Supporting Healthy Living for Oregonians with Chronic Disease:

Patient Self-Management Collaborative

Laura Chisholm, MPH, MCHES
Self-Management Technical Lead
Oregon Public Health Division

Irma Murauskas, BSN, MPH
Director of Primary Care Transformation
Oregon Primary Care Association

Oregon Public Health Association
October 14, 2014
Patient Self Management (SM) Collaborative

What we set out to do:

• Enhance SM support systems (patient centered interactions + service delivery) within the clinic visit
  o Motivational interviewing
  o Team-based care

• Develop + refine referral systems
  o Oregon Tobacco Quit Line
  o Living Well & Tomando Control SM workshops
  o “Closing the loop”
How It Worked:

• Collaborative learning model
  o Multidisciplinary clinic teams
  o Practical, interactive approach
  o Emphasis on peer/shared learning

• Clinic teams attend learning sessions (F2F + web based)
  o Motivational interviewing
  o SM resources and support skills
  o Clinical process improvement for patient-centered care and SM referral

• Measurement/metrics
  o To drive improvement + increase understanding
Patient Self-Management Collaborative – participating FQHCs

- Multnomah County Health Department (9 sites)
- OHSU Richmond Clinic*
- Yakima Valley Farmworkers Clinic (2 sites)
- Northwest Human Services
- West Salem Clinic
- Community Health Centers of Benton & Linn Counties
- Umpqua Community Health Center*
- Siskiyou Community Health Center*
- La Clinica

* = did not complete collaborative
Advantages of SM Support - the Clinic Perspective:

- Empowers the patient to be in control of their own care + chronic disease
- Patients want smoking cessation and SM support
- The Quit Line and Living Well are proven interventions
- Relieves pressure on providers + clinic staff
- Fulfills Meaningful Use reporting requirements
- Supports medical home accreditation
Can it be done? Yes!

Clinic successes:

- Referral protocols + status tracking
- New electronic medical record templates (OCHIN)
- Documentation + reporting of SM data:
  - Patient goals, barriers, progress, confidence level
- Care plans that include patient goals
- Work flow changes
- More patients are getting connected to resources
- Deeper understanding of what’s required on both a clinical + operational level to improve SM support systems + service delivery
So far we’ve learned…

It’s challenging to measure success.

• What can we measure?
• What process data are meaningful?
• What clinical data are meaningful?
• How can we get consistency between different electronic record systems?
• How do we avoid clinic staff “measurement overload”? 
Defining + Measuring Success

- SM specific QI tool – Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS), adapted with permission

- PCRS is a tool that focuses exclusively and comprehensively on SM support. It’s organized into two categories: patient and organizational support

- Intention was to use this comprehensive approach as an ongoing QI tool that *hopefully* leads to improved patient and staff competence in the SM process
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Goal Setting/Action Planning</td>
<td><img src="image" alt="Image of PCRS" /></td>
</tr>
<tr>
<td>4. Problem-Solving Skills</td>
<td><img src="image" alt="Image of PCRS" /></td>
</tr>
<tr>
<td>5. Emotional Health</td>
<td><img src="image" alt="Image of PCRS" /></td>
</tr>
</tbody>
</table>
% of patients with documented SM goal(s) and/or update of goals within the last 6 months. N=1

POF /w Self Mgt Goals (SDM1)
- Jan-Mar '13: 38%
- April-June: 52%
- July-Sept: 62%
- Oct-Dec: 71%
- Jan-Mar '14: 65%

Asthma w/ Self Mgt Goals (SDM2)
- Jan-Mar '13: 25%
- April-June: 36%
- July-Sept: 42%
- Oct-Dec: 47%
- Jan-Mar '14: 48%
Large improvements shown across all measures over the life of the project. The largest improvements are in systems for documentation of SM support services; referral coordination; and links to community resources.

Average Scores by Item (all clinics combined)

- PSM Educ/ problem solving: Spring '12: 5.6, Spring '14: 7.7
- Goal Setting/ Action Planning: Spring '12: 5.0, Spring '14: 7.5
- Pt. Empowerment: Spring '12: 5.6, Spring '14: 7.8
- Link to community resources: Spring '12: 5.2, Spring '14: 8.2
- Continuity: Spring '12: 4.3, Spring '14: 8.8
- Referral Coord.: Spring '12: 4.2, Spring '14: 7.1
- Ongoing QI: Spring '12: 4.6, Spring '14: 7.8
- Document SMS: Spring '12: 5.9, Spring '14: 8.5
- Integration SMS: Spring '12: 5.4, Spring '14: 8.3
- Care Team: Spring '12: 5.4, Spring '14: 8.3
- Educ/ Train.: Spring '12: 5.4, Spring '14: 8.3
## PCRS Summary by Clinic – July 2012

<table>
<thead>
<tr>
<th>I1. Pt Self Mgt education and problem solving skills</th>
<th>All 5 clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>I2. Goal Setting/Action Planning</td>
<td>All 5 clinics</td>
</tr>
<tr>
<td>I3. Patient Empowerment and engagement</td>
<td>LCHC, NEHC, NPHC, SBHC</td>
</tr>
<tr>
<td>I4. Link to Community Resources</td>
<td>NPHC, SBHC, MCHD, NEHC, HIV</td>
</tr>
<tr>
<td>II1. Continuity of Care</td>
<td>LCHC, SBHC, HIV, NEHC, NPHC</td>
</tr>
<tr>
<td>II2. Coordination of referrals to Self-Mgt Programs</td>
<td>NPHC, HIV, SBHC, LCHC, NEHC</td>
</tr>
<tr>
<td>II3. Ongoing Quality Improvement</td>
<td>SBHC, NEHC, NPHC, LCHC, HIV</td>
</tr>
<tr>
<td>II4. Systems for Documentation of Self-Mgt Support Services</td>
<td>NPHC, SBHC, HIV, LCHC, NEHC</td>
</tr>
<tr>
<td>II5. Integration of Self Mgt Support into Primary Care</td>
<td>NPHC, SBHC, LCHC, HIV, NEHC</td>
</tr>
<tr>
<td>II6. Primary Care Delivery Team (Integral to Practice)</td>
<td>NPHC, SBHC, LCHC, HIV</td>
</tr>
<tr>
<td>II7. Education &amp; Training</td>
<td>HIV, SBHC, LCHC, NEHC, NPHC</td>
</tr>
</tbody>
</table>

### Implementation Levels:
- **A**: System-wide adoption & integration
- **B**: Team-level implementation / Organized & consistent
- **C**: Patient provider-level implementation sporadic & inconsistent
- **D**: Inadequate/ Non-existent implementation

### Clinics:
- LCHC
- NEHC
- NPHC
- SBHC
- HIV
- MCHD
- YVFWC
- Linc.
### PCRS Summary by Clinic – July 2014

<table>
<thead>
<tr>
<th>I1. Pt Self Mgt education and problem solving skills</th>
<th>D: Inadequate/ Non-existent implementation</th>
<th>C: Patient provider-level implementation sporadic &amp; inconsistent</th>
<th>B: Team-level implementation/ Organized &amp; consistent</th>
<th>A: System-wide adoption &amp; integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I2. Goal Setting/Action Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I3. Patient Empowerment and engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I4. Link to Community Resources**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II1. Continuity of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II2. Coordination of referrals to Self-Mgt Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II3. Ongoing Quality Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II4. Systems for Documentation of Self-Mgt Support Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II5. Integration of Self Mgt Support into Primary Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II6. Primary Care Delivery Team (Integral to Practice)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II7. Education &amp; Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Success!

I’m your new diabetes educator, here to talk about your disease.

Sure, what would you like to know?

haidee
So far we’ve learned…

The time is right!

- New emphasis on prevention
- Advent of medical homes and CCOs
- Shift toward outcomes-based payments
- Patient-centeredness is a key value
So far we’ve learned…

Self-management support

• Knowledge
• Self-efficacy
• Empowerment
• Activation
• Engagement

= Patient-Centeredness
Next steps

- Conduct final evaluation
- Identify best practices
- Develop tools to support change
- Spread learning through transformation initiatives