



Consortium for Older Adult Wellness

# Partners Across States: Implementing CDSMP in Medical Settings

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Photos from Western Colorado Senior Games 2009,  
Grand Junction Parks & Recreation





## Who Are We?

- **COAW:** A 501(c)(3) non-profit organization founded in 2001 by Colorado Gerontologist, Christine Katzenmeyer.
- A statewide consortium with 80+ partnering organizations/agencies across Colorado.
- Today the organization is a network of over 600 professionals in a variety of disciplines.
- Expertise focusing on healthy aging of the older adult; provision of evidence-based training to health professionals and lay leaders on older adult injury/disability prevention and how to teach older adults to self-manage.
- Class offering examples include: 1) Healthier Living Colorado™ (CDSMP), 2) N'Balance™, 3) Therapeutic Tai Chi for Older Adults 4) Matter of Balance





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## Some of Our Partners

- Health TeamWorks
- Qualis Health
- Colorado Beacon Consortium
- Independent Physician Associations
- Colorado Community Health Network
- Kaiser Permanente
- Centura Health







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changing healthcare to include prevention and wellness

# The Expanded Chronic Care Model: Integrating Population Health Promotion

## COMMUNITY

## HEALTH SYSTEM

Build Healthy Public Policy

Create Supportive Environment

Strengthen Community Action

Self- Management/  
Develop Personal Skills

Information Systems

Delivery System Design/Re-orient Health Services

Decision Support

Activated Community

Informed Activated Patient

Productive Interactions & Relationships

Prepared Proactive Practice Team

Prepared Proactive Community Partners

Population Health Outcomes  
Functional & Clinical Outcomes





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*“But talking to patients takes too much time!!”*



*“...and who in a practice has time??”*







## The Intervention Design— *“What do we each bring to the table?”*

### COAW

- Statewide network of local organizations housing trained lay teachers for CDSMP and fall prevention facilitation.
- Coordinators to work with local organizations and take referrals from practices.
- Mechanism for tracking referred patient enrollment in CDSMP workshops and communicate with practices.
- Centralized data collection.

### Partners

- *Coaching in practices statewide.*
- *Organizational commitment to increasing practice capacity for improving patient self-management support.*
- *Opportunity to work with practices in standardizing referral and patient “action planning” follow-up workflow processes.*





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## Healthier Living Colorado™ Proven Outcomes

- Increase in healthy behaviors (including exercise and cognitive symptom management techniques, such as relaxation).
- Positive changes in health status (less pain, fatigue and worry; less health distress).
- Increased self-efficacy, or the degree of belief people have that they can perform the behavior required to produce a desired outcome.





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## Healthier Living Colorado™ Benefits to the Practice

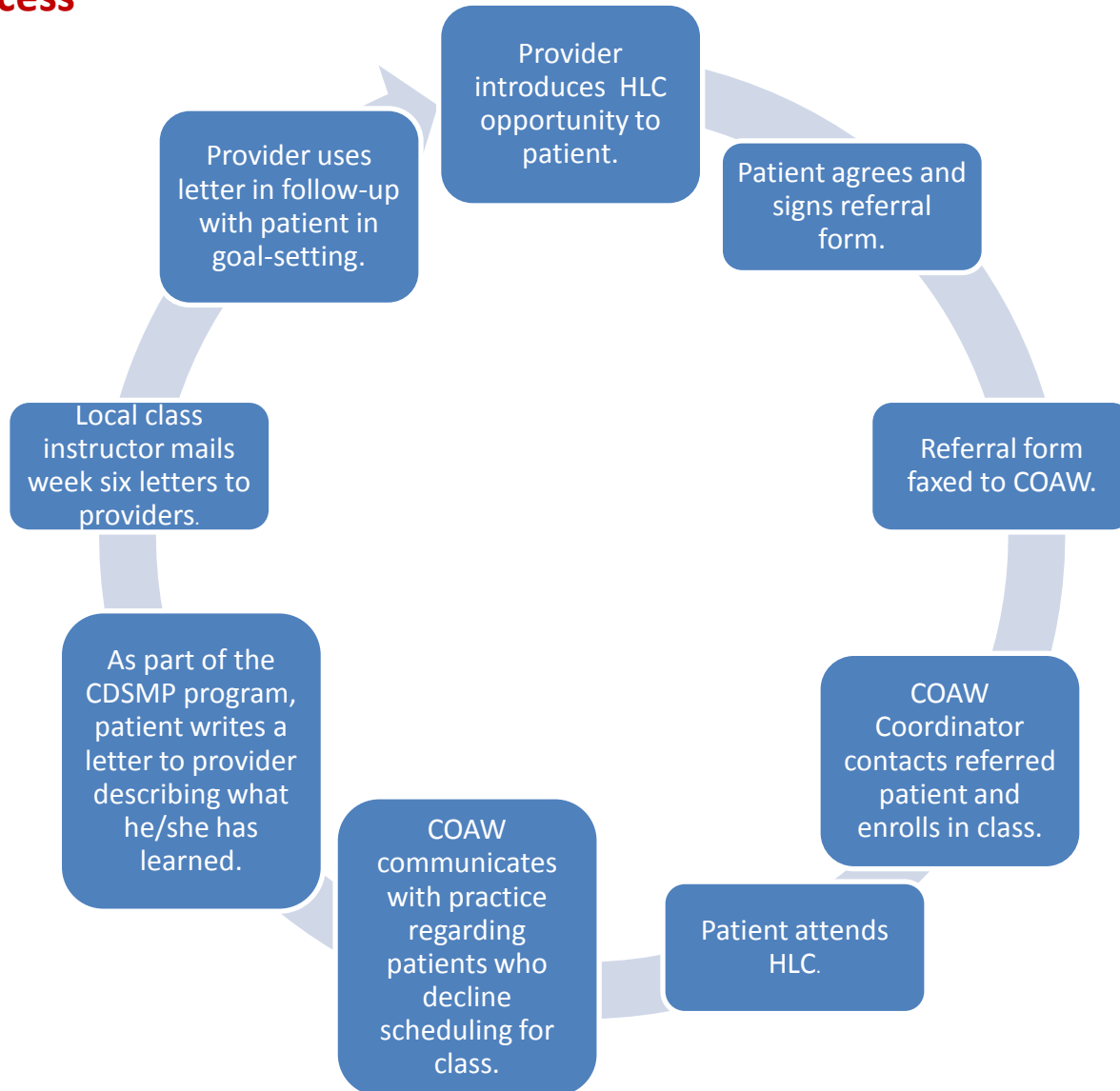
- External resource
- No need to re-create the wheel
- Reinforces communication “feedback loop”
- Documents self-management in PCMH terms
- Documents the shift in patient interaction
- Quality measures
- Delivery of data to practice
- Patient activation and patient engagement
- Increase in patient confidence levels







## The Process





## Who is looking for CDSMP?

- Centers for Medicare and Medicaid  
*Ex: Recent Medicare Advanced Primary Care Pilot*
- Department of Health and Human Services  
*Ex: 2009-10 \$27m ARRA award to states for implementation of CDSMP*
- State Medicaid agencies  
*Ex: Colorado HCPF Regional Care Collaborative RFP*
- NCQA in medical home recognition





## Challenges

- Practices have *varying levels of readiness*.
- *Practices require training in assessing patient readiness.*
- A lot weighs on the *communication and messaging with the practice and patient.*
- *Practices require feedback information* about their patient's response to being referred to such a program.
- Building “community linkages” is a *more complicated than anticipated.*







## Breakthroughs

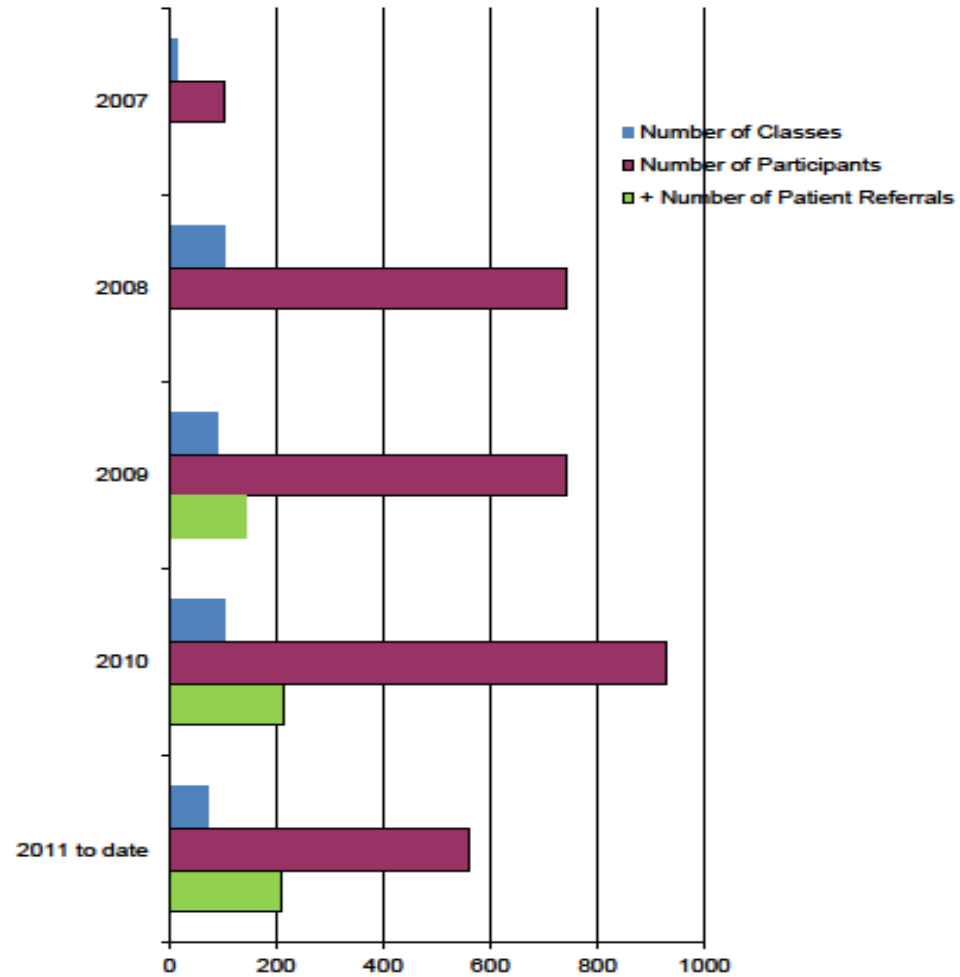
- ***Creation of an introductory presentation that is a facilitated discussion*** around the practice's definition of patient self-management, patient education and how working on practice changes in this area supports medical home transformation.
- ***QIC support*** in helping the practice learn basic skills in assessing patient readiness for participation.
- Establishment of ***protocol for number of times COAW outreaches to referred patients*** before reporting back to referring practice.





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### Patient Referrals to Healthier Living Colorado Program (Chronic Disease Self-Management Classes) 2007-2011





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### Healthier Living Colorado™

a self-management class for your patients with chronic conditions

Fax Referrals to: 303-984-5962

Questions? [Lynnzy@COAW.org](mailto:Lynnzy@COAW.org) or 303-475-2183

## Referral Form

### PATIENT INFORMATION

Patient Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Gender  Male  Female

I understand that COAW will inform my provider about my participation in Healthier Living Colorado™.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Best Phone number to reach you: \_\_\_\_\_

Best time of day to contact you: \_\_\_\_\_

May we leave a message  Yes  No

Language  English  Spanish Other (specify) \_\_\_\_\_

Type of Insurance \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Email: \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_







# Feedback Form

My Name Mary Smith Today's Date January 8, 2011

Dear Health Care Providers,

I wanted to let you know that I have been attending the Healthier Living Colorado™ class to help me better manage my own health. Today we are in our final class of the 6 weekly sessions and we are sending you our thoughts about our chronic conditions, taking care of ourselves, and what we want our Health Care Providers to know about what we are learning and doing.

Learning to manage my chronic condition has helped me to:

*I realized there are a lot of things I can do to help myself. I need to talk to my family about getting out more. I've been feeling very depressed-maybe I need to talk to you, my doctor, about this, too.*

What I have learned about my health is: *This isn't going to go away just because I take a pill three times a day. I can make some changes in how I deal with the pain. Eating a few more fruits has helped my digestion.*

I didn't know that my chronic condition was affected by:

*Worrying about what I can't do won't help me any. I need to fix my sites on what I enjoy doing. I am working on being more positive. It has been nice to talk with others with similar concerns.*

The things that have helped me the most to manage my chronic conditions are:

*Exercising a little more has helped my knees. I am going to keep with it and maybe take a water exercise class. I've been using a pill box so I keep track of when I am taking the pills better—I didn't know it would hurt me to skip some.*

My Action Plan for the next six months is: *This is my life and I want to stay as healthy as I can for as long as I can. I want to lower my blood pressure so I can be here to see my grand kids graduate from college.*

I would like this to be sent to my doctor or clinic:

Yes       No

My health care provider's name and address is: *Dr. Smart 1234 Main St. Denver 80202*





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## Linking and Looping

### “Feedback loop” findings:

“What chronic condition?”

“Moving does help.”

“Who knew being cranky made it worse.”

“Planning my doctor visits might help.”

“Talking with my family/friends/providers helps.”

“This way is harder and I feel better about it all.”

### Understanding practice-wide implementation

#### Practice-wide messaging

#### Continuing the conversation...

**This is easier than you may think.**

**This is harder than you may think.**





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# Questions?

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