Supporting Healthy Living for Oregonians with Chronic Disease:

Patient Self-Management Collaborative

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Oregon Public Health Association
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OPCA Oregon Primary Care Association

Oregon Health Authority

Patient Self Management (SM) Collaborative

What we set out to do:

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

- Develop + refine referral systems
  - Oregon Tobacco Quit Line
  - Living Well & Tomando Control SM workshops
  - “Closing the loop”

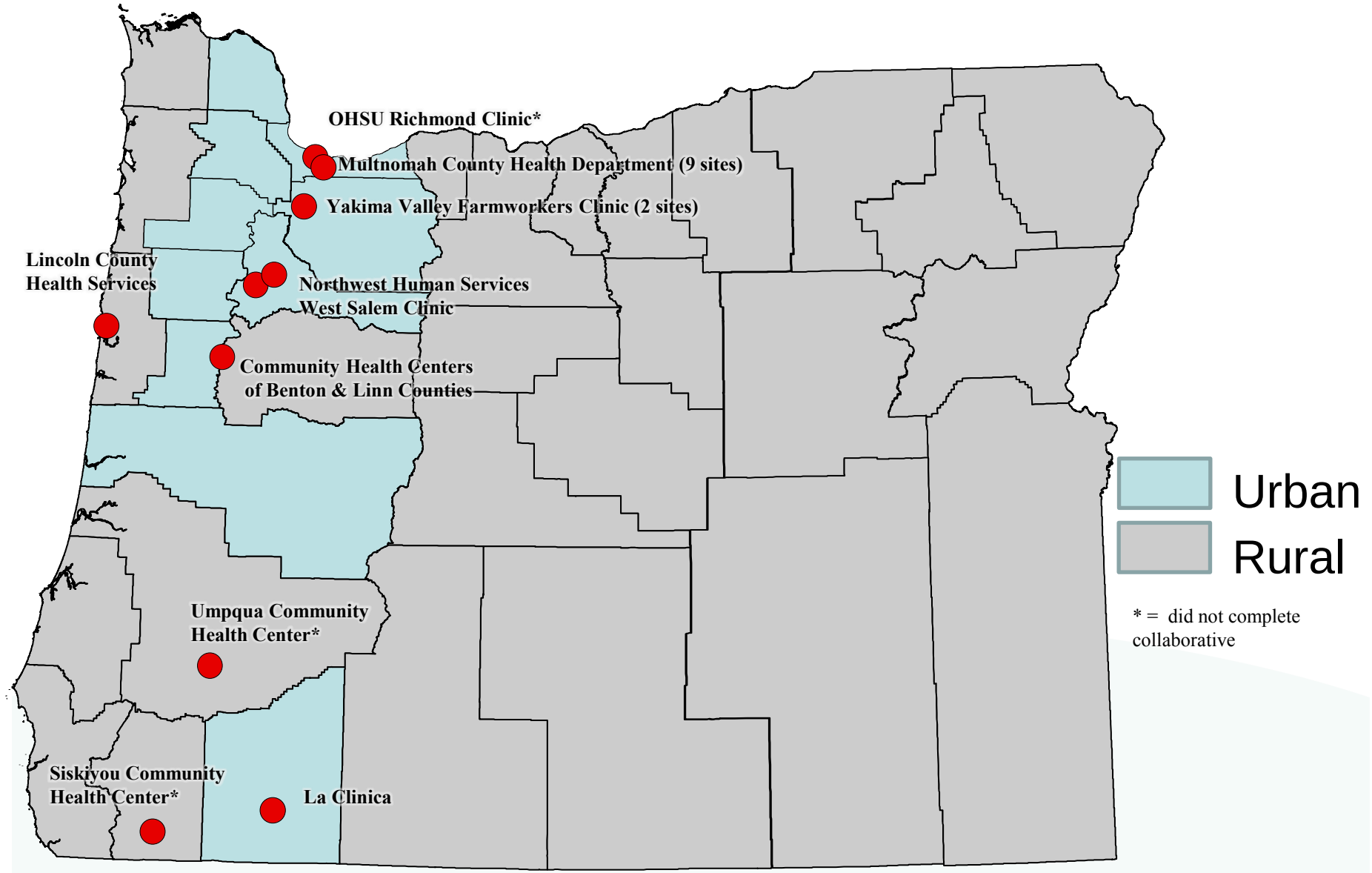
How It Worked:

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

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

- Measurement/metrics
  - To drive improvement + increase understanding

Patient Self-Management Collaborative – participating FQHCs



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

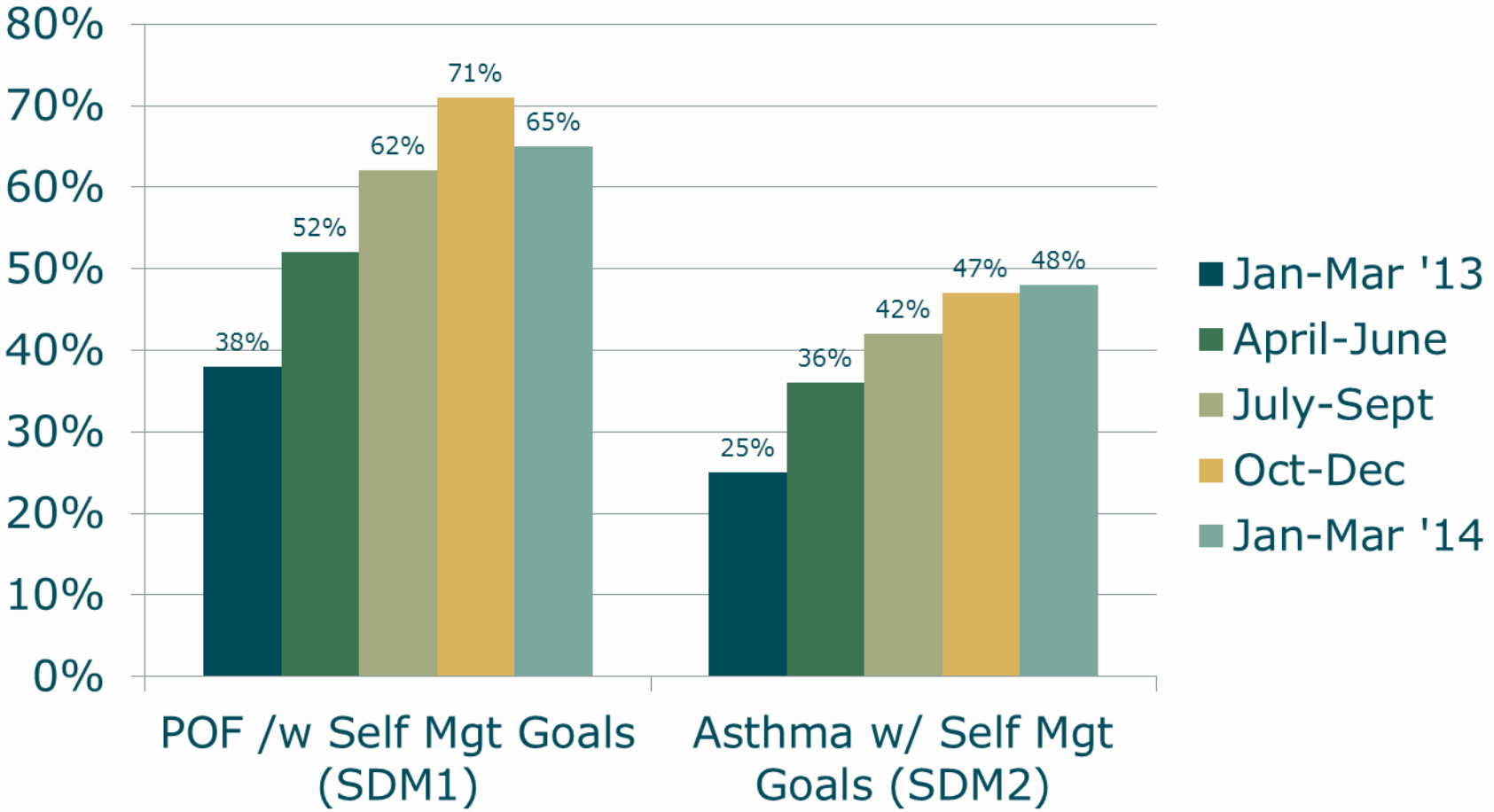
- SM specific QI tool – Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS), adapted with permission

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

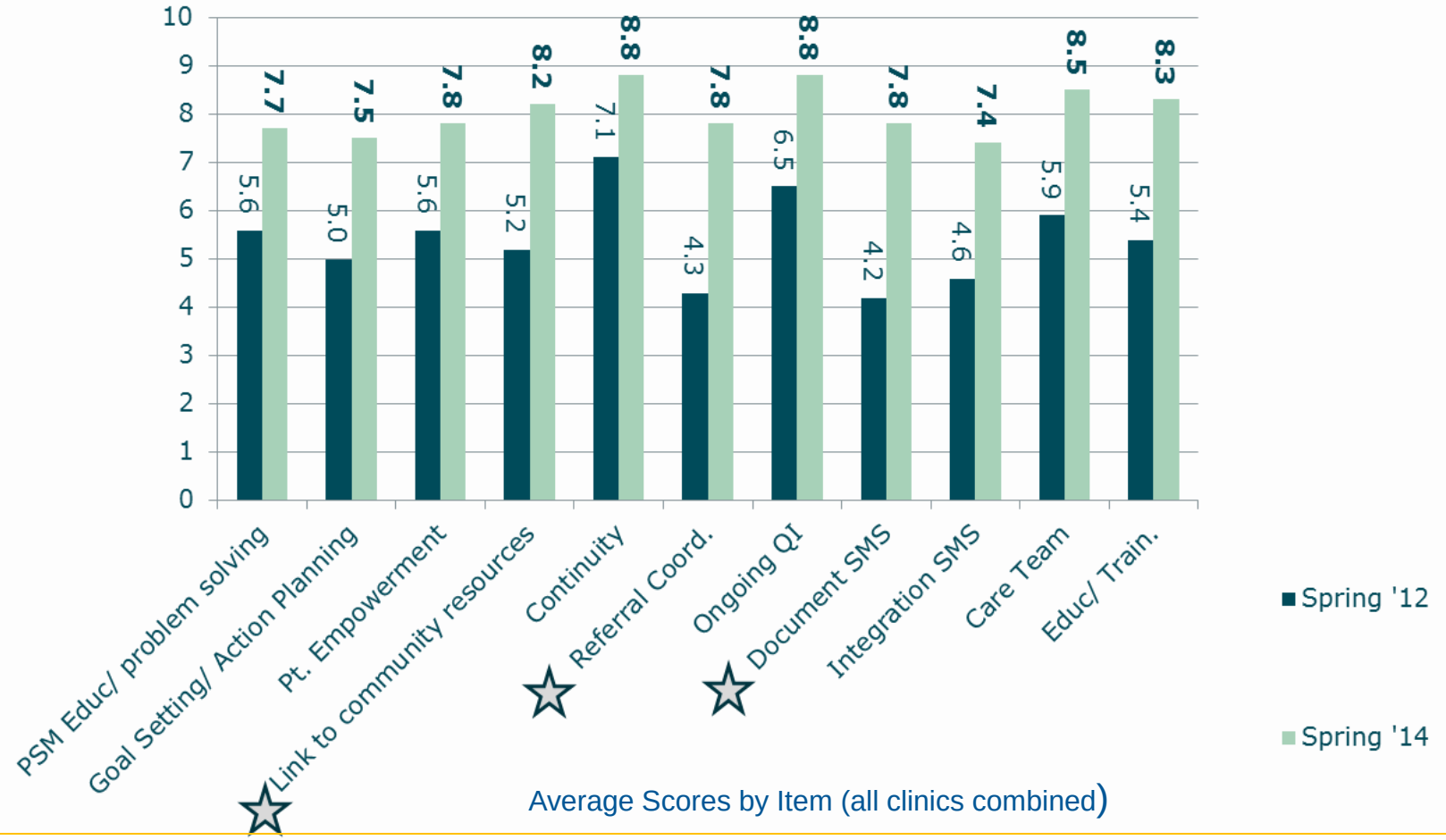
- Intention was to use this comprehensive approach as an ongoing QI tool that *hopefully* leads to improved patient and staff competence in the SM process

I: PATIENT SUPPORT (circle one NUMBER for each characteristic)				
Characteristic	Quality Levels			
	D	C	B	A (=all of B plus these)
3. Goal Setting/ Action Planning	…is not done 1	…occurs but goals are established primarily by health care team rather than developed collaboratively with patients 2 3 4	…is done collaboratively with all patients/ families and member(s) of their health care team; goals are specific, documented and available to any team member; goals are reviewed and modified periodically 5 6 7	…is an integral part of care for patients with chronic diseases; goals are systematically reassessed and discussed with patients; progress is documented in patient charts 8 9 10
4. Problem-Solving Skills	…are not taught or practiced with patients 1	…are taught and practiced sporadically or used by only a few team members 2 3 4	… are routinely taught and practiced using evidence-based approaches and reinforced by members of the health care team 5 6 7	…. is an integral part of care for people with chronic diseases; takes into account family, community and environmental factors; results are documented and routinely used for planning with patients 8 9 10
5. Emotional Health	…is not assessed 1	…is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent 2 3 4	…assessment is integrated into practice and pathways established for treatment and referral; patients are actively involved in goal setting and treatment choices; team members reinforce consistent goals 5 6 7	…systems are in place to assess, intervene, follow up and monitor patients' progress and coordinate among providers; standardized screening and treatment protocols are used 8 9 10

% of patients with documented SM goal(s) and/or update of goals within the last 6 months. N=1

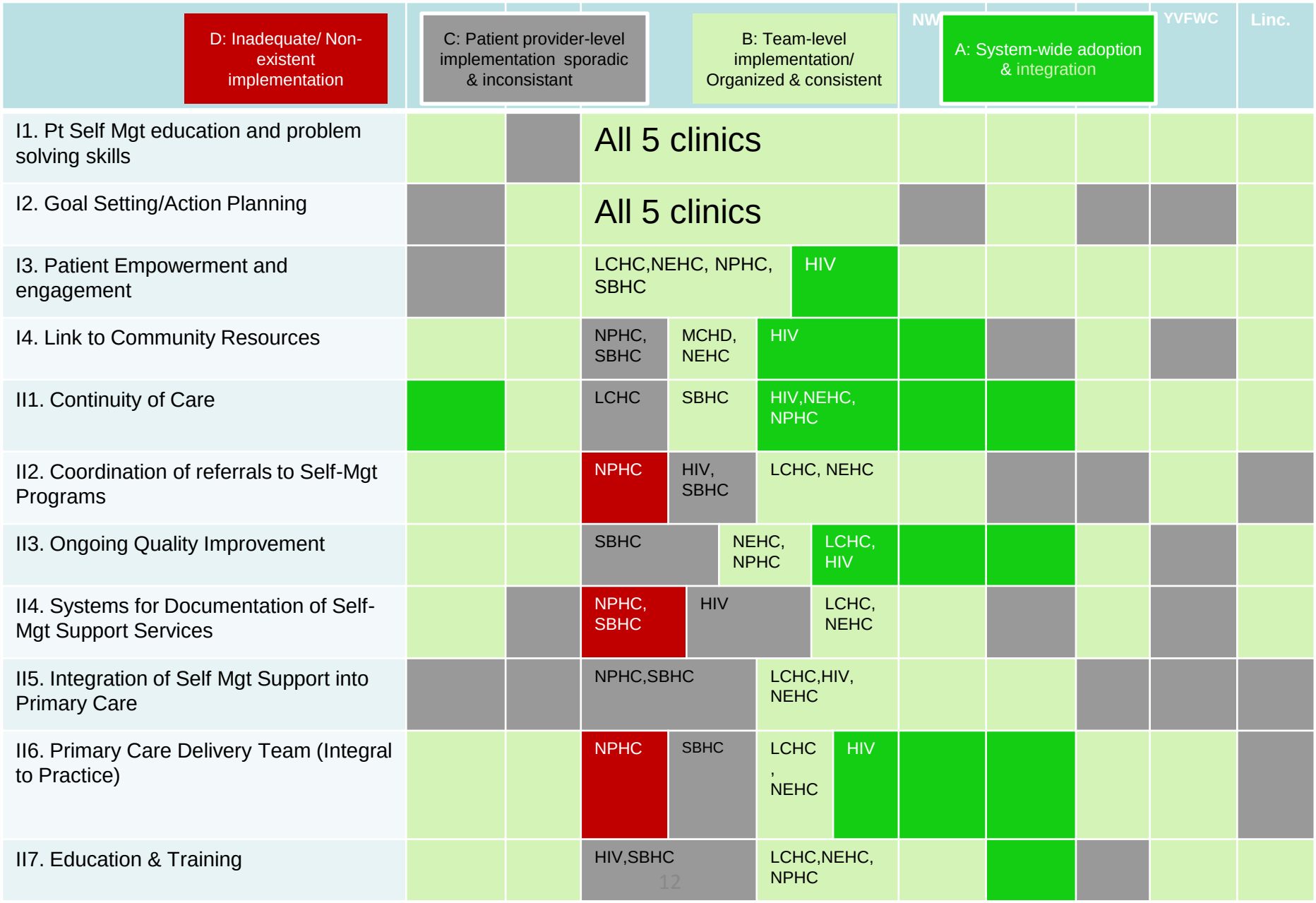


Large improvements shown across all measures over the life of the project. The largest improvements are in systems for documentation of SM support services ; referral coordination; and links to community resources .

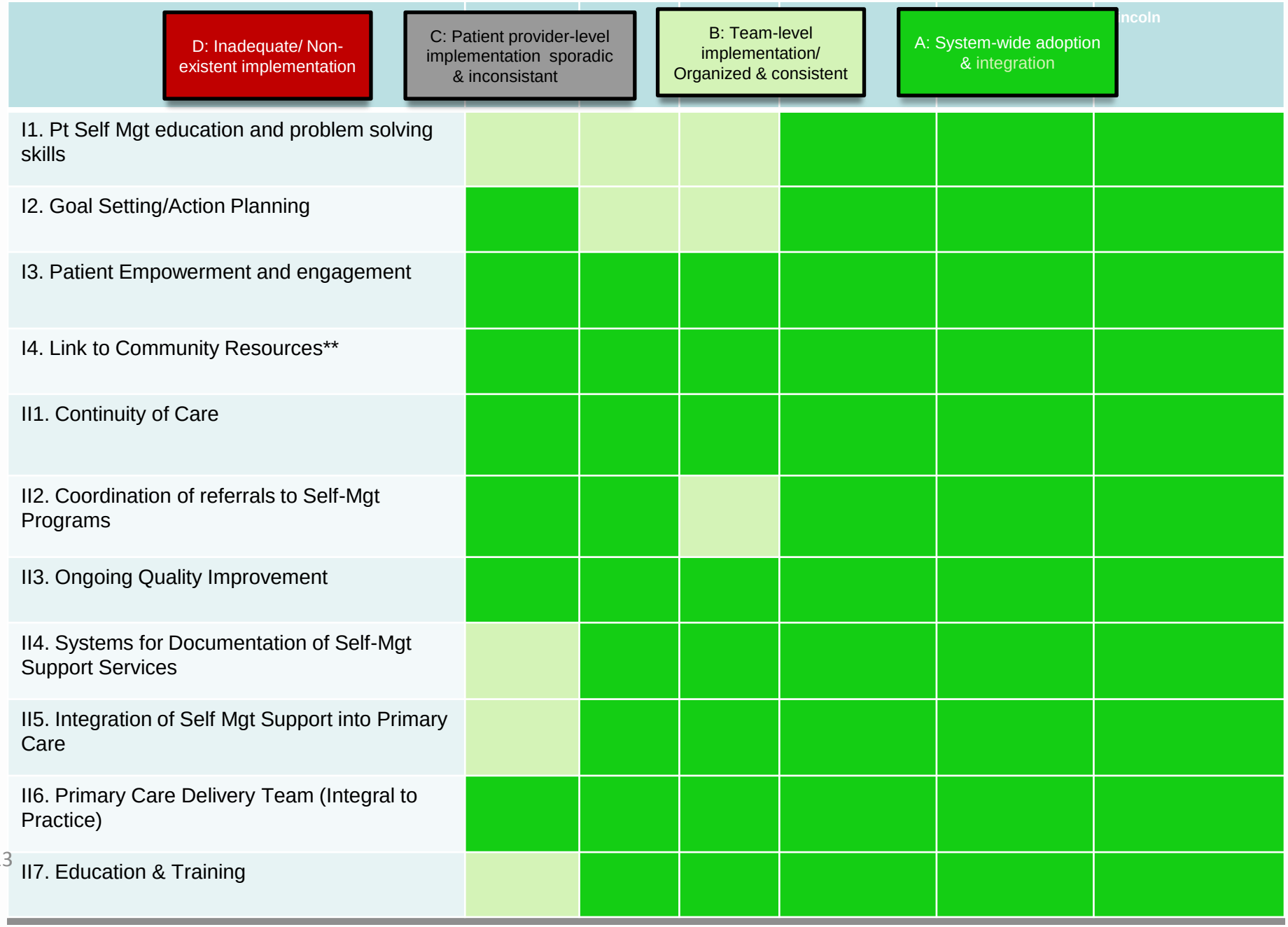


Average Scores by Item (all clinics combined)

PCRS Summary by Clinic – July 2012



PCRS Summary by Clinic – July 2014



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