Offering Evidence-Based Programs in Rural Communities: Lessons Learned from Wisconsin

Speakers:

• Betsy Abramson, J.D., Deputy Director, Wisconsin Institute for Healthy Aging
• Michelle Comeau, Special Projects Assistant, Wisconsin Institute for Healthy Aging
• Shannon Myers, CWP, Community Research Specialist and Special Projects Assistant, Wisconsin Institute for Healthy Aging
Implementation of Evidence-Based Prevention Programs in Rural Wisconsin Counties

Betsy Abramson, JD, Deputy Director
Wisconsin Institute for Healthy Aging

Meg Wise, PhD, MLS
Melissa Dattalo, MD, MPH
Anne Hvizdak
August 18, 2015
Outline

- What is the Bringing Healthy Aging to Scale (BHAS) project?
- Outcomes
- Lessons Learned
Bringing Healthy Aging to Scale

- Can the use of quality improvement tools help rural counties implement evidence-based prevention programs for older adults?

<table>
<thead>
<tr>
<th>Living Well</th>
<th>Self-management of chronic illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stepping On</td>
<td>Prevention of falls</td>
</tr>
</tbody>
</table>
Quality Improvement Tools

- NIATx Quality Improvement Principles
  1) Understand and involve the customer
  2) Fix key problems that keep the director up at night
  3) Pick a powerful Change Leader
  4) Get ideas from outside the organization or field (networking)
  5) Use rapid-cycle testing to establish effective changes
Bringing Healthy Aging to Scale

- **Goal:** 16 counties assigned to implement either Stepping On or Living Well workshops over the course of a year

- **Randomized Controlled Trial**
  - 8 counties received a BHAS Coach to aid in using NIATx quality improvement model
  - 8 counties were randomized to a waiting list for a future coaching opportunity
  - Each county received $2,500 for staff to work with coaches/partners and to develop a sustainability plan
BHAS Counties

- Columbia
- Marquette
- Oneida & Vilas
- Bayfield
- Iowa
- Richland
- Sawyer
- St. Croix

- Buffalo & Pepin
- Jackson
- Juneau
- Pierce
- Sauk
- Vernon
- Kewaunee
- Rusk
BHAS Aims

- Improve leader selection and retention
- Increase partnerships
- Increase participant enrollment
- Increase number of workshops
BHAS Outcomes

- Number of workshops held
- Number of participants reached
- Participant surveys
- Interviews with Change Leaders and Coaches
Did NIATx Coaching Work?

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

<table>
<thead>
<tr>
<th>Average improvement in first year</th>
<th>Counties with coaching (n=8)</th>
<th>Counties without coaching (n=8)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of workshops*</td>
<td>1.4</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Number of participants*</td>
<td>14.1</td>
<td>3.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Number of completers^</td>
<td>10.3</td>
<td>2.6</td>
<td>7.6</td>
</tr>
</tbody>
</table>

*2-Sample Mann-Whitney U-Test \( p \leq 0.10 \)

^2-Sample Mann-Whitney U-Test \( p \leq 0.05 \)
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 $p \leq 0.05$
What can we learn from experience?

We interviewed change leaders (7/8) and BHAS coaches (3/3) who participated in the project to learn from their experiences.

- Experience and perceptions
- How to improve the process
## Are you ready for implementation?

<table>
<thead>
<tr>
<th>County</th>
<th>Total Target Workshops (over 2 years)</th>
<th>Stable &amp; Supportive Agency Leadership</th>
<th>Health Promotion Coordination Role Assigned</th>
<th>Trained &amp; Committed Workshop Leaders</th>
<th>Connections with External Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>C</td>
<td>4</td>
<td>+</td>
<td>(+)</td>
<td>(+)</td>
<td>+</td>
</tr>
<tr>
<td>D</td>
<td>3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>E</td>
<td>2</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>F</td>
<td>1</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>G</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>H</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(+): Role filled by an external partner
TOP 10 LESSONS LEARNED FROM COUNTY CHANGE LEADERS
#1: Preparation before Action

- Are you ready?

  "We were on the fast-track. Had we more time I think it would have worked better because I already had many commitments prior to accepting the NIATx challenge with Stepping On. I think having [someone] explain the change process to my change team really helped as well." ~St. Croix

- Are you and your partners on the same page?

  "I should have better educated the change team group who we started with regarding the NIATx process, so the first meeting was not so confusing." ~Iowa
#1: Preparation before Action

**Prepare**
- Key Ingredients
- Stakeholder Analysis
- Assemble Working Partners

**Implement**
- Engage Change Team
- Recruit & Support Workshop Leaders
- Recruit Participants

**Sustain**
- Adapt
- Staff Turnover
- Stable Partners
#2: Mission front and center

- Reduce falls (Stepping On)

  “I chose to really focus on Stepping On because ... falls prevention is huge. When I ask: ‘Who’s had a fall?’ nearly every hand goes up.”  
  Change Leader, St. Croix County

- Improve older adults’ health and wellbeing (Living Well)

  “I see Living Well as very valuable for the community members. Because they have very limited access to healthcare.”  
  Change Leader, Marquette County

NIATx principle: Know your customer
# 3: Know what you’re doing (Aims)

Address the crux of the problem:
- Train workshop leaders
- Engage stakeholders
- Reach isolated older adults (marketing)

As time went by:
- New aims emerged

NIATx principle:
Address the problem that keeps the director up at night
#4: Get the most from NIATx

- Familiarize change leaders in NIATx before launch
- Use examples relevant to implementing evidence based prevention programs across a county

*NIATx was designed for quality improvement within addiction treatment agencies*

- Emphasize how to engage and support a change team
- NIATx skills/processes translated to implement other evidence based programs

*St. Croix County started with Stepping On and then branched into Living Well and Living Well with Diabetes.*
#5: Effective Change Leader

- Collaborator, connector, communicator

- Passionate and enthusiastic about workshops
  
  “[Stepping On] was really a priority for me. This was really something that I wanted to do.” – Iowa County

- Resourceful and creative
  
  Coordinating rides to Stepping On workshop to and from meal sites. St. Croix County

- Engage (recruit, train, support and honor) a reliable and manageable team of workshop leaders
  
  Include workshop leaders in change team. St. Croix County

NIATx principle: Pick a powerful change leader
#6: Set clear expectations

Communicate time, effort, and timeline…

- Workshop leaders: training & facilitation
- Change team: meetings, outside activities & tenure
- Number of workshops to be held
#7: Partnerships w/in and x-counties

With limited resources...many hands (minds and perspectives) make light work ... and better outcomes

“A big piece of the value of these classes is the relationships that we built with hospitals and clinics, senior centers....”

- Vilas and Oneida counties jointly trained and shared Living Well leaders
- Bayfield teamed up with Ashland County to implement Stepping On

NIATx principle: Networking
#8: Engage stakeholders

- County aging units/ADRC
- Hospitals and clinics
- Physical therapists
- Nutrition sites
- Retired professionals
- Community/senior center
- Nursing homes
- Older adults

Staff from these stakeholder groups joined the change team.

*NIATx principle: Networking*
Success relies on effective workshop leaders...

- Engage retired professionals
- Reduce barriers to training
- Things happen... helps to have a small team of workshop leaders
#10: If you’ve offered a good program…

Word of mouth is your best marketing tool…

“A woman who was referred by her physical therapist brought a friend the second week. She didn’t even ask! He finished out the class and she was just talking it up to everyone she knew.” St. Croix County

“Word of mouth is a wonderful thing. … We haven’t had a challenge in filling our classes.” Bayfield County
Next Steps

- Readiness Checklist
- Best Practice Manual
- Expand Use of Change Teams
- Sustainment Follow-Up
- Further Dissemination
BHAS Grant Team

- Betsy Abramson
- Melissa Dattalo
- Jay Ford
- Anne Hvizdak
- Kim Johnson
- Karen Kedrowski
- Kris Krasnowski
- Jane Mahoney
- Meg Wise

Contact:
betsy.abramson
@wihealthyaging.org

Funding for this project was provided by the UW School of Medicine and Public Health from the Wisconsin Partnership Program
High-Level Evidence Based Prevention Programs
Reaching individuals to take evidence-based prevention programs

BRONZE  SILVER  GOLD
Promotion of evidence-based prevention programs

- Have brochure or flyers in the office
- Hang promotional material around workspaces or in high-traffic areas around town.
- Newspaper/Radio
Promotion of evidence-based prevention programs

- Promotional materials and Outreach
- Presentation
  - In community
  - To medical staff
- Partnering with a health care facility
  - Promo material
  - Host Site
  - Encourage patients
Referral Process

1. Provider uses letter to follow-up with patient in goal setting.
2. Patient agrees and signs a referral form.
3. Coordinator contacts referred patient and enrolls in a workshop.
4. Clinician introduces SME opportunity to patient.
5. Referral form is sent to Workshop Coordinator.
6. Patient communicates with clinic regarding referral status (enrolled, declined, waitlisted).
7. Coordinator communicates with clinic regarding referral status (enrolled, declined, waitlisted).
8. In the workshop patient writes a letter to provider describing what they’ve learned.
9. Patient attends SME.
10. Patient letter is sent to provider.
Connecting to Providers

**Where do you start?**

- Local Clinic or Hospital
- Non-clinicians can be influential
- Address benefits from both patient and practice standpoint
- Complementary Process
- [http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/](http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/)
Piloted Model:
Family Health/La Clinica, Wautoma, WI

How the project started:

• Prompted by a grant received to focus on a FQHC and develop a referral process
• Connected with the CEO and CFO
• Had 3 Staff meeting during their lunches to introduce the programs and to follow up
• A workgroup was developed to tailor a referral process
Yes!
I feel you could truly benefit from these workshops – can I make a referral?

Facts/Fax sheet is faxed to ADRC

ADRC calls patient to inform and sign-up for upcoming workshop

ADRC tracks outcome of referrals and updates referring provider

Leader provides clinic with patients goal summary throughout workshop

Post workshop goals to providers
Piloted Model: Family Health/La Clinica, Wautoma, WI

Adaption

• Referring challenges to a predominately Spanish speaking population
  • La Clinica supported two staff to be trained in the Spanish version of the diabetes self-management workshop

• Providers time restrictions
  • Health Educators able to refer
Piloted Model: Wild Rose Hospital, Wild Rose, WI

How the project started:

• This partnership took 6 years

• Only had capacity for “Silver” (promotional materials and host site) – No champion

• ADRC involvement in “CHIP” - meaningful awareness how the program helps with hospital goals

• Workgroup established with new Quality Assurance champion
Adaption

• Provider encourages patient, Nurse fills out referral form, and Nurse Manager carries out the fax referral to ADRC

• Currently discussing ways to embed the evidence-based prevention programs into an electronic referral system (EPIC)
Key Components

- Champion
- Complementary Process
- Proactive and Systemic Approach
- System and Program Flexibility
- Maintenance
Go for the GOLD
but start wherever you are and build from there

Have patience
Partnerships take time

Pilot, Evaluate, Maintain
Each partnership will be different but similar
Thank You!

Betsy Abramson
Betsy.Abramson@wihealthyaging.org

Michelle Comeau
Michelle.Comeau@wihealthyaging.org

Shannon Myers
Shannon.Myers@wihealthyaging.org