This product was developed by the Help Yourself: Chronic Disease Self Management Program at Marshall University School of Medicine in Huntington, WV and the New River Health Association in Scarbro, WV. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

A Team Approach to Chronic Disease Self-Management at New River Health Association

Linda Stein, M Ed, MSW; New River Health Association

Tammy Campbell, RN, MSN, CFNP; New River Health Association

Sally Hurst, BA; Robert Wood Johnson Diabetes Initiative/Marshall University School of Medicine

"A Showcase"

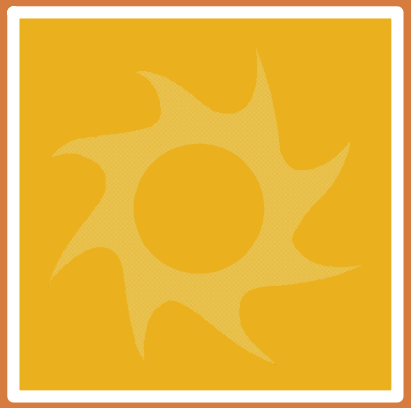
May 24 and 25, 2005

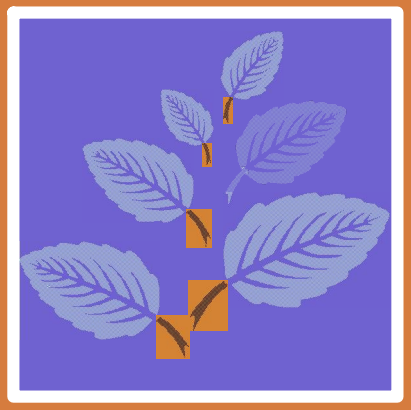
New River Health Association

DIABETES INITIATIVE

Advancing Diabetes Self-Management

Building Community Supports for Diabetes Care





Agenda

- Background of Chronic Disease Self Management at NRHA
- CAP Program – Expanded Case Management
- Depression Collaborative
- RWJ Advancing Diabetes Self-Management Project

Background of Chronic Disease Self Management at NRHA

NEW RIVER HEALTH ASSOCIATION

- Serving Fayette and Raleigh Counties since 1978
- Focus on preventive care and outreach
- Our greatest resource is our people

NRHA Chronic Disease Initiatives

- HTN Tracking (1980 – 86)
- Healthy Heart Project (1987-89)
- Diabetes Self Care Clinic (1991 – present)
- Docs Need SOCs (1998)
- Chronic Pain Interdisciplinary Team (1994 – present)
- Medical Group Visits (2001- present)
- Diabetes Support Group (2000-pesent)
- CHOW Project

NRHA Clinical Leaders
Pat Samargo, RN
Daniel Doyle, MD

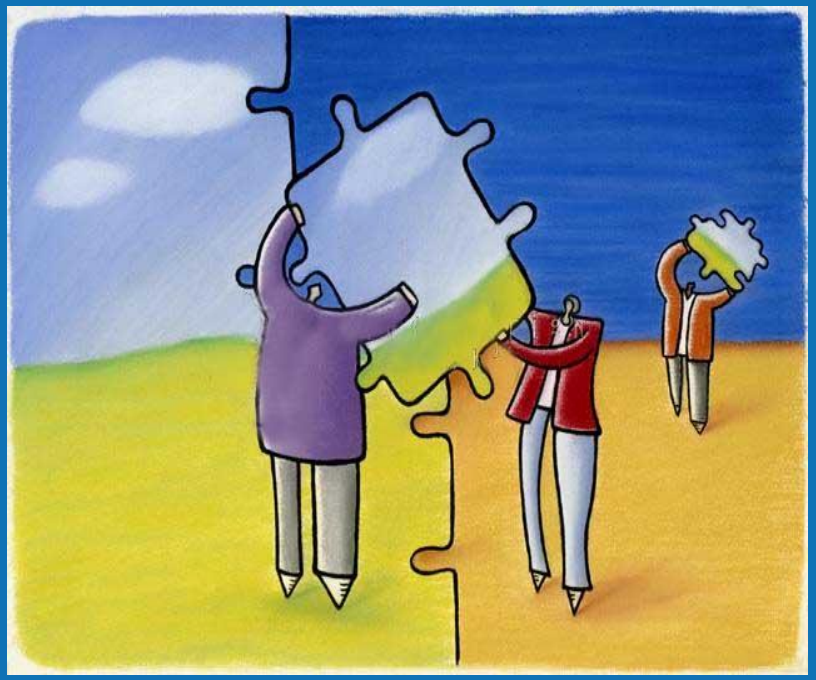
Lay Outreach Background

- Lay home visiting program – Began 1982
- Intensive training/Strong supervision
- Curriculum as guide
- Mother/Baby Play Groups

- CAP Advanced Care Management-Community Health Outreach Workers - CHOWs

Self – Management Messages A "Perfect Fit" for Lay Outreach

- Build on strength- based philosophy of MIHOW
- Outreach workers help patients with chronic disease make change
- Ongoing relationship and support help patients maintain healthy changes



CHOWs

- Community Health Outreach Worker Project
- Using local people and building on their interests and skills
- Training and supervision are critical to success
- CHOW provides education, support and resource referral to patients with diabetes and other chronic conditions.

Community Health Outreach Workers (CHOWS)

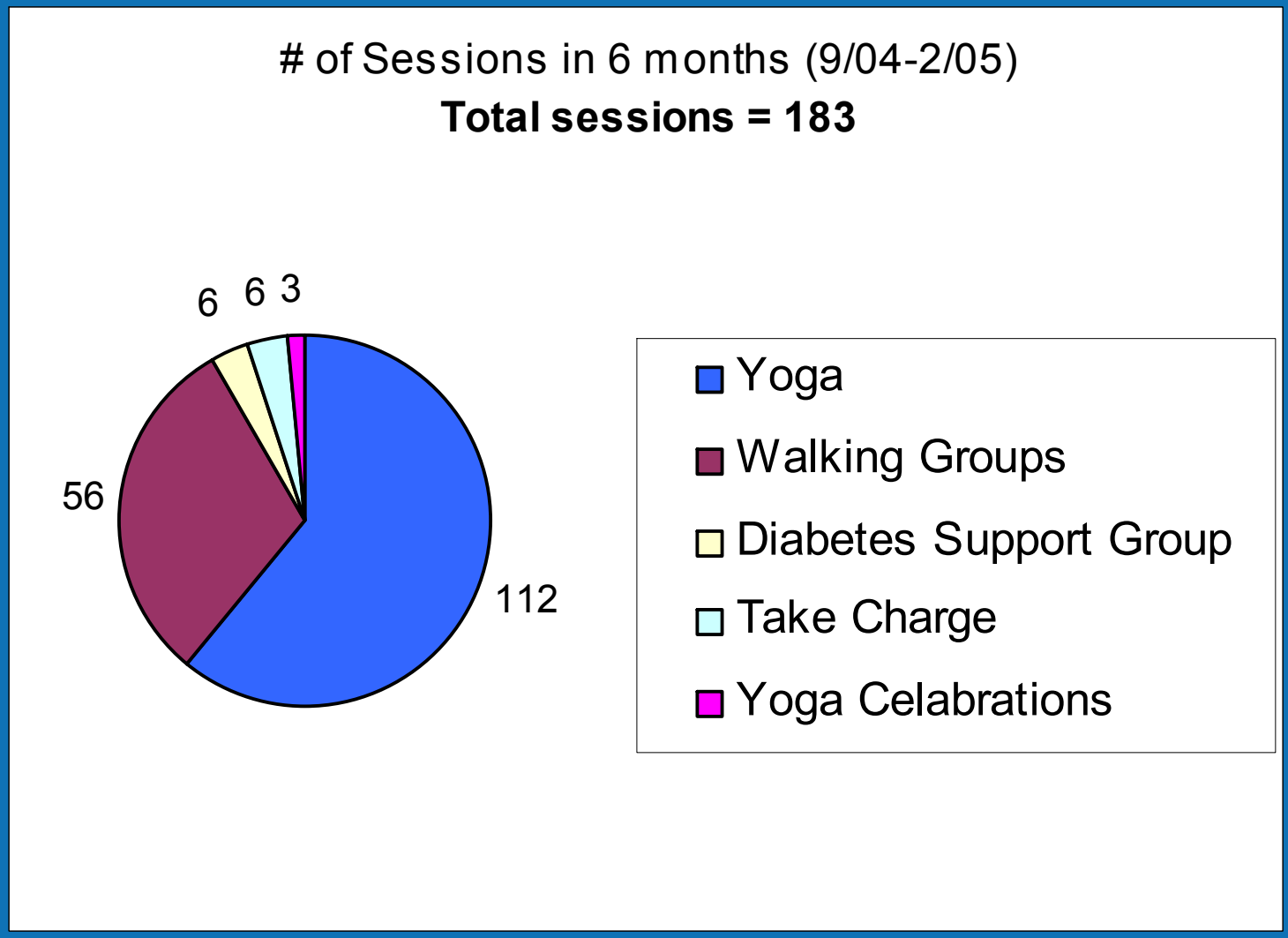
Lori Keller

Kara Ware

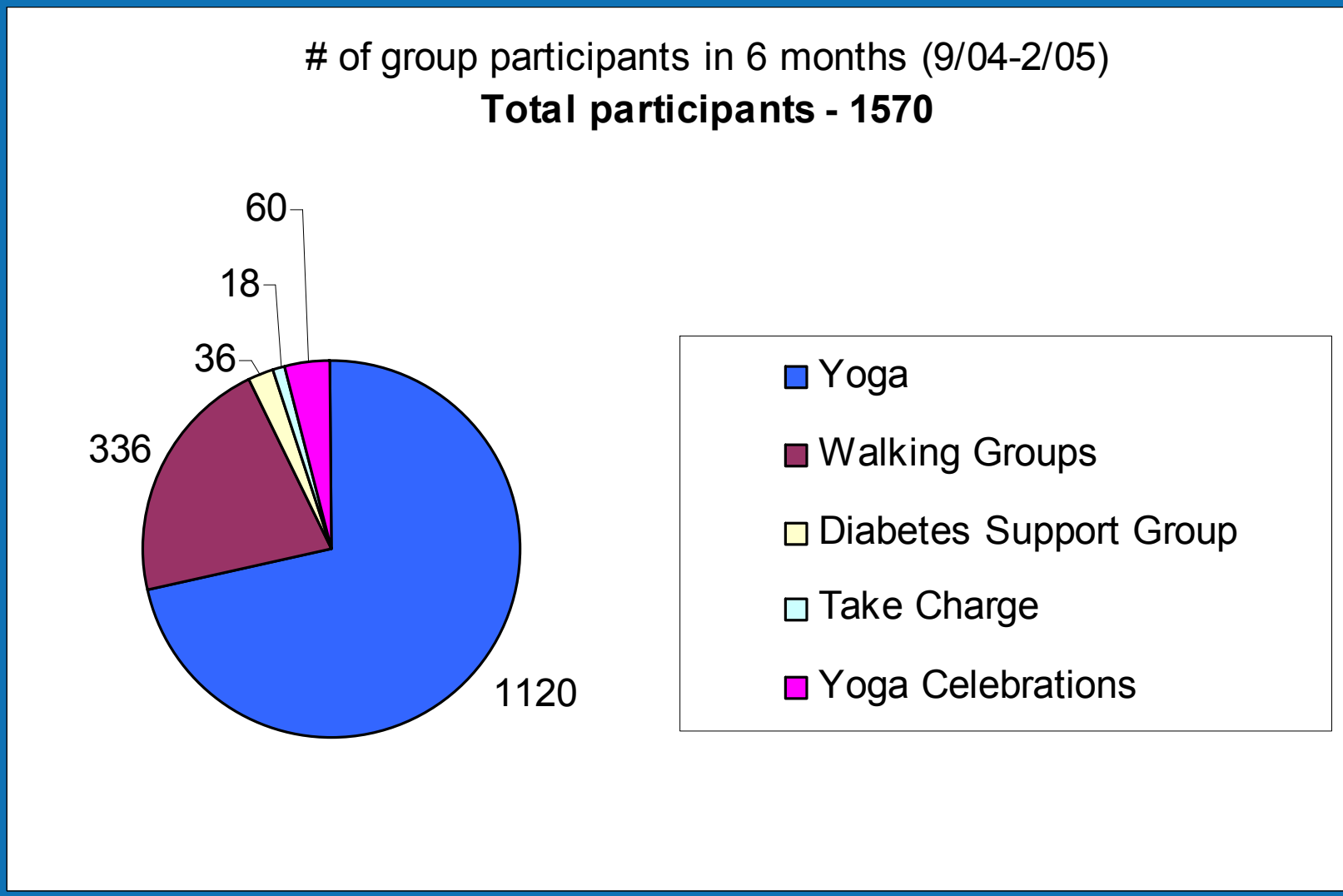
Group Interventions

- Easy Does It Yoga
- Young Adult and Back Care Yoga
- Walking groups
- Help Yourself
- Take Charge
- Diabetes Support Group
- Weight Loss support Group

CHOW group sessions



Participants at CHOW groups



CHOW's lead isolated patients into groups

- Visit individually
- Offer group menu and help patients choose which is most appropriate
- Encourage them as valued participant
- Celebrate and honor success
- Develop leadership from within group
- Cultivate helping roles

Easy Does It Yoga

Appreciation Hugs for All

CHOW Medical Visit Intervention

- CHOWS partner with Provider/Nurse team
- Providing Health Education, Resource Referral, Support, and Goal setting
- Making productive and pleasant use of waiting time

Depression Collaborative

Depression Collaborative

- *Initiative promoted through Bureau of Primary Health Care*
- *Pilot site was New River Family Health at Scarbro*
- *Provider had special interest in treatment of depression*
- *Mental health services offered at this site*
- *Timing was perfect to coincide with other self-management initiatives*

Blues Clues Team

Standing, left to right: Jacquelynn, Tammy, Alice, and Gail.

Seated, left to right: Linda and Debra.

The Initial Preparation

- *Learning sessions provided by Bureau of Primary Health Care*
- *Provider identified patients that were likely to be included and continues to identify patients when they present for appointments at the clinic.*
- *Team completed chart abstractions during team meeting time.*
- *Entered patients into registry provided by Bureau of Primary Care. Initial size of our depression population was 74. Current size is 110.*

Initial Patient Enrollment

- *Entered patients into registry provided by Bureau of Primary Care.*
- *Initial size of our depression population was 74.*
- *Current size is 110.*

Self management Aim Statement

NRHA will redesign the clinical practice using the Chronic Care Model to identify and treat our patients with depression through use of a standardized assessment tool.

We will accomplish this by:

40% depressed pts with 50% reduction in PHQ-9

70% of pts with documented PHQ-9

70% of pts who have a dx of depression and a documented PHQ score within the last 6 months

70% of pts with depression as identified with the PHQ9 will have a documented h Self Management (SM) Goal

70% of patients with a diagnosis of major depression or dysthymia on an antidepressant at last visit

Self Management Aim Statement

70% of pts with depression as identified with the PHQ9 will have a documented Self Management (SM) Goal

Self management Strategies

Various self management (SM) planning forms introduced to patients:

- *Using bright pink SM plan to capture patient identified goal(s)*
- *"Prescribing" SM goals that are listed on a prescription blank*
- *Giving patient SM form with pictures and ideas about self care prior to provider visit*
- *Simple information sheets on their disease and its management*

Self management Reinforcement

- *Self management goals initiated or reinforced by CHOWs*
- *Patients attending Easy-Does-It Yoga and Back Care Yoga*
- *Some patients participating in free, 6-week "Help Yourself" SM course (based on Kate Lorig model)*
- *Each patient at Medical Group Visit (MGV) leaves with SM goal(s)*

Key Outcome Measures for Depression

Measure	Goal	Current Status as of 4/2004
Depressed patients with 50% reduction in PHQ	>40%	24%
Depressed patients with documented PHQ reassessment between 4-8 weeks of last New Episode PHQ	>70%	11%
Documentation of self management goal setting	>70%	87%
Patients who have a diagnosis of depression and a documented PHQ score within the last 6 months	>70%	68%

Data and Results

Measure	Goal	Status as of 4/2004
Documentation of self management goal setting	>70%	87%

Key Self-Management Depression Measures

Measure	Goal	Current Status as of 2/2005
CSD* patients with 50% reduction in PHQ	**>40%**	**21%**
CSD* patients with documented PHQ reassessment between 4-8 weeks of last New Episode PHQ	**>70%**	**13%**
Documentation of self management goal setting	**>70%**	**66%**
Patients who have a diagnosis of depression and a documented PHQ score within the last 6 months	**>70%**	**61%**

Next Aim Statement

. . . and treat our patients with CVD (spread). . .

We will accomplish this by:

70% CVD Patients with SM Goal Setting in Last 12 Months

80% CVD Patients with Fasting Lipid Profile Documented appropriately

60% CVD Patients (CAD or DM) with Fasting LDL <100

90% CAD Patients on Aspirin or antithrombotic Agent

70% CVD Patients Age >= 55 (CAD or DM) on ACE

70% CAD Patients on Beta Blockers

50% CVD Patients Screened for Depression (12 months)

90% CVD Patients with DM 2 HbA1c's in Last 12 months, at least 3 months apart

30% CVD Patients with BMI >25 Who Have Lost 10 Pounds (12 Months)

40% CVD Patients with Regular Exercise (3Xweek @ least 20 minutes) Documented within Last Year

12% CVD Patients Who Are Smokers (Documented within last 12 months)

75% CVD Patients with Medication SM Training

CVD Key Measures

Measure	Goal	Current Status as of 2/2005
Hypertension Patients with BP < 140/90	**>50%**	**41%**
CVD Patients with Two BP's in Last Year	**>90%**	**75%**
CVD Patients with SM Goal Setting in Last 12 Months	**>70%**	**80%**

Self Management Challenges

- *Talking with patients about depression*
- *Finding time to set SM goals with the patient during the visit*
- *Making sure the SM goals belong to patient and not provider*
- *Getting patients to move forward and build on their SM goals*
- *Assuring the continuation of follow-up on SM goals outside office visits*

Self Management Tips for Success

We found the following things to be extremely important to our success with SM:

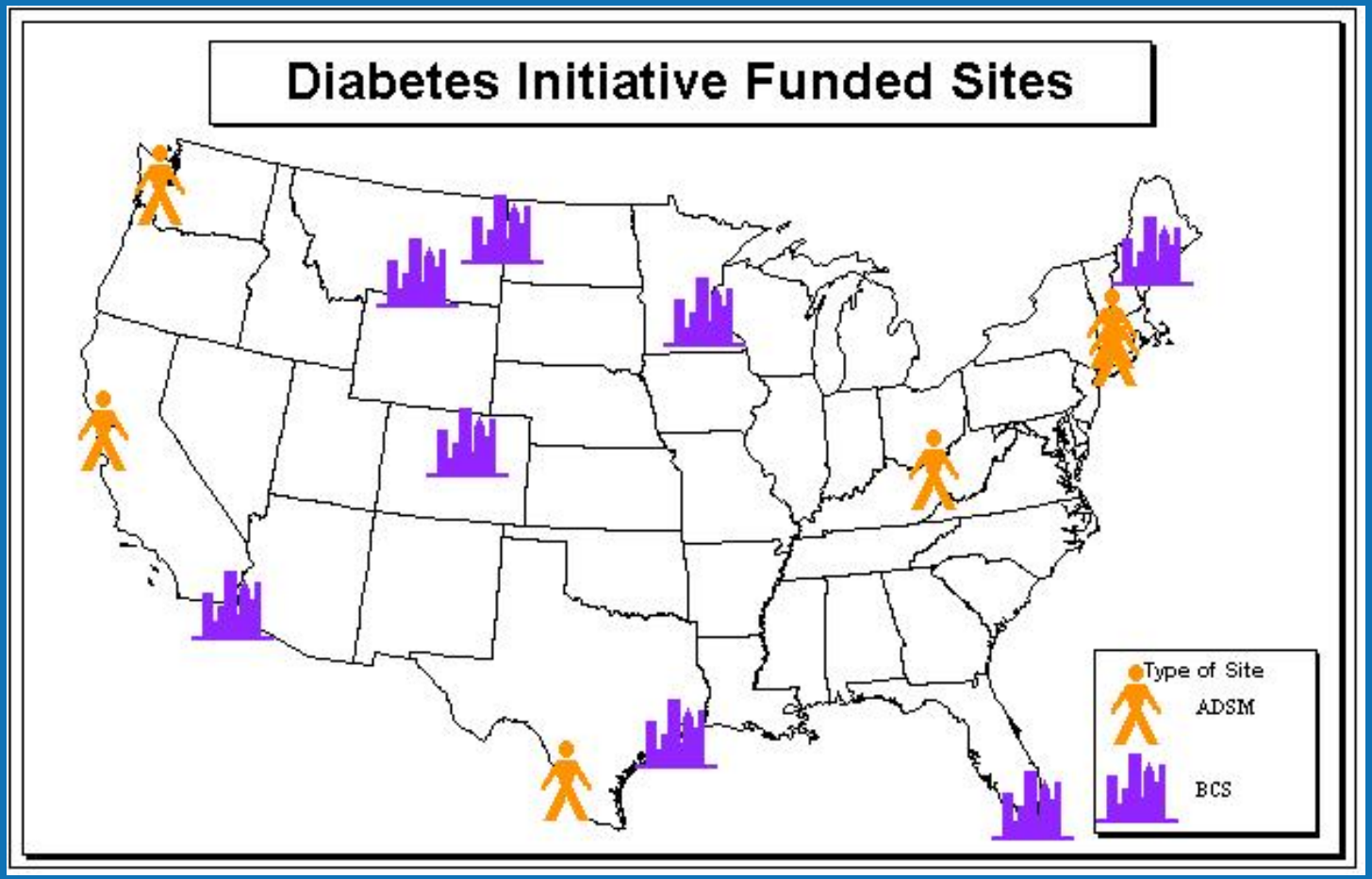
- *Support staff who are interested/trained in mental health issues*
- *Team huddle every morning*
- *Access of all team members to SM goals (free to edit, add to, etc.)*
- *The sum is greater than the parts: Working as a team got us further than we could have ever gotten otherwise*

Key Partnerships

- *Clinical Regional Advisory Network (CRAN), Region III*
- *WV Bureau for Public Health & Bureau for Behavioral Health*
- *WV Primary Care Association*
- *Partners In Health Network – Southern WV network of primary care clinics and hospitals*
- *Community Access Program (CAP) – Federal grant program supporting lay home visitors for people living with chronic diseases including depression*
- *Hospice of Southern WV*
- *Women's Resource Center*
- *Compassionate Friends and similar community support groups*
- *Marshall University/ RWJ Self-Management Project*

RWJ Advancing Diabetes Self-Management

A partnership of rural health centers and churches working to promote innovative ways to help people experience the benefit of taking control of their chronic condition



Underlying assumptions

- Clinics are interested in advancing self management but have little time to develop resources and strategies
- Only the patient can be responsible for his or her day-to-day care
- People with chronic conditions must deal not only with their disease (s), but also the impact these have on their lives
- People with chronic conditions have similar concerns and problems

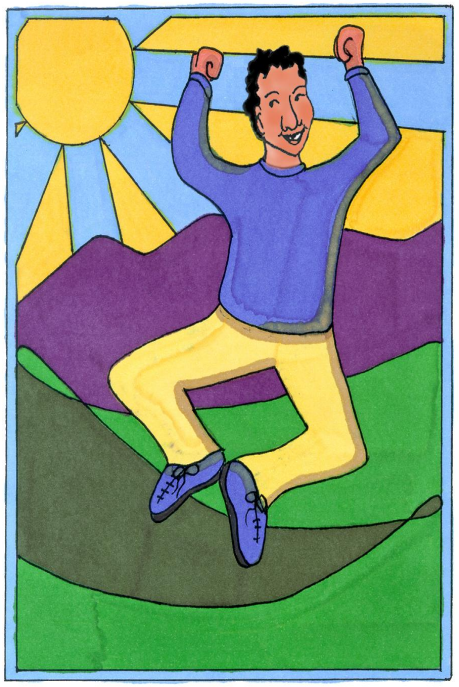
RWJ Strategies

- Social Marketing Campaign
- Stanford University Chronic Disease Self – Management Program (Kate Lorig)
- Support Medical Group Visits
- Assessment of Primary Care Resources and Support (tool)
- Support use of lay outreach workers
- Organize patient support and volunteer programs

Are you Ready?

Balance Your Plate

Choose to Move



Kick the Habit

Ask Us How!

Developed by Marshall University Center for Rural Health
with thanks to the
Robert Wood Johnson Foundation
Advancing Diabetes Self-Management Grant

For more information about how you can enjoy a healthier life while living with a chronic condition…
Call:

NRHA "Help Yourself "Program

- Leaders training (11/2003)
- 6 Help Yourself course series (6 week program)
- 63 New River patients and employees have completed the course
- Evaluation – Stanford questionnaire
- Pre and 6 month post

Help Yourself Evidence – It works!

Questionnaire results -

- Increase in number of minutes per week of exercise
- Increase use of coping strategies
- Improved communication with physicians
- Improved health status
- Significant reduction of pain
- Reduced disability
- Less fatigue
- Less health distress or worry about their condition
- Improved role function

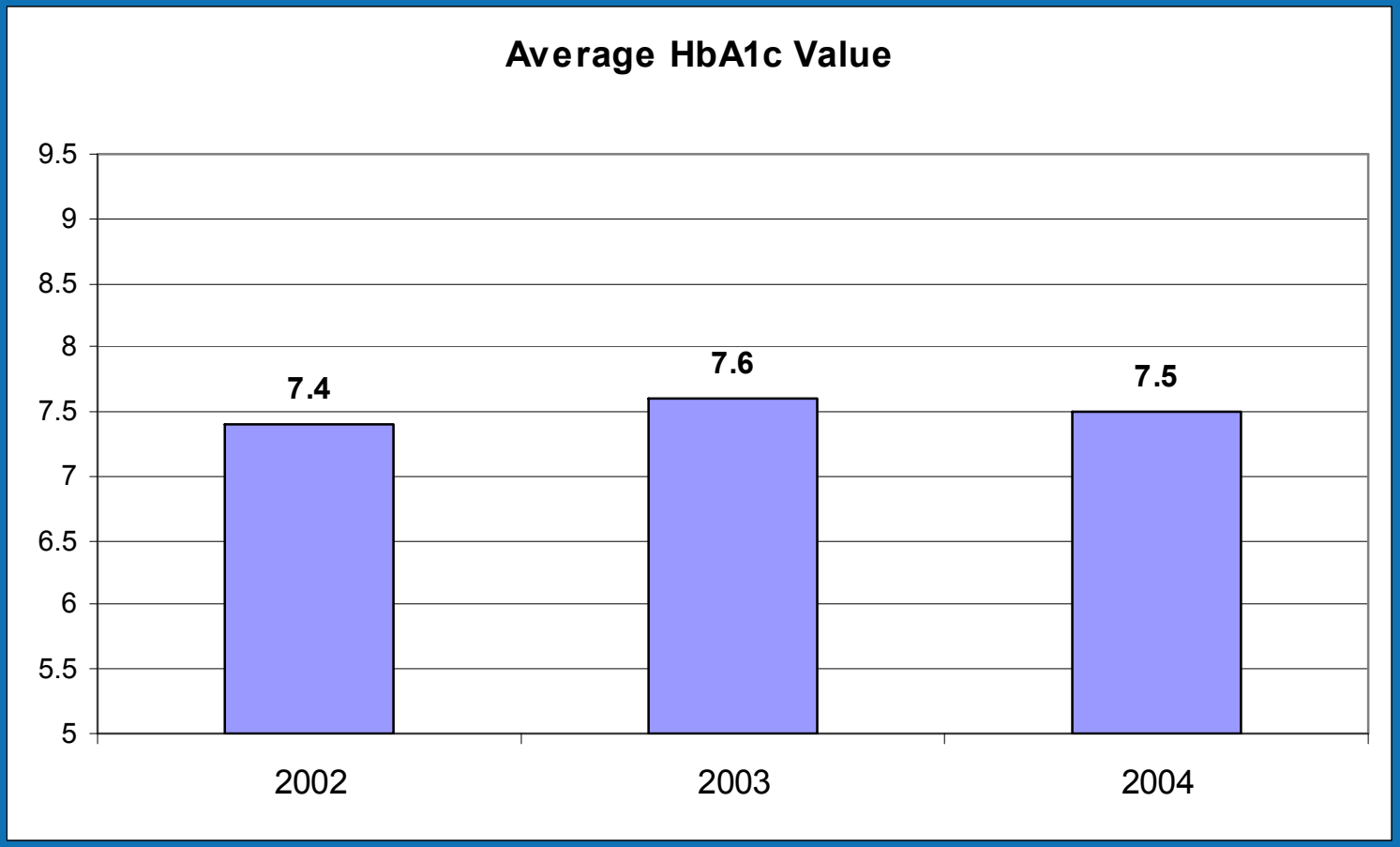
Medical Group Visit - A Team Approach

- Provider, Nurse, Facilitator
- Providers get help with the many tasks of a chronic care patient visit
- Access to self-management resources and preventive services
- Lab results are reviewed and explained/ health topics discussed
- Patients actively participate as part of the team
- Patients teach and learn self-management skills

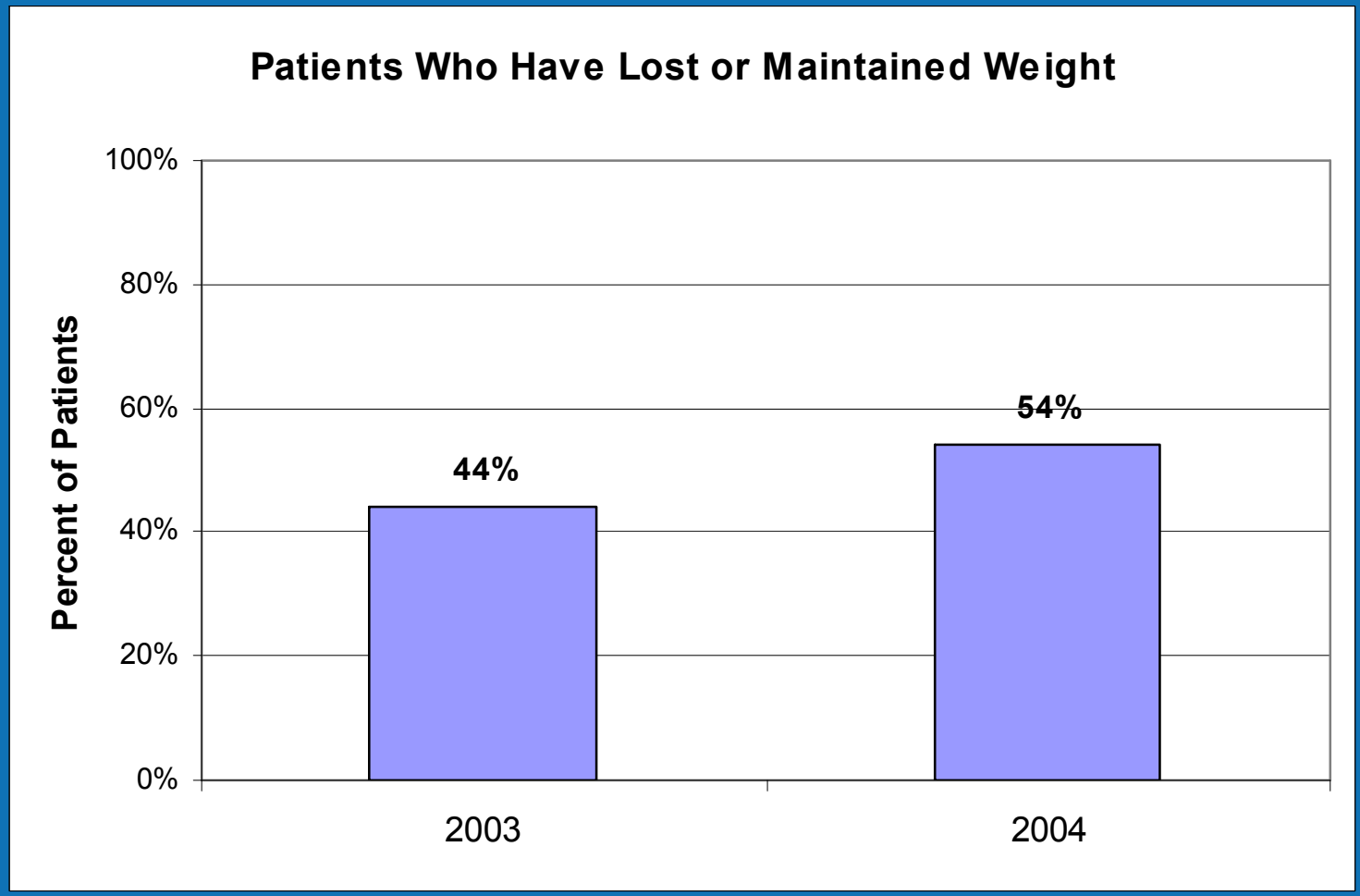
Medical Group Visits at New River Health

- Began - May 2001 with 1 team
- As of May 2005 - 8 teams
- 113 MGV sessions
- 1089 patient encounter

Marshall Chart Audit



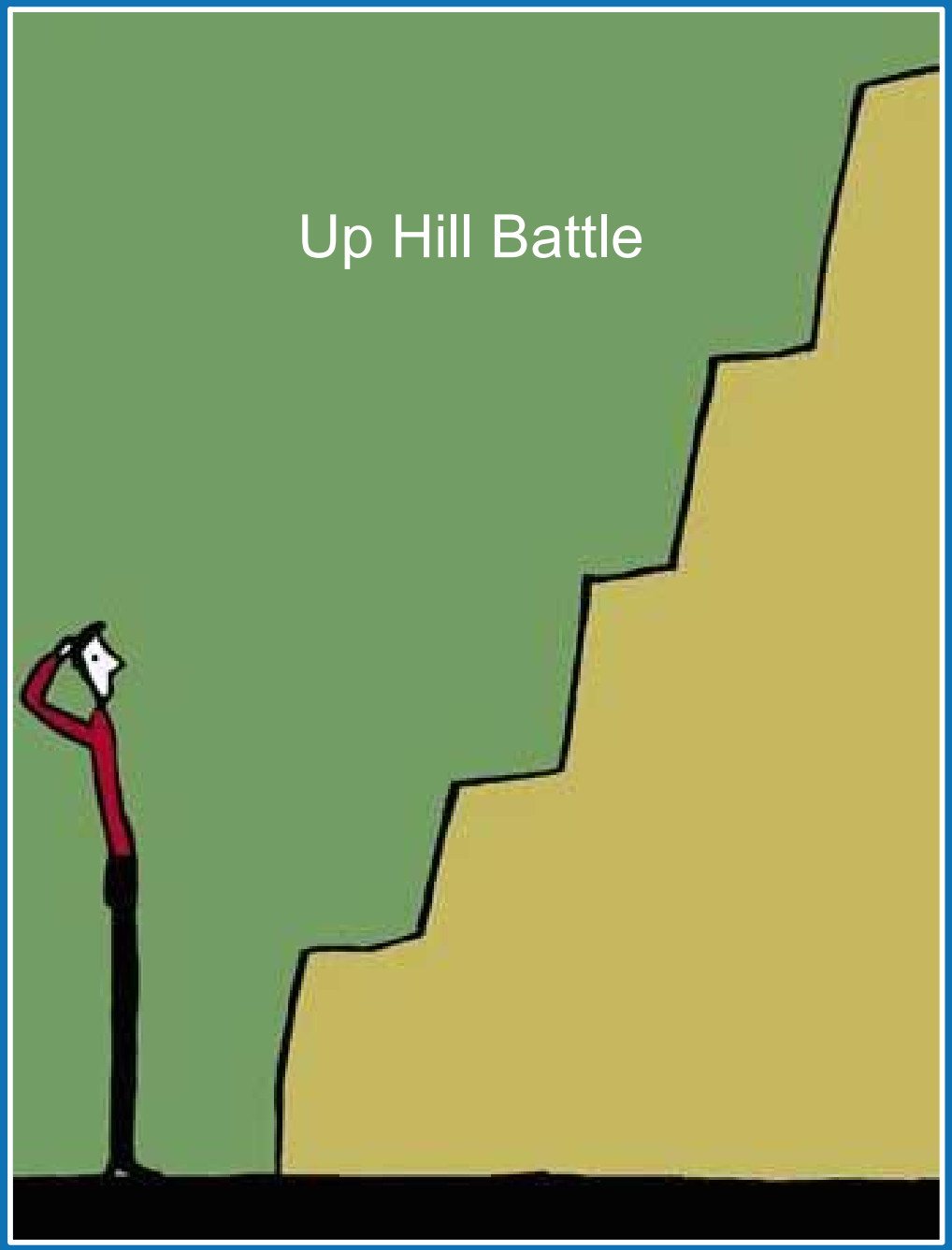
Marshall Chart Audit Data



Marshall
Self Management tools, TA and support

- Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (Assessment tool)
- CDSMP leaders training
- Social marketing materials
- Staff training/Planning support


Long Road


Up Hill Battle

To achieve the highest possible functioning and quality of life….no matter where along the path you begin.

The process-- for both patients and clinics-- is goal setting, problem-solving and small steps.

Questions….?