Webinar Instructions

Thank you for joining today, please wait while others sign in.

- Phone Dial in: 1-866-740-1260
- Access code: 4796665#
- Due to the large number of participants, all lines will be muted during the call.
- If you want to ask a question, please type in your question into the box.
To improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged.

Federally Qualified Health Centers (FQHCs) and CDSMP – Perfect Together

October, 2011
Agenda

“Federally Qualified Health Centers (FQHCs) and CDSMP - Perfect Together”

- AoA’s National Partnership with the Health Resources and Services Administration and Federally Qualified Health Centers
  - Robert Hornyak, U.S. Administration on Aging, Acting Director, Center for Policy, Planning and Evaluation

- Missouri - What Works and Lessons Learned
  - Beth Richards, Program Manager, Missouri Arthritis & Osteoporosis, University of Missouri

- New Jersey - Profile of a Successful Partnership
  - Gerry Mackenzie, Program Manager, NJ Department of Health and Senior Services, Community Resources, Education & Wellness
  - Carol Mallette, Director, Diabetes Outreach and Education System, Southern Jersey Family Medical Centers

- Q&A - All
MISSOURI CDSMP REFERRAL

Federally Qualified Health Centers
Missouri Chronic Disease Collaborative

- The Missouri Department of Health and Senior Services (MDHSS) and Missouri Primary Care Association (MPCA) have contractually been partnering since 2000 around chronic disease initiatives – primarily diabetes, cardiovascular disease, and stroke: referred to as the Chronic Disease Collaborative.

- This successful clinical effort includes 23 primary care organizations (FQHCs) that primarily serve low-income, uninsured and underinsured persons.

- The collaborative utilizes benchmarks and score card measures to identify quality of care improvement opportunities and encourages the FQHCs to implement evidence-based interventions in their clinics to improve access to preventive care and chronic disease management services for those suffering from heart disease and diabetes.
CDSMP and the Collaborative - Challenges

- In 2009, prior to ARRA funding, the FQHC’s rejected contractual language to refer to CDSMP.

- In 2009-2010, FQHCs were educated through state-wide meetings on CDSMP.

- In 2010-11 contracts, CDSMP referral language was included; MPCA state-wide meeting in-services continue to update/communicate with FQHCs.
CDSMP and the Collaborative - Successes

- FQHCs are actively referring, but are also program delivery partners.
- Quarterly meetings with MPCA as MDHSS to review progress on Collaborative – CDSMP at the table.

- CDSMP future possibilities:
  - Outcomes data through MPCA EMR system
  - Outcomes data has intrigued other programs to be involved at MDHSS.
Swope Health Services – Kansas City Area

- Swope Health Central
- Swope Health Independence
- Swope Health Northland
- Swope Health South
- Swope Health West
- Swope Health Midtown (KS)
- Swope Health Wyandotte (KS)
- Swope Mobile
FQHC support

- **State-wide communication during quarterly MPCA meetings**

- **Local and regional infrastructure including Area Agencies on Aging (AAAs) and Regional Arthritis Centers (RACs) provide on-going communication with FQHCs**
  - On-site visits to FQHCs to provide brochures for referral, ensure staff have tools they need to make active referrals
  - Quarterly partner and leader meetings (regionally)
Next Steps

- Better tools for active referral

- Comparison of in-house self-management education vs. referral to CDSMP

- Focusing on Health Centers NOT making active referrals

- Focusing on Centers with staff turn-over to educate new staff on CDSMP.
“WHO WE ARE”

SOUTHERN JERSEY FAMILY MEDICAL CENTERS, INC.

• Community and Migrant Health Center

• 7 Locations

• 2 Medical Mobile Units

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
“DOES”

The Diabetes Outreach and Education System is

DESIGNED TO INCREASE PUBLIC AWARENESS AND ACTION THAT WILL HELP COMMUNITIES LEARN TO PREVENT & CONTROL DIABETES

OUTREACH IS DIRECTED TO 5 SOUTHERN NJ COUNTIES

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
WHAT HAVE WE DONE?

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
• Disseminated NDEP and other diabetes educational materials
• Created a Regional Diabetes Advisory Council and a Coalition
• Conducted Diabetes Day Fairs
• Hosted Diabetes Educational Workshops for providers
• Participated in the Bureau of Primary Care’s Diabetes Health Disparities Collaborative
• Facilitated Diabetes Self Management sessions

Reached potentially more than 1,000,000 people annually
WHILE WE CONDUCTED SOME DIABETES SELF-MANAGEMENT PROGRAMS......

WHERE COULD WE FIND A PROGRAM THAT WAS EVIDENCE-BASED AND WOULD ALLOW OUR PATIENTS TO MANAGE THEIR DIABETES AND RELATED CHRONIC DISEASE?

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
THROUGH THE NJDHSS WE LEARNED ABOUT THE STANFORD UNIVERSITY EVIDENCE-BASED CHRONIC DISEASE SELF-MANAGEMENT PROGRAM (CDSMP) AND THE DIABETES SELF-MANAGEMENT PROGRAM (DSMP)

OFFERING LIFESTYLE SKILLS TO BETTER MANAGE YOUR HEALTH

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
DOES STAFF PARTICIPATED IN PEER LEADER & MASTER TRAININGS ON CDSMP/DSMP

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
SOUTHERN JERSEY FAMILY MEDICAL CENTERS, INC.

ARMED WITH KNOWLEDGE

• Promote the program internally
• Secure buy in
• Identify sites for sessions
• Set calendar
• Develop marketing/outreach tools
• Recruit peer presenters
• Market program
• Order/assemble supplies
• Prepare for sessions

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
MARKETING TOOLS

Brochures

Self –Management
Prescription Pad

Posters
RECRUITMENT EFFORTS

• Partners

• Word of mouth

• Newspaper advertising

• Notices to patients

• Posters

• Support from provider staff

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
TO SUPPORT THE PROPOSED BEHAVIOR CHANGE

CDSMP/DSMP TRAINING FOR SJFMC STAFF

CONDUCTED 2 PEER LEADER TRAININGS
- 1 CDSMP WITH 14 PARTICIPANTS
- 1 DSMP FOR 8 PARTICIPANTS

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SOUTHERN JERSEY FAMILY MEDICAL CENTERS, INC.

WORKSHOPS FOR COMMUNITY MEMBERS
- 4 CDSMP WORKSHOPS
- 66 PARTICIPANTS

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WORKSHOPS FOR SJFMC PATIENTS

- 1 CDSMP WORKSHOP    7 PARTICIPANTS
- 3 DSMP WORKSHOPS    27 PARTICIPANTS
OUR APPROACH

- Review program goals
- Set the tone
- Encourage participation
- Stick to curriculum
- Topics covered
  - Dealing with Frustration
  - Appropriate exercise
  - Appropriate use of medications
  - Communicating effectively
  - Nutrition

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EVALUATION

FOR SJFMC PATIENT POPULATION
Data collection through PECS

Pre-Measures
Post-Measures
Results

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
PRE & POST DSMP MEASURES

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
Total Cholesterol

<table>
<thead>
<tr>
<th></th>
<th>Pre Measure</th>
<th>Post Measure</th>
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<tr>
<td>Total Cholesterol</td>
<td>158</td>
<td>146.8</td>
<td>11.2</td>
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FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
DSMP OUTCOMES

Results were for a three month period. With continued DSMP interventions, indicators will continue to improve.
LESSONS LEARNED

Participants give high marks to the program

Feedback on activities offer encouragement, support and improved use of resource tools

Participants report that group support and accountability influence their behavior in positive ways

Participants understand about action planning as a healthy lifestyle skill

Staff enjoy hosting presentations as much as participants

FEEL BETTER. BE IN CONTROL. DO THE THINGS YOU WANT TO DO.
“LOTS OF TIMES I COME TO THESE PROGRAMS BECAUSE I KNOW THEY NEED SOMEONE TO FILL A SEAT. FOR THE FIRST TIME I CAME TO A PROGRAM THAT I THINK REALLY HAS VALUE FOR ME AND I THANK YOU!”