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Today’s Objectives

• List three reasons why health care providers and organizations should develop linkages to self-management programs for patients with chronic conditions.

• List two barriers experienced by primary care practices in consistently referring patients to self-management programs, and how the barriers can be overcome.

• Describe two outcomes that primary care providers often observe in their patients who complete a self-management program.
Today’s Speakers

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Topics of today’s webinar

• Evidence Base for Self-Management Programs
• Attractions and Barriers for Health Care Referrals/Recommendations for Self-Management Programs
• Overcoming Barriers
• Sustaining Health Care Involvement in Self-Management Programs
• Resources

Menu of Self-Management Programs

• Active Living Every Day (ALED)
• Chronic Disease Self-Management Program (CDSMP)
• Chronic Disease Self-Management Program Plus Hypertension Module (CDSMP+H)
• Diabetes Self-Management Program (DSMP)
• National Diabetes Prevention Program (NDPP)
• Walk with Ease

• Spanish-language Diabetes Self-Management Program
• Tomando Control de su Salud (Spanish-language CDSMP)
Self Management Program Evidence Summary


History of Self Management Programs in Chautauqua County

- August of 2009 - First Living Healthy was taught in the County
- February of 2012 - Renewed Practice outreach began as the referral process was refined
- February 2013 - Physician Referrals for Living Healthy surpassed peer leader capacity

History of Self Management Programs in Chautauqua County

- December 2013 - Additional Living Healthy leaders were trained, Diabetes and Chronic Pain options were added to program offerings
- March 2014 - Consumer Engagement Specialist was hired by CCHN to coordinate self-management programming
- Summer 2014 - Diabetes Prevention Program, Powerful Tools for Caregivers, and Smoking Cessation added to program offerings
Jamestown Primary Care -
Interest in Self Management Programs
• Patients seen with multiple chronic conditions has been steadily increasing
• Improve patient health
• Meets component of PCMH certification
• IDS participation - to meet QI measures
• ACO participation - to meet QI measures

The Clincher - Why Refer?
• Quality data is tracked by physician by an increasing number of insurance companies. Higher quality scores = Higher reimbursement
• One example - The percentage of patients with Diabetes whose HgA1c < 9
• Moving the needle on patient lab scores requires lifestyle changes

The Clincher - Why Refer?
• Lifestyle changes require more touch points between the patient and health care providers.
  – Educating & Empowering patients
  – Discovering what changes an individual can make and how to support that change
Barriers to Referral

- Workflow Changes for referrals
  - Constantly evolving as technology is incorporated
- Staff Education
  - Understanding the programs - credibility of curriculum
  - Referral process training
- Cultural Changes
  - Patient Empowerment
  - Staff Empowerment - All levels of practice staff can refer patients, not just physicians

2012-2013: Beginnings of a referral process

- JPC built the referral into their EHR as an order which could be faxed directly to CCHN
- CCHN followed-up with potential participants for enrollment
- Letter of confirmation was sent to participant
- Participant was called the day before the class started
- Physician offices were sent a letter of completion for the participants from their office

2014: A More Sophisticated Referral and Tracking Process

- Currently JPC and CCHN are piloting a referral process through the Practice’s EHR and the ACO’s Health Information Exchange
  - As the number of self-management programs increased, it was decided to discontinue use of the order for an all encompassing referral form
  - Built into the EHR to self populate with patient demographic information and relevant clinical data
2014: A More Sophisticated Referral and Tracking Process
- Clinician only needs to select the program for which the patient is being referred
- The referral is sent directly from the EHR and routed through the HIE
- CCHN staff receive the referral and follows up with the patient for enrollment
- A referral outcome (patient declined, completed, or did not finish) is sent to physician via the HIE directly to the EHR where it is routed to the patient’s profile.

In Development for Referral and Tracking
- Creation of patient disease registry reports in the EHR to identify appropriate patients for referrals
- Utilization of “Alerts” to notify clinical staff when a patient has been identified as a potential candidate
- Administering the Patient Activation Measure to better understand a patient’s confidence in managing their condition
- Using Motivational Interviewing techniques to address issues with patient confidence and/or commitment to self management

JPC Referrals, Enrollment, Completion

<table>
<thead>
<tr>
<th>2013</th>
<th>So far in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>46 referrals</td>
<td>50 referrals</td>
</tr>
<tr>
<td>20 enrolled</td>
<td>18 enrolled</td>
</tr>
<tr>
<td>10 completed</td>
<td>24 to still be contacted</td>
</tr>
<tr>
<td>45% of completers</td>
<td>7 in current class</td>
</tr>
<tr>
<td>Increased by at least one PAM level</td>
<td>3 of 11 completed</td>
</tr>
</tbody>
</table>
Observed Effects on Patients Who Completed the Programs: Case Study

- 67 Year old female with Diabetes, Hyperlipidemia and Reynaud’s Disease
  - Patient battling weight gain and her cholesterol continue to climb
  - Goals were set during Annual Medicare Wellness visit (LDL, 100)
  - Patient was referred to and completed Living Healthy class
- Over a three month period:
  - HgA1C: 6.4 decreased to 5.9
  - LDL: 149 decreased to 140

Other Challenges, Concerns, Opportunities?

- Feedback to Primary Care Physician - Information flow will allow physicians and staff to encourage patients and support their participation.
- Incorporate into Primary Care Office as part of group visits.

Resources
Resources

• Working with Patient-Centered Medical Homes: Implementing Evidence-Based Programs in Health Centers and Practices
  • Description: 3-part webinar series
    1. Making Sense of Healthcare Transformation
    2. Referral Systems that Meet Practice Needs in Support of the Patients
    3. Your Role in Workflow, Work plans, and Making Sure It Works for All
  • [Link](http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/docs/pdf/arthritis_marketing_guide.pdf)

• Developed by: Center for Healthy Aging and partners
  [Link](http://www.ncoa.org/improve-health/center-for-healthy-aging/grantee-webinars.html)
  • Description: Library of Webinars
    1. “Sustainability in a Changing Healthcare Landscape”
    2. “Diabetes and Chronic Disease Self-Management: Moving Toward Sustainability”
Resources

• Motivational Interviewing in the Primary Care Setting
  https://www.harvardpilgrim.org/portal/page?_pageid=253,2272039&_dad=portal&_schema=PORTAL

• Comprehensive information and training in motivational interviewing
  http://www.motivationalinterview.org/

Thank You