The Community Health Center Patient Self-Management Collaborative

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Objectives for Today

- Describe the CHC Patient Self-Management Collaborative
- Identify potential roles for:
  - county Tobacco Prevention & Education Program and Healthy Communities coordinators
  - local self-management program partners
- Clarify next steps and plans for future communication on the project
- Hear your thoughts & ideas

Project Objectives

- Help community health center staff support patients with chronic conditions more effectively
  - Focus on asthma, other conditions (tobacco addiction, diabetes, hypertension, high cholesterol)
- Increase participation in self-management and tobacco cessation programs among Oregonians experiencing low socioeconomic status
  - Develop, test and document referral protocols
  - Establish data sharing systems between clinics & self-management resources

Organizational Roles

- Oregon Primary Care Association
  - Plans & coordinates project
- Public Health Division/HPCDP:
  - Coordinates with community partners
  - Provides technical assistance (evaluation, planning, programs)
  - Administers grant, reports to CDC
- Funded by 5-year project grant from CDC Asthma Program

Background: Health Disparities

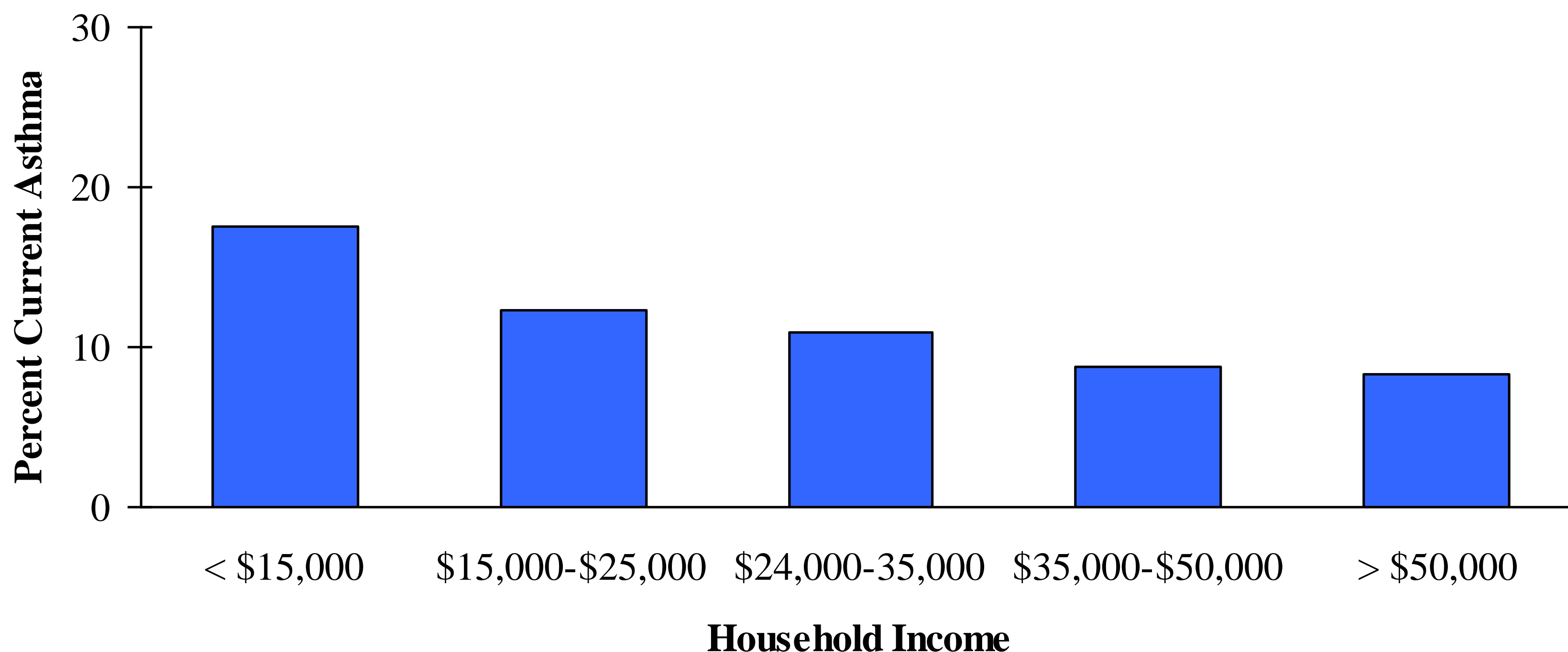
Prevalence of Selected Chronic Conditions Among Economically Disadvantaged Oregonians, Medicaid, and Oregonians, 2005

Prevalence	% of Economically Disadvantaged Oregonians	% of Medicaid Recipients	% of General Population
Arthritis	30%**	39%**	26%
Asthma	14%**	19%**	10%
Heart Attack	7%**	7%**	4%
Heart Disease	5%**	8%**	4%
Stroke	6%**	8%**	3%
Diabetes	11%**	13%**	6%
High Blood Pressure	28%**	34%**	23%
High Blood Cholesterol	34%	37%**	32%

** Statistically significant difference, compared to Oregon General Population

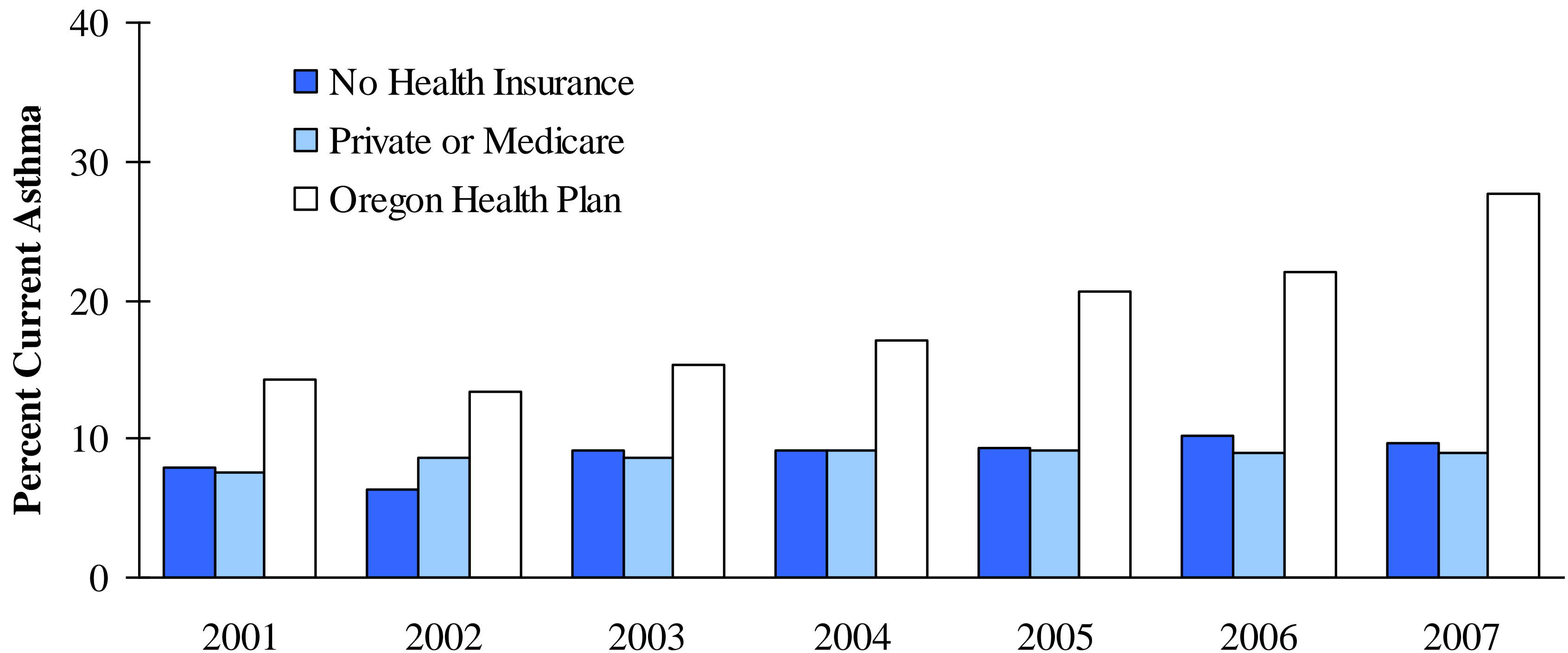
Source: *Keeping Oregonians Healthy*, July 2007.

Background: Health Disparities



Source: Behavioral Risk Factor Surveillance System (BRFSS).

Background: Health Disparities



Source: Behavioral Risk Factor Surveillance System (BRFSS).

Background: Clinic Perspective

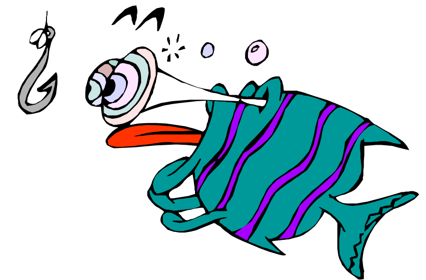
- Community Health Centers (FQHCs) see a large proportion of low-income and un-/underinsured patients
  - Lots of patients with multiple conditions, many stressors
  - Statewide: 45% uninsured, 35% Medicaid, 7% Medicare
  - May be only care option for many
- Clinical visits are rushed, and often focus on acute, rather than chronic conditions
  - Referrals often won't happen without automatic systems in place

Background: Community Perspective

- Self-management & cessation resources are available in many communities:
  - Oregon Tobacco Quit Line
  - Living Well/Tomando Control
  - Arthritis Foundation Exercise Program

- Programs need participants
- It's been challenging for many to connect with health care systems for referrals

An Exciting Opportunity



- Oregon is well positioned to do this work
  - Strong community collaboration and partnerships
  - Well-developed self-management/cessation resources
  - Clinics have strong interest in self-management support

- Project has a unique focus:
  - Community health centers, self-management programs, opportunity for state-wide spread

Objectives: In-Clinic Support

Increase support for self-management

- Develop provider skills in motivational interviewing, identifying patients for referrals, supporting ongoing positive behavior change
- Develop team-based care delivery structure to support patients
- Collect and track data on self-management & cessation counseling

Objectives: Sustainable Referral Systems

- Develop or refine referral systems to Living Well/Tomando, Quit Line and AF Exercise Program
  - How does/should the process work?
  - What information flows, how?
  - Track results: referrals made, patients participated, their clinical outcomes

- Identify what works, spread throughout clinics and to different patient populations, replicate throughout state

How It'll Work

Collaborative learning model (set up much like Healthy Communities institutes)

- Each clinic sends a multidisciplinary team, they choose who participates
- Practical, interactive approach
- Emphasis on peer learning

4-5 clinic teams will attend monthly learning sessions for 18 months

- Kickoff meeting October 1, 2010
- Motivational Interviewing training in November
- Quit Line / 5As training in December

Participating Clinics

First group of clinics begins this fall:

- NW Human Services (Salem)
- Community Health Centers of Benton & Linn Counties (Corvallis)
- Umpqua Community Health Center (Roseburg)
- La Clinica del Valle (Medford)
- Siskiyou Community Health Center (Grants Pass)

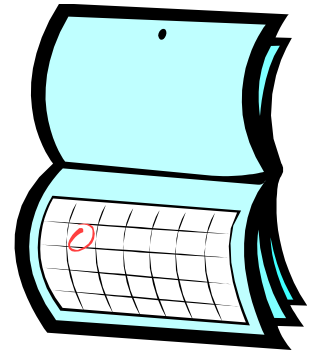
Second group of clinics will begin in fall 2011

Calendar of Events

- Project kickoff – October 1, 2010 (Eugene)
- Motivational Interviewing Training – November
- Quit Line & Cessation webinar – December

2011 learning topics:

- Living Well & Tomando Control programs
- Arthritis Foundation Exercise Program
- Cultural competency
- In-person meeting connected to LW Forum

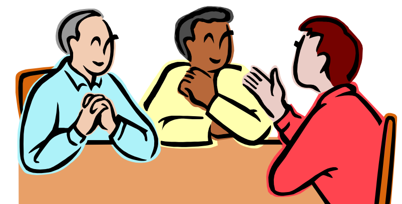


Community Partner Roles

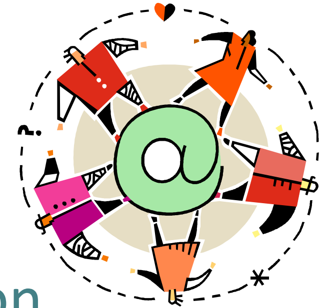
- Help clinics understand self-management program partnerships and delivery in your community
  - Who's involved, who does what?
  - How programs are delivered now, plans for expansion
- Advise development and/or fine-tuning of referral protocols to Living Well/Tomando, AF Exercise Program and Quit Line
  - Strategize on outreach to patients, referral processes, data sharing, process improvement

Roles, Continued

- Work with partners to designate one "community ambassador" per clinic
  - Ambassador is clinic's key community self-management contact
  - One community ambassador per clinic is invited to attend the 10/1 kickoff in Eugene
  - Healthy Communities coordinators are encouraged to take this role as work plans and schedules allow
  - Work with your partners to decide who
  - Let Laura & Carol know by **September 24**
- Opportunity to participate in collaborative team work if invited
  - Clinics decide team composition
  - Will involve periodic team meetings and Collaborative webinars/conference calls



Communication Plan



- "Community Ambassadors" (key contacts):
  - Will receive regular Collaborative communication
  - Will have access to online learning community hosted by OPCA
  - Are invited to connect through quarterly calls
- Other interested partners:
  - Will be invited to participate in specific meetings/calls
  - We'll keep you posted as the curriculum is finalized
- HC and TPEP coordinators should discuss specific work plan questions with your liaison
  - Contact Laura, cc your liaison for questions and technical assistance requests

Discussion:

- What has your connection been with your clinic to date?

- What are your successes/challenges in working with them?

Discussion

- What do you see as your potential contributions to setting up (or fine-tuning) systems for referring clinic patients to self-management programs?

Discussion

- What would make this project successful for you?
- If the project could achieve one thing in your community, what would you want that to be?

Thank You!

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