Final Evaluation Report:

The Oregon Community Health Center
Patient Self-Management Collaborative

Oregon Asthma Program
November 30, 2014
The Oregon Asthma Program thanks the following people for their contributions to this report:

Oregon Asthma Program staff:

- Laura Chisholm, MPH, MCHES - Self-Management Technical Lead
- Rodney Garland-Forshee, MS - Asthma Epidemiologist
- Chipo Maringa, PhD, Health Promotion Research Analyst
- Shaun Parkman, MS - Asthma Evaluation Specialist

Oregon Primary Care Association staff:

- Irma Murauskas, BSN, MPH - Director of Primary Care Transformation,

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For more information about:

- Chronic disease self-management programs in Oregon: [http://www.healthoregon.org/takecontrol](http://www.healthoregon.org/takecontrol)
- Oregon Tobacco Quit Line: [www.quitnow.net](http://www.quitnow.net)
- Federally Qualified Health Centers in Oregon, visit [www.orpca.org](http://www.orpca.org)
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Executive Summary

**Purpose**

The Patient Self-Management Collaborative (PSMC) was conducted through a partnership between the Oregon Asthma Program (OAP) and the Oregon Primary Care Association (OPCA) from 2009-2014. Clinic teams from nine Federally Qualified Health Centers (FQHCs) received training and technical assistance to build capacity for patient self-management support, both within the clinic setting and through development of systematic referrals to evidence-based self-management resources, including the Stanford Chronic Disease Self-Management Program (CDSMP) and the Oregon Tobacco Quit Line. Project evaluation used a mixed methods design to document the process of the collaborative, to characterize changes in clinic capacity to support patient self-management and their spread to non-participating clinic teams, and to describe changes in self-management resource access and participation.

**Results**

Five out of six clinics that completed the full PSMC developed new referral protocols to CDSMP, the Quit Line, or both. All participatng clinics reported increased capacity to support self-management and cessation as a result of PSMC participation. Participating clinics that had the capacity to report on documentation of self-management goals, tobacco use interventions, and Quit Line referrals demonstrated improved rates for most related measures.

Four clinics that participated in the full collaborative increased the number of CDSMP programs offered on site. Oregon Tobacco Quit Line participation also increased in clinics that developed specific referral protocols. Additionally, average scores on measures of clinical support for patient self-management showed substantial increases in all areas of focus. All participating FQHCs achieved medical home recognition during the project, and three clinics noted that their participation specifically assisted them in fulfilling recognition requirements. Most completing clinics also indicated significant changes in their organizational commitment to a culture that supports self-management, and all participating clinic teams reported changing
organizational priorities related to self-management support during the collaborative. Although nine clinic teams participated and six completed the collaborative, practice changes spread to a total of eleven clinic sites, including a large urban primary care system that serves the highest volume of Medicaid beneficiaries in Oregon.

Clinics noted a variety of barriers to sustainable change: competing priorities, reporting technology limitations, lack of dedicated quality assurance staff time, staff and leadership turnover, lack of consistent support for team-based care among some providers, and the financial impact of dedicating provider time to training.

Project implementation challenges included lack of established self-management related clinical training curricula and evaluation measures, limitations in clinic reporting capacity, and the existence of many other competing priorities.

**Recommendations**

- Continue to provide structured support for self-management quality improvement in primary care clinics.
- Focus on high-impact training and technical assistance activities, including motivational interviewing training, clinic-specific coaching, and opportunities to connect with other clinics interested in enhancing patient self-management.
- Allow for flexibility in collaborative implementation; due to the diversity of FQHCs in Oregon, clinics with high readiness to change likely to have different resources and priorities and serve different patient populations.
- Continue to refine primary care self-management support reporting metrics that are not burdensome to clinics, and whenever possible build these into incentive programs.
- Continue to nurture the new state-level public health/primary care partnership established under the auspices of the PSMC.
Introduction

This report describes final evaluation findings for the Patient Self-Management Collaborative (PSMC), a project conducted through a partnership between the Oregon Public Health Division and the Oregon Primary Care Association (OPCA). The Oregon Asthma Program (OAP) conducted this project from 2009-2014 with funding from a five-year cooperative agreement with the Centers for Disease Control and Prevention Asthma Control program. The OAP provided a grant to the Oregon Primary Care Association to implement the Patient Self-Management Collaborative with clinic teams from up to ten FQHCs. Participating FQHCs were offered a series of learning opportunities to build capacity for patient self-management support both within the clinic setting and through referrals to evidence-based self-management resources, including the Stanford Chronic Disease Self-Management Program and the Oregon Tobacco Quit Line.

Evaluation Purpose

This evaluation was designed to determine the project’s impact upon two goals:

- To enhance self-management support within clinics that primarily serve low income, high need patients that tend to experience higher levels of asthma, other chronic disease, and disability; and

- To explore and document promising practices for self-management referral systems within FQHCs, including identification of potential barriers, enabling factors, and lessons learned to inform future learning collaboratives.

This report aims to fill the need for both the OAP and its partners to understand the impact of the PSMC on participating clinics and the patients they serve. Similarly, Oregon-based organizations guiding health system transformation, as well as many states and federal partners, are interested in the outcome of this project to inform planning for future initiatives. Based on data gathered between 2010 and 2014, this report describes the process of the collaborative, as well as immediate outcome data collected from the six participating FQHCs that completed the collaborative.
Background

Context

The PSMC coincided with an accelerated health system transformation initiative in Oregon that included the creation of Medicaid Coordinated Care Organizations (CCOs). Established by state legislation in 2009, CCOs are responsible for managing Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries’ medical, dental, and behavioral health needs under global (capitated) budgets, and are eligible for incentives related to how many of their enrollees receive care in primary care medical homes. Prior to joining the collaborative, all participating FQHCs were in the process of applying for recognition as a Primary Care Medical Home through the National Committee for Quality Assurance,\(^1\) gaining recognition as a Patient-Centered Primary Care Home through the Oregon Health Authority,\(^2\) and/or qualifying to receive enhanced payments under the federal Meaningful Use incentive program.\(^3\) Several participating FQHCs were also involved with other transformation activities and learning collaboratives, such as the Primary Care Renewal, Safety Net Medical Home, and Advanced Primary Care Practice initiatives. In addition, participating FQHCs were responsible for reporting Universal Data Set (UDS) data to the Health Resources and Services Administration.

Vision

The OAP proposed the PSMC as part of a long-term strategy to reduce disparities in asthma morbidity and mortality among low-income Oregonians, especially those served by the Oregon Health Plan (OHP/Medicaid/CHIP). As seen in Figure 1 below, prior to the PSMC, asthma prevalence among OHP members was documented

\(^1\) See [http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx](http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx) for program details.


at significantly higher rates than among Oregonians with private insurance, Medicare, and the uninsured.

**Figure 1: Oregon Adult Asthma Prevalence by Insurance Status, 2001-2007**

![Graph showing asthma prevalence by insurance status from 2001 to 2007.]

The PSMC aimed to work through safety net clinics to increase self-management knowledge and skills among low-income Oregonians with asthma. Initial project goals were to enhance support for self-management in the clinical setting, increase participation in the Stanford Chronic Disease Self-Management Program through development of sustainable clinical referral systems, and promote tobacco cessation in low-income smokers with asthma by increasing utilization of the Oregon Tobacco Quit Line.

**Living Well and Tomando Control**

Living Well with Chronic Conditions⁴ (LW) is Oregon’s brand for the Chronic Disease Self-management Program (CDSMP)⁵ developed at the Stanford University Patient Education Research Center. The Spanish language/Latino cultural version of LW is called Tomando Control de su Salud (TC). Delivered in community and health system settings, these six-week programs teach people with one or more chronic conditions behavioral and cognitive skills that enable them to successfully manage their

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⁴ See [www.healthoregon.org/livingwell](http://www.healthoregon.org/livingwell) for program details.

disease and become active participants in their health care. Workshops are facilitated by two trained leaders who follow a scripted agenda and curriculum. One or both of the leaders are non-health professional peers living with a chronic disease.

As part of the Oregon Health Authority, Public Health Division’s Health Promotion and Chronic Disease Prevention section, the OAP has supported development of statewide infrastructure for LW and TC program delivery since 2001. Since data collection began in 2005, more than 10,000 Oregonians have participated in a Stanford program, approximately 13 percent of whom reported having asthma. LW and TC were chosen as interventions within the PSMC because of their availability in Oregon and their ability to simultaneously enhance self-management of asthma and other comorbidities.

The Oregon Tobacco Quit Line

The Oregon Tobacco Quit Line offers free, evidence-based, individual telephonic and online counseling to support those quitting tobacco. Tobacco users who contact the Quit Line are asked if they have asthma or another chronic condition and receive individually tailored, culturally sensitive cessation counseling. Quit Line services include coaching to develop a personalized quit plan; information about medications and nicotine replacement therapy; assistance for Medicaid enrollees in determining eligibility for nicotine free patches or gum; and referral to local evidence-based self-management programs (including LW/TC) when appropriate.

The Quit Line was chosen as an intervention for the PSMC because smoking is an important risk factor for asthma exacerbations. Those receiving evidence-based assistance in quitting smoking are two to three times more likely to succeed if they use prescription nicotine replacement therapies and get counseling such as that provided by the Quit Line. Services are also available to all those living in Oregon with access to a phone. Although the Quit Line offered fax referral systems in 2009, few clinics had developed systematic processes to connect patients who were ready to quit with Quit Line services.
**Logic model**

OAP and OPCA staff collaboratively developed a logic model to guide program evaluation in late 2010. The logic model (Appendix A) was updated in 2012 to reflect adjustments in clinical measurement strategy, and again in 2014 to reflect additions to the final evaluation.

**Resources**

The OAP received a five-year grant from the US Centers for Disease Control and Prevention’s National Asthma Control Program, which supported staff time for the project manager, evaluator, and analyst. Between April 2010 and August 2014, the OAP funded the OPCA a total of $267,000 to conduct the PSMC. This funding supported OPCA staff, including a project manager, coordinator, and a motivational interviewing instructor. Other resources contributing to the project included clinic teams from nine FQHCs, community self-management program delivery organizations, the Oregon Tobacco Quit Line, and local public health authorities (particularly those receiving Healthy Communities and Tobacco Prevention and Education Program funding from HPCDP).

The following FQHCs participated in the first cohort of the collaborative (fall 2010 to summer 2014):

- Community Health Centers of Benton and Linn Counties - Benton Health Center, Corvallis (CHC-Benton)
- La Clinica del Valle - Central Point (La Clinica)
- Yakima Valley Farm Workers Clinic - Salud Clinic, Woodburn (YVFWC)
- Northwest Human Services - West Salem Clinic (NWHS)
- Umpqua Community Health Center - Myrtle Creek Clinic (Umpqua CHC)
- Siskiyou Community Health Center - Cave Junction Clinic (Siskiyou CHC)

The following FQHCs joined a second cohort of the collaborative, which ran from fall 2011 to summer 2014:

- Multnomah County Clinics - eight sites in Portland metro area (MCC)
- Lincoln Community Health Center - Newport clinic (Lincoln CHC)
- OHSU Richmond Family Medicine - SE Portland (OHSU-R)

The Siskiyou CHC Cave Junction Clinic withdrew from the collaborative after one year.
of participation. OHSU-Richmond and Umpqua CHC discontinued their participation after two years.

Activities

The OAP and OPCA participated in monthly project planning and progress monitoring meetings. OPCA conducted site visits to recruit FQHCs. Beginning in the second year of the collaborative, participating FQHCs signed memoranda of understanding with OPCA, which were updated annually. Each FQHC chose a clinic site to participate, and recruited a multidisciplinary team to participate in collaborative training events and implement practice changes within their clinic. Each team consisted of three to eight members and included a mix of clinical providers (physician assistants, nurse practitioners, registered nurses, behavioral health specialists), clinical staff (medical assistants, licensed practical nurses, health navigators, care coordinators), and administrative staff (medical directors, nurse managers, quality improvement managers, clinic managers, executive directors). Each team’s mix of participants reflected the staffing model of the participating clinic, and most also included a representative of a partner organization offering community-based LW/TC programs. A list of community partners is provided as Appendix B.

OPCA coordinated regular in-person training and technical assistance opportunities to build capacity for patient self-management among PSMC clinics. These included bi-annual in-person collaborative meetings, monthly webinars to encourage collaborative learning between teams, and clinic-specific coaching to troubleshoot barriers and brainstorm solutions. Training and technical assistance focused in the following topic areas:

- Motivational interviewing
- Tobacco cessation interventions
- Chronic disease self-management programs
- Data for quality improvement
- Patient-centered communications
- Plan, Do, Study, Act cycles and managing change processes

In the first year of the collaborative, all PSMC events were specific to the collaborative;
in subsequent years, OPCA offered a PSMC track at its annual Quadruple Aim Symposium and leveraged numerous other opportunities to integrate self-management related topics into other meetings. See Appendix C for a list of training and technical assistance activities.

Outputs

OPCA developed training curricula based on clinic needs ascertained through annual clinic assessments. Supported by OPCA’s training and technical assistance offerings, clinics identified areas of focus and conducted quality improvement activities to develop, test, and implement new protocols for self-management referral and clinic process flow changes to support self-management. Clinics signed memoranda of understanding with OPCA identifying their organizational commitment to PSMC participation.

Outcomes

Anticipated immediate outcomes for the project included enhanced support for patient self-management during clinic visits and establishment of protocols to refer patients to LW, TC and/or the Quit Line. The final project evaluation measured progress in these areas, as well as changes in patient access to and participation in onsite and community-based self-management resources.

Impact

This report also describes progress toward longer-term outcomes of the PSMC, including participating clinics’ advancement toward becoming more patient centered, as measured by their recognition as Patient Centered Medical Homes (PCMHs) by the National Committee for Quality Assurance and/or as Patient Centered Primary Care Homes (PCPCHs) by the Oregon Health Authority. The PSMC evaluation also aimed to describe key changes in practice and organizational priorities related to self-management support, as well as any spread of newly developed self-management protocols and systems to additional clinic sites of participating FQHCs. The anticipated long-term outcome is that patients are better able to manage their chronic conditions.
**Evaluation Questions**

The questions answered by this evaluation, and their associated data sources, are as follows:

**Table 1: Evaluation Questions and Data Sources**

<table>
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<tr>
<th>Evaluation Question</th>
<th>Data Collection Method</th>
<th>Data Sources</th>
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</thead>
<tbody>
<tr>
<td>1. Did clinic teams and community partners participate in collaborative training events?</td>
<td>Attendance reports</td>
<td>Training and webinar attendance records collected by OPCA</td>
</tr>
<tr>
<td>2. Did clinics develop, test, and document referral protocols to evidence-based self-management and cessation resources?</td>
<td>Open-ended survey questions, count of documented referral protocols</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics</td>
</tr>
<tr>
<td>3. How did clinic capacity to support self-management and cessation increase?</td>
<td>Open-ended survey questions, structured interviews; PCRS data reported by clinics</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics; structured interview transcripts</td>
</tr>
<tr>
<td>4. Did the number of Chronic Disease Self-Management Program workshops offered onsite at clinics increase?</td>
<td>Chronic Disease Self-Management Program Summary Forms</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics; National Council on Aging database</td>
</tr>
<tr>
<td>5. Did patient participation in self-management programs increase?</td>
<td>Chronic Disease Self-Management Program Participant Information Forms, open-ended survey questions</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics; National Council on Aging database; structured interview transcripts</td>
</tr>
<tr>
<td>6. What is the spread of clinic self-management protocols and systems as a result of the PSMC?</td>
<td>Open-ended survey questions responded to by OPCA; structured interviews</td>
<td>Progress reports submitted by OPCA; clinic interview transcripts</td>
</tr>
<tr>
<td>7. Did participation in the collaborative enhance clinics’ progress toward medical home recognition? Which aspects contributed most strongly?</td>
<td>Open-ended survey questions responded to by OPCA; structured interviews</td>
<td>Progress reports submitted by participating PSMC clinics</td>
</tr>
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<td>Evaluation Question</td>
<td>Data Collection Method</td>
<td>Data Sources</td>
</tr>
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<tr>
<td>8. Did clinics become more patient-centered? Which aspects contributed most strongly?</td>
<td>PCRS assessment; Open-ended survey questions; structured interviews</td>
<td>Completed PCRS assessments submitted quarterly by participating PSMC clinics, patient satisfaction survey responses</td>
</tr>
<tr>
<td>9. How did participation in the PSMC change clinic practices and priorities related to self-management support?</td>
<td>Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
<tr>
<td>10. What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?</td>
<td>Open-ended survey questions; Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
<tr>
<td>11. What were the major barriers to sustainable change, and how might they be overcome in the future?</td>
<td>Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
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<td>12. What resources are needed to continue this work, and what organization(s) should lead it?</td>
<td>Semi-structured interview questions responded to by FQHC program leads and OPCA project staff</td>
<td>Semi-structured interviews conducted by OAP</td>
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**Methods**

This evaluation used a mixed methods design to document the process of the collaborative, characterize changes in clinic capacity to support patient self-management and their spread to non-participating clinic teams, and to describe changes in self-management resource access and participation. Data collection methods are described in Table 1 above. The evaluation plan (Appendix D) was first drafted in grant year one (2009-2010) and revised in May 2012 to correspond with the PSMC clinical measurement plan developed by OPCA. The evaluation plan was further
updated with stakeholder input in August 2014. At that time, the OAP engaged several newly identified health system transformation stakeholders to update the evaluation questions and inform the process of final evaluation data collection.

**Process Data – Quantitative**

OPCA tracked clinic participation in training and technical assistance events on an ongoing basis, and reported overall participation to OHA biannually. OAP staff reviewed counts of participation in PSMC activities provided in OPCA reports to identify the top three best-attended events per year. An FQHC was counted as participating in an event if at least one representative of the clinic team was present.

**Clinic Data – Quantitative**

Using a reporting template provided by the OPCA, clinics regularly reported data related to project goals. In order to answer questions regarding clinic capacity to support self-management and patient centeredness (evaluation questions 3 and 6), clinic teams completed the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS – Appendix E)\(^6\) on a biannual basis. This tool provided a framework for participating care teams to self-assess chronic disease self-management supports in their clinics by means of Likert scale scoring on ten aspects of patient and organizational support. Participating clinics reported quantitative results of their PCRS self-assessments to the OPCA (using a template customized for each clinic that included previous scores, targets and annual performance goals.

Other measures related to shared decision making and promotion of self-management principles included documentation of self-management goals by patients with asthma, PCRS scores, and organizational commitment to a culture of patient self-management. Those related to patient-centered communications measured receipt of motivational interviewing training, incorporation of the Patient Centered Observation

Form into clinic practice and utilization of the Patient Activation Measure. Clinics also reported on measures to quantify improved patient participation in cessation and self-management programs; including tobacco use status, receipt of tobacco cessation intervention, referrals to the Quit Line, and referrals to LW/TC. Specific measures are described in detail in Appendix F.

Following finalization of PSMC clinical measure specifications, clinics reported those data to OPCA quarterly from spring 2013 through the end of the grant in August 2014. OPCA amalgamated and summarized these data into summary progress reports submitted to the OAP annually. OPCA analytical staff amalgamated quantitative quarterly reports from FQHCs into tables that were shared with participating clinics at the conclusion of each quarter. Additionally, these data were provided to OAP in the form of annual summary progress reports. OAP staff culled data from these reports to answer evaluation questions.

**Self-Management Program Availability and Participation – Quantitative**

Clinics reported counts of patients referred to LW/TC workshops and counts of those who participated in a workshop in their biannual reports to OPCA. Additionally, OAP received de-identified patient information forms and workshop summary forms from LW and TC program leaders for in-clinic programs conducted during the PSMC project period. Data from these forms were entered into the National Council on Aging self-management program database. An OAP staff member reviewed database reports to determine counts of participants in programs hosted by PSMC clinics, which were reviewed by a research analyst. An OAP staff member reviewed database reports to determine counts of participants in programs hosted by PSMC clinics, and a data analyst reviewed data for accuracy.

Additionally, the Oregon Tobacco Quit Line vendor provided monthly counts of patients fax referred to the Quit Line, as well as counts of those who accepted services,

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8 For the latest versions of reporting forms and protocols, see [http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/reportprograminfo.aspx](http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/reportprograminfo.aspx).
in their reporting to OAP. An OAP staff member reviewed these reports to determine monthly patient counts by clinic; a research analyst reviewed the data for quality.

OAP program staff obtained counts of LW and Tomando Control programs and participants from the National Council on Aging chronic disease self-management program database, and reviewed monthly reports from Oregon’s Quit Line vendor, Alere Wellbeing, to create counts of patients referred to the Quit Line by PSMC clinics. A data analyst reviewed these data to ensure accuracy.

**Key Informant Interviews - Qualitative**

In October 2014, OAP staff conducted 30- to 60-minute structured interviews with representatives of participating clinics and took detailed notes during the interviews. See Appendix G for the interview protocol and list of key informants. Following interviews, OAP staff conducted thematic analysis of interview transcripts. The Asthma Epidemiologist reviewed the original data and narrative to ensure accuracy and completeness.

**Results**

The following section describes PSMC results related to the evaluation questions described above, as indicated by evaluation data collected throughout the project.

1. **Did clinic teams and community partners participate in collaborative training events?**

   Attendance reports indicate that in the first year of the collaborative, all but one event was attended by all participating clinics. Attendance fell off slightly in the following years, with the PSMC track of OPCA’s Quadruple Aim Symposium\(^9\) as the most consistently well attended event for the remainder of the collaborative. The other most heavily attended events were:

\(^9\) An annual Oregon FQHC conference dedicated to achieving the Triple Aim of better health, better outcomes, and lower health care costs, as well as the elimination of health disparities.
- Year 2: OAP’s annual self-management conference (the Self-Management Forum) and a webinar on the Oregon Tobacco Quit Line
- Year 3: OPCA’s day-long Patient Centered Medical Home Foundations event
- Year 4: OPCA’s day-long Advanced Payment and Care Model meeting

Community LW/TC provider organization representatives joined initial kickoff meetings for both cohorts; some had existing relationships with clinics, while others were initially less well acquainted. Community partners did not attend most of the following training and technical assistance events, which focused heavily on clinical processes.

2. Did clinics develop, test, and document referral protocols to evidence-based self-management and cessation resources?

Five out of six clinics that completed the full PSMC developed new referral protocols to LW/TC, the Quit Line, or both. BHC had LW/TC and Quit Line protocols at the start of the PSMC. All clinics continued quality improvement projects to refine new or existing referral protocols during the course of the collaborative. Please see Appendix H for sample protocols.

**TABLE 2: Referral Protocols in Place at Close of the Patient Self-Management Collaborative, by Clinic**

<table>
<thead>
<tr>
<th>FQHC Name</th>
<th>Referral System</th>
<th>Status</th>
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<tbody>
<tr>
<td>Multnomah County Clinics (eight clinic locations)</td>
<td>Clinic-hosted LW/TC</td>
<td>New</td>
</tr>
<tr>
<td>Multnomah County Clinics (eight clinic locations)</td>
<td>Quit Line</td>
<td>New</td>
</tr>
<tr>
<td>Northwest Human Services (West Salem clinic)</td>
<td>Clinic-hosted LW/TC</td>
<td>Updated (discontinued year 4)</td>
</tr>
<tr>
<td>Northwest Human Services (West Salem clinic)</td>
<td>Community-hosted LW/TC</td>
<td>New</td>
</tr>
<tr>
<td>Northwest Human Services (West Salem clinic)</td>
<td>Quit Line</td>
<td>New</td>
</tr>
<tr>
<td>FQHC Name</td>
<td>Referral System</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Benton (Corvallis clinic)</td>
<td>Community-hosted LW/TC</td>
<td>Updated</td>
</tr>
<tr>
<td></td>
<td>Quit Line</td>
<td>Updated</td>
</tr>
<tr>
<td>La Clinica Del Valle (Central Point and Phoenix clinics)</td>
<td>Clinic-hosted LW/TC</td>
<td>New</td>
</tr>
<tr>
<td></td>
<td>Quit Line</td>
<td>New</td>
</tr>
<tr>
<td>Lincoln Community Health Center (Newport and Lincoln City clinics)</td>
<td>Quit Line</td>
<td>New</td>
</tr>
<tr>
<td>Yakima Valley Farm Workers Clinic (Salud/Woodburn and Lancaster clinics)</td>
<td>Quit Line and in-house cessation classes</td>
<td>New</td>
</tr>
<tr>
<td></td>
<td>Clinic-hosted TC</td>
<td>New</td>
</tr>
</tbody>
</table>

3. How did clinic capacity to support self-management and cessation increase?

All participating clinics reported increased capacity to support self-management and cessation as a result of PSMC participation. These increases included training of clinical staff on evidence-based self-management support interventions (motivational interviewing and LW/TC leader training), as well as clinical process changes to support implementation and referrals to these interventions (new work flows, enhanced documentation and reporting capabilities). Highlights are described in Table 3 below:
## Table 3: Increases in Capacity to Support Self-Management by Clinic

<table>
<thead>
<tr>
<th>FQHC Name</th>
<th>Reported Capacity Increases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multnomah County Clinics (eight clinic locations)</td>
<td>Trained community health workers to provide in-house LW/TC programs&lt;br&gt;New in-house LW/TC programs&lt;br&gt;Electronic Quit Line referral flow&lt;br&gt;Patient flow changes to enhance engagement&lt;br&gt;Patient Centered Office Visit protocol</td>
</tr>
<tr>
<td>Northwest Human Services (West Salem clinic)</td>
<td>New LW/TC referral work flows&lt;br&gt;Patient flow changes to enhance engagement&lt;br&gt;Process for electronic documentation of self-management goals</td>
</tr>
<tr>
<td>Benton (Corvallis clinic)</td>
<td>Updated LW/TC referral work flow&lt;br&gt;Updated Quit Line referral work flow&lt;br&gt;Expanded clinical health care teams to Include community health workers</td>
</tr>
<tr>
<td>La Clinica Del Valle (Central Point and Phoenix clinics)</td>
<td>Staff trained as LW/TC leaders&lt;br&gt;New LW/TC programs, high completion rates&lt;br&gt;Process for electronic documentation of goals&lt;br&gt;Patient flow changes to enhance engagement&lt;br&gt;Expanded care team&lt;br&gt;Patient-Centered Office Visit protocol</td>
</tr>
<tr>
<td>Lincoln Community Health Center (Newport and Lincoln City clinics)</td>
<td>New LW/TC referral work flows&lt;br&gt;Electronic Quit Line referral flow</td>
</tr>
</tbody>
</table>
Yakima Valley Farm Workers Clinic (Salud/Woodburn and Lancaster clinics)

New on-site TC programs (Lancaster clinic)
Began tracking tobacco use status
Process for closed-loop Quit Line referrals
Provider-level self-management patient progress reporting
Self-management questions incorporated into template for all coded visits

Participating clinics that had the capacity to report on documentation of self-management goals, tobacco use interventions, and Quit Line referrals demonstrated improved rates for most related measures. Four clinics were able to report rates of tobacco use status and receipt of cessation counseling. Two clinics were able to track Quit Line referrals within the population of patients served by the care team participating in the PSMC. One of those was able to track referrals for patients with asthma within that specific patient population. These results are illustrated in Figure 2 below.

**FIGURE 2: RATES OF PATIENT RECEIPT OF SELF-MANAGEMENT AND CESSATION INTERVENTIONS, 2013 AND 2014**

10 2013 data corresponds to the second quarter of project year 4 through the first quarter of project year five. 2014 data corresponds to the second quarter of project year five.
Figure 3 below describes a more granular time flow for Quit Line referrals. Following a significant increase over a baseline of 4% in the first year of reporting, referral rates rose to an average of 15% for both groups.

**Figure 3: Quarterly Rates of Patients in PSMC Population Receiving Quit Line Referrals, Northwest Human Services and Multnomah County Clinics, 2013-2014**

4. Did the number of Chronic Disease Self-Management Program workshops offered on-site at clinics increase?

Two clinics that participated in the full collaborative increased the number of LW and/or TC programs offered on site. LCDV began offering LW and TC programs at their Central Point clinic in 2012 as a direct result of PSMC participation, and continued to host an average of one LW and one TC program each year through 2014. The Central Point clinic also hosted one Stanford Chronic Pain Self-Management Program (CPSMP). Prior to the PSMC, NWHS West Salem Clinic had offered one on-site TC program in 2010; the clinic hosted a total of 32 additional LW and TC programs through the end of the collaborative in 2014. Additionally, West Salem Clinic hosted one CPSMP and two Stanford Diabetes Self-Management Programs during the collaborative.
Two other participating clinics reported increased on-site LW/TC programming during interviews, yet the OAP did not receive corresponding data forms through its statewide reporting system. In addition to two on-site programs at YVFWC’s Salud Medical Center in 2010 and two in 2011 that were supported by data forms, staff described new on-site programs at the Lancaster clinic but supporting data were not reported to the OAP. Additionally, Multnomah County staff described new on-site programs at their Rockwood and Clinica de Buena Salud sites during the final year of the collaborative; data from these programs were also not reported to the OAP.

Lincoln CHC and the Benton/Corvallis clinic did not host LW or TC programs, and instead referred patients to community-based programs during the collaborative.

5. Did patient participation in self-management programs increase?

Three clinics hosted on-site programs; in two of these, participation in LW and TC programs increased during the collaborative, as described in Table 4 below. The third clinic increased its patient participation in self-management programs during the PSMC, but discontinued on-site programs and began referring to community-based programs in the final year of the collaborative due to recruitment challenges. Year one data represent the baseline amount of referrals that took place during the planning year prior to convening the collaborative, and are useful for comparison to later years. A total of 456 patients participated in on-site English- and Spanish-language CDSM programs during the collaborative, with an average of 114 participants per year in project years 2-5 compared to 41 per year in project year 1 (baseline).

**Table 4: Number of Participants in On-Site Living Well and Tomando Control Programs**

<table>
<thead>
<tr>
<th>FQHC Name</th>
<th>Number of On-Site LW/TC Participants Per Project Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (09-10)</td>
</tr>
<tr>
<td>Multnomah County Clinics</td>
<td>0</td>
</tr>
<tr>
<td>FQHC Name</td>
<td>Number of On-Site LW/TC Participants Per Project Year</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>NW Human Services</td>
<td>7  92  41  119  42</td>
</tr>
<tr>
<td>La Clinica del Valle</td>
<td>0  13  28  28  13</td>
</tr>
<tr>
<td>Lincoln Community Health Ctr.</td>
<td>19  0  0  0  0</td>
</tr>
<tr>
<td>Community Health Centers of Benton &amp; Linn Counties</td>
<td>6  6  0  0  0</td>
</tr>
<tr>
<td>Yakima Valley Farm Workers Clinic</td>
<td>9  74  0  0  0</td>
</tr>
</tbody>
</table>


MCC and LCHC put LW/TC referral processes in place during the collaborative, yet both clinics referred few patients due to lack of regular, publicly available programs in the community.

Oregon Tobacco Quit Line participation also increased in clinics that developed specific referral protocols, as described in Table 5 below. Year one data represent the baseline amount of referrals that took place during the planning year prior to convening the collaborative, and are useful for comparison to later years. Participating clinics referred a total of 1,522 patients to the Quit Line during the collaborative, with an average of 380 referrals per year compared to 10 per year at baseline. Neither YVFWC nor NWHS fax referred patients to the Quit Line early in the collaborative, but began referring patients in years three and four respectively. LCDV, MCHD, LCHC and BHC clinic referred a few patients per year prior to joining the collaborative, but each showed a different pattern of frequency of referrals in years 2-5. MCHD clinics significantly increased the volume of patient referrals in the final two years of the collaborative, while LCHC’s referrals peaked during their first active year in the collaborative (year 3). BHC referrals increased during their first active year (year 2), decreased in years three and
four, and increased again in year five. Although UCHC did not complete the collaborative, the Myrtle Creek clinic continued to refer patients.

**TABLE 5: OREGON TOBACCO QUIT LINE REFERRALS BY CLINIC AND YEAR**

<table>
<thead>
<tr>
<th>FQHC Name</th>
<th>Number of Quit Line Referrals Per Project Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (09-10)</td>
</tr>
<tr>
<td>Multnomah County Clinics (8 locations)</td>
<td>4</td>
</tr>
<tr>
<td>NW Human Services (West Salem Clinic)</td>
<td>0</td>
</tr>
<tr>
<td>Community Health Centers of Linn and Benton Counties</td>
<td>1</td>
</tr>
<tr>
<td>(Corvallis clinic)</td>
<td></td>
</tr>
<tr>
<td>La Clinica Del Valle (Central Point &amp; Phoenix clinics)</td>
<td>3</td>
</tr>
<tr>
<td>Yakima Valley Farm Workers Clinic (Salud &amp; Lancaster clinics)</td>
<td>0</td>
</tr>
<tr>
<td>Lincoln Community Health Center</td>
<td>0</td>
</tr>
<tr>
<td>Umpqua Community Health Center (Myrtle Creek clinic)</td>
<td>2</td>
</tr>
<tr>
<td>Total referrals</td>
<td>10</td>
</tr>
</tbody>
</table>

Data source: Oregon Tobacco Quit Line monthly fax referral reports

6. **What was the spread of clinic self-management protocols and systems as a result of the PSMC?**

Four of the six FQHCs that completed the collaborative indicated that protocols and systems developed during the PSMC had spread within clinics to other care teams,
or to other clinic locations. YVFWC spread the referral process developed at the Salud clinic in Woodburn to the Lancaster clinic in Salem; the clinic manager noted that “The self-management work flow touched everybody at the clinic.” Although only one MCC clinical team completed the collaborative, participation by members of the clinic system’s centralized quality assurance team enabled system-wide rollout of LW/TC and Quit Line referral protocols developed via the PSMC to eight sites. LCDV spread new LW/TC programs to one additional clinic location (Phoenix). Because LCHC’s two sites share providers, all new protocols were implemented in both the Newport clinic and the satellite clinic in Lincoln City.

7. Did participation in the collaborative enhance clinics’ progress toward medical home recognition? Which aspects contributed most strongly?

All six FQHCs that completed the collaborative were working toward medical home recognition at the beginning of the project, and all achieved Oregon PCPCH recognition by the end of the collaborative. Two of those FQHCs (La Clinica and YVFWC) also received national PCMH recognition, and one (NWHS) received recognition from The Joint Commission.11

In monthly reports and interviews, three clinics (Lincoln, La Clinica, and YVFWC) noted that participation in the collaborative specifically assisted the FQHC in fulfilling requirements for medical home recognition. LCHC also leveraged participation in the PSMC to support successful applications for a related grant and a medical home collaborative.12 Northwest Human Services, Multnomah County Clinics and CHC of Linn and Benton County were very close to achieving PCPCH recognition when they joined the PSMC. Respondents from these clinics noted that participation in the PSMC helped them improve support for patient self-management overall. However, due to timing the collaborative did not specifically assist these clinics in meeting medical home recognition requirements.

11 http://www.jointcommission.org/

12 The Patient Centered Primary Care Home Institute supported by the Oregon Health Authority.
8. Did clinics become more patient-centered? Which aspects contributed most strongly?

Over the course of the collaborative, average scores on the PCRS measures of clinical support for patient self-management—used in this evaluation as a proxy for patient-centeredness—showed substantial increases in all areas of focus. As seen in Figure 3 below, the most notable increases occurred in linkage to community resources, referral coordination, and development of systems to document self-management support. These changes also demonstrated an increasingly team-based approach among clinic staff and providers. As the executive director of the Lincoln County clinic noted, “It [the PCRS tool] set a tone in the organization that in primary care you’ve got to work efficiently. It’s not about provider efficiency but about team efficiency.”

**Figure 3: Average PCRS Self-Assessment Scores, PSMC Years 3 and 5**

In addition to PCRS scores, NWHS and the YVFWC system developed the capacity to report on documentation of patient self-management goals. YVFWC was able to report on documentation of self-management goals among patients with asthma. Figure 4 below describes consistent improvements over baseline documentation rates.
of 38% for the population served by the PSMC participating clinic team and 25% of those patients with asthma in early 2013, as compared to 69% and 53% respectively at the end of the collaborative in summer 2014.

Five of six clinics that completed the PSMC also indicated significant changes in their organizational commitment to a culture that supports self-management. Staff from all six clinics—more than 50 total staff members—received training in motivational interviewing. In addition, two clinics implemented the Patient Centered Observation Form within the flow of their standard patient office visit.

Clinic teams identified OPCA’s bi-annual Quadruple Aim Symposia, training on patient-centered office visit skills, and face-to-face motivational interviewing trainings as the aspects of the PSMC that contributed most strongly to these improvements. As described above under evaluation question seven, all participating clinics also achieved recognition as medical homes from either state- or national-level accreditation bodies during the collaborative; this trend also indicates an increase in patient-centeredness due to the strong emphasis on accountability for and documentation of this aspect of quality care within medical home accreditation.

9. How did participation in the PSMC change clinic priorities related to self-management support?

Most participating clinic teams reported changing organizational priorities related to self-management support during the collaborative. The YVFWC system made self-management support an organizational priority for their entire Pacific Northwest clinic system during the PSMC; their organizational experience was captured in a video.\(^\text{13}\) LCHC embedded self-management support within position descriptions as an expected role for staff and providers. MCC indicated that having a collaborative team with dedicated staff to focus on self-management support kept this work “on the front burner” amidst a variety of ongoing quality improvement initiatives. In addition, all participating clinic teams noted a shift toward a more team-based approach regarding self-management support responsibilities. Additional training in support for patient self-

\(^{13}\) Accessible through https://vimeo.com/110602859 (password is “smcv”)
management and enhanced data collection capabilities created new opportunities for medical assistants, patient navigators, and community health workers to ask about tobacco use, follow up on referrals, and track patients’ progress toward self-management goals.

10. **What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?**

During interviews, clinic staff identified a variety of PSMC elements that substantially affected sustainable changes in support of self-management and community-clinic linkages. MCC staff noted that support for continued Quit Line referral process improvement, as well as finding the right staff (community health workers) to champion self-management programs, was key to their successes. YVFWC and LCHC both noted that the opportunity for peer-based learning with teams from other clinics was very helpful in identifying common barriers. LCHC and MCC also noted that the accountability provided by the collaborative structure provided motivation to continue to prioritize self-management among competing priorities. YVFWC and LCHC noted that the individual clinic coaching sessions were helpful in troubleshooting barriers, and that progress made toward embedding self-management support in job descriptions helped to counteract erosion of knowledge due to staff turnover. As the LCHC executive director noted, “Information that we had was embedded in policies, but it helped me realize how important it was to firmly embed [self-management support duties] so that if all staff changed tomorrow we would still know how to do the work.”. Both CHCB and LCDV noted that the staff training provided by the PSMC (motivational interviewing, patient-centered office visits, self-management program leader training) was particularly influential in creating sustainable change for their organizations.

Survey data supplied to OPCA indicated that regularly scheduled webinars that enabled group interactions regarding PCRS data review, provided the opportunity for team check-ins, and allowed focused content discussion were among the top three educational and technical assistance opportunities that supported sustainable change. Also in the top three were the process of creating memoranda of understanding to
delineate project expectations and commitments, and having access to an OPCA coach for individualized technical assistance.

11. What were the major barriers to sustainable change, and how might they be overcome in the future?

Clinics noted a variety of barriers to sustainable change. MCC described two major challenges: shifting organizational priorities for quality improvement projects concurrent with changes in leadership, and many other quality improvement initiatives that competed for staff time. YVFWC, as part of a large clinic system spanning several states with its own unique electronic medical record system, cited participating clinics’ lack of decision making authority to make changes regarding technology and reporting within a shared electronic medical record system. This clinic team also noted lack of quality assurance staff time dedicated to self-management support projects as a barrier. Conversely, dedicated staff time, greater flexibility of electronic medical record systems, and identification of high-level project champions were noted as potential means to overcome these issues.

Lincoln CHC cited major turnovers in clinic staff and management as a barrier to change; although including self-management support roles in position descriptions was described as a means to surmount this challenge, new staff still must be trained on new procedures such as electronic medical record data extraction and referral protocols. Similarly, CHC Benton cited staff and management turnover as a barrier to future sustainability, as well as a lack of consistent support for team-based care among some providers. CHC Benton also predicted challenges related to lack of a high-level administrative champion for future self-management related quality improvement, especially in the face of competition from other projects. La Clinica noted that reduced productivity and billing revenue while providers received training will continue to challenge the clinic’s ability to continuously train full practice teams in motivational interviewing and other key self-management support skills.

12. What resources are needed to continue this work, and what organization(s) should lead it?
All participating clinics noted that continued support for self-management quality improvement projects would be an important means to prioritize this work among myriad other opportunities related to health system transformation. Several clinics also described the importance of a collaborative or other type of official project in maintaining organizational commitment to the topic, especially in terms of its requirement of dedicated time for quality assurance staff, management, and clinical teams to undertake plan-do-study-act improvement cycles. Specific requests included having a venue to continue conversations with peers from clinics sharing similar goals and challenges; ongoing learning opportunities for new staff, including training on motivational interviewing and patient-centered office visit techniques; and individualized technical assistance for assist clinics in addressing their unique challenges and opportunities related to self-management support. In the words of the CHC Benton Health Navigation Program Manager, “We’re going to keep chipping away at it like water on a rock.”

Discussion

Accomplishments and Outcomes

The PSMC was successful overall. Nine clinic teams participated and six completed the collaborative. Many practice changes they implemented, however, spread to a total of eleven clinic sites, including eight clinics within a large urban primary care system that serves the highest volume of Medicaid/CHIP beneficiaries in Oregon. All participating teams increased their overall capacity to support self-management, both within the clinic setting and—through development and refinement of referral protocols—outside the clinic walls. Patient participation in self-management workshops and receipt of Quit Line services increased overall in PSMC clinics, and both clinic-hosted and community-based LW/TC programs gained a stronger footing in areas served by participating FQHCs. Half the clinics that finished the collaborative also attributed their ability to fulfill medical home accreditation requirements to their participation in the collaborative.
Clinic teams also described progress toward implementing a team-based approach to chronic disease care during the PSMC. Expanded responsibilities for medical assistants, health educators, and patient navigators included documentation of self-management goals during the rooming process, delivery of motivational interviewing interventions during visits, and post-visit coaching to increase follow-through on LW/TC and Quit Line referrals. Although these changes met with resistance from providers in at least one participating FQHC, clinics described a general trend toward reduced burden on providers and increased responsibilities for self-management support among previously underutilized staff.

One FQHC implemented system-wide electronic medical record changes to allow documentation of self-management goals, and enabled systematic reporting to clinic teams on their performance on this measure. This clinic system also developed the capability to track documentation of self-management goals among patients with asthma. Performance on this measure within the population of patients served by the participating care team doubled during the PSMC, from a 25% rate of documentation in project year three to 53% at the end of project year five.

During the course of the collaborative, most participating clinics—some of which were affiliated with large clinic systems—experienced significant cultural shifts in favor of self-management. Interviewees unanimously agreed that motivational interviewing training for medical assistants, patient navigators, and other members of care teams helped to increase these commonly underutilized medical professionals' ability to contribute meaningfully to self-management support. In addition, one large, regional clinic system identified self-management support as a core organizational value and implemented major changes in its information technology systems to enable continued quality improvement in this arena. Although it is outside of the scope of this evaluation to establish a direct, causal relationship between PSMC participation and these organizational priority shifts, it is likely that the PSMC played a significant role.

Perhaps the most significant accomplishment of the PSMC was to establish self-management support as priority for both participating clinics and for the Oregon Primary Care Organization. As a result of the new OAP partnership, this influential and highly
respected organization became an important champion for self-management support within Oregon FQHCs, and helped the OAP to articulate the importance of support for patient self-management as a key aspect of patient-centered care.

**Key Challenges**

One of the biggest challenges in implementing the PSMC was the lack of existing curricula, coaching tools, and other resources to assist project planning. An environmental scan conducted in the fall of 2009 identified only one tested quality improvement tool specifically designed for use in initiatives to enhance self-management support in primary care (the PCRS, described above), and according to the tool’s lead author it had never been used for evaluation. The recruitment pool for both cohorts represented clinics in a variety of stages of change with widely varying resources, and this diversity made curriculum planning challenging. In addition, the newness of the partnership between the OAP and the OPCA necessitated an entire year of planning prior to launch of collaborative learning sessions in year 2. It was clear from the outset that public health and primary care perspectives on self-management support were complimentary. However, both organizations needed time to learn each other’s language, develop an understanding of the cultural differences between individually- and population-based approaches to supporting positive outcomes, and come to a mutual understanding of the best way forward. However, the protracted planning period eventually resulted in a strong partnership based in respect, trust, and common goals.

Although the PSMC was initially envisioned as a project specific to asthma self-management support, the difficulty of reporting on disease-specific processes and outcomes became apparent as clinic recruitment began. This was a particular issue in relation to clinic data systems. Many of the participating FQHC systems had extensive experience in quality improvement and collaborative learning, yet most clinics used a regional medical record system that was not locally customizable. Therefore only the two clinics that used different record systems were able to report data on their population of patients with asthma. Although the PSMC quality improvement activities
benefitted patients with asthma as part of the general patient population, for most clinics it was not possible to quantify results for those with asthma.

Evaluation data collection was further complicated by the need to identify measures that could be simultaneously useful for clinic’s quality improvement processes, meaningful for project evaluation, and low-impact in terms of reporting burden. All of these considerations made it crucial for OAP and OPCA to be flexible and willing to negotiate in order to maintain clinic participation. The process of developing memoranda of agreement between OPCA and participating FQHCs greatly assisted this process, and helped to reduce issues related to allocation of human resources to complete the project. However, diversity of priorities among participating clinic teams and disparities in the availability of staff resources (especially among small, rural clinics) made it extremely challenging to identify a common set of measures and reinforce consistent expectations. Although a metrics workgroup convened in the first year of the collaborative, the process of finalizing PSMC metrics lasted until the end of year three; as a result, much of the quantitative data collected only represented changes that took place during the final two years of the four-year collaborative.

The PSMC also highlighted the challenges of creating “closed loop” referral systems between primary care clinics and community-based self-management resources that fed information back to care teams about referral status, receipt of services, and other information helpful for self-management support (patient self-management goals, progress, barriers, etc.). PSMC evaluation data indicated that long-standing, trusting relationships likely make for more successful clinic-community linkages, especially when the primary care delivery system specializes in serving vulnerable populations.

The timing of state and national health reform legislation created fertile ground for the PSMC because clinics’ financial incentives were better aligning to support the Triple Aim. However, the process of health system transformation that coincided with the collaborative was a mixed blessing. While self-management support and patient-centered care were becoming increasingly understood as crucial means to achieve the Triple Aim, clinics participating in the PSMC had many other competing priorities. Chief
among these were increased reporting requirements, including requirements for submission of data to medical home recognition programs, to the Health Resources and Services Administration’s universal data set reporting system, and other concurrent collaboratives. The extra reporting required as part of PSMC participation was particularly burdensome for clinics with fewer resources.

Unanticipated Outcomes

Two clinics that did not directly participate in the collaborative became LW/TC host sites. Although the Umpqua CHC Myrtle Creek satellite clinic participated in only part of the collaborative and never held LW or TC program on site, the main Umpqua CHC clinic in Roseburg became a host site, offering one LW program in 2012, five in 2013, and one in 2014. Additionally, the La Pine Community Health Center in Central Oregon, which was recruited to join the collaborative but chose not to participate, began hosting self-management programs following the local LW/TC coordinator’s attendance at the recruitment visit. This meeting established a partnership to provide on-site programs open to patients and community members.

Two participating clinics also began to offer other Stanford programs on site during the collaborative. La Clinica del Valle’s Central Point clinic hosted one Stanford Chronic Pain Self-Management Program (CPSMP), and Northwest Human Services West Salem Clinic hosted one CPSMP and two Stanford Diabetes Self-Management Programs during the collaborative.

Another unexpected outcome of the PSMC was its identification of a useful means of collecting evaluation data for tracking progress in self-management related quality improvement initiatives in primary care. The PCRS tool was originally designed as a self-assessment for QI processes, but its successful use as part of the PSMC also indicated it as a potential source for evaluation data in future initiatives. Although some clinic teams noted that the quarterly PCRS self-assessment process felt burdensome, OPCA staff agreed that the tool holds promise for helping clinic teams operationalize step-by-step self-management support improvements.
Limitations

The limitations of this evaluation center upon availability of data. Although the first cohort of the collaborative convened in autumn of 2010, it took more than two years to identify the measures noted in Appendix F, so clinic reports only demonstrated progress in the final two years of the PSMC. In an ideal world, measures would have been established much earlier to enable tracking of clinic progress over the full duration of the PSMC. It was also difficult to corroborate counts of Quit Line referrals provided by clinics with reports of referrals received by the Quit Line. Additionally, data regarding LW/TC programs and referrals were inconsistently reported and were therefore not trackable through the statewide Stanford Chronic Disease Self-Management Program data collection system.

Recommendations

- Continue to provide structured support for self-management support quality improvement in primary care clinics. With self-management support now increasingly understood as a key aspect of patient centered care, community health center staff, providers and administrators will continue to be interested in this work. However, with multiple competing priorities and increased workload due to Medicaid expansion, self-management support is likely to fall off the priority list unless clinics are provided with opportunities to participate in projects such as the PSMC that require organizational commitment of clinic resources. Results of this evaluation indicate that memoranda of agreement will be a possible means of ensuring this commitment.

- Focus on high-impact training and technical assistance activities. Clinic staff consistently indicated that continued training to expand knowledge to other care teams and counteract staff turnover would be important to sustain the quality improvements they achieved during the PSMC. Opportunities to connect with other clinics interested in enhancing patient self-management will likely
continue to be in demand, especially as financial incentives continue to align with the Triple Aim.

- **Allow for flexibility in collaborative implementation.** Due to the high level of variability in staffing, clinic flow processes, and priority issues among FQHCs, organizations with high readiness to engage in quality improvement to enhance self-management support will likely have different needs and varying priorities driving their work. Thus, it is important to enter this work with the expectation that clinics will make improvements without being overly specific about the particular changes they must implement in their practices and record systems. The PSMC’s combination of large-group activities and individualized coaching appeared to be an effective means of addressing the needs of diverse organizations with similar goals.

- **Continue to refine primary care self-management support reporting metrics that are not burdensome to clinics.** The PSMC demonstrated that it is possible to identify measures of clinic support for self-management that can simultaneously satisfy the needs of clinic quality assurance staff as well as project evaluators. However, due to the high burden of required reporting upon FQHCs, self-management related metrics must align with existing reporting requirements whenever possible to ensure retention of clinic teams. Variability in electronic medical record system capabilities between FQHCs adds an extra layer of complication; clinic quality assurance staff and state primary care association staff are valuable resources in navigating these challenges.

- **Continue to nurture the new state-level public health/primary care partnership established under the auspices of the PSMC.** The Oregon Primary Care Association was well positioned to continue to champion self-management support within FQHCs, and their work on the PSMC was effective and well received by clinic teams. In addition to contributing financial resources and overall project planning and implementation guidance, the OAP offered expertise in self-management support and population-based approaches to quality improvement. The resulting partnership enriched both organizations by developing a common agenda, sharing expertise in areas of individual strength
and expertise, and establishing a strong working relationship that holds promise for future productive collaborations. This successful aspect of the PSMC indicates that state-level public health and primary care associations can work together effectively to achieve mutual goals related to self-management support for patient populations with asthma and other chronic conditions.
## Appendix A: Patient Self-Management Collaborative Evaluation Logic Model

### Resources
- CDC Asthma funding
- Oregon Asthma Program staff
- Oregon Primary Care Association staff
- Participating Federally Qualified Health Centers (FQHCs)
- Community self-management programs and partners
- Oregon Tobacco Quit Line
- Local public health authorities
- Healthy Communities funding to local public health authorities
- Tobacco Prevention and Education Program funding to local public health

### Activities
- Clinic teams and community partners participate in Collaborative, receive training in:
  - Motivational interviewing
  - Tobacco cessation interventions
  - Chronic Disease Self-Management Programs
  - Data for quality improvement
  - Patient-centered communications
  - Plan, Do, Study, Act cycles and managing change processes
- The Oregon Asthma Program and the Oregon Primary Care Association hold monthly project management meetings
- Oregon Primary Care Association and participating FQHCs submit regular progress reports and evaluation measures

### Outputs
- Self-management program referral protocols
- Clinic process flow changes to support patient self-management
- PSMC training curricula

### System Outcomes
- Clinic teams develop, test and document referral protocols to evidence-based self-management resources
- Clinics increase the offering of onsite Chronic Disease Self-Management Programs
- Clinics increase support patient self-management within clinic visits

### Impact
- Clinic self-management protocols and systems spread to other FQHCs
- Clinics achieve medical home recognition
- Clinics become more patient-centered
- Patients are better able to manage their chronic conditions

### External influences:
- health care cost escalation, aging population with high chronic disease burden, federal and local health care financing reform, spread of Meaningful Use, the Oregon Patient Centered Medical Home and NCQA Patient-Centered Primary Care Home initiatives, increased burden on community health centers due to economic crisis and un/under-insurance, Oregon health system transformation and advent of Coordinated care Organizations.
## Appendix B: Community Partners

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<thead>
<tr>
<th>Federally Qualified Health Center (FQHC)</th>
<th>Community Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC of Benton &amp; Linn Counties</td>
<td>Benton County Health Department, TC/LW</td>
</tr>
<tr>
<td></td>
<td>Healthy Communities, Benton County Health Department</td>
</tr>
<tr>
<td></td>
<td>Benton County Health Department, Tobacco Prevention</td>
</tr>
<tr>
<td>La Clinica del Valle</td>
<td>Rogue Valley Council of Governments, LW/TC Programs</td>
</tr>
<tr>
<td></td>
<td>Jackson County Health &amp; Human Services, Healthy Communities</td>
</tr>
<tr>
<td></td>
<td>Jackson County Health &amp; Human Services, Healthy Communities</td>
</tr>
<tr>
<td>Lincoln County Health Services</td>
<td>Lincoln County Health Services, TC/LW/Tobacco Prevention</td>
</tr>
<tr>
<td>Multnomah County Health Department</td>
<td>Patient Advocate</td>
</tr>
<tr>
<td></td>
<td>Community Resource Representative, Multnomah County Health Department</td>
</tr>
<tr>
<td>Northwest Human Services, Salem</td>
<td>Marion County Health Department, Tobacco Prevention</td>
</tr>
<tr>
<td></td>
<td>Marion County Health Department, Healthy Communities</td>
</tr>
<tr>
<td></td>
<td>Polk County Public Health Department, Tobacco Prevention</td>
</tr>
<tr>
<td></td>
<td>Willamette Valley Physician Health Authority, LW/TC</td>
</tr>
<tr>
<td>OHSU Family Medicine at Richmond, Portland</td>
<td>No community partners</td>
</tr>
<tr>
<td>Siskiyou Community Health Center, Cave Junction</td>
<td>Rogue Valley Council of Governments, LW/TC Programs</td>
</tr>
<tr>
<td></td>
<td>Josephine County Public Health Division, Tobacco Prevention</td>
</tr>
<tr>
<td>Umpqua Community Health Center, Roseburg</td>
<td>Withdrew from the collaborative, May 2012</td>
</tr>
<tr>
<td>Yakima Valley Farm Workers Clinic</td>
<td>Marion County Health County, Tobacco Prevention and Education Coordinator</td>
</tr>
<tr>
<td></td>
<td>Marion County Health Department, Healthy Communities</td>
</tr>
<tr>
<td></td>
<td>Gerardo Trejo Martinez, Health Educator (Marion County)</td>
</tr>
<tr>
<td></td>
<td>Yakima Valley Farm Workers Clinic, TC</td>
</tr>
</tbody>
</table>
Appendix C: PSMC Training Events

The following in-person and webinar training and technical assistance events were offered to clinic teams participating in the Patient Self-Management Collaborative. All events in year 2 were exclusive to PSMC clinic teams; in subsequent years PSMC training events were opened to a broader audience of Federally Qualified Health Centers. Many of the training events listed below were supported by other funds from the Oregon Primary Care Association.

**Project Year 2 (September 2010-August 2011):**

In-person:

- Kickoff: Self-management of chronic disease in the clinic setting and partnering with Community self-management programs
- Motivational interviewing two day in-person training
- Oregon Living Well Forum

Webinars:

- Implementing Motivational Interviewing: Self- Management Support in the Office Visit
- Team building & team based care
- AAR/5As cessation interventions and the Quit Line
- Model for Improvement, PDSA cycles & change processes
- PDSA training
- Lean Training

**Project year 3 (September 2011-August 2012):**

In person:

- Kick-Off, Cohort 2
- Introduction to Motivational Interviewing – two day in-person
- Living Well with Chronic Conditions Forum
- PCMH Foundations
- Quadruple Aim Symposium (PSMC-specific track)
- Anchoring the 2011 NCQA PCMH Standards in Your Practice
- Introduction to Motivational Interviewing,

Webinars:
- Orientation and Welcome
- Team Building
- Tobacco Cessation, Oregon Tobacco Quit Line
- Connecting Clinic & Community
- Measurement 101
- Baseline PCR Results
- PSMC Progress to Date
- Intro to Run Charts
- QI Expertise
- Creating Run Charts + Intro to Run Chart Rules
- Project Charters
- PDSAs
- Culture of Experimentation
- Employee Engagement

**Project Year 4 (September 2012-August 2013):**

In Person Trainings:
- Patient Centered Observation Form Training (PCOF):
- IISC Facilitative Leadership Training
- PCMH Foundations
- Quadruple Aim Symposium (PSMC-specific track)
- Introduction to Motivational Interviewing
- Tools for Leadership Success
- Optimizing Your Practice
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- NCQA Workshop
- Facilitative Leadership Training for Medical + Dental Directors
- Introduction to Motivational Interviewing (two 2-day series)

Webinars:
- NACHC/OPCA/SCPHCA BSI Training
- PSMC Skill Building/Group Coaching Calls
• Care Coordination, referrals and closing the referral loop
• PCRS data review
• MI skill building monthly webinar
• Integrated Behavioral/Mental Health billing in the FQHC Primary Care Home, Webinar
• Measurement Strategy Menu Negotiation
• Partner Agreement, Measurement strategy
• PCMH-A,8 Change Concepts, PAM tool
• Measurement Expectations + Oregon Quit Line Referrals
• PCRS, second Data Point Results Review
• Measurement 101
• Cascading measures
• QI 101
• Visual Management
• Mapping Tools
• Creating and Using Dashboards
• Monthly Motivational Interviewing skill-building webinars

**Project Year 5 (September 2013-August 2014):**

Webinars:

• Monthly PCRS PSMC Data Coaching Webinars
• Monthly Motivational Interviewing skill-building webinars

In-Person Trainings:

• Fall Quadruple Aim Symposium
• Patient-Centered Office Visit Skills with Larry Mauksch
• NCQA Workshop
• Introduction to Motivational Interviewing
• Self-Management Support Training
• Patient-Centered Office Visit Skills with Larry Mauksch
• Advanced Care Summit/Convening- Improving the Health of a Population
• Developing High-Functioning Teams
• Tools for Leadership Success
Appendix D: Individual Evaluation Plan Outline

Oregon Asthma Program

Individual Evaluation Plan

Patient Self-Management Collaborative

Prepared by:
Laura Chisholm, MPH, MCHES
Shaun Parkman, MA
Chipo Maringa, PhD
Rodney Garland-Forshee, MS
Kirsten Aird, MPH
Leah Fisher, MPH

Oregon Health Authority – Public Health Division

November 20, 2012

Updated August 30, 2014
1. INTRODUCTION

The Oregon Asthma Program (OAP) provides funding to the Oregon Primary Care Association (OPCA) to implement the Patient Self-Management Collaborative (PSMC) with eight Federally-Qualified Health Centers (FQHCs). Participating FQHCs are offered a series of learning opportunities to build capacity for patient self-management support both within the clinic setting and through referrals to evidence-based self-management programs, including the Stanford Chronic Disease Self-Management Program and the Oregon Tobacco Quit Line.

Evaluation Purpose

The purpose of the PSMC evaluation is to determine the impact of the project on self-management support within clinics that primarily serve low income, high need patients that tend to experience higher levels of chronic disease and disability. The secondary purpose of the evaluation is to identify promising practices for establishment of enhanced clinical self-management report and self-management referral systems within FQHCs, including potential barriers, enabling factors, and lessons learned to inform future collaboratives.

Stakeholders

There are several stakeholders for this evaluation as outlined in table F.1 below.

Table F.1. Stakeholder Assessment and Engagement Plan

<table>
<thead>
<tr>
<th>Stakeholder Name</th>
<th>Stakeholder Category</th>
<th>Interest or Perspective</th>
<th>Role in the Evaluation</th>
<th>How and When to Engage</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCA</td>
<td>Primary</td>
<td>Implementer of initiative and provider of technical assistance for other FQHC initiatives</td>
<td>Developed evaluation plan, collects and reports data to inform evaluation</td>
<td>Engaged at the beginning of the project and continues to be kept informed throughout the evaluation process</td>
</tr>
<tr>
<td>FQHCs participating in the PSMC</td>
<td>Primary</td>
<td>Implementer of initiative</td>
<td>Reviewed evaluation plan, reports data to inform evaluation</td>
<td>Engaged at the beginning of the project and continue to be kept informed throughout the evaluation process</td>
</tr>
<tr>
<td>Community self-management partners</td>
<td>Primary</td>
<td>Assists with implementation of initiative</td>
<td>Works with FQHCs to report data to inform evaluation</td>
<td>Engaged at the beginning of the project and continue to be kept informed throughout the evaluation process</td>
</tr>
<tr>
<td>Acumentra Health, Oregon Healthcare Quality Corporation, OHA Office of Health Policy &amp; Research, OHA Transformation Center</td>
<td>Primary</td>
<td>Implementers and/or funders or future initiatives to support self-management in primary care</td>
<td>Reviewed evaluation plan; consumer of evaluation report</td>
<td>Engaged during final evaluation planning and evaluation period</td>
</tr>
<tr>
<td>Role</td>
<td>Status</td>
<td>Description</td>
<td>Role Description</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>FQHCs not participating in the PSMC</td>
<td>Secondary</td>
<td>Potential adopter of PSMC best practices</td>
<td>Consumer of evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform of initial successes throughout project and share evaluation findings upon completion of the project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local public health authorities</td>
<td>Secondary</td>
<td>Support self-management infrastructure development and community/clinical linkages</td>
<td>Consumer of evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engaged at the beginning of the project and continue to be kept informed throughout the evaluation process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Secondary</td>
<td>Funder of initiative</td>
<td>Consumer of evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform of initial successes throughout project and share evaluation findings upon completion of the project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other state Asthma programs</td>
<td>Tertiary</td>
<td>Potential to replicate project with FQHCs and other health clinics</td>
<td>Consumer of evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform of initial successes throughout project and share evaluation findings upon completion of the project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other state chronic disease programs</td>
<td>Tertiary</td>
<td>Potential to replicate project with FQHCs and other health clinics</td>
<td>Consumer of evaluation report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Share evaluation findings upon completion of the project</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. DESCRIPTION OF WHAT IS BEING EVALUATED

Need
The PSMC is a new initiative that has never been implemented in Oregon before. There is a need for both the OAP and its partners to understand the impact of the PSMC on participating clinics and the patients they serve. Similarly, Oregon-based organizations guiding health system transformation, as well as many states and federal partners, are interested in the outcome of this project to inform planning for future initiatives.

Context
Most participating FQHCs are in the process of applying for Primary Care Medical Home certification through the National Committee for Quality Assurance as well as Patient-Centered Primary Care Home certification through the Oregon Health Authority. Several participating FQHCs are also involved with a variety of transformation activities and learning collaboratives, such as the Primary Care Renewal and Advanced Primary Care Practice initiatives. In addition, participating FQHCs are responsible for reporting Universal Data Set (UDS) data to the Health Resources and Services Administration. Most participating FQHCs are in the process of implementing Stage 2 Meaningful Use; this designation indicates that these clinics are receiving incentive payments for meeting federal requirements for reporting and other practical use of electronic health record data. Many FQHCs struggle to keep their electronic health record technology up to the pace of the different demands of primary care transformation, and many also have very limited resources for data collection, reporting and tracking. Overall, all of these initiatives and demands make for implementation of a project that does not provide a financial incentive a challenge. However, OPCA has continued to closely align the work of the PSMC so it can assist FQHCs in meeting requirements for Primary Care Medical Home and Patient-Centered Primary Care Home recognition.

Stage of Development
The evaluation plan was first drafted in Year One, when the OAP and OPCA were planning the PSMC. The evaluation plan was revised in May 2012 to correspond with the PSMC measurement plan developed by OPCA. The evaluation plan was then continuously implemented, as progress reports are provided by participating FQHCs and OPCA on an annual basis. The plan was further updated with stakeholder input in August 2014. Due to the potential availability of funding to further enhance primary care support for self-management via the Patient Centered Primary Care Home Institute, several newly identified health system transformation stakeholders were engaged to update the evaluation questions and inform the process of final evaluation data collection.
Resources/Inputs
Resources contributing to this project include the following:

- CDC Asthma funding
- OAP staff
- OPCA staff
- Eight FQHCs
- Community self-management programs and partners
- Oregon Tobacco Quit Line
- Local public health authorities
- Healthy Communities and Tobacco Prevention and Education Program funding to local public health authorities
- National Committee for Quality Assurance and Patient-Centered Primary Care Home standards

Activities
OPCA coordinates a variety of regular training and technical assistance opportunities in order to build capacity for patient self-management among PSMC clinics. OPCA also facilitates monthly PSMC webinars with participating teams to encourage collaborative learning. Training and technical assistance opportunities offered to PSMC clinics include the following topic areas:

- Motivational interviewing
- Tobacco cessation interventions
- Chronic Disease Self-Management Programs
- Data for quality improvement
- Patient-centered communications
- Plan, Do, Study, Act cycles and managing change processes

In addition, the OAP participates in these training events and holds monthly meetings with OPCA to oversee grant deliverables and to provide feedback on project planning.

Participating PSMC clinics report on their progress to the OAP and OPCA annually, and complete the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS) tool quarterly. PSMC clinics will also be required to report other data biannually once OPCA has finalized PSMC measurement specifications.

Outputs
Through the grant provided to OPCA, the primary products of the PSMC are tailored training events and a corresponding curriculum to document the work of the collaborative.

Outcomes
Outcomes of the PSMC are as follows. These outcomes were revised in May 2012 as a result of a need to focus on what can actually be measured and achieved within the context of the PSMC. In response to requests from participating FQHCs to further streamline and simplify clinic reporting requirements, outcomes and associated measures were further revised in August 2013.
Short term/intermediate:
- Clinic teams develop, test and document referral protocols to evidence-based self-management resources.
- Clinic teams increase the offering of onsite Chronic Disease Self-Management Programs.
- Patient participation in self-management programs is increased.

Long term:
- Clinic self-management protocols and systems are spread to other FQHCs.
- Clinics achieve medical home recognition.
- Clinics become more patient-centered.
- Patients are better able to manage their chronic conditions.

**Table F.2. Program Description Template**

<table>
<thead>
<tr>
<th>Resources/Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial</strong></td>
<td><strong>Subsequent</strong></td>
<td><strong>Short-Term/Intermediate</strong></td>
<td><strong>Long-Term</strong></td>
</tr>
<tr>
<td>CDC Asthma funding</td>
<td>Tobacco cessation training</td>
<td>Data for quality improvement</td>
<td>Training events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>training</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OAP staff</td>
<td>Chronic Disease</td>
<td>Patient-centered communications</td>
<td>PSMC curriculum</td>
</tr>
<tr>
<td></td>
<td>Self-Management Programs training</td>
<td>training</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPCA staff</td>
<td>PDSA cycle training</td>
<td>Motivational interviewing</td>
<td>Patient participation in self-management programs is increased.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>training</td>
<td></td>
</tr>
<tr>
<td>Eight FQHCs</td>
<td>Introductory webinar and kickoff</td>
<td>Technical assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>meeting</td>
<td>webinars</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community self-management programs and partners</td>
<td>OPCA and clinic progress reporting</td>
<td>Reporting of Quit Line referrals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon Tobacco Quit Line</td>
<td>OPCA and clinic progress reporting</td>
<td>Reporting of Quit Line referrals</td>
<td>Tobacco users who want to quit receive referrals to the Quit Line.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Communities and Tobacco Prevention and</td>
<td>Clinic measurement reporting,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>including PCRS tool</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program funding to local public health authorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>National Committee for Quality Assurance and Patient-Centered Primary Care Home standards</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Logic Model**
See the attached logic model.
3. **Evaluation Design**

**Evaluation Questions**

The process evaluation questions that this plan intends to answer are as follows. Questions in italics were added during the August 2014 final revision.

1. Did clinic teams and community partners participate in collaborative training events?
2. How did clinic capacity to support self-management and cessation increase?
3. Did clinics develop, test, and document referral protocols to evidence-based self-management and cessation resources? *To what degree did clinics make use of electronic referrals? What were the major barriers and enabling factors related to timely, successful referrals?*

The outcomes evaluation questions that this plan intends to answer are as follows. Questions in italics were added or edited during the August 2014 final revision.

4. Did the number of Chronic Disease Self-Management Program workshops offered onsite at clinics increase?
5. Did patient participation in self-management programs increase?
6. What is the spread of clinic self-management protocols and systems as a result of the PSMC?
7. Did participation in the collaborative make clinics more patient-centered? *Which aspects contributed most strongly?*
8. Did participation enhance clinics’ progress toward medical home recognition? *Which aspects contributed most strongly?*
9. *How did participation in the PSMC change clinic practices and priorities related to self-management support?*
10. *What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?*
11. *What were the major barriers to sustainable change, and how might they be overcome in the future?*
12. *What resources are needed to continue this work, and what organization(s) should lead it?*
**Stakeholder Needs**
Primary stakeholders for the PSMC evaluation include organizations directly involved: OPCA, FQHCs participating in the PSMC, local public health authorities (via the Council of Local Health Officials), community self-management partners (via the Oregon Self-Management Network), Acumentra Health (Oregon’s Medicare Quality Improvement Organization); and OHA programs leading and guiding health system transformation (Office of Health Policy and Research/Patient Centered Primary Care Home Institute; Oregon Transformation Center; Medical Assistance Programs).

A variety of other organizations are identified as secondary stakeholders, including:
- Non-participating FQHCs
- CDC and other state asthma and chronic disease programs
- Other OHA/PHD direct service programs (Maternal and Child Health, Immunizations)
- Coordinated Care Organizations
- Patient centered medical homes

Stakeholders will be interested to know how the PSMC works and what the outcomes of the project are. Successes and challenges related to implementation of the PSMC will also be of interest to stakeholders.

Evaluation findings will be used to make necessary adjustments the PSMC curriculum so that if the initiative proves to be successful, it can be replicated. Replication of the PSMC can occur with other non-participating FQHCs or at the state level for state asthma and other chronic disease programs that wish to undertake a similar partnership with their primary care association and FQHCs.

Intended users of the evaluation tend to view state reports, case studies and clinical data as credible information.

**Evaluation Design**
The design for the PSMC evaluation is mixed methods. The PSMC project evaluation will include case studies; some longitudinal data, including PCRS assessment scores and other clinical process measurements; and qualitative data collected via semi-structured interviews with project leads of participating FQHCs. A mixed-methods design allows the OAP to look more closely at both process and outcomes related to the implementation of a new initiative. Additionally, video interviews will collect success stories and viewpoints from patients, clinicians, staff and administrators that will be used as teaching tools and resources for encouraging clinic participation in future related initiatives.
4. **DATA COLLECTION**

**Data Collection Methods**
New data will be collected to answer the evaluation questions. New data that will be collected will include progress reports from OPCA and participating PSMC clinics, quarterly PCRS assessments, biannual clinic project measurement data, and qualitative data related to the outcome evaluation questions outlined in section 3 above.

OPCA will collect progress reports, quarterly PCRS assessments and project measurement data from participating clinics. Clinics will be responsible for completing the progress reports, implementing the PCRS assessment annually, and collecting and reporting on clinical process data necessary to fulfill the project measurement data. Clinical process data will be collected through clinic electronic health record systems. Only deidentified data will be shared with OPCA and the OAP by participating clinics.

OAP staff will conduct interviews with clinic leads to collect qualitative data. OPCA will work with a subcontracted videographer to collect video footage.

No samples will be used as all participating PSMC clinics will be required to collect and report data.

Progress report templates are developed collaboratively between the OAP and OPCA. Progress report templates will be updated and revised as necessary in order to reflect the work of the PSMC.

Clinic data will be reviewed for quality and consistency by clinical quality improvement staff as well as OPCA’s Director of Measurement and Reporting.
# Data Collection Method – Evaluation Question Link

## Table F.3: Evaluation Questions and Associated Data Collection Methods

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Data Collection Method</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did clinic teams and community partners participate in collaborative training events?</td>
<td>Attendance reports</td>
<td>Training and webinar attendance records collected by OPCA</td>
</tr>
<tr>
<td>2. How did clinic capacity to support self-management and cessation increase?</td>
<td>Open-ended survey questions</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics</td>
</tr>
<tr>
<td>3. Did clinics develop, test, and document referral protocols to evidence-based self-management and cessation resources?</td>
<td>Open-ended survey questions, count of documented referral protocols</td>
<td>Progress reports submitted by OPCA and participating PSMC clinics</td>
</tr>
<tr>
<td>4. Did the number of Chronic Disease Self-Management Program workshops offered onsite at clinics increase?</td>
<td>Chronic Disease Self-Management Program Summary Forms</td>
<td>Living Well database</td>
</tr>
<tr>
<td>5. Did patient participation in self-management programs increase?</td>
<td>Chronic Disease Self-Management Program Participant Information Forms, open-ended survey questions</td>
<td>Living Well database, progress reports submitted by OPCA and participating PSMC clinics</td>
</tr>
<tr>
<td>6. What is the spread of clinic self-management protocols and systems as a result of the PSMC?</td>
<td>Open-ended survey questions responded to by OPCA</td>
<td>Progress reports submitted by OPCA</td>
</tr>
<tr>
<td>7. Did participation in the collaborative enhance clinics' progress toward medical home recognition? Which aspects contributed most strongly?</td>
<td>Open-ended survey questions responded to by OPCA</td>
<td>Progress reports submitted by participating PSMC clinics</td>
</tr>
<tr>
<td>8. Did clinics become more patient-centered? Which aspects contributed most strongly?</td>
<td>PCRS assessment, quantitative and qualitative patient surveys (if used by individual clinics)</td>
<td>Completed PCRS assessments submitted quarterly by participating PSMC clinics, patient satisfaction survey responses</td>
</tr>
<tr>
<td>9. How did participation in the PSMC change clinic practices and priorities related to self-management support?</td>
<td>Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
<tr>
<td>10. What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?</td>
<td>Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
<tr>
<td>11. What were the major barriers to sustainable change, and how might they be overcome in the future?</td>
<td>Semi-structured interview questions responded to by FQHC program leads</td>
<td>Semi-structured interviews conducted by OAP</td>
</tr>
</tbody>
</table>
12. What resources are needed to continue this work, and what organization(s) should lead it?  
Semi-structured interview questions responded to by FQHC program leads and OPCA project staff  
Semi-structured interviews conducted by OAP

5. DATA ANALYSIS AND INTERPRETATION

Indicators and Standards

Table F.4. Indicators and Success

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Criteria or Indicator</th>
<th>Standards (What Constitutes “Success”?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did clinic teams and community partners participate in collaborative training events?</td>
<td>OPCA Safety Net Medical Home initiative training participation records</td>
<td>100% of clinics have at least one team member participating in each collaborative training event</td>
</tr>
<tr>
<td>2. How did clinic capacity to support self-management and cessation increase?</td>
<td>Clinic staff trained in motivational interviewing and/or use of the Patient-Centered Observation Form</td>
<td>100% of clinics have documented policies that support self-management and cessation</td>
</tr>
<tr>
<td>3. Did clinics develop, test and document referral protocols to evidence-based self-management and cessation resources?</td>
<td>Clinic progress reports provided on monthly coaching webinars</td>
<td>100% of clinics have documented referral protocols to evidence-based self-management and cessation resources in place</td>
</tr>
<tr>
<td>4. Did the number of Chronic Disease Self-Management Program workshops offered onsite at clinics increase?</td>
<td>Workshop schedules</td>
<td>100% of clinics that offer Chronic Disease Self-Management Programs have increased workshop offerings over time</td>
</tr>
<tr>
<td>5. Did patient participation in self-management programs increase?</td>
<td>Quit Line registration and Chronic Disease Self-Management Program participant counts</td>
<td>100% of clinics have increased patient participation in the Quit Line or the Chronic Disease Self-Management Program over time</td>
</tr>
<tr>
<td>6. What is the spread of clinic self-management protocols and systems as a result of the PSMC?</td>
<td>Conference and training presentations</td>
<td>At least 5 clinics not participating in the PSMC have adopted self-management protocols and systems</td>
</tr>
<tr>
<td>7. Did participation in the collaborative enhance clinics’ progress toward medical home recognition? Which aspects contributed most strongly?</td>
<td>PCPCH recognition reports on the Oregon Health Authority website</td>
<td>100% of PSMC clinics have achieved PCMH and/or PCPCH recognition</td>
</tr>
</tbody>
</table>

This section of the plan corresponds with Chapter 3, Steps 4 and 5 of the State Asthma Program Evaluation Guide.
8. Did clinics become more patient-centered? Which aspects contributed most strongly?  & PCR assessments & 100% of PSMC clinics have improved in at least one PCRS domain to become more patient-centered  

9. How did participation in the PSMC change clinic practices and priorities related to self-management support? &  

10. What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)? & PCR assessments  
CDC Chronic Disease Prevention & Health Promotion Domain 4  
Description  

11. What were the major barriers to sustainable change, and how might they be overcome in the future? &  

12. What resources are needed to continue this work, and what organization(s) should lead it? &  

### Analysis
Qualitative and quantitative analysis will be used to support this evaluation. The OAP and OPCA will share the responsibility of qualitative and quantitative analysis.

### Interpretation
The OAP with support from OPCA will be responsible for interpreting qualitative and quantitative data. Qualitative data collected via interview will be reviewed by the OAP Evaluation Lead and Data Analyst, and the final report will be checked against the qualitative data set by these two staff in order to reduce reporting bias.

### 6. COMMUNICATION AND REPORTING

This section provides information about how information from the individual evaluation plan process and results will be used and shared.

**Use**
The OAP will share the evaluation findings with stakeholders and will encourage secondary distribution of the evaluation results. The OAP will submit conference abstracts to share the evaluation findings with a larger audience.
Evaluation findings will be used to inform future OAP and other Oregon chronic disease program efforts with health systems. Evaluation findings will be used by the OAP and the broader health system to implement policies to further support patient self-management.

The OAP will be responsible for disseminating evaluation recommendations. Implementation of evaluation recommendations will be the responsibility of the OAP, OPCA, and health clinics.

**Communication**
OPCA serves as a partner on the PSMC evaluation and will participate in ongoing evaluation efforts and planning through in-person meetings. Participating PSMC clinics will receive regular updated on the status of the evaluation via conference calls and in-person meetings. CDC will receive regular evaluation updates during regular conference calls and site visits.

Local public health authorities, community self-management partners, FQHCs not participating in the PSMC, other state asthma and chronic disease programs will receive notification of the evaluation findings via email.

7. **Evaluation Management**

This section provides information about how the individual evaluation will be managed and implemented and who will participate in what capacity. It will also provide a timeline for conducting activities related to this evaluation. You may find that some of the tables suggested here fit better in other sections of the plan. Regardless of how you structure your plan, it is important that you carefully think about each of these implementation steps and who is responsible for doing what by when.

- Develop several tables that summarize the major activities included in implementing the evaluation, the persons involved in this implementation, and associated timelines.

**Evaluation Team**

**Table F.5. Roles and Responsibilities of the Evaluation Team Members**

<table>
<thead>
<tr>
<th>Individual</th>
<th>Title or Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura Chisholm</td>
<td>Self-Management Technical Lead</td>
<td>Develop and update evaluation plan, develop data collection tools, ensure timely submission of progress reports and data from OPCA and the PSMC clinics, conduct semi-structured interviews, conduct analysis, write final report</td>
</tr>
<tr>
<td>Chipo Maringa</td>
<td>HPCDP Data Analyst Asthma</td>
<td>Conduct quantitative analysis as needed, develop data tables, assist with final evaluation report</td>
</tr>
<tr>
<td>Rodney Garland-Forshee</td>
<td>Asthma Epidemiologist</td>
<td></td>
</tr>
<tr>
<td>Leah Fisher</td>
<td>Asthma Program Coordinator</td>
<td>Assist with final evaluation report</td>
</tr>
<tr>
<td>Kirsten Aird</td>
<td>Chronic Disease Programs Manager</td>
<td>Consultation during evaluation plan development and review final evaluation report</td>
</tr>
<tr>
<td>OPCA Staff</td>
<td>TBD</td>
<td>Develop data collection tools, collect training attendance rosters and progress</td>
</tr>
</tbody>
</table>
Brandon Lane  
Health Care Data Specialist (OPCA)  
Collect clinical data from PSMC clinics, conduct quantitative analysis

Irma Murauskas  
Director of Primary Care Transformation (OPCA)  
Develop data collection tools, develop and submit OPCA progress reports and corresponding PSMC progress reports, review final evaluation report

### Data Collection Management

#### Table F.6. Data Collection Plan

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Data Collection Method</th>
<th>Activities Needed</th>
<th>Person(s) Responsible</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did clinic teams and community partners participate in collaborative training events?</td>
<td>Training and webinar sign in sheets</td>
<td>Distribute and collect attendance sheets</td>
<td>Irma Murauskas</td>
<td>Following each training event</td>
</tr>
<tr>
<td>2. How did clinic capacity to support self-management and cessation increase?</td>
<td>Progress reports</td>
<td>Distribute progress report template, collect and review reports</td>
<td>Irma Murauskas, Laura Chisholm</td>
<td>Annually in October</td>
</tr>
<tr>
<td>3. Did clinics develop, test, and document referral protocols to evidence-based self-management and cessation resources?</td>
<td>Referral protocols</td>
<td>Collect referral protocols</td>
<td>Irma Murauskas</td>
<td>Ongoing as developed</td>
</tr>
<tr>
<td>4. Did the number of Chronic Disease Self-Management Program workshops offered onsite at clinics increase?</td>
<td>Progress reports, workshop data reports</td>
<td>Distribute progress report template, collect and review reports, encourage timely submission of workshop data</td>
<td>Irma Murauskas, Laura Chisholm</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5. Did patient participation in self-management programs increase?</td>
<td>Progress reports, workshop data reports</td>
<td>Distribute progress report template, collect and review reports, encourage timely submission of workshop data</td>
<td>Irma Murauskas, Laura Chisholm</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
6. What is the spread of clinic self-management protocols and systems as a result of the PSMC?

Informal reports from non-PSMC clinics

Maintain awareness of spread of self-management protocols and systems

Irma Murauskas, Laura Chisholm

Ongoing

7. Did participation in the collaborative enhance clinics' progress toward medical home recognition? Which aspects contributed most strongly?

PCMH and PCPCH recognition reports

Collect reports on PCMH and PCPCH recognition progress

Irma Murauskas

Annually in October

8. Did clinics become more patient-centered? Which aspects contributed most strongly?

PCRS assessments

Collect PCRS assessments and analyze change over time

Irma Murauskas, Brandon Lane

Quarterly

9. How did participation in the PSMC change clinic practices and priorities related to self-management support?

Semi-structured interviews with clinic project leaders

Conduct interviews after project close

Laura Chisholm

September 2014

10. What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?

Semi-structured interviews with clinic project leaders

Conduct interviews after project close

Laura Chisholm

September 2014

11. What were the major barriers to sustainable change, and how might they be overcome in the future?

Semi-structured interviews with clinic project leaders

Conduct interviews after project close

Laura Chisholm

September 2014

Data Analysis Management

The primary data to be analyzed will be quarterly PCRS assessments. As clinics submit other clinical data to OPCA, those data will be analyzed accordingly by OPCA and OAP staff. Qualitative data from interviews will be analyzed by OAP staff using open coding and checked by a second staff member.

Table F.7. Data Analysis Plan

<table>
<thead>
<tr>
<th>Analysis to Be Performed</th>
<th>Data to Be Analyzed</th>
<th>Person(s) Responsible</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in patient-centeredness over time</td>
<td>PCRS assessments</td>
<td>Brandon Lane</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Change in quality of care and/or patient outcomes over time</td>
<td>Tobacco use status, tobacco use counseling, other measures as determined</td>
<td>Brandon Lane, Rodney Garland-Forshee, Chipo Maringa</td>
<td>Biannually</td>
</tr>
</tbody>
</table>

Communicating and Reporting Management

Table F.8. Communication and Reporting Plan
### Audience 1: OPCA

<table>
<thead>
<tr>
<th>Applicable?</th>
<th>Purpose of Communication</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Include in decision making about evaluation design/activities</td>
<td>In person meetings</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Inform about specific upcoming evaluation activities</td>
<td>In person meetings</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Keep informed about progress of the evaluation</td>
<td>In person meetings</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present initial/interim findings</td>
<td>Email</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present complete/final findings</td>
<td>Email</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Document the evaluation and its findings</td>
<td>Email</td>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

### Audience 2: FQHCs, community self-management partners and local public health authorities

<table>
<thead>
<tr>
<th>Applicable?</th>
<th>Purpose of Communication</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Include in decision making about evaluation design/activities</td>
<td>Email</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Inform about specific upcoming evaluation activities</td>
<td>Email</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Keep informed about progress of the evaluation</td>
<td>Email</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Present initial/interim findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present complete/final findings</td>
<td>Email</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Document the evaluation and its findings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Audience 3: Health system transformation stakeholders (Acumentra, OHA transformation programs, Coordinated Care Organizations, Patient centered medical homes)

<table>
<thead>
<tr>
<th>Applicable?</th>
<th>Purpose of Communication</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Include in decision making about evaluation design/activities</td>
<td>Conference calls, email</td>
<td>Year 4.5</td>
<td>Identified and engaged for final evaluation planning</td>
</tr>
<tr>
<td>Yes</td>
<td>Inform about specific upcoming evaluation activities</td>
<td>In-person meeting</td>
<td>Year 4.5</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Keep informed about progress of the evaluation</td>
<td>Conference calls</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present initial/interim findings</td>
<td>Conference calls, email</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present complete/final findings</td>
<td>Email, conference</td>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>
### Audience 4: CDC

<table>
<thead>
<tr>
<th>Applicable?</th>
<th>Purpose of Communication</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Include in decision making about evaluation design/activities</td>
<td>Conference calls, email</td>
<td>Biannually</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Inform about specific upcoming evaluation activities</td>
<td>Conference calls</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Keep informed about progress of the evaluation</td>
<td>Conference calls</td>
<td>As necessary</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present initial/interim findings</td>
<td>Conference calls, email</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present complete/final findings</td>
<td>Email, conference calls</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Document the evaluation and its findings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Audience 5: Other state public health direct service, asthma and chronic disease programs

<table>
<thead>
<tr>
<th>Applicable?</th>
<th>Purpose of Communication</th>
<th>Possible Formats</th>
<th>Timing/Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Include in decision making about evaluation design/activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Inform about specific upcoming evaluation activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Keep informed about progress of the evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Present initial/interim findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Present complete/final findings</td>
<td>Email</td>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Russ-Eft and Preskill, 2001, pp. 354–357.

**Timeline**

Planning and administrative tasks occurred during the initial design of the PSMC and will be reviewed and revised quarterly or as needed. No pilot testing will occur, although progress report templates will be updated as necessary to capture appropriate data.

Data collection and analysis will occur biannually. Progress reports will be submitted and reviewed annually.

Information dissemination will occur at the conclusion of the evaluation in the final quarter of Year 5 and in the 60 days after project close. At that point, evaluation findings will be reviewed.
and necessary changes to the PSMC curriculum will be made. The OAP, OPCA, clinics and other partners will discuss next steps for the project based on the evaluation findings and will develop a plan to implement next steps.

There are no foreseeable bottlenecks or sequencing issues, as the PSMC has been scaled to allow for a sufficient evaluation period.

**Evaluation Budget**
Staff time at both the OAP and OPCA will be used to conduct the evaluation activities. An additional $15,000 has been allocated for the video documentation portion of the evaluation.
Appendix E: Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)\textsuperscript{1,2,3}

You can view the original tool on the Diabetes Initiative website: www.diabetesinitiative.org

Note: Oregon Primary Care Association is using the PCRS tool in a modified form. We have adapted revisions to the PCRS with the permission of the author, Carol Brownson, March, 2012

You can view the original tool on the Diabetes Initiative website: www.diabetesinitiative.org

\textsuperscript{1} http://diabetesinitiative.org/lessons/tools.html


Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

**Background and User Guide**

**Purpose**

This survey was developed by the Advancing Diabetes Self Management (ADSM) Program of the Robert Wood Johnson Foundation Diabetes Initiative. The ADSM grantees wanted a tool that would further delineate and facilitate assessment of the self-management component of the Chronic Care Model. The purpose of the PCRS is to help primary care settings focus on actions that can be taken to support self-management by patients with diabetes and/or other chronic conditions.

**The PCRS tool in the modified format will…..**

1. Function as a self-assessment, feedback and quality improvement tool
2. Characterize optimal performance of providers and systems as well as gaps in resources, services and supports
3. Promote discussion among patient care team members that can help build consensus for change and plans for improvement

**Who should use this tool?**

This tool was developed for primary health care settings interested in improving self-management support systems and service delivery. It is to be used with multi-disciplinary teams (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that work together to manage patients’ health care.

**Why another assessment tool?**

The PCRS can be used along with other tools such as the Assessment of Chronic Illness Care (ACIC). While it is consistent with and complementary to the ACIC, the PCRS focuses exclusively and more comprehensively on self-management support. Using the PCRS to initiate quality improvement processes should lead to improved patient and staff competence in self-management processes and improved behavioral and clinical outcomes among patients.

**How is the PCRS organized?**

---

Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

The survey tool in this modified format consists of 11 characteristics of self-management support that are separated into two categories: patient support and organizational support. (Definitions provided in the Appendix). Below the characteristic name are descriptions of four levels of performance from lowest on the left (D) to highest on the right (A).

- **D** is the lowest level; it is an indication of inadequate non-existent activity.
- **C** pertains to the patient-provider level. At this level, implementation is sporadic or inconsistent; patient-provider interaction is passive.
- **B** pertains to the team level. At this level, implementation is done in an organized and consistent manner using a team approach; services are coordinated.
- **A** is the highest level; it assumes the B level plus system-wide adoption and integration of that aspect of self-management support, along with having a system in place that measures specific self-management goals.

With the exception of level D, each level has three numbers from which to select. This allows team members to consider to what degree their team is meeting the criteria described for that level; that is, how much of the criteria and/or how consistently their team meets this criteria.

**Using the results:**

- It is recommended that the team meet to review the tool, complete the assessment and share comments, insights and rationale for scores.
- Discussion should NOT be focused on “right” or “wrong”, but rather why various ratings were given. The value of this tool is not in the number the team assigns, but in the improvement process that is initiated by discovery of discrepancies or gaps in capacity.
- Based on the discussion and consensus among members, teams may chose to develop quality improvement plans in one or more areas of self-management support.
Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D</td>
</tr>
<tr>
<td>1. Patient Self-Management education and problem solving skills</td>
<td>...does not occur</td>
</tr>
</tbody>
</table>

|                | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Appendix F
## Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

### I: Patient Support/Patient Centered Care/Interactions

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D</td>
</tr>
<tr>
<td><strong>2. Goal Setting/Action Planning</strong></td>
<td>...is not done</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>3. Patient Empowerment and engagement</strong></td>
<td>...does not occur</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
# Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

## I: Patient Support/Patient Centered Care/Interactions

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Link to Community Resources</td>
<td>D</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A (=all of B plus these)</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

- **D**: ...does not occur
- **C**: ...is limited to a list or pamphlet of contact information for relevant resources
- **B**: ...occurs through a referral system; team discusses patient needs, barriers and resources before making referral
- **A**: ...systems are in place for coordinated referrals, referral follow-up and communication among practices, resources, organizations and patients

## II. ORGANIZATIONAL SUPPORT

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continuity of Care</td>
<td>D</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Foundational PCPCH Element)</td>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A (=all of B plus these)</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **D**: ...does not exist
- **C**: ...is limited; some patients have an assigned primary care provider (PCP); planned visits and routine lab work occur sporadically
- **B**: ...is achieved through assignment of patients to a PCP or designated primary care team member, scheduling of routine planned visits with appropriate team members, and involvement of most team members in ensuring patients meet care guidelines
- **A**: ...systems in place to support continuity of care, to assure all patients are assigned to a provider or team member, to schedule planned visits and to track and follow up on all patient visits and labs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Quality Levels</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Coordination of Referrals to</td>
<td>D</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td>9</td>
<td>10</td>
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- **D**: ...does not exist
- **C**: ...is sporadic, lacking systematic follow-up,
- **B**: ...occurs through team and office staff working together to document,
- **A**: ...is accomplished by either provision/referral to self-
## Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

### II. ORGANIZATIONAL SUPPORT

(Circle one NUMBER for each characteristic)

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<thead>
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<td>(Foundational PCPCH Element)</td>
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<td>4. Systems for Documentation of Self-Management</td>
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## Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

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5. Integration of Self-Management Support into primary care (Foundational PCPCH Element)

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6. Patient care delivery team (internal to the practice) (Foundational PCPCH Element)

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7. Education & Training

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### II. ORGANIZATIONAL SUPPORT (Circle one NUMBER for each characteristic)

<table>
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<td>C</td>
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Appendix: Definitions of self-management support characteristics in the PCRS

**PATIENT Centered Care/ Interactions**

1. **Self-management education**: An interactive, collaborative and ongoing process of providing information and instruction to support people’s ability to successfully manage their health condition, their daily life activities, and the emotional changes that often accompany having a chronic condition.
Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

2. **Collaborative goal setting/Action Planning:** The process of providers and patients working together on identifying something the patient wants to accomplish and agreeing on a plan for getting started. Well formulated goals are “SMART” (Specific, Measurable, Action-oriented, Realistic, and Time-limited).

3. **Patient Empowerment and engagement:** Patient involvement means that patients--and their families--are involved in planning and making decisions about the patient’s health care. In this approach, patients are viewed as key members of the health care team and have access to useful information to promote health and manage disease. Patient involvement implies shared decision making about care and ensuring that the patient’s values guide all clinical decisions.

4. **Link to community resources:** Community resources include programs, services, and environmental features that support self-management behaviors. Programs and services that support self management may be available through community agencies, schools, faith-based organizations or places of work.

**ORGANIZATIONAL SUPPORT**

1. **Continuity of Care:** The coordination and smooth progression of a patient’s care over time and across disciplines. Continuity of care is supported by systems that use a team approach to care, schedule planned visits and follow up on visits and lab work.

2. **Coordination of referrals:** Effective collaboration and communication among primary care providers and specialists. Coordination of referrals is supported by systems that track referrals, monitor incomplete referrals, and ensure follow-up with patients and/or the specialists to complete referrals.

3. **Ongoing Quality Improvement:** The process of using data on a regular basis to identify trends, undertake processes to improve aspects of service delivery, and measure the results. Patient care teams often use the Plan, Do, Study, Act (PDSA) rapid cycle improvement process to facilitate the improvement process.

4. **System for Documentation of Self-Management Support Services:** Standardized processes used by members of the patient care team to record patient self-management goals and progress notes into patient charts (or electronic medical records) and routinely monitor their progress.

5. **Integration of Self-Management Support into Primary Care:** Integration occurs when self-management support is a fundamental and routine part of all chronic illness care, and is visibly supported by leadership.
Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

6. **Patient Care Team:** A patient care team is a multidisciplinary group (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that works together to manage a patient's health care.

7. **Physician, Team and Staff Self-Management Education & Training:** Opportunities for members of the patient care team to increase their knowledge and improve skills and practices for improving self-management support. Health care systems can support continuing education and training by setting an expectation for excellence, offering training to all team members, ensuring that new team members have access to orientation and training, assessing and monitoring performance and providing incentives for the adoption of new practices and skills.
Appendix F: PSMC Clinic Measures

1. **Goal: commitment to a culture of shared decision making and promotion of patient self-management principles; self-management policies and protocols established and integrated.**
   a. % of patients in a population of focus (POF) with documented self-management (SM) goals at the most recent clinical visit
   b. % of patients with diagnosis of asthma with documented SM goals at the most recent clinical visit
   c. Increasing scores in CHC identified priority domain(s) of the Assessment of Primary Care Resources and Supports for Chronic Disease Self-Management (PCRS)
   d. Commitment to a culture of patient self-management: 50% of the following in place by August, 2014:
      i. the organization’s vision and mission statement
      ii. training and orientation of current and new staff
      iii. job descriptions
      iv. staff performance metrics

2. **Goal: Improved patient-centered communications**
   a. % of pilot care team staff who attended a face to face motivational interviewing training
   b. % of care teams that incorporated the Mauksch Patient Centered Observation Form (PCOF) into clinic practice and administered the assessment (within each “teamlet”) at least 2 times per year
   c. % of care teams that utilize the Patient Activation Measure (PAM)

3. **Goal: Improved patient-driven participation in self-management programs.**
   a. % of patients who are both in the POF and identified as tobacco users who are referred to the Oregon Tobacco Quit Line
   b. % of patient who are have a diagnosis of asthma and are identified as tobacco users who are referred to the Oregon Tobacco Quit Line
   c. % of patients who are in the POF and are identified as tobacco users and have been referred to the Oregon Tobacco Quit Line, who have a closed loop referral.
   d. % of “closed loop” referrals to Living Well or Tomando Control programs

4. **Goal: Improved health outcomes**
   a. % of patients aged 18 and over queried about any and all forms of tobacco use
   b. % of identified tobacco users aged 18 and over who received tobacco cessation intervention
Appendix G: Key Informants and Interview Questions

Key Informants

- Yutonah Bowes, Northwest Human Services
- Lola Hackett, Northwest Human Services
- Erin Kirk, OHSU Richmond Clinic
- Erin Moller, Yakima Valley Farm Workers Clinic
- Sylvia Ness, Multnomah County Clinics
- Ida Saito, La Clinica del Valle
- Kelly Volkmann, Community Health Centers of Benton and Linn Counties
- Rebecca McBee Wilson, Lincoln Community Health Center

Key Informant Interview Questions

- How did participation in the PSMC change clinic practices and priorities related to self-management support?
- What have been your biggest wins?
- Did referrals to self-management programs and the Quit Line increase? Decrease? Stay the same?
- Did participation enhance your organization’s progress toward medical home recognition? Which aspects contributed most strongly?
- What elements of the PSMC made the biggest impact on sustainable changes in support of in-clinic self-management and community-clinic linkages (referrals)?
- What has been the response from staff and providers? Patient response?
- What was your clinic’s experience with the PCRS tool? Was it helpful?
- What impact has participation in the PSMC had on team-based care? Culture change? Spread to multiple teams/clinics?
- Did changes that your team made during the PSMC spread to other clinic teams? To other locations?
- Do you think the work you’ve done in this area (increased focus on self-management support, motivational interviewing, etc.) is sustainable? How will it be sustained?
- What were the major barriers to sustainable change in your organization related to self-management, and how might they be overcome in the future?

- What’s the future of self-management support and patient centered care at your FQHC? What resources are needed to continue this work, and what organization(s) should lead it?

- Is there anything else you’d like to share about your experience?
Appendix H: Sample Referral Protocols

Multnomah County Oregon Tobacco Quit Line Referral and Internal Counseling Process

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Evidence shows that brief clinical interventions are effective, as are state run Quit Lines that provide more in depth coaching and support for quitting\textsuperscript{14}.

The Oregon Tobacco Quit Line counseling & referral process is for our clients who are ready to talk about cutting back or quitting tobacco and would like some help doing so. Once referred, Quit Line staff will attempt to contact our client several times to get them into their services. The Quit Line will send us a report 1 month after referral to notify us of what the outcome of the referral is at that point.

Process Overview:

\textsuperscript{14} Treating Tobacco Use and Dependence Clinical Practice Guideline, U.S. Department of Health and Human Services, Public Health Service, May 2008
**Process Details**

**Step 1: Tobacco Screening**

Person rooming the patient determines patient readiness to quit, documents, orders and pends referral.

---

**Tobacco Cessation Referral and Counseling Details (Step 1)**

- **Ask** “Do you use tobacco?”
  - If **yes**
    - **Assess** “Would it be okay to talk about cutting back?”
      - If **yes**
        - **Document** “Tobacco Use” in Vitals in Epic
      - If **no**
        - Document 1. ‘Ready to Quit’ = “Yes” in Epic Vitals
        - Document 2. ‘Mark as Reviewed’

- **Order & Pend Referral**
  - “I will let your provider know”

---

a) **Person rooming the patient asks if they use tobacco. The answer is documented in the vitals section of the chart.**
Person rooming the patient asks if it would be okay to talk about cutting back. If the patient answers, “yes” this is indicated in the vitals section of the chart (as ready to quit). If the patient answers, “no” this is indicated in the vitals section of the chart (as not ready to quit).

Person rooming the patient clicks on ‘Mark as Reviewed’ when they are finished.

b) Person rooming the patient Orders and Pends a referral to the Oregon Quit Line using referral #9077 for ‘smoking cessation’.
c) Person rooming the patient uses smartphrases .MCRTQ or .MCNRTQ in ‘progress notes.’

\[ .MCRTQ = \text{“patient ready to discuss options for quitting”} \]

\[ .MCNRTQ = \text{“patient declines discussing options for quitting”} \]

**Step 2: Provider counsels patient on quitting use of tobacco products; Provider documents counseling in Vitals & Progress Notes.**

### Tobacco Cessation Referral and Counseling Workflow (Step 2)

**YES**
- **Patient wants to talk about tobacco use**

**Advise**
- "I'm so glad you decided to quit smoking! Let's talk about your choices for medication and coaching."

**Assist**
1. **Medication**
   - Share information about their options for medication to help them quit.
2. **Counseling**
   - "It can be really helpful to have someone coach and support you when you quit. The Tobacco Quit Line has great, free coaching services I'd like to refer you to. Would it be okay if someone from the Quit Line calls you?"

**Arrange**
- Sign the pended Quit Line referral
- OR (if they decline Quit Line but still want to quit)
- Arrange for you or a team member to follow-up during the first week and again during the first month after quit date.

**Document**
1. Counseling Given "Yes" in Epic Vitals
2. Use tobacco to document how counseling was given in Epic Progress Notes

**NO**
- **Patient does not want to talk about tobacco use**

**Advise**
- Counsel patient on their use of tobacco.

**Minimum**
- "Quitting tobacco is one of the most important things you can do to protect your health. We will keep checking with you to see when you are ready to talk about cutting back."

**Best Practice**
- Use motivational enhancement to help patient move from pre-contemplation to Action

**Document**
1. Counseling Given "Yes" in Epic Vitals
2. Use tobacco to document how counseling was given in Epic Progress Notes

**Sign pended referral**

**Cancel pended referral**
Provider documents counseling in Vitals:

Provider documents how counseling was giving in Progress Notes:

- Type .tobacco and choose ‘referred to Stop Smoking Clinic / Program’ or ‘provided smoking cessation counseling’

**Note:** Even if patient is not interested in quitting or cutting back at this time, counseling should still be provided per workflow above.
Step 3: Patient agrees to Quit Line referral and provider signs the

a) If patient does not agree, the referral process **stops** here and is documented in progress notes. OR

b) If the patient does agree, provider **signs the order** and process is documented in progress notes.

c) If the patient agrees, but does not want to work with Oregon Quit Line, the provider makes arrangements to follow-up with the patient at 1 week and 1 month.

**Note:** Inform patient that if they are covered by Family Care insurance, they are required to do the Quit Line coaching to receive more than 14 days of medication to help them quit.
Quitline Referral Processing

Tobacco Cessation Referral and Counseling Workflow (Steps 4, 5 & 6)

- Oregon Quitline Referral appears in queue
- Print fax referral (19021) from letter templates
- Have patient — initial & sign letter — circle best times to be contacted
- Share report with provider & panel manager
- Close Referral once report is received
- Fax letter to Quit Line 1-800-483-5114

Step 4: TCA completes Quit Line referral letter with patient

TCA sees referral order for the Quit Line which prompts them to:

a) **Fill in** and **Print** Oregon Quit Line fax referral letter 19021 from letter templates
b) **Before the patient leaves, the TCA has the patient **initial & sign** the letter and **circle best times to be contacted** on the form
c) Make sure patient knows that if they are covered by Family Care insurance, they are required to do the quit line coaching to receive more than 14 days of medication to help them quit. The provider should already have told them this.
TCA faxes referral letter to the Oregon Quit Line at the # on the form (1-800-483-3114).
Oregon Tobacco Quitline works with patient. They provide report on progress 1 month after they receive the referral.

Step 6: TCA receives report, closes referral & gives report to provider and panel manager

The Oregon Quit Line may still be working with the patient but the referral is closed upon receiving the 1 month report. If the 1 month report is not received the TCA should contact the state Tobacco Prevention & Education program
Example of Fax Referral Reports

Fax Referral Reports

Clinic

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<th>Pending</th>
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<th>Already Enrolled</th>
<th>Not Reached</th>
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<th>Current Received</th>
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Step 7: Panel Manager enters details in problem list

The report includes details such as whether the patient was reached and if they enrolled or declined services. These details should be included in the problem list for the patient.

**If you have updates or questions regarding this Job Aid, contact Health Promotion Coordinator Sylvia Ness (sylvia.ness@multco.us, ext. 25445)**
Self-Management Referral Pathway

**Client with self-management needs has appointment at CHC**

- BCHS staff makes self-management referral in OCHIN (could be provider or medical assistant)

**Referral goes to Health Navigator (HN)**

- HN contacts patient and refers to program(s):
  - HN changes referral status to "in progress"
  - All progress notes will be recorded in referral order

**Class facilitator sends report of class completion to HN**

- HN documents completion of class in OCHIN referral form

**To close the loop back to the PCP: HN sends PCP a note in OCHIN about class completion**

**In OCHIN/EHR:**
- Staff opens referral from "preference list"
- Selects "Internal referral to health navigator"
- Selects: LW, TC, or Quit Line/tobacco Cessation programs

**HN runs referral report on weekly basis:**
- Filters to run only "internal referrals" by provider
- Referral status will default to "new request"

**HN gets program result and PNF from LW/TC coordinator and Quitline report from Quitline coach:**
- Notes and PNF to be sent to Rocio
- Rocio to fwd E. Linn patient info to Fabiola
- HN enters info into OCHIN using dot phrase
- Referral status is changed to "closed"

**Acronym Key:**
- CHC – Community Health Center
- BCHS – Benton County Health Services
- HN – Health navigator
- OCHIN – Electronic medical records system
- PCP – Primary care provider
- LW/TC = Living Well with Chronic Disease/Tomando Control de su Salud
- PNF – Provider Notification Form

BCHS, Feb 2011
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