member intervention
 - a. The intervention is a three-tiered approach utilizing:
 - i. Direct mail to introduce the program;
 - ii. Outreach via Interactive Voice Response (IVR) messaging; and
 - iii. Affirmative transfer to enrollment specialists who use motivational interviewing techniques to enroll members in Chronic Disease Self-Management Program (CDSMP) and/or Diabetes Self-Management Program (DSMP) in English or Spanish (in-person workshop at affiliated CBO partner location, online program with contracted vendor, or mail-based toolkit fulfilled by Partners in Care Contact Center).
4. Contact Center/Communication Systems
 - a. Member outreach, engagement, and enrollment to one of the three CDSME modalities;
 - b. Very IT intensive; and
 - c. Need Contact Center specialist to manage operations.

Challenges/Barriers to Success

1. Time – Need to allow 6-12 months from planning to launch. Vetting of interventions, IT standards, subcontractors took a lot of time.
2. Cost – Significant expense to setting up IT systems and contact center.

Results and Impact

Major accomplishments include: being awarded the contract from Blue Shield of California; building a CDSME workshop network in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura counties; and assembling, staffing, and implementing a contact center.

The initiative/contract effective date is April 1, 2015; therefore, the impact is not yet known. Blue Shield will be conducting a random trial of 100 members comparing those that participated in the current outsourced Blue Shield Disease Management program and those that participated in the Blue Shield Disease Management program plus this Chronic Disease Self-Management pilot. If the trial shows positive results, Blue Shield plans to move the program from a pilot status to offering it to accounts in 2017. However, initiating this pilot program enhances the collaboration between health systems and proponents of self-management programs and should increase access to CDSME workshops.

Implications

The lesson learned is to begin early. Building a network, doing the associated paperwork to execute contracts, meeting all the IT requirements, and developing a contact center with the needed equipment, software, and staff can take from 8-12 months.

The next steps are to complete the statewide network by setting up network contracts within each county to offer CDSMP workshops to members. After the network is established, new contracts need to be secured. We also plan to continue updates and improvements to IT infrastructure, as well as hire and retrain staff to maintain the systems.

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Chronic Disease Self-Management Education Success Story

*Integrating CDSMP
into the Comprehensive Primary Care Initiative*



Contact Name: Susan Milligan, Ellen Pihlstrom

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Background

Poudre Valley Health Care's Community Health Improvement Department has been supportive of programs to help our community members fulfill our mission to "improve lives through relevant, integrated strategies and proven methods that impact health and wellness." In 2002, the Community Health Improvement Department was looking for evidence-based programs for our clients. Stanford University's evidence-based Chronic Disease Self-Management Program (CDSMP) aligns directly with our mission and vision and therefore was selected as one of these programs. Hospital management approved assigning the former Community Health Education Coordinator, Susan Milligan, R.N., to become a CDSMP leader and ultimately, master trainer. Susan led this effort for more than 10 years, creating linkages with community medical groups and replicating the pre/post research conducted by Stanford University.

Time Period of Achievement

Establishing linkages with physician groups started in 2012, and we continue to build these relationships.

Location of the Story

This initiative was established in Larimer County, which spans more than 2,600 square miles in North Central Colorado.

Key Organizations Involved

University of Colorado Health/Poudre Valley Health Care, Associates in Family Medicine, and Colorado Health Medical Group

Population Served

Anyone in Larimer County who lives with a chronic disease, diabetes, and/or pain

Intervention

To achieve success, we:

- Continually kept abreast of current issues in health care.

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- Collected pre- and post-workshop data since 2003 (six months after the workshop ended), as well as testimonials from participants to highlight program effectiveness.
- Learned what the Comprehensive Primary Care Initiative included and what outcomes were needed.
- Met with the executive director of Associates in Family Medicine and provided the program overview, results, and the participant data.
- Correlated what participants learned in the program to the needed outcomes of the Comprehensive Primary Care Initiative.
- Engaged the executive director in our enthusiasm for the program and helped him to see that with a small amount of time spent on the referral, patients could get the needed encouragement to self-manage their health and experience better health outcomes. Similar steps were taken with the CEO of Colorado Health Medical Group.
 - We are fortunate to be able to offer these classes at no cost to participants because of the support from the University of Colorado Health, U.S. Administration for Community Living, Comprecare Foundation, Larimer County Office on Aging, and WISH Foundation.

Once the executive director of Associates in Family Medicine and the CEO of Colorado Health Medical Group were convinced and engaged, we began working with our Quality Assurance Coordinator on ways to make referrals through patients' electronic medical records.

A Health Care Feedback form is given to the participants during the fifth session to be returned to the leaders the following week. The form – which asks participants to share what they learned through the workshop, to identify what helped them the most, and to set short-term action plans and long-term goals – is then given to the Quality Assurance Coordinator to share with the participant's physician, after which it is placed in the patient's medical file.

It was agreed that Poudre Valley Health Care would provide the support (books, charts, leaders, office supplies, training). Physician groups were encouraged to support the program by allowing some of their staff to lead workshops. Poudre Valley Health Care provided CDSMP leader training at no charge for staff from both physician groups. We have trained three staff members from Associates in Family Medicine and two from Colorado Health Medical Group. Working closely with these groups, we offer about 12 workshops per year.

Challenges/Barriers to Success

- We are continuing to work with the electronic medical record (EMR) staff to make direct referrals through the EMR.
- We continue to remind and promote CDSMP to physicians.
- Some referrals are very difficult. Patients are often too overwhelmed to add a six-week workshop to their schedule. We continue to follow up with them for several months, encouraging them to attend.

Results and Impact

A very positive working relationship has been established with the Associates in Family Medicine and Colorado Health Medical Group.

Those who most need the intervention are given the opportunity to participate at no charge. Leaders and participants of the CDSMP classes often come back with impressive stories about how the program has changed their lives. As leaders, we get wonderful feedback that we are guiding people to live a healthier life through self-management.

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Implications

We will continue to build and promote partnerships throughout the community, especially with health care providers.

There is an ongoing need to market the program and remind the community and health care professionals about the availability of the program.

We will continue to work closely with those in charge of the EMR to incorporate an easy way for physicians to refer to CDSMP.

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Chronic Disease Self-Management Education Success Story

*Sustaining CDSME Partnerships with Title IIID
Older Americans Act Funds in a Regional Health System*



Contact Name: Sarah Gauger

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Background

There is often a problem with community partners sustaining CDSME due to the inability to reimburse for program coordination and facilitation of workshops.

Time Period of Achievement

Approximately one year

Location of the Story

Griffin Hospital in Derby, Connecticut is a regional hospital system located in the lower Naugatuck Valley of South Central Connecticut

Key Organizations Involved

Griffin Hospital and the Agency on Aging of South Central Connecticut (AASCC)

Population Served

The target population served is community dwelling adults and persons with disabilities with chronic conditions in the Griffin Hospital region.

Intervention

- For many years, Griffin Hospital received Title IIID funds from AASCC for senior outreach and information and referral. These funds were used for blood pressure screenings and falls prevention as part of the Valley Parish Nurse Program in the lower Naugatuck Valley.
- After Griffin sponsored a Chronic Disease Self-Management Program (CDSMP) workshop in late 2013 and the Director of Griffin's Community Outreach and Parish Nursing program saw how the programs benefited hospital participants, she decided to have parish nurses and volunteers trained to facilitate the CDSMP and Diabetes Self-Management Program (DSMP) Live Well Programs.

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- A Live Well leader training was held in February 2014 at Griffin Hospital. For the 2014-2015 grant year, AASCC issued a request for proposals. Griffin Hospital submitted an application requesting funding from AASCC to pay their trained leaders to hold Live Well programs in the lower valley region. Subsequently, AASCC awarded funding to Griffin to reimburse facilitators to offer the workshops under Title IIID.
- Every month, the director sends invoices for payment to AASCC. All trained leaders must submit the applicable data collection sheets to the CDSMP/DSMP regional coordinator (housed at AASCC) for the Live Well Program. The director's staff and parish nurses continue to offer these workshops throughout the year. An annual program site visit is made by the AASCC program coordinator.

Challenges/Barriers to Success

The greatest challenge initially was how Griffin was going to be able to continue to offer community health outreach programs with the transition of Title IIID requirements to 100% evidence-based programs. Griffin had been an outstanding community partner and had received Title IIID funding for a number of years but was in jeopardy of losing the funding as a result of the change in program requirements.

Results and Impact

Both DSMP and CDSMP workshops are held on a regular basis at Griffin Hospital and in the community. In spring 2015, two DSMP and two CDSMP workshops are being sponsored by Griffin. The workshops are offered at no cost to participants in the region. Participants benefit directly, and a vital connection is made between the participants and the health system whose primary mission is to “empower individuals to be actively involved in decisions affecting their care and well-being through access to information and education.”

Implications

Many of the resources needed to maintain program sustainability are right in front of us. We just need to open our minds to the resources we already have.

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Chronic Disease Self-Management Education Success Story

*Prioritizing CDSMP Sustainability
Partnerships in the District of Columbia*



Contact Name: Joni Eisenberg

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Background

The District of Columbia (DC) has a need, as do many jurisdictions, to sustain the delivery of Chronic Disease Self-Management Program (CDSMP) workshops beyond the reach of any one particular grant. The DC Department of Health (DOH) has been the lead agency coordinating CDSMP workshops, with support from a one year National Association of City & County Health Organizations (NACCHO) grant. To sustain the workshops beyond this year, we need ways to cover the direct costs for conducting workshops (including recruitment of participants, materials, stipends for lay leaders, and space for workshops).

Time Period of Achievement

August 2014-March 2015 (ongoing)

Location of the Story

District of Columbia

Key Organizations Involved

DOH has convened a “DC Living Well with Chronic Conditions Partnership.” Emerging from this partnership has been at least five specific organizations that have been able to open the door toward sustainability of the District’s targeted CDSMP workshops. These organizations include three partners that have made commitments to sponsor a certain number workshops through payment of some of the costs associated with the program, such as materials and peer leader stipends.

- One of the Senior Wellness Centers affiliated with the DC Office of Aging (DCOA) has identified federal (Title III) funds that can cover the costs of a series of 2015 workshops. The funds may be available in future years, and other DCOA affiliated centers may also apply for the funds in future years.

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- United Health Care (an insurance company) has offered to sponsor two CDSMP workshops this year, targeting a specific community-based organization within the Partnership (the Ward 7 Health Alliance).
- Unite Here Health is an arm of a national labor organization representing low wage workers, most of whom obtain their health care via Kaiser Permanente. DOH entered into a partnership with United Here Health to conduct CDSMP workshops in DC for members with chronic disease.

In addition to the three groups, two community-based organizations involved with our Partnership have helped pave the way for CDSMP sustainability: the Community Wellness Alliance (CWA) and the Ward 7 Health Alliance. CWA has helped to create an infrastructure to move the CDSMP initiative forward. The Ward 7 Health Alliance has committed to help with sponsorship of several workshops in priority neighborhoods.

Population Served

- Targeted populations served by the District's CDSMP workshops include wards with the highest rates of chronic disease (Wards 5-8), as well as specific settings within the wards (such as public housing units); and
- Select employees of partnering organizations, such as low wage workers who are members of Unite Here Health.

Intervention

- **Prioritized sustainability as a top goal** based on lessons learned. Years ago, DOH had obtained a large CDSMP grant and conducted a significant number of workshops. However, several years after the grant concluded, there was no remaining evidence of any CDSMP activity.
- **Maintained an early open door policy for potential sustainability partnerships.** Very early (June 2014) in the development of the District's new CDSMP initiative, the DOH CDSMP coordinator received an email from NCOA about a potential partnership with Unite Here Health. Recognizing the potential for sustainability, we immediately leaped at the opportunity to collaborate. The rest is history.
- **Ongoing involvement with CBO health networks in targeted communities.** Although there are a plethora of health-related coalitions in the District, the number of community-based and community initiated health coalitions and networks dedicated to serving populations with the highest rates of chronic disease is limited. Through ongoing participation in such networks, the DOH CDSMP coordinator has been able to make the connections and pave the way for sustainability opportunities.
- **Convened a CDSMP partnership with a mix of organizations** (including CBOs and third party payers). One key goal of the Partnership is to set the tone for ongoing collaboration to ensure the sustainability of CDSMP workshops to targeted populations.
- **Seized on opportunities.** Prioritizing sustainability as a goal has meant ensuring that sustainability opportunities were maximized as they presented themselves.

Challenges/Barriers to Success

Although a great deal has been achieved toward the creation of CDSMP sustainability partnerships, the coordination of CDSMP workshops still requires substantial support from DOH. Long term, the way to achieve sustainability is to receive support from Medicaid and Managed Care Organizations, a process not yet begun.

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Results and Impact

- Resources were secured from a mix of five organizations that will provide key fiscal and organizational support for conducting additional CDSMP workshops in 2015, with potential for additional ongoing resources in future years.
- A foundation has been laid to conduct a select number of CDSMP workshops to communities with highest rates of chronic disease in the District without DOH obtaining an additional grant.

Implications

- Steps toward sustainability of CDSMP workshops can be made with minimal effort if the coordinating agency keeps their “eyes on the prize” and prioritizes sustainability as a top goal, while reaching out to a diverse group of organizations and institutions that have both the potential resources to support CDSMP and the will to serve underserved communities.
- Outcomes are sometimes achieved through unanticipated opportunities. For example, although DOH has maintained an ongoing relationship with DCOA, the opportunity for fiscal support for three CDSMP workshops came by way of a new Senior Wellness Center Director, with no direct connection to the central DCOA office. The Senior Wellness Center Director was aware of the CDSMP workshops because one of the nutritionists on staff had been trained as a CDSMP lay leader and wanted to promote the workshops at the Center.

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Chronic Disease Self-Management Education Success Story

CDSMP and Transition Centers



Contact Name: Megan Moulding Stadnisky

Organization: Georgia Department of Human Services Division of Aging Services

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Background

Offenders with chronic conditions returning to the community without adequate resources to support their health

Time Period of Achievement

Last quarter of 2014

Location of the Story

Atlanta, Georgia in a federal transition center

Key Organizations Involved

Urban League of Greater Atlanta, Georgia Department of Human Services, Georgia Department of Corrections, Georgia Division of Aging Services, Governor's Re-entry Task Force

Population Served

Inmates of a federal transition center

Intervention

In partnership with the above mentioned agencies, the Division of Aging Services (DAS) Chronic Disease Self-Management Education (CDSME) Coordinator presented multiple times to the Governor's Re-entry Taskforce about the Chronic Disease Self-Management Program (CDSMP), including benefits other states had experienced by offering this program to offenders within various correctional facilities. The Urban League of Greater Atlanta received a grant to implement multiple programs within federal and state transition centers in the Atlanta metropolitan region. After hearing about CDSMP, the Urban League team invited the DAS CDSME Coordinator to pilot a CDSMP workshop with residents at a federal transition center. Within two months, the workshop was scheduled and participants recruited.

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Challenges/Barriers to Success

(1) Continued funding and sustainability to offer CDSMP in additional facilities; (2) Residents in transition centers are focused on obtaining employment that they will be able to keep once released into the community; therefore, CDSMP may not be a priority for all who could potentially benefit; and (3) Some transitioning residents in the centers are released early or transferred without notice.

Results and Impact

75% of the original participants completed the six-week workshop. Of those who did not complete, one was granted early release and one obtained full time employment. Department of Human Services representatives within the Commissioner's office, transition center staff, and Urban League executives attended the graduation. Participants made great personal strides with their physical and mental health and shared their personal stories with the staff and decision makers who were in attendance.

Offenders within correctional facilities age faster than those in the community and suffer with multiple chronic conditions. If we are able to offer more workshops to residents of transitional facilities, in theory, we will have citizens returning to the community with tools to improve and/or sustain their health. Better health can contribute to maintaining employment and engaging in positive relationships with family and friends.

Implications

A recruitment session is definitely needed. Leaders should meet potential participants prior to the beginning of a workshop. Transition Center staff need to have full understanding of the program's objectives and can help support participants outside of the workshop.

Next steps include working with Georgia Department of Corrections, Urban League, and Department of Human Services to secure funding to implement workshops in state transition centers across the state. The DAS CDSME Coordinator helps to establish partnerships with Area Agencies on Aging (AAA) and Department of Corrections to forge these local level partnerships, which can also serve to help AAAs sustain the implementation of CDSMP workshops within the community.

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Chronic Disease Self-Management Education Success Story

*New Marketing Materials
Help Leaders in Kansas Engage Partners*



Contact Name: Ariel Unselt

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Background

- Kansas has lacked effective marketing materials and consistent messaging that is easily accessible.
- Kansas City overlaps states, Kansas and Missouri, causing confusion for Chronic Disease Self-Management Education (CDSME) leaders and partners. The Missouri Arthritis Program currently has a *We Do CDSME* marketing campaign that has been well received. Kansas needed to take this into consideration, while determining how to proceed with updating marketing materials and developing consistent messaging.
- Leaders have expressed the need for marketing materials targeted towards specific types of organizations, such as health care systems and worksites, in order to recruit partner organizations and participants. Targeting marketing materials assists leaders in recruiting organizations to embed CDSME programming within their systems.
- KDHE has recently partnered with Kansas Foundation for Medical Care (KFMC) to streamline program implementation. KFMC is the only other active license holder of Stanford programs in Kansas. This partnership will increase collaboration between leaders trained by both organizations and a more immediate need for consistent marketing materials across the state.

Time Period of Achievement

The Kansas Arthritis Program (KAP) began discussing targeted marketing materials with partners in August 2014 and received the completed designs from Nye & Associates in February 2015.

Location of the Story

The marketing toolkits are intended for the use by all Kansas leaders and partners and will be available on our self-management website. We hope that state personnel who are implementing CDSME programs will find the materials useful, as well.

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Key Organizations Involved

Kansas Department of Health and Environment, Kansas Foundation for Medical Care, Sedgwick County Health Department, Johnson County Health Department, Missouri Arthritis Program, Nye & Associates

Population Served

- CDSME leaders in Kansas
- Potential partners who can embed CDSME programming
- Health care patients
- Employees
- Older Kansas adults

Intervention

The Kansas Department of Health and Environment Arthritis Program:

- Organized strategic planning meetings with three Chronic Disease Risk Reduction grantees who are implementing CDSME programs. Each county is focused on targeting either health care systems or worksites to embed the programming. The grantees all noted how helpful it would be for them to have marketing materials with messaging specific to the organization type.
- Decided it would be the most beneficial to leaders and current partners to develop three marketing toolkits targeting worksites, health care professionals, and community organizations (faith-based, senior centers, and others).
- Discussed with the Missouri Arthritis Program the possibility of using their *We Do CDSME* campaign materials to develop KAP's toolkits. This would ensure that Kansas and Missouri had consistent marketing materials and decrease confusion among Kansas City residents.
- Researched which marketing materials already existed for worksites and health care systems, as well as what messaging was most effective (health care professionals – cost, convenience, credibility; worksites – return on investment, money saved; community organizations – personal stories). KAP also compared national data to Kansas data to determine what would be most effective in the toolkits.
- Laid out content for each component of the toolkits such as flyers, fact sheet, table tents, and calendar posts. All toolkit component content was sent to leaders, partners and colleagues for feedback.
- Made appropriate edits to toolkit components based on feedback received.
- Contracted with a third-party vendor to design toolkit components based on the Missouri Arthritis Program's *We Do CDSME* campaign and included the content that received feedback.

Challenges/Barriers to Success

- A short turnaround time hindered reviews from providers. We had a nurse on staff review the materials and provide guidance on what she thought would be most effective.
- KAP sent content from the worksite toolkit to KDHE's Worksite Wellness Specialist who forwarded it to organizations she has worked with in the past; KAP received very favorable feedback from Blue Cross Blue Shield of Kansas, as well as the Worksite Wellness Coordinator at the Sedgwick County Health Department.
- It will take an extended period of time to evaluate the effectiveness of the marketing toolkits to determine whether workshop participation is increasing within the partner organizations and the level of organizational recruitment.

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Results and Impact

Major accomplishments: The greatest accomplishment thus far is how excited Kansas leaders are to use the toolkits. Leaders are enthusiastic about the simple design and messaging, as well as the bright colors to attract people's attention. Having this resource available to leaders and partners will increase leaders' enthusiasm to engage others and increase program reach.

Bright, fun, and simple marketing materials will catch the eyes of partners, as well as potential participants of all ages. Leaders can use these toolkits to increase the number of partnering organizations embedding CDSME programming and promoting them to attract participants. The marketing materials also act as an incentive to potential partners, such as health care clinics and hospitals. Health care staff and physicians can use the materials in conjunction with putting a referral process in place to improve quality of life for their patients. Many leaders work with senior centers, nursing homes, and other organizations where the materials can be made available. Widespread dissemination of materials will make it the easy choice for older adults to attend a workshop to improve their health.

Implications

The short turnaround time for content feedback might have decreased the amount of responses received for suggested edits. In hindsight, KAP would have built a longer timeframe to allow partners and reviewers more time to provide feedback.

Next Steps: Develop a database to track organizations in Kansas using the targeted marketing toolkits. Promote continued collaboration among partners to facilitate the sustainability of CDSME programs.

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Chronic Disease Self-Management Education Success Story

Are You Sick and Tired of Being Sick and Tired?



Contact Name: Jennye Grider

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Background

Kentucky has a population of more than 4.3 million residents of which 42% live in rural areas, and a significant portion of the rural population resides in counties categorized as Appalachian. In fact, over half of Kentucky counties are considered 75% or more rural. While ethnic and racial diversity is increasing in Kentucky, it largely remains racially and ethnically homogeneous, when compared to other states across the U.S. The 2013 American Community Survey conducted by the U.S. Census estimates that 86% of Kentucky residents are non-Hispanic white. The African-American population of 8% is concentrated in the cities of Louisville and Lexington, with additional African-American population pockets in a limited number of Western Kentucky counties. Hispanics comprise only 3% of the population outside of Louisville. Only 1% of the population is estimated to be “not proficient” in English.

Two key social indicators, income and educational level, have major implications for the health status of Kentuckians. It is well documented that people with low income and/or low levels of education tend to suffer from poorer health and inadequate access to health care. Only 20% of Kentucky adults have bachelor’s degrees or higher, compared to 27% of adults, nationally. Furthermore, only 82% of Kentuckians have finished high school, compared to 86%, nationally. The 2012 Small Area Income and Poverty Estimates shows that 19% of all Kentuckians live under the poverty level, compared to 16% nationally. An additional 21% of Kentuckians have incomes between 100% and 199% of the federal poverty level, compared to 19% nationally.

Within Kentucky, the rural communities with the poorest health indicators are in the Eastern/Appalachian Region of Kentucky. The Appalachian Regional Commission (ARC) periodically assesses the economic well-being of the 399 counties in Appalachia using a model with four levels; with “distressed” representing the most troubled counties. More than two-thirds of Kentucky’s Appalachian counties are in this category, and eight of the ten poorest counties in the entire Appalachian region are in Kentucky. However, western Kentucky counties are also very rural in nature and have high rates of poverty and poor health outcomes. In the more urban areas of Louisville, Lexington, and Covington, health disparities cluster in neighborhoods with the lowest levels of income and education, just as in the rest of the state.

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Kentucky has among the poorest health rankings in the nation for many chronic conditions and risk factors. Behavioral Risk Factor Surveillance System data (2013) shows that:

- Kentucky has the 5th highest rate of obesity in the nation - 33.2%, compared to 28.9% nationwide.
- Kentucky ranks the 10th lowest in getting the recommended 150 minutes of weekly physical activity - 46%, compared to the national average of 50%.
- Kentucky has the 5th highest percentage of adults who have been diagnosed with high blood pressure - 39.1%, compared to a national median of 31.4%.
- Kentucky has the 18th highest rate of diabetes among adults in the nation - 10.6% of the adult population, compared to 9.7% nationally.

Time Period of Achievement

2010 to present

Location of the Story

Five County Area Development Districts (FIVCO ADD) - Rural Eastern Kentucky (Greenup, Carter, Boyd, Elliott, Lawrence Counties)

Key Organizations Involved

Kentucky Department for Aging and Independent Living, Kentucky Senior Centers

Population Served

Rural Kentucky

Intervention

- Initially market CDSME as Better Choices, Better Health, with the attempt to recruit new participants in rural eastern Kentucky. Developed flyers and distributed to senior citizen centers, churches, and housing complexes.
- Upon evaluation of the marketing strategy, there were limited responses, compared to other areas of the state.
- CDSME leaders collaborated to discuss the potential of rebranding CDSME as “Are You Sick and Tired of Being Sick and Tired?” and decided this could be a successful strategy.
- CDSME leader began to market as “Are You Sick and Tired of Being Sick and Tired?”

Challenges/Barriers to Success

When the original CDSME grant was awarded to Kentucky, the lead CDSME staff in the FIVCO region of Kentucky began to attend community meetings where she described CDSME and sought partners in rural eastern Kentucky. Kentucky is a very unhealthy state, and there has been a great deal of emphasis on improving health and reducing weight.

Professionals and other members of the community provided “push back” and comments that they were tired of hearing about how they needed to lose weight and improve health.

A FIVCO staff member reviewed the master trainer materials looking for ways to market the program. She went to small communities and posted flyers at churches, housing complexes, and senior centers with the phrase “*Are you sick and tired of being sick and tired? Then attend a Living Well workshop*” on the top of the flyer. She used positive messages from the training manual to market the program as something that would improve overall well-being and emphasized goal setting, stress relief, and better health.

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Results and Impact

Senior centers had full classes, a waiting list, and the highest rate of completers. Word of mouth from the participants was the most effective form of recruitment.

Implications

People perceive things differently. Sometimes trying a different approach can lead to a success. For example, changing the marketing of CDSME from “Better Choices, Better Health” to “*Are you sick and tired of being sick and tired? Then attend a Living Well workshop*” was an effective approach to recruitment and retention in rural Kentucky.

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Chronic Disease Self-Management Education Success Story

*Neighborhood Health Center Reaches a Diverse
Urban Population with CDSME*



Contact Name: Alexandra Avedisian

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Submitted by Ana Karchmer, CDSME Program Coordinator, Massachusetts Executive Office of Elder Affairs. Help was also provided by Christine McLaren, Healthy Living Center of Excellence Regional Coordinator at Old Colony Elder Services in Brockton.

Background

The Brockton Neighborhood Health Center (BNHC) serves an extremely diverse patient population including Brazilian, Cape Verdean, Haitian, Latino, Portuguese, African American, and Caucasian. Additionally, 74% of patients live in poverty, with 17% having income levels below 200% of the federal poverty guidelines. The health center currently offers primary, preventive and specialty health, mental health, and dental services to 27,589 patients, provided 160,520 patient visits in fiscal year 2014, and continues to grow rapidly. One of the health center's key tenets is to provide care and services in partnership with patients. As part of its patient care model, BNHC educates its patients about preventive health care, from disease transmission to substance abuse to nutrition, in order to achieve and maintain positive health outcomes. Taking personal responsibility for one's health is one of the most important lessons patients, young and old, learn. It is within this context that chronic disease self-management implementation is key to developing the self-management skills of BNHC patients.

Starting in 2012, BNHC collaborated with Old Colony Elder Services in Brockton to implement Tomando Control de su Salud. The offerings were limited in the beginning, with BNHC implementing two workshops with 11 completers. While the program could certainly benefit BNHC patients, the team faced many challenges to successful implementation. A new strategy needed to be implemented in order to have a success self-management education program at the health center.

Time Period of Achievement

Calendar year 2014

Location of the Story

Greater Brockton, Massachusetts

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Key Organizations Involved

- Old Colony Elder Services (OCES) has been partnering with BNHC since before 2012 to implement Chronic Disease Self-Management Education (CDSME). In the past year, OCES has functioned as the Regional Coordinating agency for the Healthy Living Center of Excellence and as such, provides training, technical assistance, and support in all areas of implementation. In addition, OCES staff co-facilitates workshops with BNHC staff;
- Local markets, banks, churches, and health care providers;
- The Brockton Housing Authority and Housing Coordinators; and
- Local Council on Aging.

Population Served

The vast majority (72%) of BNHC's patients resides in Brockton, but some patients come from surrounding communities. The CDSME workshops are open to anyone. In addition, 74% of BNHC's patients are living in poverty, and an additional 17% have household income levels below 200% of the federal poverty guidelines (\$47,100) for a family of four in 2013. 58% of BNHC's patients are female.

Intervention

- A more focused and deliberate recruitment strategy was implemented that involves individualized recruitment, using phone calls and home visits to develop personal relationships.
- Offer workshops in more convenient locations, such as residential public housing settings and adult day health centers.
- Engage Community Health Workers (CHWs) to help secure transportation and referrals to other services. For example, CHWs work with patients to enroll them in the local transportation service (GATRA) and coordinate with local Councils on Aging to provide transportation to workshops. CHWs also refer patients to SNAP, area food pantries, and Meals on Wheels to ensure that they have access to proper food choices.
- Develop a graduation ceremony to recognize participants' achievements. The health center's Chief Executive Officer (CEO), Chief Operating Officer (COO), and Chief Financial Officer (CFO) attend the graduations.
- Providers refer patients by electronic referral to CHWs and reinforce participation with patients.
- Offering CDSME in Portuguese increased access and participation.
- Collaboration with the Brockton Public Housing Authority and housing coordinators increased participation and patient engagement.
- CHWs are trained in various CDSME programs, which means they went through leader training a few times thus skills and comfort level were enhanced. BNHC has a total of six staff members trained in the various programs.

Challenges/Barriers to Success

- Transportation to workshops
- Financial situation
- Depression limits patients' energy, focus, and follow-through
- Serving a diverse patient population
- High incidence of chronic illnesses
- Need more bi-lingual groups leaders to implement in various languages
- Staff time/payment for groups offered at night

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Results and Impact

- In 2014, BNHC offered 17 workshops, reaching 270 participants and 233 completers (with a completion rate of 83%, higher than the state average of 77%). Eighty percent of program participants are African American and 7% Latino. Eighty seven percent of participants have a high school education or lower compared to 46% statewide. Eighty six percent have multiple health conditions; 72% have hypertension and 52% have diabetes.
- Most of the workshops offered have been CDSMP, but the health center has also offered Tomando Control de su Salud, Chronic Pain Self-Management, and Diabetes Self-Management. CDSMP was offered in both English and Portuguese in order to reach the high percentage of Cape Verdean and Brazilian patients (38% of BNHC patients).
- BNHC has already scheduled five workshops for the first half of 2015. Both the Chronic Pain Self-Management Program and the Chronic Disease Self-Management Program (CDSMP) will be offered.
- Partnerships with local organizations have been developed and/or strengthened through support for CDSME programs.
- BNHC staff members continue to support some of the skills learned at the workshops in order to sustain achievements.

Implications

- Enrollment requires persistence and direct outreach.
- Helping participants overcome barriers is critical to enroll people who can benefit most from the workshops.
- Asking other organizations for support is very successful and enables BNHC to provide a meaningful graduation which helps to sustain results.
- Collaboration increases community's support of healthy living.
- In public housing settings, word of mouth is a very effective recruitment tool.
- Use CDSMP as a building block and then invite patients to participate in disease specific self-management programs if appropriate (pain and diabetes).
- Program leaders sharpen their skills by being trained as leaders in the different Stanford programs.
- Support from the health care team is key.

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Chronic Disease Self-Management Education Success Story

Maryland's Evidence-Based Academy



Contact Name: Judy Simon

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Background

Maryland's Evidence-Based Academy was developed in order to:

- Address identified knowledge gaps and increase skills of local Living Well coordinators;
- Recognize and encourage strong relationships between aging and health partners for the purpose of building a sustainable network after the grant period; and
- Invest in skill building and professional development for local partners to help ensure overall success and sustainability of the Living Well program.

Time Period of Achievement

February 2013 through present, annual Evidence-Based Academies

Location of the Story

This initiative is located statewide. The Academy is held in a central location so that all partners are able to participate.

Key Organizations Involved

Maryland developed a Leadership Team to guide the activities of the grant. Team members included: Maryland Department of Aging (MDoA), Maryland Department of Health and Mental Hygiene (DHMH) [including the Office of Population Health, Office of Minority Health and Minority Health Disparities, and the Center for Chronic Disease Prevention and Control], MAC, Inc. [AAA charged with developing Living Well over eight counties], Consortium for Older Adult Wellness (consultants), Center for Excellence in Aging and Community Wellness, Quality & Technical Assistance Center (consultants)

Population Served

Local Living Well (CDSME) coordinators; Secondary audience: AAA directors, local health partners

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Intervention

We have held two Evidence-Based (EB) Academy events. Prior to developing the Academies, we held an introductory grant kick-off event to set the stage for expectations for grantees. Information about the kick-off event can be obtained upon request. The EB Academies are 1 ½ day events that include an evening awards banquet. Beginning with the second Annual Evidence-Based Academy, CEUs were offered.

MDoA convened a Leadership Team that planned all aspects of the kick-off event and Academies over the months prior to each event. Attendance at the EB Academy events was mandatory for grantee coordinators. We used grant funds to pay for travel and lodging expenses for two staff from each area. Additional staff were welcome to attend but not paid with grant funds.

Evaluations showed that the Academies have been a big success. Participants were very pleased with the content and felt that they learned valuable information. Our consulting partners at COAW have been instrumental in helping to develop and implement each event.

See below for details about each event. Presentation slides and other event materials are available upon request.

Kickoff event on February 14, 2013 was held to set the stage for local aging partners regarding vision, expectations, and requirements of the grant, and to gain buy-in from prospective grantees as we build on our successes from previous years' experience delivering the Living Well program. The agenda included the following:

- Statewide Vision & Partnership Networks, including history of Living Well successes in Maryland and a presentation about Maryland's ADRC;
- Fidelity and Resource Planning;
- Grant Participation and Requirements – including institutional review board requirements for confidentiality and requirements for semi-annual self-assessments; and
- Training Academy Skill Building Activities – this included an interactive session on holding workshops, recruiting, and other practical aspects for delivering the program.

1st Annual Evidence Based Academy – September 9-10, 2013

1½ day learning conference for Living Well Coordinators. Topics were chosen based on a survey sent to the coordinators asking them what information that would be most relevant for them. Topics included:

- The new health care landscape and its relevance to CDSMP (making the case to health care professionals)
- Fidelity
- Partnerships
- Messaging

Some of the sessions were split in two tracks – one that provided basic information, and one that provided information for more experienced coordinators. In addition, the meeting featured roundtable discussions for coordinators to learn from the experiences of their peers. Three coordinators presented information on work they were doing that could be useful to others.

In the evening of the first day, we held an awards dinner to congratulate grantees on successes achieved during the year.

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At the end of day two, all participants set an action plan for what they would accomplish in the next week, based on what they learned in the Academy. This was followed up several weeks later with a conference call to report on our successes with the action plans.

2nd Annual Evidence Based Academy – August 18-20, 2014

The same structure was used as the previous year, but we also invited health partners to participate. In addition, we invited AAA directors to participate on day two in order to get their buy-in for long-term sustainability of the program. In addition to local staff, the Academy was attended by representatives of the state health department, key leadership at the Department of Aging, and a new hospital partner. Topics continued to focus on partnerships with health care, and also included the following:

- Sustainability
- Where we are with continuous quality improvement (CQI) measures
- Cultural competency (in particular, outreach to African American community, a focus of our grant)
- Panel discussion about partnering with health care
- Update by the sustainability workgroup highlighting the critical importance of evidence-based programs/CDSME as a key component of AAA services

In the evening of the first day, we held an awards dinner to congratulate grantees on successes achieved during the year. In addition, we had speakers to present a national perspective of CDSMP.

At the end of day two, all participants set an action plan for what they would accomplish in the next week, based on what they learned in the Academy. This was followed up several weeks later with a conference call to report on successes with the action plans.

Challenges/Barriers to Success

Using the expertise of consultants was of prime importance in making the events successful, interesting, and useful to the participants. Each partner on the Leadership Team contributed immensely to each event. We recommend using a team approach and learning from participants what their needs are to provide a balanced, well-coordinated event where all participants walk away excited to work on something new that they have learned.

For the first Academy, participants were dubious about a 1½ day event that took them away from their “real” jobs. Everyone was pleasantly surprised to find that the Academy was worth the time away, and they were genuinely excited to go back and use the information learned from their participation.

The challenge for the second Academy was to ensure that we built upon the enthusiasm and success of the first Academy, so that the participants came away with the same excitement and determination to apply what they learned.

Engaging AAA directors was a challenge. Not many were able to attend, even though we offered to pay their travel and lodging costs. However, the ones who did attend found it useful, and we are hopeful that they will spread the word to their colleagues for future Academies. MDoA formed a Sustainability Workgroup with interested AAA directors during the year prior to the Academy, to explore ideas for long-term sustainability. This workgroup presented at the Academy and encouraged their colleagues to attend.

Results and Impact

AAA grantees are developing meaningful partnerships with their peers to build sustainable networks and improve efficient use of the workforce (i.e., sharing leaders, trainers, other resources across jurisdictional

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and agency boundaries). Because of the opportunities for networking and shared learning that were built into the agenda, coordinators are now more willing to ask for and offer assistance to one another.

While many of the local coordinators were already working with health care providers, new in-depth information about the health care landscape, including terms and definitions, was provided to increase confidence in their abilities to further the partnerships.

The most salient impact is that as a result of their increased confidence, local coordinators are providing more workshops in health care settings and are getting more referrals from health care providers. We are not there yet, but progress is being made.

Implications

- Use of a core leadership team and the expertise of consultants to plan and implement the conferences contributed to the success of the events.
- When attendance is mandated, it is important to deliver a quality product.
- Leveraging grant funding was effective in getting people to attend the events.

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Chronic Disease Self-Management Education Success Story

*Partnering with Health Care Systems
to Improve the Lives of Cancer Survivors*



Contact Name: Leigh Ann Eagle, Executive Director
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Email: lae2@macinc.org

Background

In 2010, a total of 27,801 new cases of cancer were diagnosed in Maryland. Cancer is the second leading cause of death in Maryland, accounting for 23.7% of all deaths in 2010. A total of 10,249 Maryland residents died from cancer in 2010. Maryland ranks 24th among all states and the District of Columbia in total cancer mortality for the period 2006-2010.

MAC, Inc. has had a robust program to serve breast cancer survivors since 2007. Its services include patient navigation, wellness and holistic services, such as chiropractic, gym (including warm water pool and anti-gravity equipment), support groups, and a cancer-fighting community garden. In the spring of 2015, a cancer fighting kitchen will be added, and a greenhouse is in the future.

Effective January 2015, the Cancer Program Standards: Ensuring Patient-Centered Care (Commission on Cancer) requires that every provider of cancer services must have a Survivorship Care Plan that will provide a comprehensive treatment summary and follow-up plan to patients who are completing treatment. The process is monitored, evaluated, and reported to the cancer committee each year.

Time Period of Achievement

The Stanford Chronic Disease Self-Management Program (CDSMP) and Chronic Pain Self-Management (CPSMP) were utilized beginning in 2012 and were highly successful in assisting breast cancer survivors to better manage their recovery. In May 2014, three of the Center's Master Trainers attended the first Leader/Master Trainer training for Stanford's Cancer Thriving and Surviving Program (CTSP).

Location of the Story

The Maryland Department of Health and Mental Hygiene and National Susan G. Komen Foundation provided funding to support expansion of CTSP first on the Eastern Shore, then expanded to Central and Western Maryland in 2015-2016.

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Key Organizations Involved

MAC Inc., Living Well Center of Excellence, Peninsula Regional Medical Center, the Maryland Department on Aging, the Maryland Department of Health and Mental Hygiene (DHMH), the National Susan G. Komen Foundation, and the Susan G. Komen Maryland Chapter

Population Served

Individuals with cancer, cancer survivors, and caregivers

Intervention

DHMH provided funding to pilot CDSMP and CPSMP workshops with cancer survivors and assisted with development and institutional review board approval of a quality of life survey that would be used pre-and post- workshop. A strong partnership with Peninsula Regional Medical Center resulted in the opportunity to have MAC staff utilize hospital referrals to recruit cancer patients who were being discharged from active treatment into CDSMP and CPSMP. Nearly 70 individuals completed one or both workshops. Significant self-reported outcomes included: reduced fatigue, reduced pain, increased aerobic and strengthening exercises, and improved ability to manage daily activities.

Cancer Survivors Percent Improvement in Mean Score from Pre- to Post-Test Surveys

Survey Question(s)	Chronic Disease	Chronic Pain	Total (All Respondents)
General Health	13.0	5.9	9.5*
Symptoms	-4.0	18.3	7.3
Fatigue	10.7	18.6	14.3*
Shortness of Breath	-10.0	36.6	16.9
Pain	11.4	19.1*	15.5*
Strengthening Exercise	116.7*	9.4	26.3*
Aerobic Exercise	36.4*	11.1	19.0*
Confidence About Doing Things	13.3	5.1	8.9*
Daily Activities	15.3	19.2	17.4*
Medical Care	12.9	-4.3	3.6

If the question's scale was arranged that a decrease in the mean was desirable, such as with a reduction of symptoms, the scale was reversed for consistency during analysis and the percent is shown as a positive number.

*Statistically significant, p-value < 0.05

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As a result of this highly successful pilot, the Susan G. Komen Foundation Maryland Chapter and the Center submitted a grant proposal to the National Susan G. Komen Foundation to support statewide dissemination of the Cancer Thriving and Surviving Program. Additional funds provided by DHMH included training for three Master Trainers, implementation of two required Master Trainer-led workshops, and two CDSMP leader workshops and two CTS cross-trainings.

Challenges/Barriers to Success

Lack of strong aging/health care partnerships and uneven workforce capacity in other parts of the state

Results and Impact

Two informational sessions were held (Eastern Shore and Central Maryland) with nine hospital systems and four health departments, as well as other cancer support programs indicating strong interest in having individuals trained. Seventeen leaders were certified at the first CTS cross training in January and two workshops are scheduled at two different hospitals on the Eastern Shore.

The CTS program can significantly improve the quality of life for individuals with or recovering from cancer and their caregivers.

“Having suffered chronic pain for over 10 years, I jumped at the opportunity to attend the “Living a Healthy Life with Chronic Conditions” and “Chronic Pain Self-Management Program.” I have incorporated the self-management concepts into my daily life with great success. Practicing these life style tools have helped me to regain the ability to enjoy activities that had previously been restricted by my disabilities.”

Implications

The timing is right for CTS to be implemented as a key component of Cancer Survivorship Programs, but the process is slowed when there are not established relationships between AAAs, other community-based organizations, and health care systems.

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Chronic Disease Self-Management Education Success Story

*Integrating CDSME into Existing
Area Agency on Aging Services*



Contact Name: Sherri King

Organization: Michigan Office of Services to the Aging

Email: kings1@michigan.gov

Background

Chronic Disease Self-Management Education (CDSME) began as an 'extra' program that the Area Agencies on Aging (AAAs) could deliver in coordination with service providers/partners in their service areas. For a number of years, the only staff at the AAA who were familiar with the programs were those directly involved with them.

Several factors played into the need to integrate and educate other staff about the CDSME programs: the scope and reach of CDSME was growing; the Older Americans Act Title IIID funding was becoming more specific; and the Aging and Disability Resource Center (ADRC) process was beginning in Michigan.

Time Period of Achievement

Implementation of the Stanford CDSME programs began in 2004 in Michigan and has grown steadily ever since.

Location of the Story

This is a statewide effort, including all 16 AAAs, their partners, and service providers.

Key Organizations Involved

Office of Services to the Aging (State Unit on Aging), Michigan Area Agencies on Aging, Michigan Department of Community Health - Chronic Disease Division, National Kidney Foundation, Michigan Area Agencies on Aging Association, Michigan State University: Geriatric Education Center and the Extension Service

Population Served

Clients served by AAA services and older adults and adults with disabilities in the AAA service area

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Intervention

1. Identify the programs/services that many AAAs offer on a regular basis:
 - Congregate meals
 - Home delivered meals
 - Caregiver services
 - Home and community-based waiver services (HCBS)
 - Title IIID funding
 - Medicaid Medicare Assistance Program (MMAP)
 - Information and referral services
 - Care management
 - ADRC
 - Volunteer programs
 - Senior employment program
2. Work with the wellness program coordinator (or other assigned person) to find ways to disseminate information about the programs to all program managers of the above areas.
3. Continue to update, educate, and monitor how each department is able to incorporate CDSME information into their discussions with clients.

Challenges/Barriers to Success

Not all AAAs place a priority on wellness activities; therefore, some agencies are more committed to distributing information about CDSME to their staff members. We aim to engage the wellness program contacts to keep the information flowing throughout the agencies.

There currently is no central location for information about CDSME programs. This is being addressed in year three of the Prevention Grant with the development of a searchable database.

The AAAs keep a list of the programs available in their service area but do not have information for surrounding areas. Consequently, residents, who live on the border between two counties and may want to attend a program in a neighboring county, do not have access to that information, even though the program in the nearby county may be closer to them.

Results and Impact

- HCBS (Waiver) will now pay for clients to attend CDSME programs, as well as the wrap-around services the client needs, such as transportation or a caregiver to accompany them.
- The message of the importance of CDSME is more uniform and widespread within the agency, causing the clients to hear it repeatedly.
- CDSME programs become part of the person-centered planning process.
- New partnerships are developing as non-traditional service providers get involved.

Implications

Lessons learned:

- It takes hearing a message multiple times before a person acts on it. Therefore, everyone who interacts with older adults and adults with disabilities should be spreading the CDSME message.
- It takes a coordinated effort to get the CDSME information to all departments and to keep it updated.

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- This effort requires promoting the programs within departments that may not be as interested in them or may not understand the benefits CDSME to enlist their buy-in.
- More funding is needed for Title IIID services.

Next steps:

- Develop a data management system for all 16 AAAs to report about CDSME integration into other programs (currently, only the five sub-grantees are required to report).
- Develop a searchable database from which a person can locate a program by county, city, zip code, type of program, or starting date so that the public, staff at the AAAs, service providers, medical providers, and others who work with older adults and adults with disabilities can find information on the programs, including what is covered in the workshops, as well as workshop dates. There will also be an online registration for the workshops.
- Provide a communication session (webinar, in person, conference call, session in existing meeting) that will update and educate all program managers about what is new, and ways to integrate CDSME into their programs.

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Chronic Disease Self-Management Education Success Story

*Clinical-Community Linkages: Embedding CDSME
through Health Care System Partnerships*



Contact Name: Beth Richards

Organization: Missouri Arthritis & Osteoporosis Program (MAOP)

Email: richardsjo@health.missouri.edu

Background

- The Missouri Arthritis and Osteoporosis Program (MAOP) has offered community based self-management education (CDSME) and physical activity programs statewide since 1984. MAOP and its partners recognized a need to expand participant reach from typically “healthy” persons with chronic health conditions to persons seeking care and treatment for chronic health conditions.
- MAOP’s Regional Arthritis Centers (RACs) had limited success with developing a referral system with health care providers and health care systems statewide.
- The primary goal in 2012 was to partner with at least one health system in each of the seven regions to embed Chronic Disease Self-Management Education (CDSME) programs within chronic disease units and client discharge planning.
- The “sale” of CDSME programs was not a challenge, but rather the support of the health system in the planning and preparation of adopting and offering CDSME programs.

Time Period of Achievement

- Partnership with five RAC hosting institutions and their wellness programs was initiated in 2010.
- As of December 2013, MAOP had 17 health system partners implementing and/or referring to Chronic Disease Self-Management Program (CDSMP) courses, with 13 more as pending partnerships.
- As of December 2014, MAOP had 43 health system partners implementing and/or referring to CDSME courses, with six more as pending partnerships.

Location of the Story

The initiative is statewide with reach through MAOP’s infrastructure of seven RAC partnerships.

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Key Organizations Involved

MAOP, RACs (especially host institutions), Heartland Health (St. Joseph, MO), Mercy Hospital (Springfield, MO), and Open Health, LLC

Population Served

Populations served include older adults and adults with chronic health conditions.

Intervention

- A network of seven RACs was established under Missouri statute in October 1984.
- The Department of Health and Senior Services and MAOP award supplemental funding to RAC partners to train CDSME leaders, implement CDSME workshops, and develop partnerships to expand reach. RAC leaders develop partnerships at local and regional levels.
 - A specific example of a key organization's involvement: The Northwest Missouri Regional Arthritis Center is situated within Heartland Health, a health care system in St. Joseph, Missouri. Heartland Health is an Accountable Care Organization (ACO) which provides CDSMP integration through the organization; this provides sustainable financing options. The Northwest RAC Manager works closely with care managers, patient-centered medical home case managers, and health coaches to refer individuals into CDSMP. Two Aetna pilot programs (Aetna and Aetna Medicare) help recover course costs. The RAC Manager also works with the Heartland Health worksite wellness program (CDSMP is an option for employees and family members to earn wellness points and rewards).
 - Another example of a key organization's involvement: The Southwest Missouri Regional Arthritis Center is situated within Mercy Hospital in Springfield, Missouri. Mercy is also an ACO providing CDSME programs. Springfield is the third largest city in Missouri with a population of nearly 160,000 (2010 census); the metropolitan area has a population of over 430,000. Springfield is home to two of the top 100 hospitals in the country, Mercy and CoxHealth. A natural competition exists between these two health systems, especially as both have multiple facilities in the southwest region of the state. The RAC Manager used this competition to the program's advantage and developed the Southwest Missouri Alliance to grow the CDSMP and Diabetes Self-Management Program (DSMP). Programs are offered on an ongoing basis in multiple counties and participants from both health systems (as well as other community partners) are referred to the next scheduled workshop, regardless of location.
- RAC managers indicated the "sale" of CDSME programs was not a challenge in partnership, but rather the support of the health system in the planning and preparation of adopting and offering CDSME programs. A business plan, to help facilitate planning/implementation of CDSME programs, was proposed as a solution.
- MAOP contracted with Open Health, LLC to develop the Health System Business Plan for CDSME. The business plan was developed with input and feedback from MAOP and RAC managers. Two themes were created for the business plan documents – "Medicine and More" and "We Do CDSME" slogans were featured in these designs.
- RAC managers use the business plan during discussions with health system administrators and staff. The business plan documents are customizable templates that allow each partner to edit and

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add their own information as appropriate. Each kit to be checked out by RACs and partners to health systems and/or physician's offices includes: a retractable banner with stand, a carpet/floor mat, computer monitor toppers, lapel pins, window clings, mirror clings, and ink pens.

- RAC Managers and their partners continue to plan and implement CDSME courses in community settings as well as within the walls of health care systems.

Challenges/Barriers to Success

Once the scope of the business plan was narrowed to supporting planning and implementation of programs, no major challenges have been encountered.

Results and Impact

- The business plan documents are being used in 14 health systems around the state.
- Eight local public health agencies purchased their own business plan kits for use in clinics and as supplemental advertising for courses.
- In one year, MAOP increased active state health care systems by 250%.
- An increase in interest for the DSMP to be offered for health care systems has been noted. Additional requests were made by health care systems for delivery and referral options into the Chronic Pain Self-Management Program (CPSMP) as well.
- An increasing number of older adults and adults with chronic health conditions are referred into CDSME programs, especially those who are in contact with health care systems for treatment of symptoms associated with their health problems.
- Between September 1, 2009 and August 31, 2010, the southwest and northwest regions held 29 CDSMP workshops, with 272 participants. By the 2012-13 grant year, the two regions had a combined effort of 503 CDSMP participants in 58 workshops. In 2013-14, the two regions provided 67 CDSMP workshops for 669 participants and four DSMP workshops for 41 participants. To-date in the 2014-15 grant year, the two regions have seen an increase of participants/workshops for both DSMP and CDSMP.
- Statewide, between September 1, 2009 and August 31, 2010, all regions held 89 CDSMP workshops, with 780 participants. In 2013-14, statewide 147 CDSMP and 6 DSMP workshops were provided with 1,344 and 54 participants, respectively.

Implications

Lessons learned:

- Determine strength of partnerships before developing tools in order to help expand upon partnerships and embed programs within health care systems.
- Even if you get buy-in at a top level within a health care system, it is very important to follow-through as to which partners will be directly implementing the program. As staff turnover in a health care system can be high, it is important to have a well-informed team of staff who help to plan and implement CDSME programs.

Next steps:

- Use the Southwest Missouri Alliance as an example for other regions who have competition in metropolitan areas to increase overall program reach and expand partnerships.

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- Continue pursuing relationships with additional health care systems, utilizing the Health System Business Plan for CDSME to help support program adoption/implementation.
- Further develop existing health care system partnerships, especially those which are in referral or beginning delivery stages to sustainable delivery partners.

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Chronic Disease Self-Management Education Success Story

*Delivery of CDSMP by Community Health
Workers in Subsidized Housing*



Contact Name: Andrea Brandsness

Organization: New Jersey Department of Human Services – Division of Aging Services

Email: andrea.brandsness@dhs.state.nj.us

Background

The Rutgers New Jersey Schools of Medicine and Nursing and their affiliated teaching hospital, University Hospital, are located in the heart of Newark, New Jersey. Newark is a densely populated city that is ethnically and culturally diverse. The population suffers from multiple adverse health indicators, including high rates of chronic diseases.

In keeping with the University's mission, Hosseinali Shahidi, MD MPH and Cindy Sickora, DNP RN, faculty of Rutgers New Jersey Medical School and School of Nursing, have merged medical, public health, and nursing expertise to create a program that engages lay community partners as members of the health care team as Community Health Workers (CHWs). The CHWs have been trained and employed by Rutgers for the past three years. They have been very effective at closing the gap between health care providers and the community they serve. Rutgers partnered with the NJ Department of Human Services Division of Aging Services to expand their capacity by training the CHWs to become peer leaders for the Chronic Disease Self-Management Program (CDSMP).

Time Period of Achievement

2011-present

During year 2011, Rutgers conducted a health needs assessment to guide the CHW's recruitment and training. The school is actively linked with the following multidisciplinary teams (CHWs, nurses, physicians, medical and nursing students, respiratory and physical therapists) who provide support and care to local residents.

Master Trainers from the Sickle Cell Association of New Jersey went to their site and provided training in CDSMP. The CHWs were newly hired and at the time did not feel comfortable with the program script, resulting in their diversion to other activities required of them such as increasing local community participation in adult and childhood immunizations, HIV tests, home visits, and recruitment and the conduct of adult walking groups.

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Location of the Story

The specific target community for this pilot program is located at the most southeasterly border of what is referred to as the East Ward of Newark, NJ. This is among the poorest communities in New Jersey, and perhaps in the nation, with a per capita income of \$11,100.

Within a ten block radius are three low income housing developments that are managed by the Newark Housing Authority (Hyatt Court, Pennington Court, and Terrell Homes). These developments represent about 3,000 residents of which approximately one quarter of the population (750 individuals) are over 60 years of age. The workshops will be offered at each of the housing developments mentioned.

Key Organizations Involved

The Jordan & Harris Community Health Center, the New Jersey Children's Health Project, the School of Nursing's FOCUS Wellness Center, Newark Housing Authority, CDSMP Master Trainers from the Sickle Cell Association of New Jersey (who went on site and provided training in CDSMP)

Population Served

The majority of the service area population is African American (~80%). Obesity, smoking, alcohol and drug abuse, hypertension, diabetes, asthma, heart disease, and lack of access to health care are common issues that are of great concern according to the CHWs.

Intervention

The New Jersey Department of Human Services Division of Aging Services partnership with Rutgers began in 2010. Under the ARRA funding, we outreached to the School of Nursing to educate students at all degree levels about CDSMP and its benefits for the prospective patients. State staff attended several classes as guest lecturers and taped the presentation for nursing instructors to use going forward. One of the faculty, Cindy Sickora, DNP RN, initiated the CHW project within the community health center. She incorporated CDSMP into her training design to expand the capacity of the CHWs.

Challenges/Barriers to Success

Rutgers encountered delays in seeking Institutional Review Board approval for the pilot.

CDSMP was included with the CHW initial CHW training in 2012. At the time, they found the program overwhelming and were more invested in specific health worker job responsibilities. Since that time, the CHWs grew professionally and personally. Due to the delay, the CHWs required re-training as peer leaders, which was completed in July 2014. The first workshop was held in September 2014.

Results and Impact

The CHWs are current or past residents of the housing developments where they are implementing the program. This status ensures trusting relationships between the community and the program and provides the CHWs with the ability to have a lasting impact on their fellow community members. The fact that the CHWs are on-site makes them an accessible contact for questions and support even after the workshops conclude.

The School of Nursing is working to generate revenue through a billing system that was implemented in May 2013. The goal of this revenue generation is to support staff who are not currently reimbursable under current third party payors.

By virtue of the geographic location, this community suffers environmental insults and economic insufficiency. There are limited resources for food and health care. Travel is difficult because car

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ownership is low and bus routes are a significant walking distance from the housing developments. There are no other mass transit systems nearby. These challenges are magnified for the aging population and individuals with disabilities. The school is utilizing its recently established network of CHWs to meet the needs of the local residents in the communities they serve.

Implications

On-going training and both formal and informal education with the CHW team is needed.

The NJ Department of Human Services has agreed to extend the contract with Rutgers to allow the school to use unspent grant funds to continue the project. Several workshops are being planned for the spring.

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Chronic Disease Self-Management Education Success Story

*Fostering a Strategic Partnership
to Reach New Mexico's Retirees*



Contact Name: Christopher D. Lucero

Organization: New Mexico Department of Health – Diabetes Prevention and Control Program

Email: christopher.lucero@state.nm.us

Background

The New Mexico Department of Health (NMDOH) Diabetes Prevention and Control Program (DPCP) has worked toward creating a statewide infrastructure to support training, implementation, maintenance, and sustainability of Stanford University's evidence-based Chronic Disease Self-Management Education (CDSME) programs, known locally as the Manage Your Chronic Disease program or MyCD. The following programs are included: Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (Spanish CDSMP), Diabetes Self-Management Program (DSMP), Programa de Manejo Personal de la Diabetes (Spanish DSMP), and the new Cancer: Thriving and Surviving (CTS) program. Since 2011, the New Mexico Retiree Health Care Authority (NMRHCA) has been a key partner in supporting the effort to expand and sustain the MyCD CDSME programs. The NMRHCA is a provider of medical insurance coverage for individuals who receive a disability or normal retirement benefit from public service in New Mexico with an NMRHCA participating employer. The NMRHCA Executive Director believes the MyCD programs are valuable community resources for NMRHCA members, as well as communities in general, and has been committed to supporting the statewide initiative by sponsoring workshops, purchasing materials, providing stipends for workshop leaders, and assisting with promoting the program by conducting direct mailings to their members.

Time Period of Achievement

2011-present

Location of the Story

Statewide in New Mexico

Key Organizations Involved

NMDOH, NMRHCA, the Solutions Group (a division of Presbyterian Healthcare Services), and the City of Albuquerque Department of Senior Affairs (COA DSA)

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Population Served

Individuals who receive a disability or normal retirement benefit from public service in New Mexico with an NMRHCA participating employer

Intervention

The DPCP formed a strategic partnership with the NMRHCA, key individuals from the Solutions Group, and COA DSA to explore reaching New Mexico's retirees with the MyCD program. To inform this process, the NM DOH presented to the Retiree Health Care Authority Board of Directors and had several conversations with the NMRHCA executive director about the value of these Stanford-developed evidence-based programs for their members. Following the conversations, the NMRHCA decided to support the MyCD programs by sponsoring several six-week workshops for their members and allowing other community members to participate as well.

Challenges/Barriers to Success

Recruitment of NMRHCA members continued to be a challenge even though the direct mailings were helpful.

Results and Impact

In 2014, the Wellness Program Coordinator for The Solutions Group submitted a report request to Presbyterian Healthcare System's Enterprise Decision Support Team to look at the HEDIS Comprehensive Diabetes Care (CDC) Detail Set and created a mailing list to promote MyCD and DSMP enrollment. This approach was different from previous direct mailings to NMRHCA members in that it was a targeted approach to reach retirees. Because the mailing was targeted to individuals with a type 2 diabetes diagnosis, the participation rate was higher.

The NMRHCA has agreed to continue sponsoring MyCD Programs. Feedback from NMRCHA members who have completed the six-week program has been positive:

- *"Thank you for the opportunity to participate in the Chronic Disease Self-Management Program offered to the New Mexico Retiree Health Care participants. This program provided practical ways to deal with pain, fatigue, understanding medication, and communication with health care professionals. I would recommend this program to anyone with a chronic condition who would like to learn skills to positively manage their condition."*
- *"The use of an action plan to assist in focusing on day-to-day activities to manage my life will be extremely useful to me."*
- *"I use so many of the tools provided in the program. Using the action plan has helped with my confidence, mood, and quality of life."*

Implications

Lessons learned include: 1) Capitalizing on New Mexico's strong existing foundation of successful evidence-based programs was extremely beneficial; 2) Remaining patient and being sensitive to the time cycle to allow trust and a partnership to develop was important; 3) Convening several conversations with key leadership provided opportunities to discuss best ways to elicit feedback on NMRCHA needs and concerns; 4) Having committed stakeholders (e.g., the Wellness Program Coordinator for the Solutions Group, the MyCD master trainer, and the program director for the COA DSA) was important in identifying best ways to promote the program and execute the activities; 5) Sharing responsibilities and communicating successes of the partnership helped to extend resources for continued implementation;

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and 6) Leveraging the expertise and relationships of the key partners involved, including the executive director for COA DSA and NMRHCA executive director was a crucial factor for success.

Next steps include: The DPCP has issued a Request for Proposal and will be working with the awarded marketing and referral contractors, and selected partners, to: 1) develop, implement, and evaluate health care provider and consumer market value strategies that demonstrate the benefits of the DPCP's evidence-based prevention and self-management programs; and 2) build a statewide referral and cross-referral system. The project team will also continue working on integrating the MyCD programs as a covered benefit by working with New Mexico's Interagency Benefits Advisory Committee which includes the Albuquerque Public Schools, New Mexico Public School Insurance Authority, State of New Mexico Risk Management Employee Benefits Bureau, and NMRHCA.

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Chronic Disease Self-Management Education Success Story

Overcoming Access Barriers



Contact Name: Philip McCallion

Organization: Center for Excellence in Aging & Community Wellness, Quality and Technical Assistance Center (New York)

Email: pmccallion@albany.edu

Background

People with existing disabilities are at higher risk for type 2 diabetes and for related complications. Complications can include kidney failure, non-traumatic lower-limb amputation, and new cases of blindness, heart disease, and stroke. Yet people with disabilities have raised concerns that they find classes difficult to access and that some leaders are not well prepared to welcome, as opposed to include, people with disabilities in their classes. A more collaborative approach with Independent Living Centers (ILCs) would help to alleviate these access issues.

Time Period of Achievement

August 1, 2014-September 30, 2015

Location of the Story

New York State (New York City, Long Island, and upstate communities)

Key Organizations Involved

The ILCs include the Capital District Center for Independence, Inc., the Resource Center for Independent Living, the Suffolk Independent Living Organization, ARISE Inc., AIM Independent Living Center, Brooklyn Center for Independence of the Disabled (BCID), Westchester ILC, and Western New York Independent Living.

Population Served

Persons with disabilities and diabetes

Intervention

A team of four staff/volunteers at each ILC were trained to deliver the Diabetes Self-Management Program and committed to reaching at least 50 individuals with physical disabilities and diabetes. Persons who are Medicaid eligible are being targeted. In support, QTAC-NY has offered training, managed quality of delivery,

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and provided access to its existing data portal to support scheduling and data collection. ILC peer counselors/case managers are also supporting linkage to supportive, community-based, long term services and supports, to assist in maintenance in the community and improved health.

Challenges/Barriers to Success

This collaboration with ILCs means that previously expressed barriers to participation have been overcome. These barriers include concerns about transportation, genuinely accessible sites, having leaders who use examples that are disability sensitive, and linkage to supports that facilitate follow-through on action plans.

Results and Impact

Materials and ideas have been developed which are being shared with all partners to further promote inclusive programming (see, for example, <https://www.youtube.com/watch?v=T9wAd1fxkeQ>).

We have increased the number of people with disabilities participating in evidence-based programs and by embedding capacity in ILCs are ensuring that such increased access will be sustained.

Implications

Not surprisingly, listening to individuals who can benefit from the program and building partnerships with the organizations they are most likely to access has led to improved program reach.

There will be continued work on supporting and expanding delivery through ILCs and on encouraging all partners to increase their preparedness in successfully including people with disabilities in classes.

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Chronic Disease Self-Management Education Success Story

*Increasing Availability and Accessibility
of Chronic Disease Self-Management Education
for Older African Americans in Oklahoma City*



Contact Name: Pat Hawkins

Organization: Faith to Government

Email: phawkinscmc@aol.com

Background

Remove structural barriers to Chronic Disease Self-Management Education (CDSME) by increasing the number of Chronic Disease Self-Management Program (CDSMP) workshops available in African American communities

Time Period of Achievement

Attended Stanford University master trainers course in December 2009 and immediately began to work with the Oklahoma Department of Human Services

Location of the Story

Oklahoma City area

Key Organizations Involved

Faith to Government, Oklahoma Department of Human Services

Population Served

African Americans in the Oklahoma City area

Intervention

Faith to Government was established in 1998 by Dr. George E. Young, Sr. to develop partnerships with governmental agencies, for-profits, and other non-profits to increase knowledge, access, and participation in programs intended to improve the quality of life for underserved populations. A collaborative agreement between the Administration for Community Living/Administration on Aging and the National Caucus and Center on Black Aged, Inc., led to the recruitment of Faith to Government, Inc. to increase the availability and accessibility of CDSME to older African Americans in the Oklahoma City area. The organization is now staffed with two master trainers and seven lay leaders and is licensed by Stanford University.

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Faith to Government conducts programs in local churches, senior housing, and community sites where many older African Americans feel respected and valued. To address cultural barriers and community acceptability, the organization engages leadership with particular influence in communities. The process involves collaboration, consistent communication, and transparency of program processes with local ministers and community leaders.

Results and Impact

Review of data show an average of 16 participants per class with an 85% completion rate, higher than the national average of about 75%.

Faith to Government, Inc. believes the true measure of their success relates to participant outcomes and what participants have to say about the program. In fact, participants are the major source of referrals for CDSMP workshops. Master trainer Pat Hawkins says that participants often ask if the program can be offered in churches where other family members attend, and most churches request that the program be repeated so that other members can participate. Participants also stop her in grocery stores and other places to discuss workshops and share their success stories.

One success dates back to the first workshop conducted in 2010. A woman who has maintained her weight loss and reduced drinking of sodas proclaims, *“Every church needs this program.”* Two participants who regularly skipped breakfast teamed up to encourage each other to eat healthier. Another participant shares that he is *“not feeling so depressed because I can no longer take care of my home as when I was younger.”* He has hired someone to help him, spends more time with his family and pets, and accepts the fact that *“No one will ever be able to do it exactly as I did!”*

Several older women bonded with a younger man and motivated him to keep his medical appointments to control his diabetes. Another older adult participant decided that she would report frequent falls to her doctor and later attended physical therapy sessions to improve her balance. Heartfelt testimonies were given at a six-month reunion, which was held to maintain community visibility. As one participant stated *“It has been a life-changer for me to accept my diabetes and know that I am not helpless!”* Participants express appreciation for the text, *Living a Healthy Life with Chronic Conditions*, and report using it to *“find answers”* about their condition. More and more, participants tell Faith to Government, *“I told my doctor about this course.”*

Implications

Cultural barriers and community acceptability can be addressed by collaboration, consistent communication, and transparency of program processes with local ministers and community leaders.

Engage local champions and hold workshops in places that are already familiar and trusted. Satisfied participants are a key referral source.

Next steps: Long-range plans are to integrate CDSMP into the community through outreach to churches and community organizations, and to engage minority leaders as stakeholders. By recruiting lay leaders from participating churches, Faith to Government leaves the church with a resource person and a continued connection to their programming. Outreach is in place with the Oklahoma Association of Black Mayors to gain access to several of the state’s historical “Black Towns,” as well as with Langston University, Oklahoma’s only HBCU (Historically Black College and University). Faith to Government, Inc. has been accepted as a preceptor site for the Directors of Health Promotion & Education (DHPE) intern program for minority serving institutions. Efforts are already in place to identify and place a Langston University student in this federally paid program. With program growth, the intern opportunity will be extended to students enrolled at Oklahoma Tribal colleges.

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Chronic Disease Self-Management Education Success Story

*Putting Patients at the Center:
The Oregon Community Health Center Patient
Self-Management Collaborative*



Contact Name: Laura Chisholm

Organization: Oregon Public Health Division, Health Promotion & Chronic Disease Prevention

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Background

The Oregon Asthma Program proposed the Patient Self-Management Collaborative (PSMC) as part of a long-term strategy to reduce disparities in asthma morbidity and mortality among low-income Oregonians, especially those served by the Oregon Health Plan (OHP/Medicaid/CHIP). Prior to the PSMC, asthma prevalence among OHP members was documented at significantly higher rates than among Oregonians with private insurance, Medicare, and the uninsured.

The collaborative worked through safety net clinics to increase self-management knowledge and skills among low-income Oregonians with asthma. Initial project goals were to enhance support for self-management in the clinical setting, increase participation in the Stanford Chronic Disease Self-Management Program (CDSMP) through development of sustainable clinical referral systems, and promote tobacco cessation in low-income smokers with asthma by increasing utilization of the Oregon Tobacco Quit Line.

Time Period of Achievement

September 2009 – August 2014

Location of the Story

Disbursed geographic areas across Oregon served by participating community health centers, including residents of Benton, Jackson, Marion, Douglas, Josephine, Multnomah, and Lincoln counties

Key Organizations Involved

- Oregon Public Health Division
- Oregon Primary Care Association
- Community Health Centers of Benton and Linn Counties (Benton Health Center, Corvallis)
- La Clinica del Valle (Central Point and Phoenix)

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- Yakima Valley Farm Workers Clinic (Salud Clinic, Woodburn and Lancaster Clinic, Salem)
- Northwest Human Services (West Salem Clinic)
- Umpqua Community Health Center (Myrtle Creek Clinic)
- Siskiyou Community Health Center (Cave Junction Clinic)
- Multnomah County Clinics (eight sites in Portland metro area)
- Lincoln Community Health Center (Newport and Lincoln City clinic)
- OHSU Richmond Family Medicine (SE Portland)

Population Served

Community health center patients (mostly Medicaid/CHIP enrollees and those uninsured prior to 2014)

Intervention

The PSMC was conducted through a partnership between the Oregon Asthma Program (OAP) and the Oregon Primary Care Association (OPCA) from 2009-2014. Clinic teams from nine Federally Qualified Health Centers (FQHCs) received training and technical assistance to build capacity for patient self-management support, both within the clinic setting and through development of systematic referrals to evidence-based self-management resources, including the CDSMP and the Oregon Tobacco Quit Line.

The OAP and OPCA participated in monthly project planning and progress monitoring meetings. OPCA conducted site visits to recruit FQHCs. Beginning in the second year of the collaborative, participating FQHCs signed memoranda of understanding with OPCA, which were updated annually. Each FQHC chose a clinic site to participate, and recruited a multidisciplinary team to participate in collaborative training events and implement practice changes within their clinic. Each team consisted of three to eight members and included a mix of clinical providers (physician assistants, nurse practitioners, registered nurses, behavioral health specialists), clinical staff (medical assistants, licensed practical nurses, health navigators, care coordinators), and administrative staff (medical directors, nurse managers, quality improvement managers, clinic managers, executive directors). Each team's mix of participants reflected the staffing model of the participating clinic, and most also included a representative of a partner organization offering community-based CDSMP.

OPCA coordinated regular in-person training and technical assistance opportunities to build capacity for patient self-management among PSMC clinics. These included bi-annual in-person collaborative meetings, monthly webinars to encourage collaborative learning between teams, and clinic-specific coaching to troubleshoot barriers and brainstorm solutions. Training and technical assistance focused in the following topic areas:

- Motivational interviewing
- Tobacco cessation interventions
- Chronic disease self-management programs
- Data for quality improvement
- Patient-centered communications
- Plan, Do, Study, Act cycles and managing change processes

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In the first year of the collaborative, all PSMC events were specific to the collaborative; in subsequent years, OPCA offered a PSMC track at its annual Quadruple Aim Symposium and leveraged numerous other opportunities to integrate self-management related topics into other meetings.

Challenges/Barriers to Success

Clinics noted a variety of barriers to sustainable change: competing priorities, reporting technology limitations, lack of dedicated quality assurance staff time, staff and leadership turnover, lack of consistent support for team-based care among some providers, and the financial impact of dedicating provider time to training. Project implementation challenges included lack of established self-management related clinical training curricula and evaluation measures, limitations in clinic reporting capacity, and the existence of many other competing priorities. Although all participating clinics developed or refined referral protocols, it was not possible to reliably track participation of patients in off-site CDSMP workshops. Participation in on-site CDSMP workshops was higher, but numbers of participants were low compared to referrals to the Quit Line. It is also likely that some on-site program data were not reported to the Oregon Asthma Program and thus were not included in the final evaluation. Two clinics were challenged in their CDSMP referrals by local organizations' struggles to maintain program delivery capacity.

Results and Impact

All six clinics that completed the full collaborative developed or refined referral protocols to CDSMP, the Quit Line, or both. All participating clinics reported increased capacity to support self-management and cessation as a result of PSMC participation. Participating clinics that had the capacity to report on documentation of self-management goals, tobacco use interventions, and Quit Line referrals demonstrated improved rates for most related measures.

Four clinics that participated in the full collaborative increased the number of CDSMP workshop offered on site. A total of 456 patients participated in on-site English- and Spanish-language CDSMP workshops during the collaborative, with an average of 114 participants per year in project years 2 - 5 compared to 41 per year in project year 1 (baseline). Oregon Tobacco Quit Line participation also increased in clinics that developed specific referral protocols. Participating clinics referred a total of 1,522 patients to the Quit Line during the collaborative, with an average of 380 referrals per year compared to 10 per year at baseline. Additionally, average scores on measures of clinical support for patient self-management showed substantial increases in all areas of focus. All participating FQHCs achieved medical home recognition during the project, and three clinics noted that their participation specifically assisted them in fulfilling recognition requirements. Most completing clinics also indicated significant changes in their organizational commitment to a culture that supports self-management, and all participating clinic teams reported changing organizational priorities related to self-management support during the collaborative. Although nine clinic teams participated and six completed the collaborative, practice changes spread to a total of 11 clinic sites, including a large urban primary care system that serves the highest volume of Medicaid beneficiaries of any FQHC in Oregon.

Current and future patients of six FQHCs in Oregon will receive the benefits of strong self-management support from their clinical care teams, including motivational interviewing interventions to establish and track self-management goals and referrals to appropriate evidence-based programs.

Implications

Lessons learned and next steps:

- Continue to provide structured support for self-management support quality improvement in primary care clinics. With self-management support now increasingly understood as a key aspect of

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patient centered care, community health center staff, providers and administrators will continue to be interested in this work. However, with multiple competing priorities and increased workload due to Medicaid expansion, self-management support is likely to fall off the priority list unless clinics are provided with opportunities to participate in projects such as the PSMC that require organizational commitment of clinic resources. Results of this evaluation indicate that memoranda of agreement will be a possible means of ensuring this commitment.

- Focus on high-impact training and technical assistance activities. Clinic staff consistently indicated that continued training to expand knowledge to other care teams and counteract staff turnover would be important to sustain the quality improvements they achieved during the PSMC. Opportunities to connect with other clinics interested in enhancing patient self-management will likely continue to be in demand, especially as financial incentives continue to align with the Triple Aim.
- Allow for flexibility in collaborative implementation. Due to the high level of variability in staffing, clinic flow processes, and priority issues among FQHCs, organizations with high readiness to engage in quality improvement to enhance self-management support will likely have different needs and varying priorities driving their work. Thus, it is important to enter this work with the expectation that clinics will make improvements without being overly specific about the particular changes they must implement in their practices and record systems. The PSMC's combination of large-group activities and individualized coaching appeared to be an effective means of addressing the needs of diverse organizations with similar goals.
- Continue to refine primary care self-management support reporting metrics that are not burdensome to clinics. The PSMC demonstrated that it is possible to identify measures of clinic support for self-management that can simultaneously satisfy the needs of clinic quality assurance staff as well as project evaluators. However, due to the high burden of required reporting upon FQHCs, self-management related metrics must align with existing reporting requirements whenever possible to ensure retention of clinic teams. Variability in electronic medical record system capabilities between FQHCs adds an extra layer of complication; clinic quality assurance staff and state primary care association staff are valuable resources in navigating these challenges.
- Continue to nurture the new state-level public health/primary care partnership established under the auspices of the PSMC. The Oregon Primary Care Association was well positioned to continue to champion self-management support within FQHCs, and their work on the PSMC was effective and well received by clinic teams. In addition to contributing financial resources and overall project planning and implementation guidance, the OAP offered expertise in self-management support and population-based approaches to quality improvement. The resulting partnership enriched both organizations by developing a common agenda, sharing expertise in areas of individual strength and expertise, and establishing a strong working relationship that holds promise for future productive collaborations. This successful aspect of the PSMC indicates that state-level public health and primary care associations can work together effectively to achieve mutual goals related to self-management support for patient populations with asthma and other chronic conditions.

Chronic Disease Self-Management Education Success Story

*Oregon State Agency Employees and
Retirees to Gain Self-Management Programs
as a Covered Benefit*



Contact Name: Laura Chisholm

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Background

Lack of financial investment in self-management programs at a systems level has resulted in a leveling of program growth.

Time Period of Achievement

In 2009, the Health Promotion & Chronic Disease Prevention (HPCDP) section of the Oregon Public Health Division began partnering with the entities that provide health benefits to state and school employees. This success story highlights the partnership that led to the decision by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) to cover self-management programs in May 2013. A Better Choices, Better Health® (BCBH) delivery contract is now being finalized with the National Council on Aging (NCOA), and the BCBH benefit will be available as a 2015 benefit.

Location of the Story

Statewide impact (most employees and retirees are in the northern Willamette Valley – Salem, Portland, Eugene)

Key Organizations Involved

Oregon Public Health Division, Oregon State Unit on Aging, Oregon Public Employees' Benefit Board, Oregon Educators Benefit Board, NCOA

Population Served

Approximately 300,000 individuals are in the entire insurance pool, including retirees.

Intervention

As part of its strategy for promoting worksite wellness and establishing financial sustainability for Living Well, the state Public Health Division has nurtured a long-term partnership with PEBB and OEBB. These labor-management boards share the mission of providing high-quality benefits at a cost affordable to employees and their families throughout the state. In addition to fielding the Behavioral Risk Factor

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Surveillance System survey of Oregon state and school employees, the Public Health Division has been working with PEBB and OEBB to begin offering Living Well to members through their health plans. This initially took place under the auspices of PEBB's Health Engagement Model (a wellness incentive program), with the eventual goal of establishing Living Well as a covered benefit.

Following several years of collaboration on worksite wellness activities with the Oregon PEBB and quality improvement projects with the Oregon Medicaid program, in 2011 the state self-management team acted as advisors to the Oregon Health Services Commission as it considered adding self-management programs as a covered benefit for Medicaid members with specific diagnoses. Although this initiative did not result in a policy change due to cost concerns, it did help to educate key decision makers about the efficacy of the programs in terms of improved chronic disease outcomes and potential cost avoidance.

Following this attempted policy change, the administrator of PEBB and OEBB championed a gradual process of adopting self-management programs as paid public employee benefits. In 2011, the Stanford Chronic Disease Self-Management Program and the free Better Choices, Better Health pilot were promoted to early retirees, and then to the general PEBB and OEBB populations. In 2013, CDSMP was promoted further as an approved activity under PEBB's Health Engagement Model, and then was adopted, along with the National Diabetes Prevention Program (NDPP), to become a covered benefit for 2014. Full implementation of this benefit is pending as Public Health works to develop a web-based system that will allow participating health plans to register, track, and pay for members to enroll in local workshops – a system that is expected to be in place by the end of 2015. In the meantime, negotiations with NCOA over a program delivery contract for BCBH have followed, and this benefit will be available in 2015.

Milestone	Time Frame
Initial meeting with HPCDP and PEBB/OEBB staff to discuss self-management programs	March 2009
HPCDP staff continue check-ins with PEBB/OEBB staff about medical plan carrier contracting timelines	May and December 2009
Medicaid Disease Management Coordinator begins advocacy for coverage of self-management programs under the Oregon Health Plan (Medicaid)	July 2010
HPCDP staff meet with PEBB/OEBB administrator about promoting self-management programs to members; PEBB begins promoting programs to early retirees	December 2010
Oregon's Health Improvement Plan ¹ is presented to the Oregon Health Policy Board. It includes establishing wide access and reimbursement	November 2010

¹ Oregon Health Authority, Oregon Health Policy Board (2010). Oregon Health Improvement Plan: Improving the health of all Oregonians where they live, work and play.
<http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Pages/index.aspx>

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for self-management interventions as a recommended action for 2011.	
Health Services Commission approves Oregon Health Plan coverage for self-management programs for enrollees with six specific diagnoses	January 2011
HPCDP staff present to PEBB and OEBB boards of directors on self-management programs	February 2011
PEBB begins promotion of Living Well, Tomando Control, and online Better Choices, Better Health® to general membership	February 2011
Health Services Commission rescinds approval for coverage due to budget concerns related to reimbursement rates for Federally Qualified Health Centers	March 2011
HPCDP staff facilitate a conference call between PEBB and NCOA regarding pricing for Better Choices, Better Health®	April 2011
HPCDP provides technical assistance to PEBB about logistics for including Living Well in the future Health Engagement Model	Summer 2011
PEBB launches Health Engagement Model without Living Well as an approved wellness program option	January 2012
Joint labor/management Health Engagement Model advisory committee established, including Living Well advocates	January 2012
PEBB announces Living Well as an approved HEM wellness program option (not a paid benefit) for plan year 2013	July 2012
HPCDP completes the Living Well Business Plan	August 2012
PEBB/OEBB boards approve Living Well and the National Diabetes Prevention Program as part of their 2014 benefit design	May 2013
HPCDP work to develop a Self-Management Hub that will allow PEBB/OEBB plans to register, track, and pay for members to participate in statewide workshops.	2014-2015
PEBB/OEBB staff negotiate contract with NCOA to provide CDSMP to enrollees	Fall 2014/Winter 2015

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Challenges/Barriers to Success

Key informant interviews and document review identified the following as major barriers to inclusion of Living Well programs as a covered benefit for PEBB/OEBB members:

- **Program delivery contracting issues:** The complexity of contracting with multiple program delivery organizations to provide statewide access for PEBB/OEBB members made adoption of Living Well and the NDPP as a statewide covered benefit an administratively challenging prospect. Due to the lack of a centralized structure for program delivery and billing, PEBB/OEBB's insurance carriers would need to contract with dozens of program delivery organizations individually to allow statewide access to programs for members. Additionally, many organizations licensed to provide Living Well programs lack the capacity to bill insurance. It is anticipated that these problems may be surmounted for the 2014 benefit year by establishing program delivery contracts with only a few organizations serving geographic areas where the majority of PEBB members reside, and which are able to bill insurance. In summer 2013, the Public Health Division will assist PEBB/OEBB and its carriers to identify organizations with readiness to scale up program delivery to include members and to undertake insurance billing. However, the PEBB/OEBB administrator views this limited program pilot as only a temporary solution because the board is committed to providing statewide access to benefits. Lack of consistent statewide program pricing will make this process even more complex.
- **Time constraints:** Due to the rapid process of benefit plan development for the 2012 benefit year, PEBB staff had little time to problem-solve the issues described above. Thus, Living Well was added to the Health Engagement Model for 2013, but not as a paid benefit. Similarly, administrative processes to support the May 2013 policy change described in this report remain to be developed. These constraints are likely to lead to incremental implementation of these new benefits via pilot contracts as described above, rather than a full-scale roll-out to all PEBB/OEBB members simultaneously.
- **Inability to measure policy impact:** Lack of administrative systems to track member participation in self-management programs will continue to complicate tracking of associated outcomes. Since there are no established billing codes, it will be challenging for carriers to establish fee-for-service payment arrangements with program delivery organizations. Additionally, detailed insurance information is not currently tracked as part of the standard demographic information collected on self-management program participants, and is outside the scope of public health data collection. Without the ability to identify individual participants and track their health care utilization and metrics, it will be difficult to quantify the impact of the policy change in terms of the predicted outcomes of increased quality of life, reduced hospitalizations and emergency room visits, and reduced rates of conversion from pre-diabetes to diabetes.

Results and Impact

State benefits boards approved CDSMP and other self-management programs as covered benefits, and concluding Better Choices, Better Health®.

Impact is not yet quantified. Due to the large size of the PEBB/OEBB population, adoption of Living Well and the DPP by PEBB and OEBB as paid benefits is anticipated to greatly expand the number of Oregonians participating in Living Well and the NDPP. Payments to program provider organizations will provide a funding stream to enhance program growth.

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Implications

Making policy changes requires time and should be regarded as ongoing and incremental. It takes time to develop trust between partner organizations and to promote knowledge and familiarity with the programs among decision makers. Given the complexity of establishing delivery and financing systems for statewide purchasers like PEBB and OEBC, it has become clear from Oregon's experience that incremental change over time is more likely than an immediate large policy change.

Lack of a centralized, statewide delivery system has proven to be the major administrative barrier to establishing Living Well as a paid PEBB/OEBC benefit. Although Oregon's Living Well delivery network organizations are committed to providing programs as a means of fulfilling their organizational missions, most licensees lack billing infrastructure. While implementation of the Living Well Business Plan is anticipated to mitigate this issue by establishing a common platform for data sharing and billing, it has taken years to establish this new system. Developing a more systematic mechanism for delivering self-management programs and a more sustainable means of paying for them at the outset of the self-management team's support for Living Well would have avoided the task of reorganizing Oregon's Living Well delivery network.

Local data are also important to decision makers when considering policy change. Policy makers consistently request examples of successful program implementation and resultant documentation of cost savings in Oregon populations. It will be important to work with program delivery partners that have capacity for data collection and analysis, and with PEBB/OEBC, to evaluate and share outcomes as policy change is implemented elsewhere.

Next steps include establishment of a centralized, statewide self-management program delivery and payment infrastructure in 2015, as well as continued evaluation of policy implementation process and impact.

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Chronic Disease Self-Management Education Success Story

Growing a Community Program Beyond a Grant



Contact Name: Lois Shelton

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Background

The two-year American Recovery and Reinvestment Act (ARRA) grant ended in 2012, but interest in, and need for, better management of chronic conditions among the 40% of 800,000 seniors in Pennsylvania who have one or more chronic conditions was evident¹. Pennsylvania has one of the highest older adult obesity rates in the United States, in addition to an unfortunate rise in the percentage of older adults who are inactive; currently slightly more than one-third of the senior population admits to little or no physical activity. Pennsylvania's health care cost for low income residents with chronic conditions was estimated to cost the Medicaid system \$1.77 billion in 2007 for the five most prevalent chronic conditions: heart disease, diabetes, hypertension, cancer, and stroke².

Time Period of Achievement

Benchmarks were set for this initiative including to grow Chronic Disease Self-Management Program (CDSMP) workshop offerings by 20% each year from 2012-2017 without any grant funding.

Other benchmarks were:

- 20% increase in outreach (number of participants from one year to next)
- 20% increase in new sites or delivery system partners
- 10% increase in physician referral (or health care referrals)
- 10% increase in reaching minorities and low income older adults

Location of the Story

Statewide initiative by the Pennsylvania Department of Aging's PrimeTime Health Program

¹ America's Health Rankings, 2013: <http://www.americashealthrankings.org/Senior/PA>

² Burden Report, Pennsylvania Department of Health, 2011: <http://www.health.state.pa.us/pdf/ChronicDiseaseBurdenReport.pdf>

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Key Organizations Involved

- Area agencies on aging
- Senior community centers
- Geisinger Health System
- Tyrone Hospital
- Boscov's Department Store – Senior Campus Courses
- Surrey Services for Seniors
- Senior residential villages
- Senior high-rise apartments
- Penn State Extension Office
- Community health and fitness centers
- Churches/religious-based facilities
- Recreation centers (e.g. YMCA)
- University centers
- Home health agencies
- Tribal centers
- Libraries

Population Served

We have successfully reached 1,213 older adults including:

- 64.4% low income older adults
- 1.3% minority – two sites continue to successfully offer CDSMP to the Hispanic community (a community church and a local Hispanic senior center)
- 8.7% Home and Community-Based Care Waiver participants
- 1.9% Nursing Home Transition consumers

Intervention

A Pennsylvania statewide initiative began in June 2012 at the end of the ARRA grant with the training of 18 new master trainers (MT). Expansion of CDSMP was only going to occur if we marketed the program beyond our AAA network, so outreach was targeted to hospital systems, the housing authority, community fitness centers, and senior center service organizations. A second MT training took place in September of 2012, growing our team of 18 MTs to 28. These individuals were fully supported by the PA Department of Aging (PDA) for operational and technical assistance, supplies, and monitoring of program integrity during that first year (this support has continued). PDA feels that this support encourages comradery and lets the CDSMP work force know that we are there for them. Because of this, we've had very low attrition. Tracking progress was necessary to ensure each MT fulfilled their requirements for full certification, especially as an additional training online for the new 4th edition was held in the summer/fall of 2013; every effort was made to protect Pennsylvania's investment in new MTs and lay leaders.

In spring of 2013, PDA paid for an out-of-state speaker from a well-established CDSM program to educate our aging network on the program, broadening awareness and understanding of the program. Additional presentations and contacts were made by the state coordinator and collaborations with organizations outside of the aging network, such as the American Academy of Family Physicians, the Department of Health and Arthritis Foundation under the State Public Health Approaches to Improving Arthritis Outcomes (CDC-RFA-DP12-1210), the Pennsylvania Housing Finance Agency, the Public Health Management

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Corporation, and Family Home Medical Support Services – just to mention a few. Slowly the requests for lay leader training, additional MT trainings, and collaborative efforts to bring CDSMP to community sites grew. A MT training was offered again in June 2014, bringing the total to 35 MTs; currently 32 remain active (limited attrition due to retirements and position changes). These 32 MTs have continued to grow our team of lay leaders to a current high of 101. Pennsylvania partners with several private and non-profit organizations, universities, local business, churches, and senior housing units.

A marketing campaign started in fall 2012 with workshop announcements in the Academy of Family Physicians monthly newsletter, PDA's weekly newsletter which reached over 32,000 providers and organizations across the state, and posting of workshops in flyers, church bulletins, newspapers, and radio announcements. Many centers felt that the Session Zero (orientation session) was also a great help in recruiting members from the community. To date, over 103 workshops have been offered at sites such as churches, associations for specific racial/ethnic groups (American Indian, Cambodian, Hispanic), senior apartment complexes, assisted living centers, a VA medical center, a physician office, hospitals, YMCA, senior community centers, college campus courses for seniors, and department stores offering adult learning programs³.

Challenges/Barriers to Success

Reaching physicians/health care providers remains a challenge. Although we met our benchmark, there is certainly room for the relationship with health care providers to improve and referrals from this sector to increase.

Reaching minorities also remains a challenge. Discussions continue on how to best market to this population.

Results and Impact

The best success is hearing from the participants; testimonials prove that the self-management workshops make a difference:

"This class aided me in focusing on positive steps I can take to better aid me to deal with not only my illness, but just as importantly, how to live a more healthy and positive life."

"The help I got from the group through brainstorming helped me to come up with several solutions to some of my problems."

When asked "Why did you take the Chronic Disease Self-Management workshop?" one consumer replied, "I have a number of chronic diseases! Diabetes, arthritis, high blood pressure, peripheral artery disease (PAD), neuropathy and several back problems, etc. The classes helped me reassess myself, gain new information and ways to help myself – I now have a better outlook and less guilt feelings about my problems."

Living a Healthy Life with Chronic Conditions ... "was certainly worthwhile...and really exceeded my expectations. It helped me to find better ways of dealing with the many frustrations that living with several chronic conditions can cause..."

A 2013 survey of participants in CDSMP revealed that 89% planned to make changes in lifestyle or home.

³ NCOA, Salesforce.com, Inc., 1/1/2012 to 11/26/2014.

With regard to impact, the overall benchmark was to grow CDSMP workshop offerings by 20% each year from 2012–2017 without any grant funding. Pennsylvania expects to come close, if not exceed the 20% benchmark by July 2015 when the state fiscal year closes.

Implications

- If you believe in the value of a program and market just right, you can gain buy-in and grow it.
- The program is expensive if you purchase books and CDs for every participant; therefore, PDA re-designed distribution of supplies. Sites receive a one-time startup kit, then they may choose to distribute supplies by any of the following methods:
 - Lending library – book/CD can be signed out after class if participant wishes to take it home for the week.
 - Stock AAAs and lay leader sites with a startup kit of books and CDs. If they choose to give the materials out for free to each participant, then they must replace their own stock.
 - Take a list of orders the first or second week of class for participants who would like to purchase their own book. Site takes on responsibility to order and receive shipment then distribute to those who ordered.
 - Give website to participants to order their own book and CD.

Next steps include:

- Encourage the aging network to reach out to local physician offices; advertise the classes by fax flyers, Dear Doctor letters, or speaking with their own physician when at an office visit.
- Arrange a 10-minute presentation on CDSMP at grand rounds at various hospitals reaching many different physicians. Time and staffing, with other responsibilities, has been a barrier to initiating this; also it can be a challenge to make one's way to the right person at various hospitals.
- Continue to support the aging network MTs and lay leaders with supplies.
- Find new methods of recruiting from minority and underserved areas.

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Chronic Disease Self-Management Education Success Story

*The Community Health Network –
Connecting the Community and Clinical Systems*



Contact Name: Darren Kaw

Organization: Rhode Island Department of Health

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Background

The 2010 Census shows 14% of Rhode Island's population was over the age of 65. About 37% of the state's older adult population has a special health care need. The Behavioral Risk Factor Surveillance System data (2013) show that for adults aged 65 and older: 67% are overweight or obese; 57% have arthritis; 24% have fallen at least once in the past 12 months; 20% have diabetes; and 8% have pre-diabetes. With the growing burden of chronic disease in the state, the health system has a need to engage patients in self-management. An activated patient who is engaged in his/her care is an integral part of achieving the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. The public health system has invested in developing self-management resources in the community; however, there is a gap in connecting these resources to the clinical system.

Providers shared a common barrier in being aware of all the resources available for their patients. For the evidence-based programs, all had the common goal of working more closely with the health system to increase reach for their programs. Better integration with the clinical system was also seen as a method of sustainability for the programs. In response to those needs, the Rhode Island Department of Health formed a committee of community partners and Department of Health programs that were implementing evidence-based programs to create the Community Health Network (CHN), a system where providers can easily work with programs to give access to their patients.

Time Period of Achievement

November 2012 to present

Location of the Story

Statewide (Rhode Island)

Key Organizations Involved

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The Department of Health's Chronic Care and Disease Management Team, Health Promotion and Wellness Team, Office of Special Healthcare Needs, and external stakeholders collaborated in the creation of the Community Health Network. The following specific programs and agencies were part of the collaborative:

- Arthritis Foundation (New England Region)
- Arthritis Program
- Asthma Program
- Chronic Disease Self-Management Education Program (Living Well Rhode Island)
- Comprehensive Cancer Control Program
- Diabetes Prevention-State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke Program
- Division of Elderly Affairs
- Rhode Island Parent Information Network
- Office of Special Healthcare Needs
- The State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health Program
- Tobacco Cessation Program
- Unintentional Injury Program
- WISEWOMAN Program
- Women's Cancer Screening Program
- YMCA of Greater Providence

Population Served

The populations served by the Community Health Network are primarily adults with chronic conditions, including but not limited to asthma, arthritis, diabetes, prediabetes, heart disease, and hypertension. There are also programs that cover youth with asthma and special needs.

Intervention

The Community Health Care Network was developed to facilitate linking the community with clinical systems. To achieve this aim, the following steps were taken:

- 1) Partnering with the community organizations that provide evidence-based programs. It was important to provide a range of programs to meet the needs of communities and provide a broad geographic reach.
- 2) Developing a system of protocols and staffing to handle referrals from practices. Funding has been leveraged from the Administration for Community Living (ACL) and the Centers for Disease Control and Prevention (CDC) to support the development of the referral system. Specific CDC funding sources include the Arthritis Program, Asthma Program, Comprehensive Cancer Control Program, Diabetes Prevention-State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke Program, State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health Program, WISEWOMAN Program, and Women's Cancer Screening Program. This included support for staffing of Patient Navigators, development of marketing materials, creation of a referral database, and implementation of evidence-based programs.

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- 3) Providing a single point for access and information about different programs. The CHN has created a standard referral flow, a patient referral form, and physician communication form. This system provides feedback about patients' referral status and enrollment into programs, which supports continuity of care. A webpage is also available with information about programs.
- 4) Ensuring program availability across the state. Partnerships between agencies and programs which offer evidence-based interventions have coordinated the offering of programs across the state. The Division of Elderly Affairs has supported this by requiring their grantees to offer chronic disease self-management education workshops.
- 5) Educating the health system and other community organizations regarding the benefits of the Community Health Network and how to access the referral system. Community Health Network staff have conducted in-person educational sessions called "academic detailing" to clinicians, care managers, businesses, and social support agencies.
- 6) Partnering with health systems. The Community Health Network has established referral relationships with the federally qualified health centers under contract with the Department of Health through the RI Chronic Care Collaborative, and the RI patient-centered medical home aligned initiative known as the Care Transformation Collaborative, which includes 350,000 patients and 65 practices.

Challenges/Barriers to Success

Barriers to success include the integration of the Community Health Network to practice workflows. Many practices are going paperless and their electronic health records are not set up to send referrals to the Community Health Network. Providers also have to change their workflow to spend time engaging patients to make referrals to Community Health Network programs.

Patients themselves may not be ready to attend programs. The logistics in arranging for programs that are offered in accessible locations and convenient times for patients is also difficult. For example, those who work during the day prefer evening classes while those who are retired prefer morning classes. Ensuring a large supply of programs to meet all these needs is an ongoing challenge.

Results and Impact

The Community Health Network currently offers 15 different programs. From November 2012 to April 2015, a total of 1,267 people have been referred to the system from 67 healthcare agencies. 718 of those people enrolled in a program (57%).

Implications

Lessons learned include:

- Building a state-level referral network requires continuous quality improvement, clear protocols/procedures, and adaptability.
- It is important to keep the perspective of a medical practice's workflow in mind when developing the system so that it can be integrated with their work and adapted to changing processes.
- Obtaining signed patient consent forms can be challenging for practices. Consent is needed to refer patients to partner programs outside of the Department of Health. To reduce the burden on practices, Community Health Network staff contact patients directly to obtain consent if needed.

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- Regular communication with providers is essential, as patients' referral and completion status provide data on continuity of care and help reinforce the utilization of the Community Health Network referral system.
- Having a shared vision of how health can be improved through community-based self-management programs is necessary to lead to culture change. This vision will help overcome barriers such as disruptions to workflows and constant revision to protocols and forms.

The next steps for the Community Health Network include developing the system further and integrating it seamlessly with the health care system. Investments will be made for direct connection to electronic health record systems so that barriers to referrals are minimized as practices are moving toward a paperless practice. Referral quality will be improved with the implementation of motivational tools and trainings from Dr. Prochaska's Pro-Change consulting company for primary care provider sites.

Sustainability for the Community Health Network programs is a collaborative effort for the Department of Health, health plans, the state Medicaid office, and Medicare. Another priority for the Community Health Network is to increase capacity to offer programs across the state. This aligns with the Department of Health's Health Equity Zones (HEZs) initiative. The Department of Health has combined funding from CDC, Maternal and Child Health, and the Prevention Block Grant to address health disparities and improve population health in underserved communities by creating HEZs. HEZs are contiguous geographic areas that are small enough for the project to have a significant impact on improving health outcomes by improving the social and environmental conditions of the neighborhood, yet large enough to impact a significant number of people. HEZs can be defined by political boundaries or by less defined boundaries (e.g., neighborhoods). Activities of HEZ agencies involve either implementing worksite wellness programs or self-management programs such as LWRI. Eleven HEZ agencies representing over 400,000 people across all five counties in RI have been chosen. These include partners such as community health centers and YMCAs, which are potential delivery system partners and can allow for statewide reach of LWRI. The next challenge will be to embed CDSME at the community level in order for greater and sustained access to programs. The HEZs present a unique opportunity to leverage funding and resources to improve the community in an innovative fashion.

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Chronic Disease Self-Management Education Success Story

*Fostering Partnerships through
Public Health Region Community Teams*



Contact Name: Michele James, Denise Rivers

Organization: South Carolina Department of Health and Environmental Control, Lieutenant Governor's Office on Aging

Email: jamesmd@dhec.sc.gov, riversd@aging.sc.gov

Background

The severity of chronic diseases and disabling conditions in South Carolina has gained national attention in the past two decades. South Carolina is among the states with the highest rates of overweight and obesity, heart disease, stroke, and diabetes; the outcomes associated with these conditions are significantly worse for minority and rural populations.

- According to the 2013 State Ranking Report of the United Health Foundation, South Carolina ranked 43rd in the nation for overall health status.
- Prevalence of hypertension in South Carolina has increased from 28.1% in 2001 to 39% in 2012.
- The percentage of obese adults in South Carolina has increased from 13.6% in 1990 to 31.7% in 2012.
- Diabetes prevalence in South Carolina has increased from 8.1% in 2001 to 11.6% in 2012.
- Over 1 million or 30% of South Carolinians aged 18 and older report having doctor diagnosed arthritis.

Time Period of Achievement

July 2013 - February 2015

Location of the Story

Statewide

Key Organizations Involved

South Carolina Department of Health and Environmental Control, South Carolina Lieutenant Governor's Office on Aging, South Carolina Public Health Regions

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Population Served

The primary target population is older adults and adults with disabilities, especially underserved and minority populations

Intervention

The South Carolina Lieutenant Governor's Office on Aging (LGOA) and the South Carolina Department of Health and Environmental Control (DHEC) have been working together to develop a diverse infrastructure of partners, including health care delivery systems, to expand access to and support sustainability of the Chronic Disease Self-Management Program (known as Better Choices, Better Health in South Carolina). Evidence-based self-management programs have been proven to increase the practice of healthy behaviors, improve self-management of health, and reduce health care utilization.

During the past year, efforts have focused on improving communication with regard to partner expectations and increasing hands-on technical assistance to enrich the quality of current and future partnerships. In an effort to foster a systemic approach toward partnership identification and development, LGOA and DHEC have provided public health regions with funding to assist Community Systems Teams with the identification of appropriate partners through the work they are already doing. Many local public health staff serve in leadership positions within their communities in a variety of roles, including social, civic, advisory, and community groups and thereby have ready access to the target population.

The partnership toolkit is a new product that was developed to assist LGOA and DHEC's state and region offices with identifying appropriate partners, planning and implementing the program, and clearly defining expectations of potential partners. The toolkit contains basic facts and other information about chronic diseases, a program brochure, a description of leader qualifications, and an explanation of a new role for an organizational liaison, who is responsible for planning, recruiting, and advertising workshops. The toolkit also includes a readiness assessment which is used to determine whether or not an organization is ready to implement, expand, and sustain CDSMP, a memorandum of understanding (MOU) which clearly outlines what is expected of the partner and can be used as a guide in the early stages of partnership development, and an implementation plan which outlines specifically what the partner agrees to do.

Results and Impact

- CDSMP is being offered on a regular basis by a number of partners who have worked with LGOA and DHEC's Division of Healthy Aging since the inception of the state CDSMP initiative in 2006.
- From July 1, 2013 through February 28, 2015, 28 host organizations offered CDSMP workshops in 30 of the 46 counties in South Carolina; currently CDSMP is available in 98 implementation sites.
- Through these partnerships, access to the program has increased throughout the state, and a greater number of residents have participated in CDSMP. During the 12-month period from July 1, 2013 through June 30, 2014, 53 sites reached 858 participants; and during the first eight months of the current project year, July 2014 through February 28, 2015, 33 sites have served 534 participants.
- The program continues to help participants make positive changes in their lives. As one of our partners, Joseph Whiting, Director Phoenix Health Education and Wellness Center in Sumter, South Carolina, proudly proclaimed, "The exciting part of teaching the workshop is watching the transformation take place. What takes place is a psychological and emotional metamorphosis. The facilitator is instrumental in leading the group from where they were to where they are now, unlocking their soon-to-be-recognized potential. I love to see the participants set free the person they will become. I see it in every workshop. This is exciting to me."

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As a result of this new approach, including the use of the toolkit, a significant number of new multi-site delivery partnership opportunities have been identified and are being developed. Among these, the University of South Carolina Consortium for Latino Immigration Studies (Tomando Control de su Salud), Coastal Carolina University, Medical University of South Carolina, Georgetown Hospital Systems, City of Chester Department of Parks and Recreation, and Richland County Recreation Commission. Our expanded network of partners, along with an increase in the availability of programs at the local level, offers great potential to substantially increase the number of adults who will have access to the Better Choices, Better Health program in South Carolina.

Implications

New partnerships with multi-site delivery systems which have led to increased access to and use of CDSMP statewide. Outreach and partner identification through collaboration with local public health staff and the use of the partnership toolkit will be instrumental in helping to achieve further expansion and long-term sustainability of CDSMP.

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Chronic Disease Self-Management Education Success Story

*Electronic Health Record Referral Success
at the University of Utah*



Contact Name: Rebecca Castleton

Organization: Utah Arthritis Program

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Background

- The University of Utah's Community Clinics have been striving to improve referral processes within their health care system for several years but continually struggled to get doctors to refer patients into their programs.
- There is potential for clinics to use electronic health records to make referrals into Chronic Disease Self-Management Education (CDSME) programs, but a system had never been developed.

Time Period of Achievement

The time period from the first University of Utah's Electronic Health Record (EHR) referral: January 2015 to the present (April 2015)

Location of the Story

The University of Utah Community Clinics, Salt Lake County (one of Utah's largest health care systems)

Key Organizations Involved

University of Utah Community Clinics and Orthopedic Center; Utah Department of Health (UDOH) Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program

Population Served

University of Utah Community Clinic and Orthopedic Center patients

Intervention

- UDOH EPICC Program contracted with the University of Utah Orthopedic Center to develop a sustainable referral policy for CDSME programs.
- Utah Arthritis Program helped facilitate collaboration between the CDSME coordinator at the University of Utah and its Orthopedic Center.

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- University of Utah CDSME coordinator outlined steps needed to generate email lists of patients seen within a certain timeframe with specific diagnoses from the EHR.
- CDSME coordinator used the generated email lists to send automated emails to patients with information about CDSME programs, a recommendation from the physician or care manager to attend the program, and a link to register directly for upcoming workshops.
- Coordinator trained staff at other clinics, including the University of Utah Orthopedic Center physical therapy staff, and care managers about how to generate email lists of patients to notify them of CDSME offerings.

Challenges/Barriers to Success

- Health care staff have different levels of skills using the EHR. Training staff who have limited knowledge about how to use the EHR can be challenging and frustrating.
- Patient lists created by diagnosis codes exclude patients that don't have a formal diagnosis in the EHR.
- Different EHRs are used by different providers and health systems. This makes expanding to other partners difficult because processes and capabilities vary widely.

Results and Impact

- Emails have been sent out to thousands of patients with certain diagnoses to recommend self-management workshops with minimal effort.
- Patients have responded well to this approach and have registered for and filled workshops quickly.
- CDSME workshops are being offered more frequently at more locations. The University of Utah Orthopedic Center has trained peer leaders and is now holding workshops in their office.
- Adults with disabilities are learning more about the CDSME workshops from their trusted providers and care managers.
- Workshops are readily available in familiar locations where older adults receive treatment.

Implications

- There is value in patients receiving a recommendation from their providers to attend CDSME self-management workshops and having a direct link to make registration easy.
- Having a champion coordinator lead the way in outlining steps to utilize the EHR is essential to getting other partners and health systems on board with a similar process.
- Training is involved in teaching providers how to fully utilize the EHR, and there is a learning curve to use it for referral purposes. However, the efforts have paid off.

Next steps include:

- Expand the use of EHR referrals to other specialties at the University of Utah.
- Implement a system for physicians to refer patients through the EHR during appointments.
- Assist other partners and health systems to develop a similar method for EHR referrals.

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Chronic Disease Self-Management Education Success Story

*Developing a Collaborative Approach with Aging,
Public Health, and Health Care to Expand
Chronic Disease Self-Management Education Programs*



Contact Name: April Holmes

Organization: Virginia Department for Aging and Rehabilitative Services

Email: april.holmes@dars.virginia.gov

Background

- The Senior Services of Southeastern Virginia (SSSEVA) Area Agency on Aging (AAA) risked falling short of their target goal for the number of workshop completers (participants who attend at least four of the six workshop sessions).
- A neighboring AAA, Peninsula Agency on Aging (PAA), had offered workshops under the auspices of the Peninsula Health District program. However, the health department's Chronic Disease Self-Management Education (CDSME) program was being phased out due to lack of funding and the necessary infrastructure to support it.
- Riverside Health System, a major hospital system located within the PAA coverage area, was interested in implementing CDSME to fill the gap in services and to improve patient outcomes.

Time Period of Achievement

The time period from the first phone conversation with Riverside Health System (October 2011) to the initial leader training at this location (July 2012) was nine months.

Location of the Story

The following localities in Southeastern/Tidewater Virginia were involved:

- Counties of Isle of Wight, James City, Southampton, and York
- Cities of Chesapeake, Franklin, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Suffolk, Virginia Beach, and Williamsburg

Key Organizations Involved

Virginia Department for Aging and Rehabilitative Services, Senior Services of Southeastern Virginia (SSSEVA), Peninsula Agency on Aging (PAA), Riverside Health System, Virginia Department of Health, Peninsula Health District, Virginia Department for Medical Assistance Services (DMAS)

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Population Served

Older adults (including those eligible for the Program of All-Inclusive Care for the Elderly [PACE])

Intervention

The Virginia Department for Aging and Rehabilitative Services:

- Awarded supplemental funding to support SSSEVA in forming partnerships with PAA, the Peninsula Health District, and Riverside to train leaders and implement workshops in an underserved area.
- Requested assistance from Dr. Kyle Allen, a geriatric specialist at Riverside and a CDSME champion.
- With guidance and support from Dr. Allen, convened a meeting at Riverside to develop a plan for implementing CDSME programs. The Riverside Center for Excellence on Aging and Lifelong Health, SSSEVA, PAA, the state and local health departments, and DMAS (the state Medicaid agency) were involved in the planning process.
- Facilitated collaboration with the partnering organizations and provided leadership, technical assistance, and support to partners throughout the process.

The Virginia Department of Health:

- Provided mini-grant funding to support Riverside in conducting a study to evaluate the effect of CDSME on health outcomes for PACE participants.

Challenges/Barriers to Success

- Marketing the program and developing an effective referral process has been challenging. Although Riverside had an internal champion to promote the program and the referral process was integrated with electronic health record, patients are not routinely being referred to workshops.
- The health outcomes study was limited to PACE participants, individuals with advanced medical needs requiring nursing home level of care. Findings of the study cannot be generalized to the overall pool of participants, and the positive effects might be mitigated by the medical vulnerability of the study participants.

Results and Impact

- SSSEVA exceeded its completer goals and gained a reputation for leadership and mentoring with regard to CDSME programs.
- PAA offered CDSME workshops in a new geographic area, initially under the umbrella of SSSEVA and later independently as a stand-alone program. Subsequently, PAA developed a mentoring partnership with another AAA to expand CDSME to an unserved part of the state.
- Riverside embedded the program through its own trained leaders and master trainers and conducted an outcome study of PACE participants. Riverside's Center for Excellence in Aging and Lifelong Health provides the perfect venue for CDSME because it focuses on "applied research for operationally sustainable programming to meet the needs of the most vulnerable members of (the) community." The implementation and evaluation of CDSME programs is aligned with the Center's mission and goals.

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- The Peninsula Health Department reestablished its role in implementing CDSME programs by obtaining its own license and working in coordination with PAA to schedule and promote CDSME workshops. It is a key partner in providing community outreach to underserved populations.

Implications

- Challenges and adversities can lead to opportunities when organizations work collaboratively.
- Identifying a champion early in the process is enormously helpful in securing a commitment from an organization.
- Having an automated referral system by itself is not sufficient for recruiting and enrolling participants into workshops. Identifying the right referral sources (e.g., persons who are known and trusted) and building upon those relationships should be considered.

Next steps include:

- Develop a step-by-step internal referral process for Riverside Health System to increase participant enrollment. Monitor the process and modify as needed to improve results.
- Ask Riverside to serve as an advocate, mentor, and role model for encouraging other health care organizations to offer CDSME programs.
- Promote continued collaboration among partners to facilitate the spread of CDSME programs.

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Chronic Disease Self-Management Education Success Story

*“What’s Going On Out There?”
Successful Services in Indian Country*



Contact Name: Shelly Zylstra

Organization: Northwest Regional Council (Washington)

Email: zylstra@dshs.wa.gov

Background

Health disparities in Indian Country are evident from state and national statistics. Studies show that Tribal members exhibit lower life expectancy, high chronic disease rates, and poorer self-reported health than other communities. Chronic Disease Self-Management Education (CDSME) programs seemed a perfect fit for the community, but assuring that the program’s impact continues after the workshops are over is imperative for tribal communities.

“Flash in the pan” health education programs are common in Indian communities. For example, a graduate student spends several years on the reservation getting to know the people and conducting effective health education programs, subsequently leaving after the dissertation is approved. A nonprofit gets a grant to conduct a program, and when the funding period ends, there is no service available. Tribal communities benefit from health education but a sustainable approach is needed to continue the services.

Time Period of Achievement

Twenty-seven years of tribal relationship building, six years of CDSME, four years of Wisdom Warriors

Location of the Story

Tulalip Indian Reservation

Key Organizations Involved

Tulalip Tribe, Northwest Regional Council/Area Agency on Aging

Population Served

Tribal elders and tribal members with chronic conditions

Intervention

Development of Wisdom Warriors, an aftercare program for the Chronic Disease Self-Management Program (CDSMP), involved the tribal diabetes program, tribal clinic, and the cultural department which

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have continued to teach health activities and develop action plans with participants during their monthly meetings. Wisdom Warriors attend monthly classes that include a teaching, an activity or craft, and a healthy meal. They make action plans for the following month. If they are successful in their action plan, they earn a bead the next month to put on their Wisdom Warrior pouch. The program is inexpensive, fits into other tribal programs, and is ultimately sustainable.

The program brings together several departments which all provide education for tribal members. The ongoing efforts allow the clinic, cultural center, elders program, and the diabetes program to work together on the same outcomes. The strengths each program brings to the table enhance success and works well for the participants.

Results and Impact

The CDSMP workshops are full with waiting lists of others who want to participate. The aftercare classes are popular with the Wisdom Warriors, and the camaraderie provides support for ongoing healthy living choices. Physicians and clinics who are noticing improved health and weight loss, are calling the tribe to find out “What is going on out there?” It is the Wisdom Warrior program working hard for tribal elders!

The dialysis center called to find out why the participants are doing so well. They are losing weight and eating well. The cardiologists at Providence Regional Medical Center in Everett are so impressed with the intervention and the effects it has had on their patients that they have asked to have the program presented at their regional Cardiology Conference in May.

Additionally, Elders wearing their Wisdom Warrior bags receive special recognition at Elders’ gathering for their efforts to achieve and sustain good health. This honors their wise health choices and their hard work in achieving their goals.

Implications

Continue to support tribal Wisdom Warriors programs throughout the state of Washington and other states as requested. Currently working with a tribal program in Oklahoma to bring CDSMP to their communities and incorporate the Wisdom Warriors with their health activities.

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Chronic Disease Self-Management Education Success Story

*Use of NIATx Process Improvement to Implement
Evidence-Based Health Promotion Programs
in Rural Wisconsin Counties*



Contact Name: Betsy Abramson

Organization: Wisconsin Institute for Healthy Aging

Email: betsy.abramson@wihealthyaging.org

Background

Many rural Wisconsin counties were having difficulty delivering the Chronic Disease Self-Management Program and Stepping On (recruiting leaders, getting leaders trained, organizing workshops, recruiting participants). The NIATx process improvement model was designed specifically for behavioral health care, and allows payers and providers to make small changes that have a big impact on outcomes by removing barriers to treatment and recovery. With grant funding from the University of Wisconsin-Wisconsin Partnership program, it was adapted for use with evidence-based programs.

Time Period of Achievement

August 2012-August 2014

Location of the Story

16 rural Wisconsin counties

Key Organizations Involved

Local county aging units/Aging and Disability Resource Centers (ADRC), Wisconsin Department of Health Services/Bureau of Aging and Disability Resources, Greater Wisconsin Agency on Aging Resources, Wisconsin Institute for Healthy Aging (WIHA), University of Wisconsin School of Engineering (Industrial Engineering) and University of Wisconsin School of Medicine and Public Health's Community Academic Aging Research Network

Population Served

Counties and individuals appropriate for CDSMP and/or Stepping On

Intervention

1. Identified 16 counties that had, or were willing to get, Leaders trained who had not successfully delivered a CDSMP or Stepping On workshop in the previous two years.

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2. Counties were randomized into two groups – eight were designated for first year intervention and other eight served as a control group. In the second year, the second eight received the intervention. Counties were provided with \$2,500 stipends to participate in program, with grant funds, and match from AAA.
3. Trained and assigned NIATx Process Improvement coaches from WIHA and the state Department of Health Services.
4. Trained county leads on basics of NIATx Process Improvement (if not yet familiar or experienced with it).
5. Assisted counties in convening a “Change Team” and identifying a “Change Leader” to implement the intervention.
6. Worked with counties in identifying Change Projects and using P-D-S-A (Plan-Do-Study-Act) Change Cycles to implement the project.
7. Quantitative and qualitative analysis. Interviews with Change Leaders and Change Team members.

Challenges/Barriers to Success

- Very rural counties
- Limited funds
- Busy schedules of Change Team members – hard to convene
- Some counties did not have Health Promotion duties assigned to specific individual
- Change Team members were from many different agencies
- Many counties experienced significant staff turnover, especially in leadership
- Some counties had weak leadership
- Some counties had weak connections/relationships

Results and Impact

1. The NIATx Coaching worked.

Did NIATx Coaching Work?

- Counties with BHAS coaches held more workshops and reached more participants within the first year

Average improvement in first year	Counties with coaching (n=8)	Counties without coaching (n=8)	Difference
Number of workshops*	1.4	0.5	0.9
Number of participants*	14.1	3.0	11.1
Number of completers [^]	10.3	2.6	7.6

*2-Sample Mann-Whitney U-Test p<0.10

[^]2-Sample Mann-Whitney U-Test p<0.05

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2. The workshops were effective

Were the workshops effective?

□ Living Well

- Improved Medical Communication*
- Fewer social role limitations
- Fewer emergency visits and hospitalizations

□ Stepping On

- Fewer falls*
- Improved falls risk behavior*
- Fewer emergency room visits*

*Change in pre-post participant survey responses for cohort 1 counties with paired t-test $p \leq 0.05$

3. There are four key components for a rural county ADRC/aging unit to implement these programs:

- Stable and supportive agency leadership
- Health Promotion Coordination duties must be assigned to a specific staff person in the ADRC/county aging unit
- Have trained (or be able to quickly get trained) and committed workshop leaders.
- Have good connections with external partners.

Are you ready for implementation?

County	Total Target Workshops (over 2 years)	Stable & Supportive Agency Leadership	Health Promotion Coordination Role Assigned	Trained & Committed Workshop Leaders	Connections with External Partners
A	5	+	+	+	+
B	5	+	+	+	+
C	4	+	(+)	(+)	+
D	3	+	+	+	+
E	2	+	-	+	+
F	1	-	+	-	-
G	1	-	-	-	-
H	0	-	-	-	-

(+) Role filled by an external partner

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Implications

Ten key lessons:

1. Counties needed to be prepared (understand the NIATx strategy, get their Change Team together, have Leaders trained or ready-to-be-trained) before Action.
2. Keep the mission front and center (chronic disease self-management or falls prevention)
3. Know what you're doing (aims – train workshop leaders, engage stakeholders, reach isolated older adults).
4. Get the most from NIATx by using examples relevant to implementing EBPPs across a county, emphasize how to engage and support a Change Team, and translate the NIATx skills/process to implement other EBPPs.
5. Have an effective Change Leader – passionate and enthusiastic about the workshop, resourceful and creative, can engage a reliable management team.
6. Set clear expectations for workshops leaders (training and facilitation), Change Team member commitment.
7. Leverage the partnerships within and cross-counties – with limited resources in rural areas, many hands and perspectives make light work and better outcome.
8. Engage the stakeholders – county aging units/ADRCs, health care providers, nutrition sites, retired professionals, community/senior centers, and older adults themselves.
9. Success relies on effective workshops leaders that are trained and ready to go. Have more than two per county.
10. Word-of-mouth is your best marketing tool in a rural county.

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