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Preface

We were fortunate to be a part of the Healthcare Transformation and Quality Improvement Program (1115 waiver initiative) administered through the Texas Department of Health and Human Services (DHHS) with financing from the Centers for Medicare and Medicaid Services (CMS). The overarching goal of the initiative was to improve the quality of care, cost-effectiveness of care, and health of the community served. Under the auspices of the Texas A&M Physicians, we received funding from the Delivery System Reform Incentive Payments Program to build and expand the infrastructure for delivering evidence-based health and wellness programs for older adults.

During this period, our programs reached over a thousand middle-aged and older adults in the nine service counties (Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington). This final community report summarizes the reach and impact of these programs delivered through the initiative between September 2013 and July 2017.

We are grateful for the opportunity to work with many excellent partners in delivering evidence-based programs for older adults throughout our service region. This Report provides valuable information for future service planning and activities.

We are pleased to share this community report with you and express our appreciation to everyone.

Marcia G. Ory, PhD, MPH
Center for Population Health and Aging
March 2018
Evidence-Based Programs

We supported the implementation of multiple health and wellness programs that have previously been shown to effectively meet the Triple Aims of better health, better healthcare, and better value. For our project efforts, we have offered several evidence-based programs in our local community. The illustration below shows the diversity of programs being offered.

**Fall Risk Reduction**

- Fall Risk Reduction
- Chronic Condition Management
- Chronic Disease Self-Management Program
- Diabetes Self-Management Program
- Cancer: Thriving & Surviving
- Chronic Pain Self-Management Program

**Chronic Condition Management**

- Chronic Disease Self-Management Program
- Diabetes Self-Management Program
- Cancer: Thriving & Surviving
- Chronic Pain Self-Management Program

**Caregiving & Medication Management**

- Stress-Busting Program For Family Caregivers
- HomeMeds®
Reach

- Between September 2013 and July 2017, 134 workshops were offered throughout the Regional Healthcare Partnership 17, which consists of Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington counties.
- During this period, we served 1,375 individuals. Among these individuals, 247 participated in more than one workshop.
- As shown in Figure 1 below, our reach continuously increased over time, as represented by the number participants encountered.

Figure 1. Number of participants reached by year

*NOTE:* The graph presents the data for three full calendar years.
Deeper Dive: Program Reach

Demographics

- Across all of the programs, the majority of the participants were older (average age = 72 years) and female (79%).
- 77% were non-Hispanic White, 12% were Black or African American, and 11% were Hispanic individuals.
- Participants who attended workshops with some exercise components were slightly older (average age = 75 years). Possible reasons for this age difference may include marketing strategies, the location of workshops, participants’ interest, and other participant- and community-level factors.

**Figure 2.** Age distribution of participants
Deeper Dive: Chronic Conditions

Chronic Conditions

- About 90% of the participants reported having one or more chronic conditions, and about 68% reported having two or more chronic conditions.
- Hypertension (56%) was one of the most prevalent chronic conditions among the participants, followed by high cholesterol (49%), arthritis (44%), and diabetes (33%) (Table 1). Furthermore, 16% reported having depression or anxiety.

Table 1. Prevalence of self-reported chronic disease types among workshop participants

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>698 (43.8%)</td>
</tr>
<tr>
<td>Depression or Anxiety</td>
<td>260 (16.3%)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>520 (32.6%)</td>
</tr>
<tr>
<td>Heart disease</td>
<td>313 (19.6%)</td>
</tr>
<tr>
<td>High Cholesterol*</td>
<td>130 (48.7%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>899 (56.4%)</td>
</tr>
<tr>
<td>Lung disease or breathing</td>
<td>208 (13.1%)</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>262 (16.4%)</td>
</tr>
<tr>
<td>Pain</td>
<td>37 (13.9%)</td>
</tr>
</tbody>
</table>

*Information about high cholesterol and chronic pain had not been collected until late into the project, and hence, the reported prevalence was estimated based on 267 participants who provided the information.
Key Findings: Class Attendance

- Attendance has been shown to be a key factor in achieving pragmatic outcomes.
- Overall, 62% of the participants completed workshops once they started.
- The attendance rate varied across programs, suggesting a need to explore these differences further.

Table 2. Completion rates by workshops

<table>
<thead>
<tr>
<th>Workshops</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Risk Reduction</td>
<td></td>
</tr>
<tr>
<td>A Matter of Balance</td>
<td>65.4%</td>
</tr>
<tr>
<td>Fit &amp; Strong!</td>
<td>49.1%</td>
</tr>
<tr>
<td>Chronic Condition Management</td>
<td></td>
</tr>
<tr>
<td>Chronic Disease Self-Management Program</td>
<td>72.4%</td>
</tr>
<tr>
<td>Diabetes Self-Management Program</td>
<td>70.9%</td>
</tr>
<tr>
<td>Cancer: Thriving &amp; Surviving</td>
<td>83.3%</td>
</tr>
<tr>
<td>Chronic Pain Self-Management Program</td>
<td>83.3%</td>
</tr>
<tr>
<td>Caregiving</td>
<td></td>
</tr>
<tr>
<td>Stress-Busting Program</td>
<td>69.6%</td>
</tr>
</tbody>
</table>

* Completion rate was not estimated for HomeMeds, because it is one-session program.
Key Findings: Program Impacts*

- After attending workshops, participants reported improvements in self-rated health, degree of health interference in their daily activities, communication with their doctors, and fear of falling.

- The participants also reported greater self-efficacy in managing chronic conditions, being more physically-active, and preventing and managing falls.

- Those in workshops with an exercise component also showed significant improvement in their general mobility.

Figure 3. Program outcomes

* This is a general highlight based on pre/post comparisons. Due to the change in the survey items over time, not all information was collected from all participants.
Key Findings: Program Satisfaction*

- Satisfaction is an important factor in participant experience and retention.
- Overall, the participants reported high satisfaction with workshops:

  - 70% Reported they got the kind of service they wanted
  - 90% Reported they would recommend the program to their friends in need of similar help
  - 95% Reported the program met most or almost all of their needs
  - 95% Reported being satisfied with the service they received
  - 98% Reported the program helped them to deal more effectively with their problems
  - 100% Rated workshops “good” or “excellent”

*Due to the change in the survey over time, not all information was collected from all participants.*
Summary Highlights

The project achieved multiple positive outcomes:

- Over 100 workshops were delivered at many sites and reached over a thousand middle-aged and older adults.

- During the project period, availability and diversity of programs increased.

- Programs consistently showed positive impacts on health-related attitudes, behaviors, and outcomes.

- Participants were highly satisfied with the programs.
With appreciation to all of our partners.

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