Essential Resources for Implementation and Sustainability of Evidence-Based Health Promotion Programs (Introductory)

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Carlene Russell, Iowa Department on Aging
Binnie Lehew, Iowa Department of Public Health

May 23, 2017

National Council on Aging
Improving the lives of 10 million older adults by 2020
Speakers

- **Betsy Abramson**, Executive Director, Wisconsin Institute for Healthy Aging
- **Megan Moulding Stadnisky**, Evidence-Based Aging Services Coordinator, Georgia Department of Human Services
- **Carlene Russell**, Executive Officer, Iowa Department on Aging and **Binnie Lehew**, Injury & Violence Prevention Program Manager, Iowa Department of Public Health

Moderator

- **Ellen Schneider**, National Council on Aging
Implementation of Evidence-Based Prevention Programs in Rural Wisconsin Counties

Betsy Abramson, JD, Executive Director
Wisconsin Institute for Healthy Aging
May 2017
Outline

- What is the Bringing Healthy Aging to Scale (BHAS) project?
- Outcomes
- Lessons Learned
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>
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<tbody>
<tr>
<td>Stepping On</td>
<td>Prevention of falls</td>
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</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 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>
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<tr>
<td>Number of completers^</td>
<td>10.3</td>
<td>2.6</td>
<td>7.6</td>
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*2-Sample Mann-Whitney U-Test p≤0.10
^2-Sample Mann-Whitney U-Test p≤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≤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>1. Stable &amp; Supportive Agency Leadership</th>
<th>2. Health Promotion Coordination Role Assigned</th>
<th>3. Trained &amp; Committed Workshop Leaders</th>
<th>4. Connections with External Partners</th>
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<tbody>
<tr>
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(+) Role filled by an external partner
Six Essential Elements for Uptake and Sustainability

1. Stable, supportive agency leadership
2. Health Promotion coordination duties assigned
3. On-going source of trained (or ready to be) committed workshop leaders
4. Strong community partnerships
5. Organizational Stability
6. Change Team Engagement
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*
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 on 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 within and across-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
- Stuff happens….. helps to have a small team of workshop leaders
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

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Georgia Department of Human Services
Division of Aging Services

Essential Resources for Implementation and Sustainability of Evidence-Based Health Promotion Programs:
Georgia’s Journey

Megan Stadnisky
Evidence-Based Aging Services Coordinator
Vision, Mission and Core Values

Vision

*Stronger Families for a Stronger Georgia.*

Mission

Strengthen Georgia by providing Individuals and Families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

Core Values

- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect.
- Manage business operations effectively and efficiently by aligning resources across the agency.
- Promote accountability, transparency and quality in all services we deliver and programs we administer.
- Develop our employees at all levels of the agency.
Division Vision and Mission

Vision

Living longer, Living safely, Living well

Mission

The Georgia Department of Human Services (DHS) Division of Aging Services (DAS) supports the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities and their families and caregivers to achieve safe, healthy, independent and self-reliant lives.
Journey Highlights

• Timeline
• Infrastructure
• Culture
• Business Planning
• Statewide Sustainability Support
• Confidence
• Pathways to Sustainability
Georgia’s Sustainability Efforts

2010 ARRA and 2011 System Integration Grant (SIG) awards

Hospital Transitions in 4 Area Agency on Aging regions

Chronic Disease Self Management Education (CDSME) Grant

Falls Prevention Grant

2011 - 2017
Infrastructure

• CDSMP – 5 AAA partners that rapidly expanded to all 12 AAAs in 2011 and served 1300 completers in two years.
• Powerful Tools for Caregivers
• Care Consultations
• DSMP
• Matter of Balance
• Hospital Transitions (Coleman and Bridge models)
• Tai Chi for Health
• Otago Exercise Program
• CONTINUOUS partnership development (Coalitions, committees, and work groups – Oh My!)
Culture

“"I do this for the money" said no social worker ever.

I have tried raising money by asking for it, and by not asking for it. I always got more by asking for it.

— Mildred Fitts

WHEN YOU LEARN HOW MUCH YOU'RE WORTH, YOU'LL STOP GIVING PEOPLE DISCOUNTS.

OLD WAY

NEW WAY
Business Planning

- 10 of Georgia’s 12 AAAs participated in optional business planning training from 2011 – 2015 through the Systems Integration Grant

  - Contracted with UGA and X Factor Consulting, LLC
  - Business Planning Workbook
  - Ted Talks – “Start with Why”
  - Focus on one required program – Community Options Counseling
  - Focus on one additional and optional program:
    - Case Management
    - Evidence-Based workshops
    - Hospital Transitions
Statewide Sustainability Support

• Following SIG business planning opportunities, CDSME and Falls Prevention Grants supported continued sustainability technical assistance with evidence-based program focus.
  • Contracted with Georgia State University’s Georgia Health Policy Center (GHPC)
    • Informational interviews with a sample of AAAs to gather sustainability baseline and common TA needs
    • Face-to-face meeting with Leadership and Programmatic representatives from all 12 AAAs and gathered specific messaging about Aging Network and EBP implementation
    • Focus group to establish concise marketing messages to sell EBPs and developed a name and tag line for all EBPs offered by Aging Network partners in Georgia:
      • Georgia HealthMatters: life enriching programs
    • Another face to face meeting to determine a programmatic logo and discuss the value and cost of workshops and services
  • 2016 – GHPC provides individual TA to 10 interested AAAs to sustain EBPs
  • 2017 – GHPC will coordinate another face to face meeting
Confidence

• Business planning participants attempted to implement their business plans.
  • At least four succeeded!!
    • Contracts with Hospitals for evidence-based Transitions Programs (x2)
    • Private Pay Case Management service
    • Options Counseling services

• AAAs tried a variety of sustainability efforts and are becoming more comfortable asking for money!:
  • Private pay
  • Sponsorships
  • Mini-grants with insurance companies
Pathways to Sustainability

• Three enterprising AAAs teamed together and created a discussion-driven and action-oriented curriculum and helpful tools for a one-day, peer-to-peer workshop based on their sustainability journey, to sell to AAAs across the country interested in developing their own Path.

• Session Outcomes:
  • **Explore** what it takes to sustain EBPs
  • **Identify** the high-impact outcomes produced through participating AAAs’ EBPs
  • **Assess** readiness to begin seeking sustainable funding through collaboration and innovation
  • **Select** the Pathway that is the most appropriate to pursue NOW
  • **Develop** a 90-day action plan to guide development and implementation of an EBP sustainability plan
To Sustainability and Beyond

• State plan goal for 2019 is for all 12 AAAs to implement sustainable practices

• Engage new organizations (ie: health care, insurance, etc.) in mutually beneficial partnerships with aging service providers

• Continuously assessing population needs to market appropriate services to benefit greatest number of Georgians

• Leverage partnerships with marketing experts to standardized effective messaging strategies to engage and serve more Georgians

• Help to market the Pathways to Sustainability consultant packages to aging service organizations across the country
Questions?

Megan Stadnisky – Megan.Stadnisky@dhs.ga.gov
Sustainability Efforts in Iowa

Carlene Russell MS, RDN, LDN
Binnie LeHew MSW, LISW
Evidenced-Based Health Promotion Programs for Older Adults: Key Factors and Strategies Contributing to Program Sustainability

Stepping On
Building Confidence and Reducing Falls

Leader Training Application
An Evidence-Based Fall Prevention Program
Created by: Wisconsin Institute for Healthy Aging

Training Sponsored by: Iowa Department on Aging

Applications Due – January 16, 2015
Notification of Acceptance – February 2, 2015
Stepping On Leader Training in Des Moines – February 24, 25 & 26, 2015
Falling does not have to be a normal part of aging.
Efforts under the 2014-2016 ACL Grant

- Expanded the number of Evidence based programs from one to three
  - MOB, SO, TCA
- Increased the number of program leaders and distribution across the state
- Gathered information on costs of implementing classes
- Developed a business plan
- Sought additional funds to sustain the work
Work under the 2016-2018 Grant

• Expanding the Evidence-based programs by one (OTAGO)
• Promoting use of the STEADI toolkit and increasing screening in inpatient and outpatient settings
• Developing a statewide strategy for falls through the Iowa Hospital Assn’s Healthcare Collaborative
  • Create goals for reducing falls within and outside of institutional settings from beginning of patient contact through referral and participation in falls prevention program
• Partner with the Iowa SIM Grant to pilot the strategy in targeted communities
• Implementation will occur during Year 2, testing the strategy to determine its strengths and gaps
• Expect to implement reimbursement models for classes
Intended Result:

An integrated, sustainable evidence-based prevention program network in all of the major regions of the state.

Iowa Falls Prevention Coalition
Thank You

Questions?