Implementing Evidence-Based Programs in Health Centers and Practices

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Consortium for Older Adult Wellness

Welcome to Webinar Three: "Your Role in Workflow, Work Plans, and Making Sure it Works for All"

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Webinar Series Learning Objectives

- Recognize and define the role your State Health Department can play in brokering the connection between health care systems and community-based implementation.
- Establish a greater number of partnerships geared toward connecting health care systems to community-based partners.
- Increase reach by brokering partnerships that are cognizant of Patient Centered Medical Home transformation and the role of community-based resources.
- Create a plan for your State Health Department to embed, scale and sustain referrals to community-based partners.

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Topics Covered in Webinar One

- Understand how national statistics on chronic disease and healthcare changes are opportunities for scaling and sustaining programs.
- Define and briefly explore our working terms for this webinar series:
  - Self-Management
  - Self-Management Support
  - Self-Management Education
  - Community-Based Programs
  - Patient Center Medical Home
  - National Committee for Quality Assurance
  - Affordable Care Act
  - Clinical/Medical Care
  - Evidence-Based Programs
- Establish an Action Plan process to be completed before the next webinar.

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Topics Covered in Webinar Two

- “Referral Systems that Meet Practice Needs in Support of the Patient” including internal systems, external systems, and centralized referral systems.

- Discussed three implementation approaches 1) embedding the evidence-based programs directly into the practice, health system, etc. 2) community-based organizations as the sites, hosts, trainers, technical assistance providers for the health systems and practices and 3) a hybrid of these toe approaches where the CBO may assist initially with technical support or training while the health system embeds the program.

- We approached referrals systems from several points of view: the State health Department, a health practice or health system, and the community partners including non-profits, Area Agencies on Aging, etc.

- Tools for your use included Referral Form, Physician Feedback Form, Workflow, and Care Compact

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Review of Homework Assignment

Are you currently involved in a “live” referral system?

Do you have partnerships in place to help develop or expand a referral system?

What do you see as your role in making a referral system successful?

What additional support do you need to develop or expand referral systems?

What can you explore or pursue between now and January 7th?

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Learning Objectives for Webinar Three:

- Target appropriate partners in health systems and practices.
- Generate an increase in referrals from health care to community-based programs.
- Examine working in collaboration to define and document reach (referrals, enrollments, completers) and return on investment.
- Discuss roles in establishing successful processes, workflow, and partner-level documentation that will facilitate connecting community-based programs to health care providers.
- Create a “Care Compact”, “Memorandum of Understanding” or “Letter of Mutual Support” outlining roles and responsibilities for community-based partners and health providers.
- Generate your Action plan for the next 3-6 months.

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Partners in Bridge Building

- www.HealthTeamWorks.org
- www.TransforMed.com
- www.transformcoach.org
- www.nachc.com
- www.ncqa.org
- www.recognition.ncqa.org

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HealthTeamWorks

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Building Systems. Empowering Excellence.

HealthTeamWorks, formerly CCGC, is a nonprofit, multi-stakeholder collaborative working to redesign the healthcare delivery system and promote integrated communities of care, using evidence-based medicine and innovative systems. Our goals are to optimize health, improve quality and safety, reduce costs and improve the care experience for patients and their healthcare teams.

News and Events

To read more about HealthTeamWorks news click here.

Follow Our Blog:

Tuesday, October 15, 2013
HealthTeamWorks Releases

Practice-Improvement coaching:
Prepare your practice for new compensation plans through HealthTeamWorks' Patient-Centered

TransforMED℠

The TransforMED Patient-Centered Model

A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
  - Patient engagement
  - Provider/patient partnership
  - Culturally sensitive care
  - Continuous relationship
  - Whole person care

Access to Care and Information
- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management
- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services
- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Health Information Technology
- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Care Management
- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Care Coordination
- Community-based resources
- Collaborative relationships
  - Emergency Room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care Transition

Practice-Based Care Team
- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at www.TransforMED.com

Practice Transformation Institute™

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Search

Moderate Care Manager Program

Self-Management Training

URAC Webinar Series

URAC

PATIENT CENTERED MEDICAL HOME AUDITOR CERTIFICATION

NCQA RECOGNITION DIRECTORY

CLINICIAN SEARCH HOME

Clinician Directory and Search

This Recognized Clinician Directory helps individuals find doctors who have demonstrated that they meet important standards of care. Results of your search will be listed alphabetically. Click on a clinician's name or group name for further details such as contact information, education and training or areas of clinical interest.

Search | Advanced Search

Complete any of the following criteria.

State: Mississippi

Recognition Program: Patient Centered Medical Home - 2011

Submit Search

Partners in Bridge Building- Continued

- Your State Medical Associations
- Your State Community Health Centers
- Search for: Practices NCQA recognized
- Your State Practice Transformation
- Ask Partners, Board Members, Health Systems for referrals and contacts
- CDC and NCOA

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Lessons Learned in Partnerships, Referral Systems, and Enrollments

- Care Compact, Collaborative Agreement, or MOU
- Referral Logs and Follow-Up
- Contact Person
- Patient Panel versus Patient Referral
- Readiness Assessments
- Yes….”and”…. Messaging

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Statewide Collaborative Agreement

The Statewide CDSMP Collaborative provides guidance to promote, implement, and coordinate the sustainability and expansion of the Chronic Disease Self-Management Program Series statewide.

Statewide Chronic Disease Self-Management Program Collaborative

Non-Financial Partnering Member Agreement

This agreement is entered into by the Statewide CDSMP Collaborative and

_____

Name of Agency

The purpose of the Statewide CDSMP Collaborative is to acknowledge our common goals of implementing, scaling, embedding, and sustaining chronic disease self-management education.

The intention is to collaboratively adopt best practices and standards that create a shared road map, and shared opportunities, toward reaching our common goals.

The goal is to have the membership of the Statewide CDSMP Collaborative include *CDSMP License Holders, State agencies, community-based organizations, interested hosting agencies, adjunct professionals, and others* dedicated to the mission of the Collaborative.

By signing this agreement you indicate you agree with the stated mission of the CDSMP Collaborative:
The Statewide CDSMP Collaborative provides guidance to promote, implement, and coordinate the sustainability and expansion of the Chronic Disease Self-Management Program Series statewide.

Toward fulfilling this shared mission you agree to become a Partnering Member within the Statewide CDSMP Collaborative.

As a **Partnering Member** of the Statewide CDSMP Collaborative your responsibilities include:

a) Understanding that while offering the CDSMP Program Series workshop(s) at your site, you will be jointly accountable to follow the rules and regulations regarding instruction and administration of the CDSMP in accordance with the Stanford licensing requirements.
b) Conducting workshops in accordance with the CDSMP Leaders Manual without changes, and creating no derivatives of the program.
c) Providing suitable space for workshops (complying with Americans with Disabilities Act standards), healthy snacks and water for attendees for your classes.
d) Actively recruiting participants for classes and lay leaders.
e) Responding within the next business day to referrals received through the CDSMP Collaborative Centralized Referral System when active.
f) Maintaining ongoing communication with the Statewide CDSMP Collaborative.
g) Submitting a calendar of classes on the attached forms including locations, projected group size, target population for participation (general chronic disease or diabetes) and delivery language (English or Spanish). This includes the identified lay leaders (2/class minimum). Submitting updates and changes to the CDSMP Collaborative as early as possible.

Statewide CDSMP Collaborative
Lynnzy McIntosh, Chair
c/o COAW
2575 S. Wadsworth Blvd.
Lakewood, Co 80227

303-984-1845
303-984-5962 Fax
Lynnzy@COAW.org
www.SelfManagementColorado.org

Care Compact

HealthTeamWorks
Building Systems. Empowering Excellence.

Creating Medical Home Communities
Systems of Care/Patient Centered Medical Home Initiative

¶

- *Consortium·for·Older·Adult·Wellness-·Primary·Care·Provider·Compact¶*

- **I.→Purpose¶**

- *•→ To·provide·optimal·health·care·for·our·participants·and·patients.¶*

- *•→ To· provide· a· framework· for· better· communication· and· safe· transition· of· care· between·primary·care·and·community·based·organizations.¶*

- **II.→Principles¶**

- *•→ Safe,·effective·and·timely·patient·care·is·our·central·goal.¶*

- *•→ Effective·communication·between·primary·care·and·specialty·care/community·based· organizations· is· key· to· providing· optimal· patient· care· and· to· eliminate· the· waste· and· excess·costs·of·health·care.¶*

- *•→ Mutual·respect·is·essential·to·building·and·sustaining·a·professional·relationship·and·*

¶

Patient·Referrals·¤	
Mutual·Agreement¤	
• Maintain·accurate·and·up-to-date·clinical·record.¶ • Agree·to·standardized·demographic·and·clinical·information·format.¶ • Ensure·safe·and·timely·referral·of·a·prepared·patient.¶ • Ensure·safe·and·timely·updates·on·patient·enrollment·status.¤	
Expectations¤	
Primary·Care¤	COAW¤
☐ PCP·maintains·complete·and·up-to-date·clinical·record·including·demographics.¶ ☐ Transfers·information·as·outlined·on·the·COAW·Referral·Form·or·through·the·COAW·website.¶ ☐ Informs·patient·of·need,·purpose,·expectations,·and·goal·of·the·referral.¶ ☐ Provides·patient·with·COAW·provided·information·and·expected·timeframe·for·contact.¶ ☐ Provides·COAW·with·a·single·referral·contact·person·for·the·PCP.¤	☐ Confirms·receipt·of·referral·and·patient·eligibility·on·a·weekly·basis·via·HIPAA·compliant·communication.·¶ ☐ Provides·single·source·referral·contact·person·for·the·PCP.¶ ☐ Provides·single·source·referral·contact·person·for·the·patient.¶ ☐ Contacts·the·referred·patient·by·the·end·of·the·following·business·day.¶ ☐ Provides·staff·training·and·support·on·making·referrals·to·self-management·programs.¶ ☐ When·PCP·is·uncertain·of·patient·appropriateness,·will·assist·PCP·prior·to·the·referral.¤

Partners in Pricing

- Many roads, many partners
- One size does not fit all
- National payment models in process
- Check on Your State models and projects
- ‘Demonstration’ before ‘Sustainability’
- Incentives within PCMH Transformation

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Agreement-Addendum between the Consortium for Older Adult Wellness and **Clinic/Agency Name,**
Regarding Delivery of the Chronic Disease Self-Management Education (CDSME) Series (includes Healthier Living Colorado™, Healthier Living Colorado-Diabetes™, Tomando Control Colorado™, Tomando Control Colorado-Diabetes™, or The Positive Self-Management Program)

Workshop series agreement

	COAW responsible	Agency responsible
Leader Stipends	_____	_____
Workshop Book and CD	_____	_____
Workshop Charts/Materials	_____	_____
Healthy Snacks	_____	_____
Recruiting Assistance	_____	_____
Referral Process/Enrollment	_____	_____
Stanford License	_____	_____
Data Collection	_____	_____

Sample Percentages for Pricing

ITEM	% of AMOUNT	COST in $$
Leader/Instructor Stipends	47%	
Books/CDs	23%	
Class Materials	3%	
Snacks	5%	
License	2%	
Data Collection	2%	
Recruiting Assistance	8%	
Referral Processing and Enrollment	10%	
Total to COAW		
Total to Agency		
Total	100%	

Cost per **completer** or per **enrolled**?

Simple data collection or for specific research?

Evaluation?

Messaging

- Readiness and Activation Levels for All Involved
- Time and Money
- Staying “Shiny”
- Messaging to be Shared with the Practice or Provider
  - How to Recommend
  - How to Refer
  - Quick Basics
  - Quick Goal Setting

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Self-management goals...a few ideas...


Go grocery shopping.

Get up on time.


Exercise regularly.


Walk for 20 minutes a day


Go for a hike.

Annual eye exam.


Take the stairs.


Quit smoking.


Take a hot bath and practice muscle relaxation.


Take my medications.


Refill my medications.


Join a class/learn something new.


Make/Keep follow-up appointments.


Check my blood sugar.


Eat more vegetables.


Brush and floss twice a day.


Measure and record blood pressure.


Quit eating sweets.


Schedule a dental appointment.

Quit drinking soda.


Get my cholesterol checked.


Go to my disease management class.

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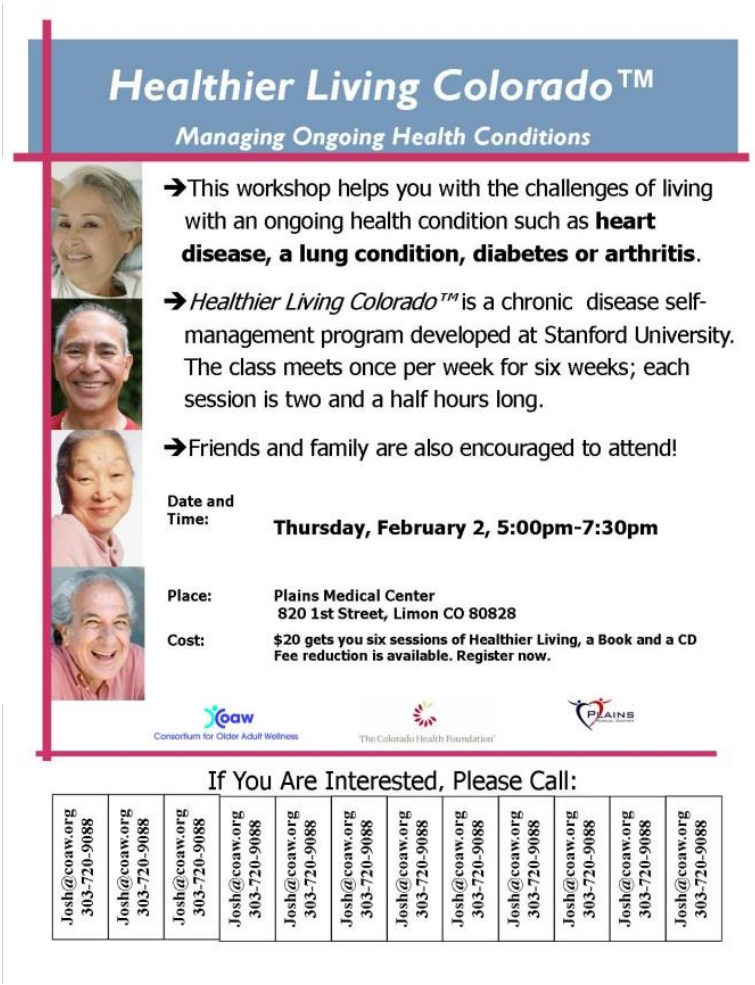
Consortium for Older Adult Wellness
Funded by: The Kaiser Permanente Community Health Fund
A Fund of THE DENVER FOUNDATION

Quick Provider Messaging

- “I am going to recommend you attend an exercise program that will help you manage your arthritis and feel better.”
- “I am going to refer you to a program that will help you manage your COPD and feel better.”
- “We are a team. We can do a great deal to assist you in managing your illness—and there are many skills you can learn to help yourself. I am going to refer you to a program that I feel will help.”

Exam room


Healthier Living Colorado™
Managing Ongoing Health Conditions
➔This workshop helps you with the challenges of living with an ongoing health condition such as heart disease, a lung condition, diabetes or arthritis.
➔Healthier Living Colorado™ is a chronic disease self-management program developed at Stanford University. The class meets once per week for six weeks; each session is two and a half hours long.
➔Friends and family are also encouraged to attend!
Date and Time: Thursday, February 2, 5:00pm-7:30pm
Place: Plains Medical Center 820 1st Street, Limon CO 80828
Cost: $20 gets you six sessions of Healthier Living, a Book and a CD Fee reduction is available. Register now.
Consortium for Older Adult Wellness
The Colorado Health Foundation
If You Are Interested, Please Call:
Josh@coaw.org 303-720-9088

Brochures

- Do you have an ongoing health condition such as hypertension, arthritis, diabetes, asthma, or cancer?
- Are you sick and tired of being sick and tired?
- Do you enjoy social interaction?
- Do you enjoy helping others?
- Are you comfortable with a class setting?
- Can you relate to others suffering from some type of ongoing health condition?

If you answered yes to any of the above questions, this class is for ***YOU!***

coaw

The Colorado Health Foundation

COAW provides the systems management, implementation support, and training for preventative evidence-based programs, such as Healthier Living Colorado™, to reduce the complications of chronic disease. COAW has served over 3,500 adults and over 500 professionals statewide.

For more information contact your healthcare provider or:
COAW
888-900-2629
info@coaw.org

Please join us for

Healthier Living Colorado™

Managing Ongoing Health Conditions

Messaging- Continued

- Training Possibilities
- Taking Responsibility
- Materials to make YOUR Case
- “Plan Do Study Act” Cycle
- Next Steps Conversations
  - What is the goal: reach, embed, sustain?
  - What worked? What needs work?
  - Training in curriculums?
  - Workforce development trainings?

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Medical Assistant *Quick* Guidelines for Self-Management Support

DO:

- Initiate the conversation with the patient about goal setting and self-management.
- Emphasize that big goals are fantastic, *and* action plans need to be small and do-able to insure success. Give brief examples if needed.
- **Listen** for the patient to be open to the possibility of making different choices.
- **Document** the patient's goal and/or action plan in Next-Gen.
- Document any barriers the patient has identified or note "no barriers".
- Give the patient a timeframe for follow-up on their self-management goal.
- Let the patient know you support their willingness to make changes, and that you look forward to hearing their results.
- Let the clinician or provider know if you feel they would benefit from a referral to a community-based program such as Healthier Living Colorado, Quit-Line, etc.

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Medical Assistant *Quick* Guidelines for Self-Management Support

DO NOT:

- Assume the patient has no interest in talking about self-management and goal setting. They may just not be familiar with these terms. Try "making changes" or "acting in a different way to help yourself feel better".
- Feel like if they are not interested today that they will never be interested in goal setting.
- **Prescribe or give patients advice in any of these areas unless it is in a clinician created care plan.**
  - ❖ Medications: Do not suggest or give approval for a change, addition, or dis-continuation of any medication or treatment without the clinician's approval.
  - ❖ Diet: Listening to a patient discuss their desire to lose weight is great. Prescribing a specific diet, dietary change, or what you suggest will help them is not. Stick to the clinician created care plan, or document for the clinician that the patient wants to

Make Your Case with Samples

- Workflow
- Care Compact
- Memorandum of Understanding (MOU)
- On-line Referrals
- Referral Form
- Referral log
- Feedback Letter
- Simple Reports

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NCQA PCMH 2011 Standards

PCMHI: Access and Continuity D. Use of Data for Population Management F. Culturally and Linguistically Appropriate Services	**PCMH4: Provide Self-Care Support and Community Resources (Must Pass)** A. Support Self-Care Process B. Document Goals, Ability, Self Management Tools, Referrals to Community Resources
PCMH2: Identify and Manage Patient Populations C. Patient Panels, Comprehensive Health Assessment	**PCMH5: Track and Coordinate Care** B. Referral Tracking and Follow-Up C. Coordinate with Facilities/Care Transitions
PCMH3: Plan and Manage Care B. Identify High-Risk Patients C. Care Management, Pre-Visit Planning, Treatment Plan and Goals, Identify Barriers D. Manage Medications	**PCMH6: Measure and Improve Performance** B. Measure Patient/Family Experience E. Report Performance

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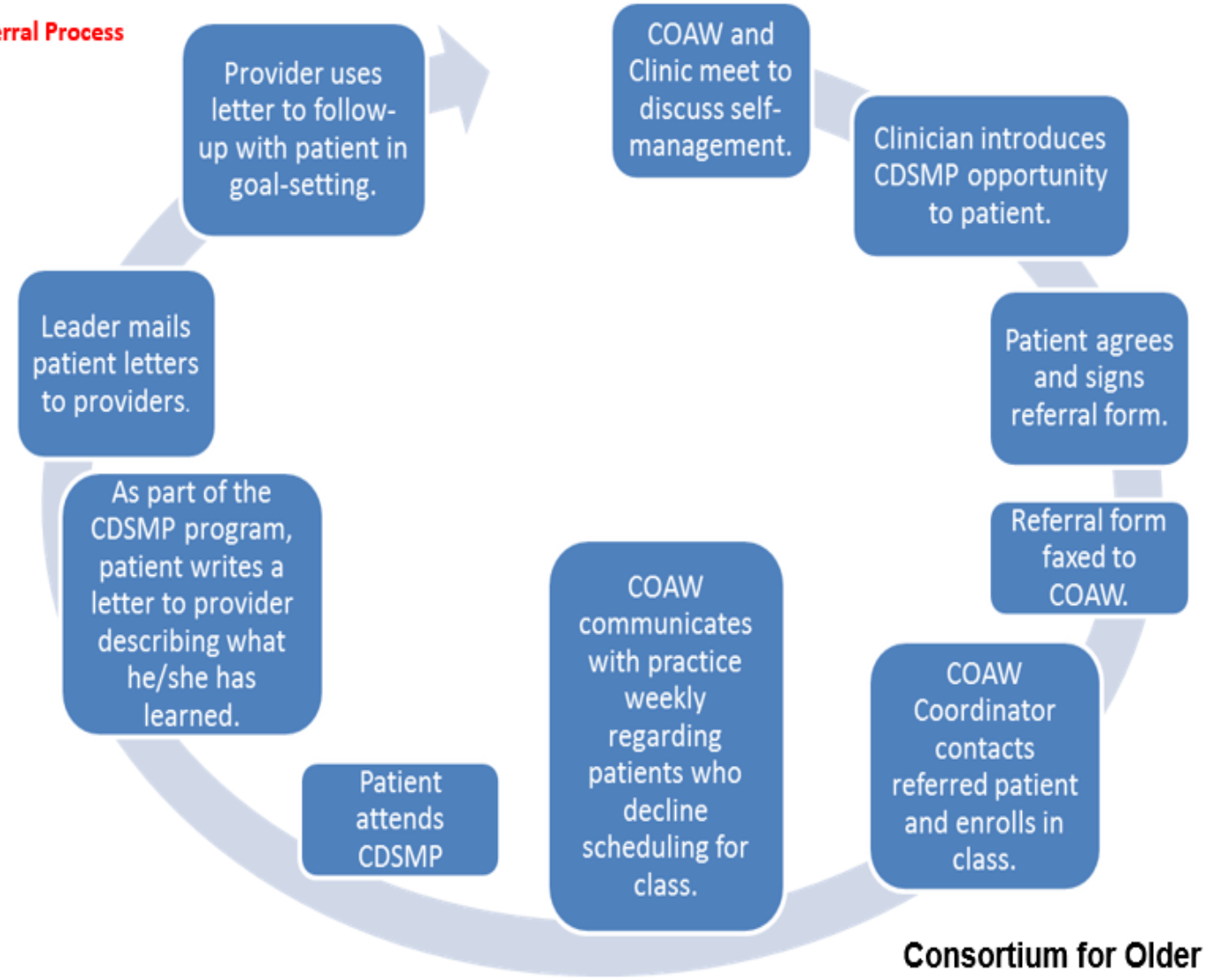
Referral Process



Consortium for Older Adult Wellness
2575 S. Wadsworth Blvd.
Lakewood CO 80227
303-984-1845
888-900-2629(COAW)

CENTRALIZED REFERRAL AND FEEDBACK PROCESS FOR MEDICAID CLIENTS

Meet with RCCOs and Clinic staff meet to discuss self-management classes.

Medicaid Client is introduced to class opportunity

Medicaid referral from a RCCO, i.e. case manager

Fax, Email, or toll free call

Secured Website – HIPAA Compliant

Staff person takes referral and sees where the closest class would be for client.

Staff person calls class contact to arrange enrollment.

Staff person calls client to invite into class and shares information.

Referring RCCO or provider receives update on client's enrollment status.

Client goes to six-week class and learns self-management skills including action planning, and problem solving.

Six month self-management goals are set and information is sent to patient's PCP and case manager.

Referral Form

Healthier Living Colorado™
a self-management class for your patients with chronic conditions

Fax Referrals to: 303-984-5962
Questions? Lynnzy@COAW.org or 303-475-2183

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:** _____

Referral Log

Tue May 14 1:32 PM

Consortium for Older Adult Wellness
2575 S. Wadsworth Blvd • Lakewood, CO 80227 • 1-800-800-COAW

HLC Referral Log

Participant	Address	Enrolled	Calls	
Chicken, Spring	222 Skippy Court YoungAtHeart, CO 00007 111-111-2222 111-222-2323 Born 05-10-2045		05-06-2013 Josh	No Answer.
			05-10-2013 Josh	No Answer.
Doe, Jane	456 Healthy Circle FiberTown, CO 00001 970-970-9797 970-970-9000 Born 04-06-1960		05-06-2013 Josh	Discussed class. Would like call back tomorrow morning.
			05-07-2013 Josh	Called back. Left voice mail.
			05-09-2013 Josh	Left voice mail regarding class.
Doo, Scooby	9951 Food St. SnackTown, CO 00003 000-000-0000 Born 05-01-2044	05-10-13 Sunrise Loveland Community Health Center	05-07-2013 Josh	Scooby was eating and said he would call back. Left name and number to reach me.
			05-06-2013 Josh	Left voice mail re: class.
			05-10-2013 Josh	Discussed nutrition topics. Scooby expressed concern with his health and registered for class.
Jetson, George	554 Super Ave. SugarTown, CO 00002 970-970-9795 970-970-9798 Born 01-01-1940	05-10-13 Sunrise Loveland Community Health Center George is bringing his wife, Jane.	05-07-2013 Josh	Left Voice Mail re: class.
			05-06-2013 Josh	George registered for class and would like to bring his wife.
Winter, Oldman	8888 Brr Street ColdTown, CO 80008 111-111-1111 112-112-1122 Born 06-07-1977		05-07-2013 Josh	Left Voice Mail re: referral to class.
			05-09-2013 Josh	Left Voice Mail re: referral to class.

Feedback Form

Consortium for Older Adult Wellness

My Name___*Mary Smith*_____ **Today's Date**__*January 8, 2012*____

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.

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 sights 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:

Long term goal:
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 grandkids graduate from college

Specific action step:
Walk with a neighbor to the library and back.

How much/often? *3 times a week* **When?** *Monday, Wednesday and Saturday*

Confidence Level (0-10): *9*

COAW will forward this letter to your provider listed below:
My health care provider's name and address is: Dr. Smart 1234 Main St. Denver 80202

Consortium for Older Adult Wellness
2575 S. Wadsworth Blvd. Lakewood, CO 80227 888-900-COAW(2629) Fax: 303-984-5962 info@COAW.org

Consortium for Older Adult Wellness

changing healthcare to include prevention and wellness

Choose A Method:

All Three Methods Are HIPAA-Compliant

EHR - Electronic Health Records

If your practice has an EHR system, simply use it to generate the referral, and send it to our secure email address:

Referral@Secure.COAW.org

FAX

If you would like to fax the referral, click this button to get the form:

Download the Form

Fill out the form, then fax it to:

303-984-5962

Online

To enter the referral online, click the button:

Enter Referral Online

Centralized Referral Systems

Referral Log

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HLC Referral Log

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			05-09-2013 Josh	Left voice mail regarding class.
Doo, Scooby	9951 Food St. SnackTown, CO 00003 000-000-0000 Born 05-01-2044	05-10-13 Sunrise Loveland Community Health Center	05-07-2013 Josh	Scooby was eating and said he would call back. Left name and number to reach me.
			05-08-2013 Josh	Left voice mail re: class.
			05-10-2013 Josh	Discussed nutrition topics. Scooby expressed concern with his health and registered for class.
Jetson, George	554 Super Ave. SugarTown, CO 00002 970-970-9705 970-970-9708 Born 01-01-1940	05-10-13 Sunrise Loveland Community Health Center George is bringing his wife, Jane.	05-07-2013 Josh	Left Voice Mail re: class.
			05-09-2013 Josh	George registered for class and would like to bring his wife.
Winter, Oldman	8888 Brr Street ColdTown, CO 80008 111-111-1111 112-112-1122 Born 06-07-1977		05-07-2013 Josh	Left Voice Mail re: referral to class.
			05-09-2013 Josh	Left Voice Mail re: referral to class.

Feedback Form

Consortium for Older Adult Wellness

My Name Mary Smith **Today's Date** January 8, 2012

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.

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 sights 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:
Long term goal:
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 grandkids graduate from college

Specific action step:
Walk with a neighbor to the library and back.

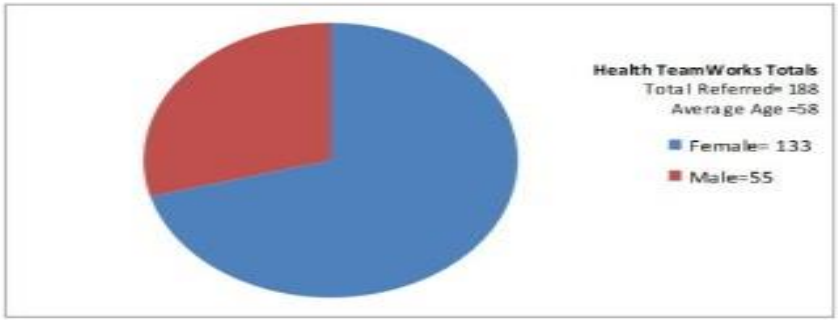
How much/often? *3 times a week* **When?** *Monday, Wednesday and Saturday*

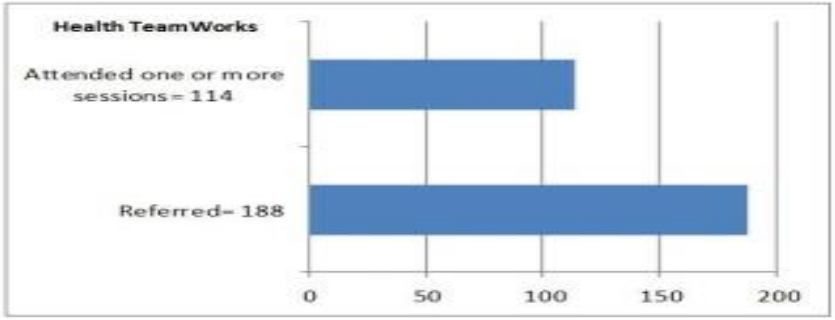
Confidence Level (0-10): *9*

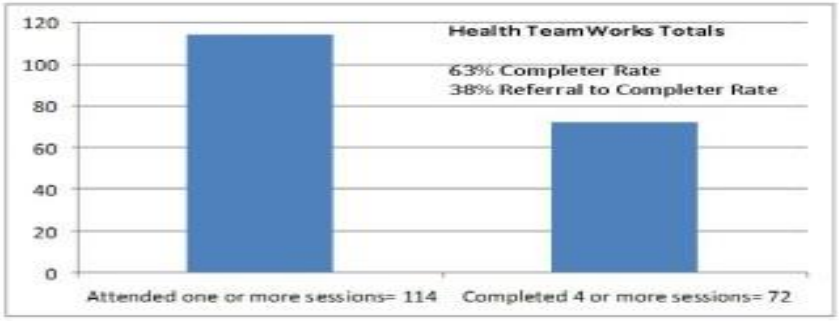
COAW will forward this letter to your provider listed below:
My health care provider's name and address is: Dr. Smart 1234 Main St. Denver 80202

Consortium for Older Adult Wellness
2575 S. Wadsworth Blvd. Lakewood, CO 80227 888-900-COAW(2629) Fax: 303-984-5962 info@COAW.org

Sample Practice Report



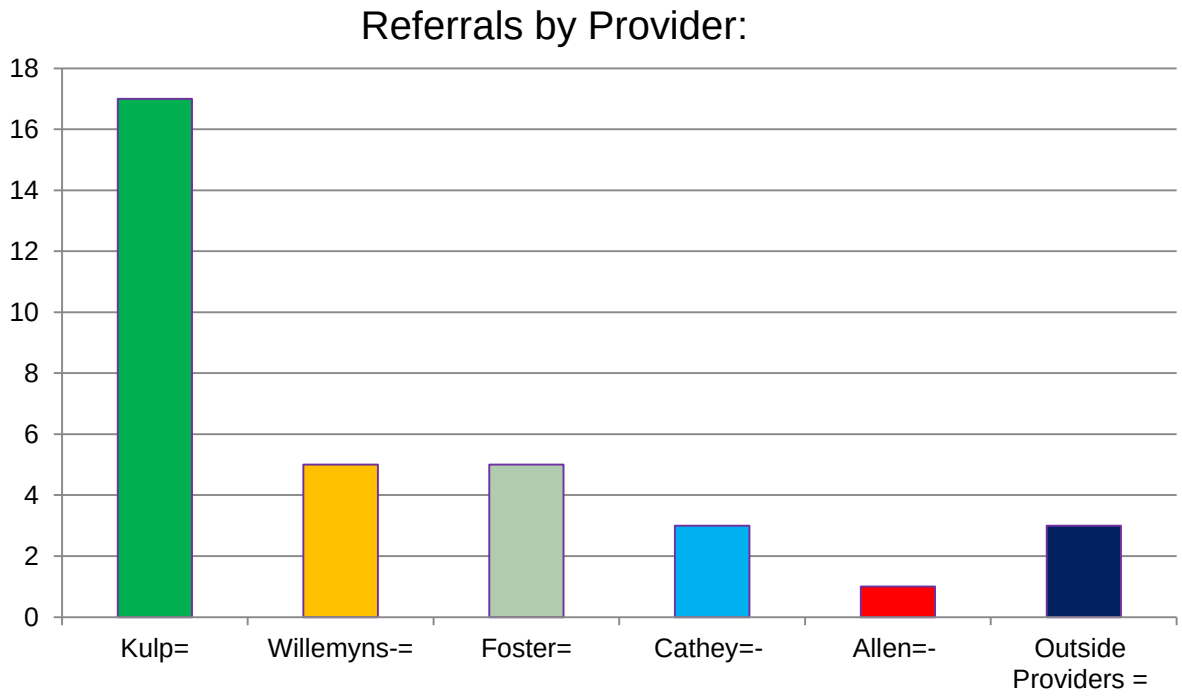




AgeWell Medical Associates Class Summary

- Referrals: 34 total referral names were faxed to COAW by March 2013
  - 11 responded YES to the April class;
  - 7 responded YES to the May class;
  - 6 responded YES to March class

- 71% return on referrals



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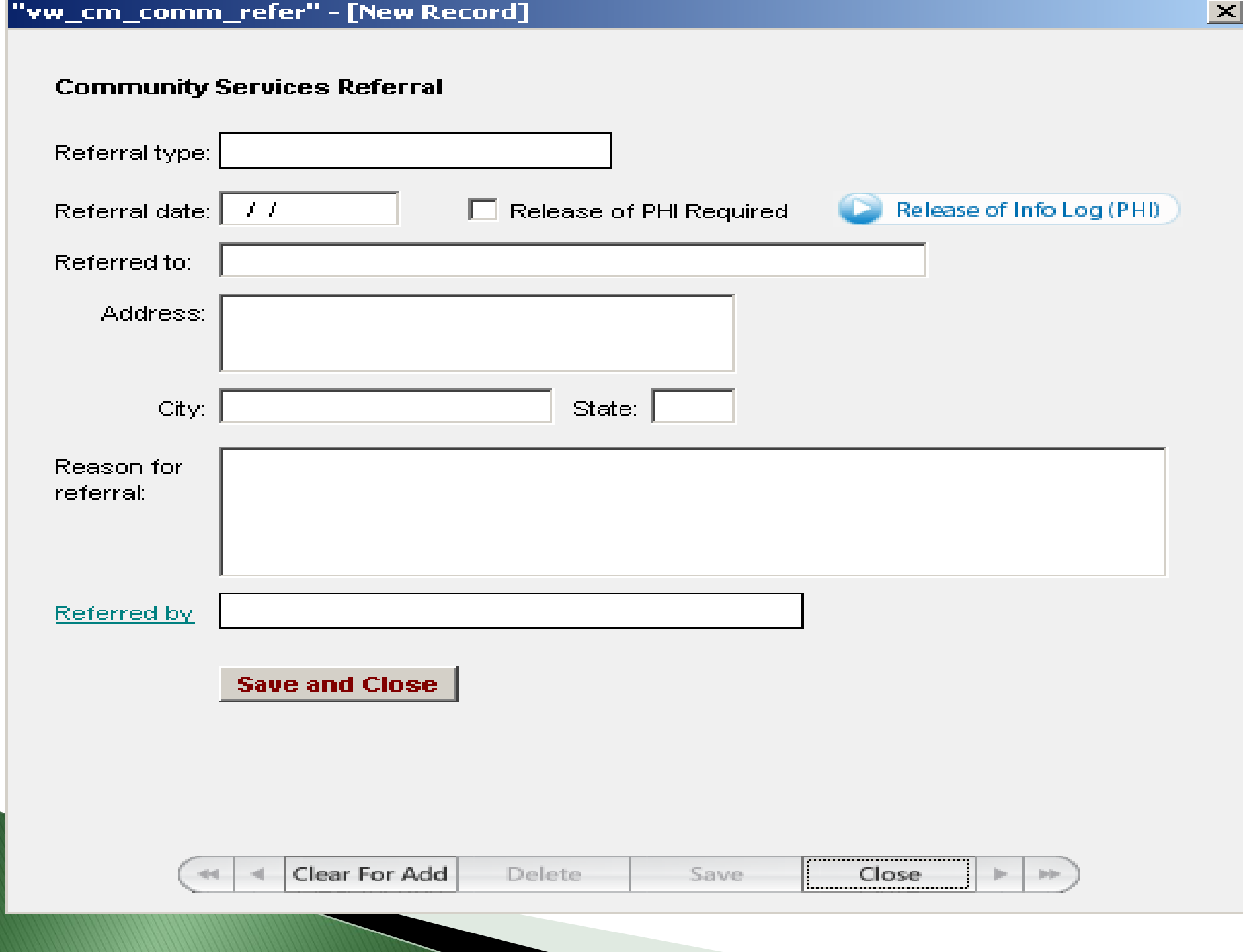
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Community Services Referral
Referral type:
Referral date: / /
Release of PHI Required
Release of Info Log (PHI)
Referred to:
Address:
City:
State:
Reason for referral:
Referred by
Save and Close
Clear For Add
Delete
Save
Close

Consortium for Older Adult Wellness

colorado communityhealth network

The Change Process: 5 Stages of Grief

- **Denial.** "*We have already given all our patients their self-management goals and tools.*"
- **Anger.** *"We will never have activated patients. PCMH transformation is just paperwork. Patient self-management means nothing."*
- **Bargaining.** *"What if we just wait a few years to apply for NCQA recognition? What if we ask all patients to just set the same goal?"*
- **Depression** *"This is overwhelming. We are too overworked as it is now. Our Providers will never get this done."*
- **Acceptance** *"We can do this. Look at the progress that we have made. Some of our patients are engaging!"*

Stages of Readiness

- State Health Department
- Community Based Organization Level
- Health System Level
- Practice Level

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Action Plan or Goal for the Next 3-6 Months

- What do you want to do?
- Is it achievable?
- When, where, how much?
- How sure are you that you can get this done on a scale of 1-10?

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How can we follow-up on Action Plans?

- Check in calls with Project Officers
- Arthritis Call- open air format
- Re-connect via webinar

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