# Patient Activation for Health

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Wallowa Valley Center for Wellness
"Supporting Community Wellness"

Winding Waters Clinic
P.C. Physicians & Surgeons
Improving the Health of Our Community

# The Full Title: Wallowa County Patient Activation Project: A Collaborative Community Effort to Improve Patient Self Efficacy Through Behavioral Health Coaches in a Primary Care Setting.

# PARTNER ROLES:

**Northeast Oregon Network**

- Tri County Rural Health Collaborative
- Grantee
- Project Management
- Grant Management
- Evaluation

**Wallowa Valley Center for Wellness**

- Community Mental Health Center
- Residential Group Homes
- Outpatient Addiction Treatment Services
- Assertive Community Treatment
- Provided the Behaviorist staffing

**Winding Waters Clinic**

- New Federally Qualified Health Center
- Tier III Patient Centered Primary Care Home
- Provided the practice implementation site

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# Northeast Oregon Network

We are a 501(c)3 health collaborative serving Union, Wallowa and Baker Counties, a frontier region in Northeast Oregon. We are an integrated vertical network.

Our mission is to increase access to and quality of integrated health care for all Northeast Oregon residents by identifying system gaps, facilitating community developed solutions, and advocating for heath policy change.

# NEON Programs

- Behavioral Health/Primary Care Integration Patient Activation Project
- Outreach and Enrollment and Coverage Education Program
- Self Health Management Programs
- Local Health Systems Planning and Project Facilitation Work
- Pathways Community Hub

# Background

- Wallowa County has elevated mortality from lifestyle preventable causes such as Heart Disease, COPD, Flu/Pneumonia, and alcohol abuse compared to state and nation wide rates.

| Comparing Total and Cause Specific Death Rates in Wallowa County (rates per 100,000) | | | | |
|---|---|---|---|---|
| | Wallowa | Rural OR | OR | US |
| Total Death Rate | 1,065.8 | 997.8 | 841.6 | 793.7 |
| Heart Disease Death Rate | 275.8 | 210.1 | 169.4 | 195 |
| COPD Death Rate | 80.4 | 63.8 | 48.8 | 44.7 |
| Flu/Pneumonia Death Rate | 25.9 | 15.8 | 13.5 | 17.2 |
| Alcohol Induced Death Rate | 17.2 | 16.7 | 13.8 | N/A |

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# Background

- The Winding Waters Clinic is a part of a community wide collaboration with Wallowa Valley Center for Wellness and Northeast Oregon Network (NEON) that was awarded a Health Resources Services Administration quality improvement grant in an attempt to sustainably improve outcomes of lifestyle preventable disease through the use of clinical behavioral health coaches.

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# Patient Activation Construct

- What is your experience in engaging patients for activation?

- Patient activation-a measure of a patient's knowledge, skills and ability to make effective decisions to manage their health-relates to healthy behavior choices, appropriate use of health care, chronic disease control, and improved disease specific outcomes.

# Objectives

1. Promote improved health outcomes, lifestyle behavior change, and increased patient self-efficacy through the utilization of patient activation interventions provided by behavioral health coaches in a primary care setting.
2. Utilize LEAN and Team STEPPS continuous quality improvement principles and practices to optimize our intervention of the three year grant period.
3. Work with payers to find sustainable long-term fudning for our behavioral health coaches by the end of our three year grant period.

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# Measures

- Patient Activation is measured using the Patient Activation Measure (PAM) questionnaire.
- Health outcome impact is measured by hemoglobin A1c, blood pressure, LDL, BMI and Tobacco Use compared to pre-intervention baseline at six-month intervals.

# QI: What Didn't Work

- PAM Measurement Not Working Effectively to Date!
- Unless a measure is integrated into the EHR, it will not get effectively administered, scored and counted.
- There are many business, cost and legal barriers to incorporating tools into EHRs.
- It took a larger collaboration state wide to get it integrated into the EHR.
- It is finally there and we can report on it, but now have to build the readministration work flows in the EHR.
- We hope to have a year's worth of data to analyze by project end.

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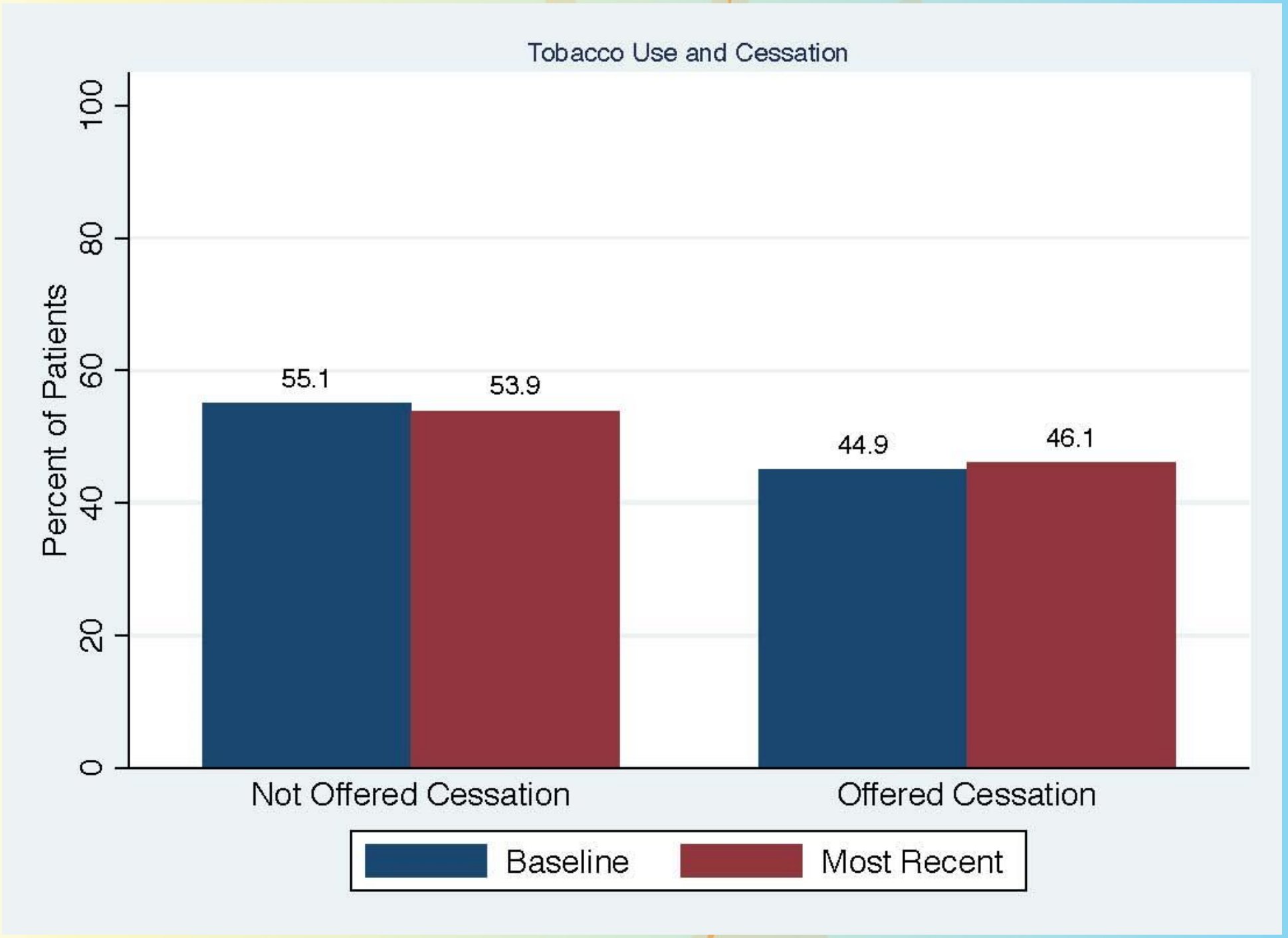
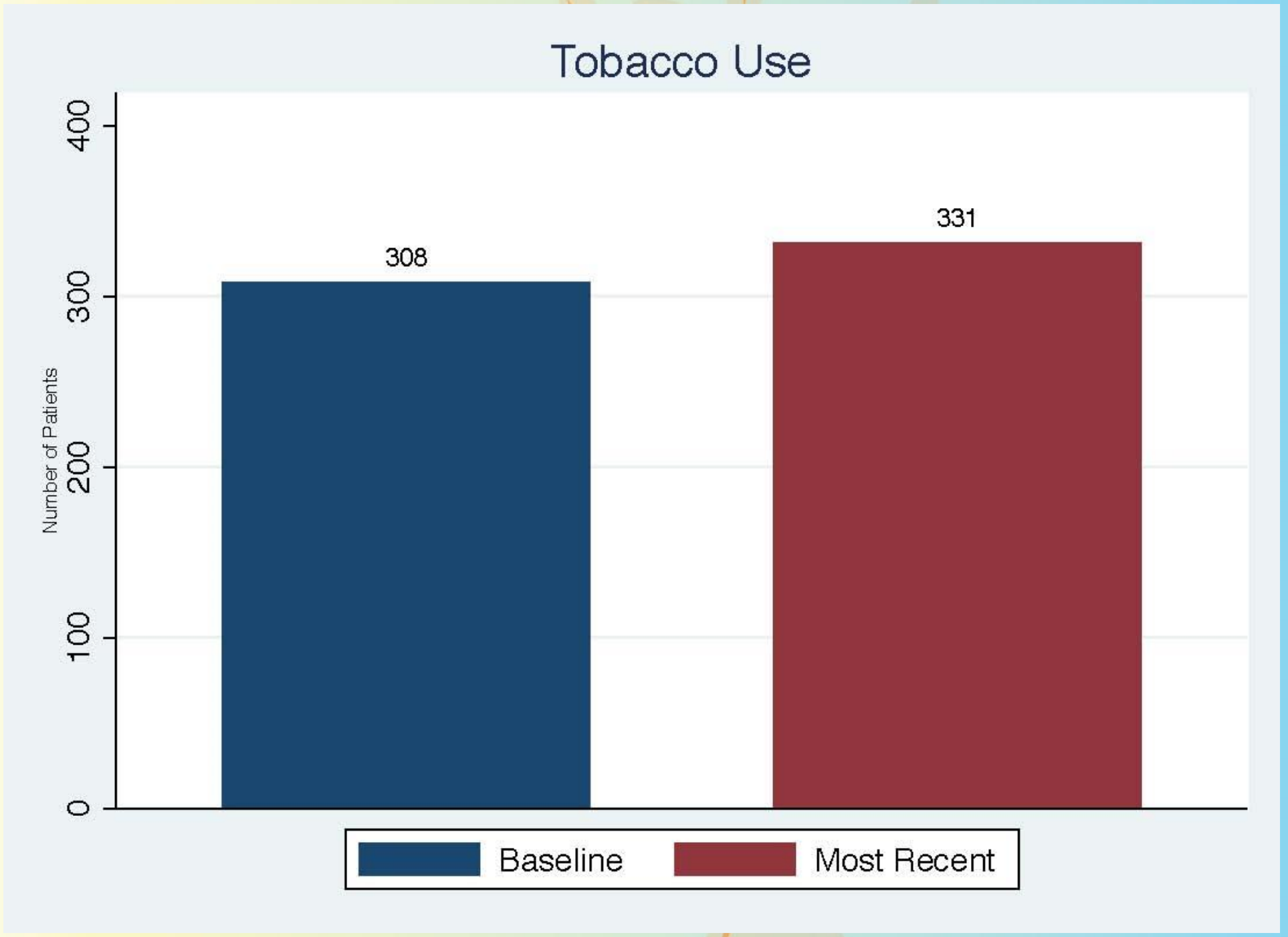
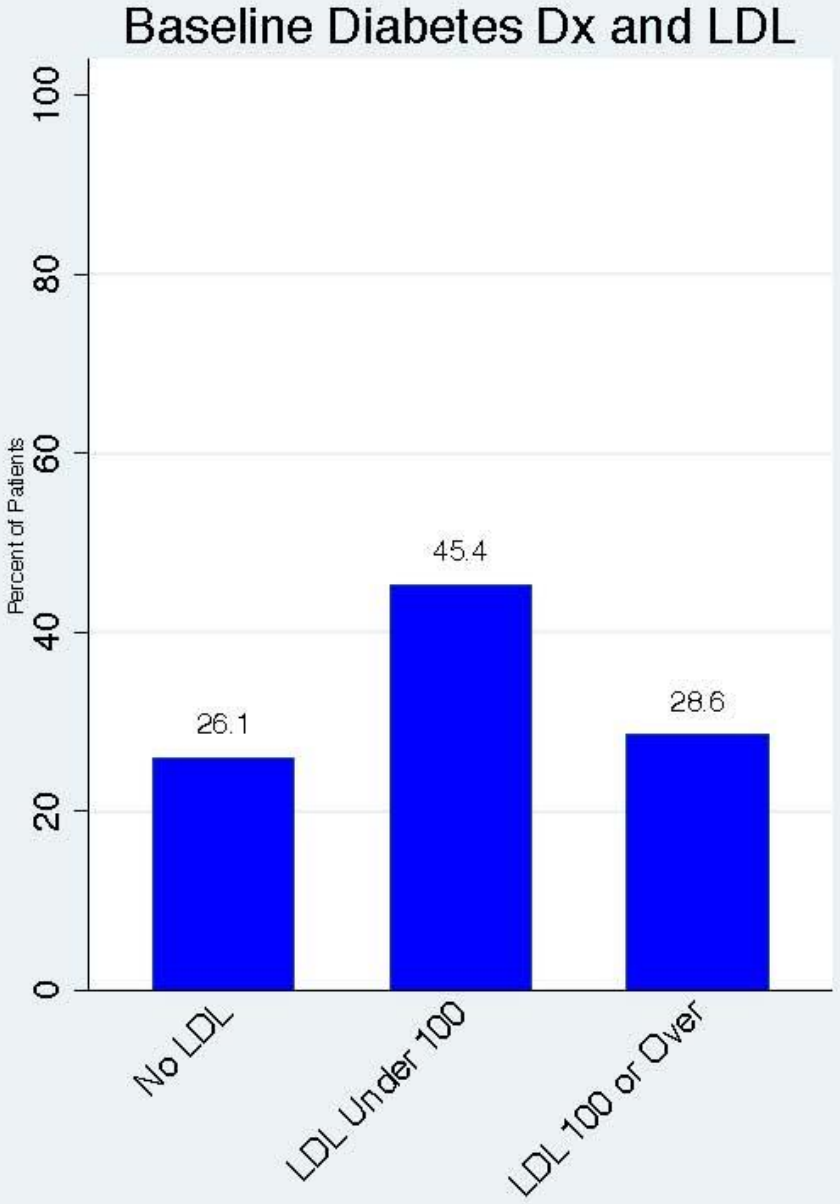
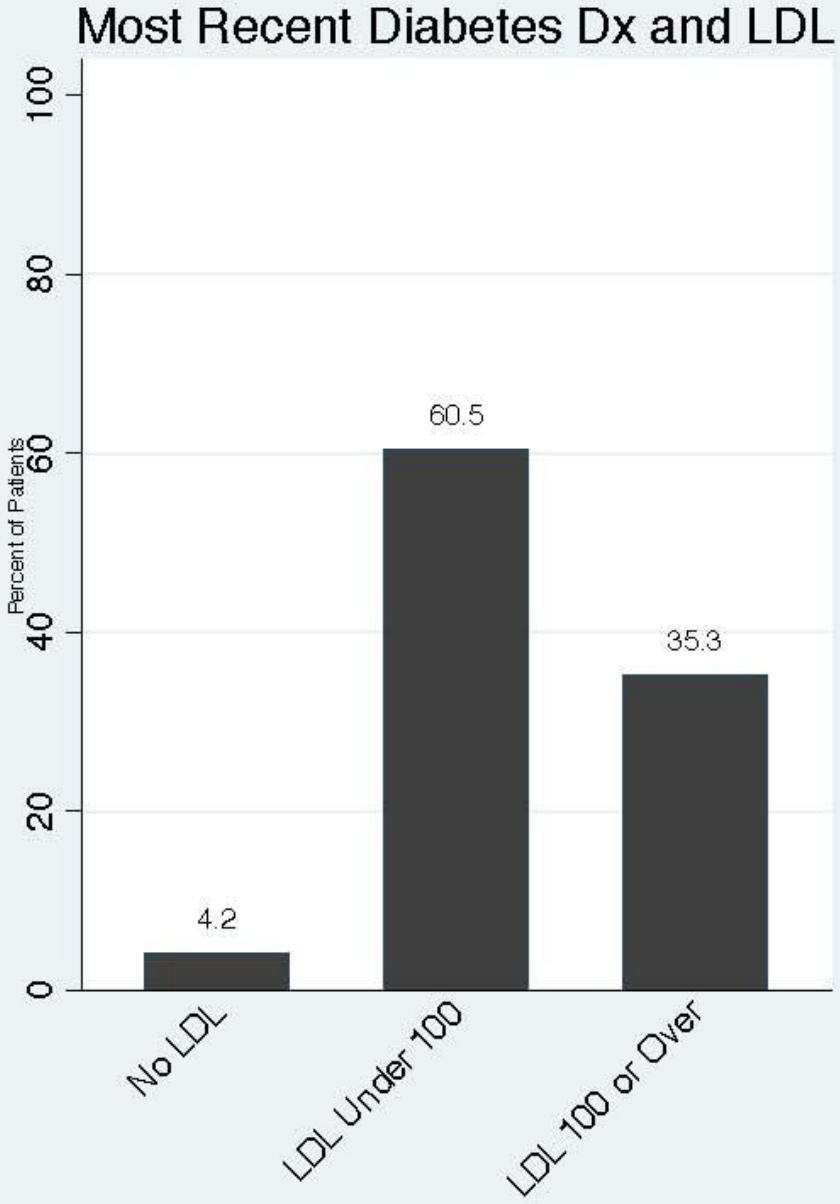

Tobacco Use and Cessation
Percent of Patients
0
20
40
60
80
100
55.1
53.9
44.9
46.1
Not Offered Cessation
Offered Cessation
Baseline
Most Recent


Tobacco Use
Number of Patients
0
100
200
300
400
308
331
Baseline
Most Recent

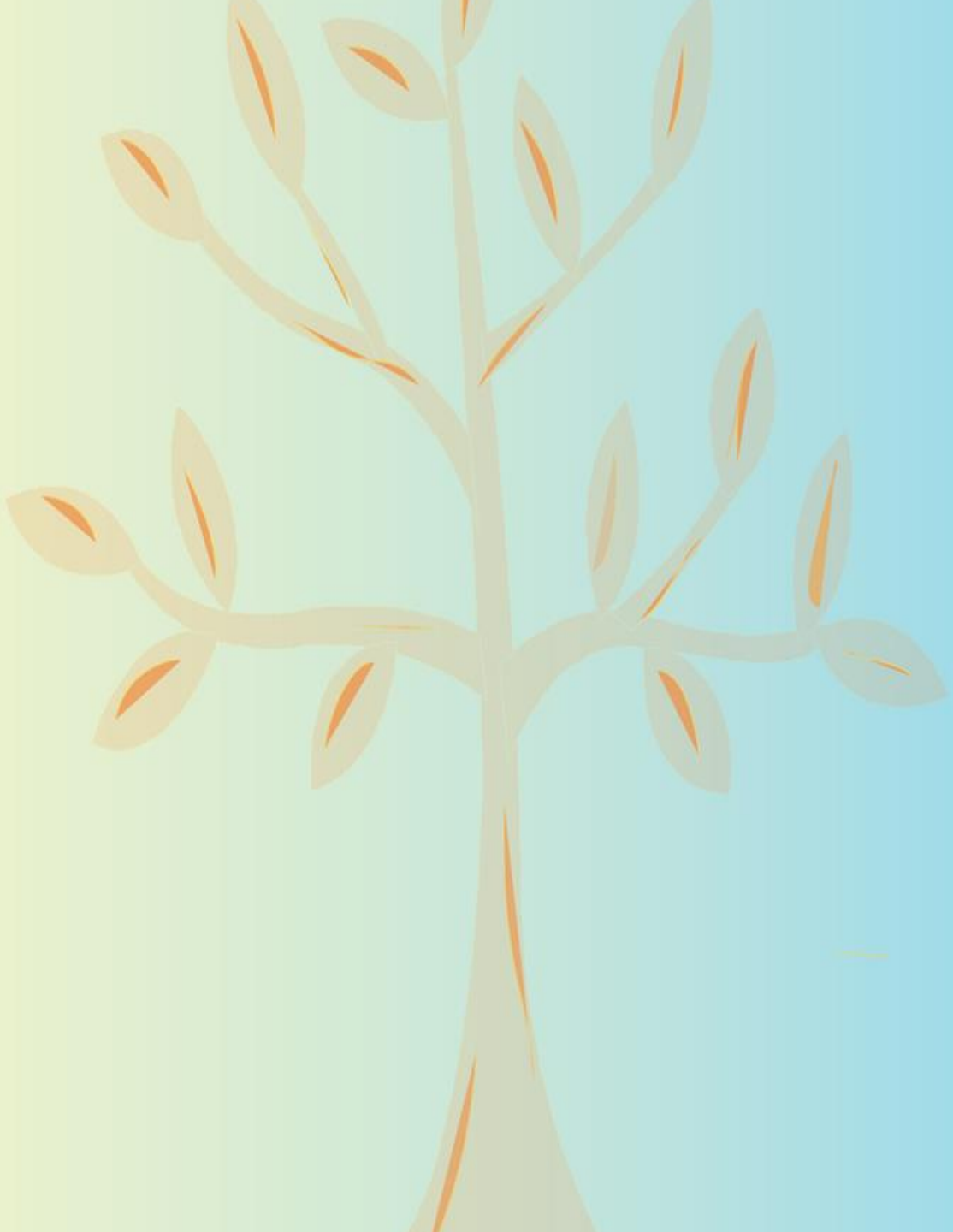
# QI: What Did Work

- We are able to measure things using clinical data collected during the course of routine care.
- Identification of measures, such as A1C and LDL, that were not being administered as frequently as they should be.
- With focus on the lab testing work flow, rates of administration improved.
- Team STEPPS methods were utilized well by team members to problem solve, especially as we ramped up implementation.

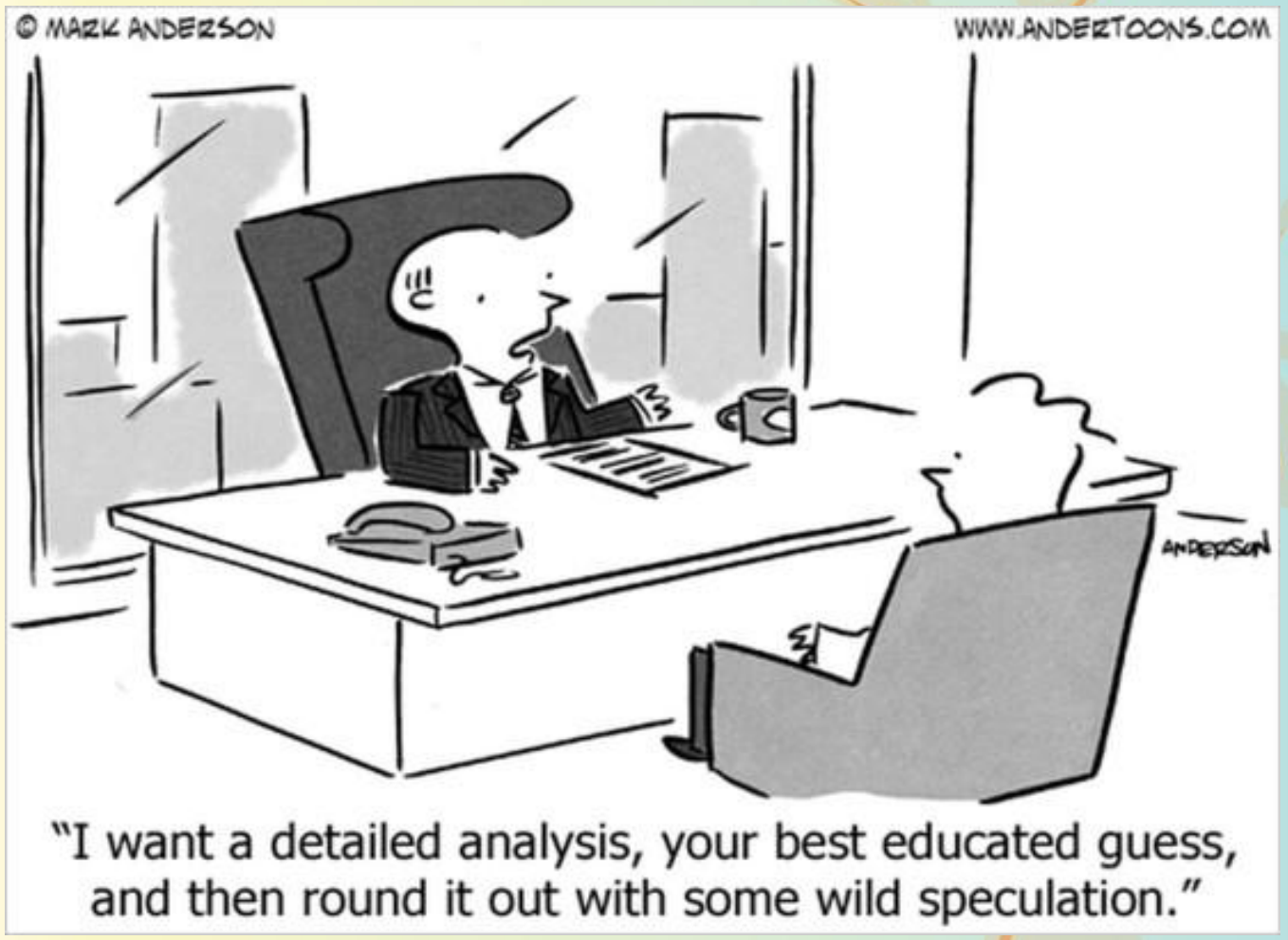

Baseline Diabetes Dx and LDL
Percent of Patients
0
20
40
60
80
100
26.1
45.4
28.6
No LDL
LDL Under 100
LDL 100 or Over


Most Recent Diabetes Dx and LDL
Percent of Patients
0
20
40
60
80
100
4.2
60.5
35.3
No LDL
LDL Under 100
LDL 100 or Over

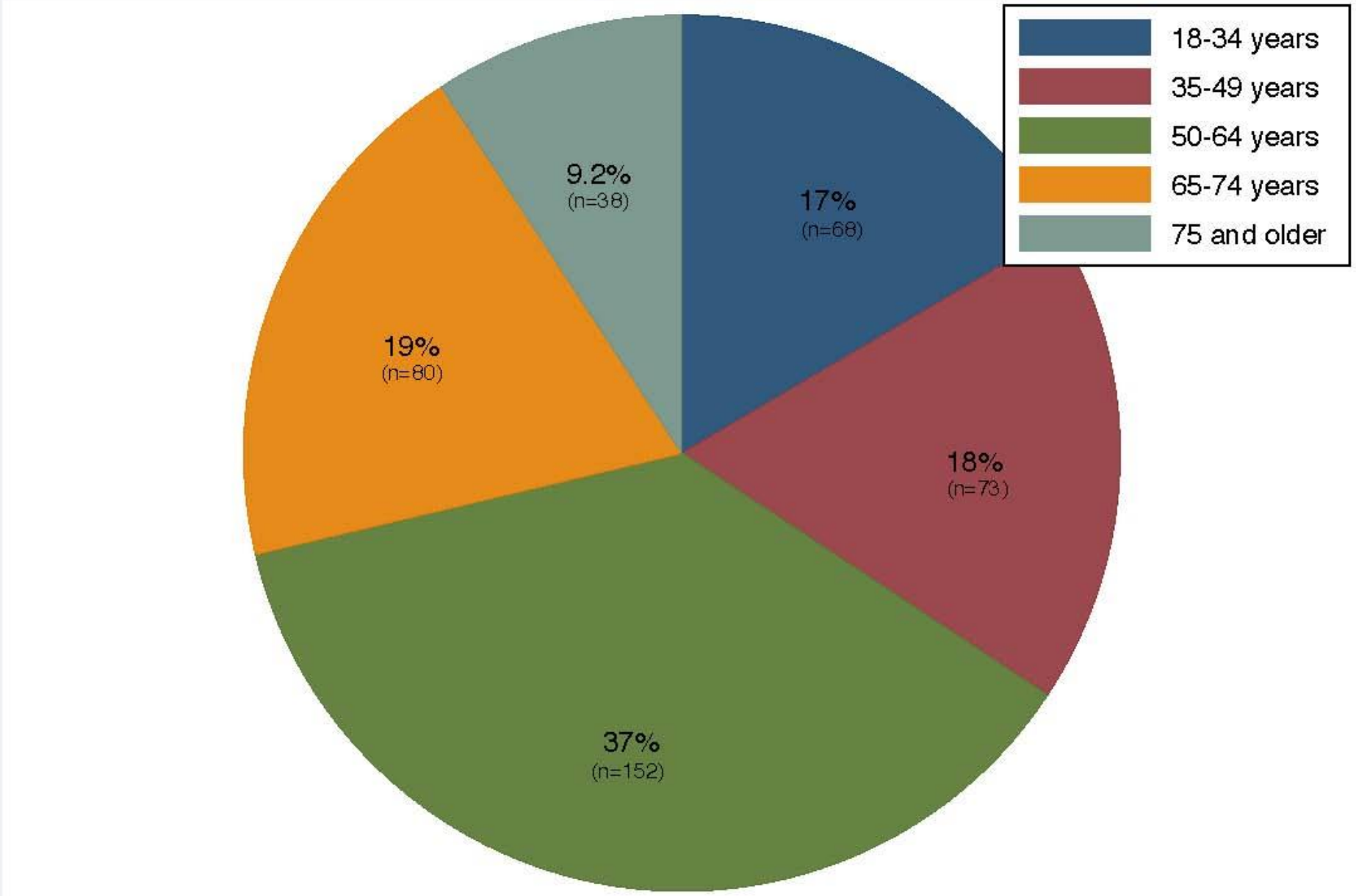
# The Data



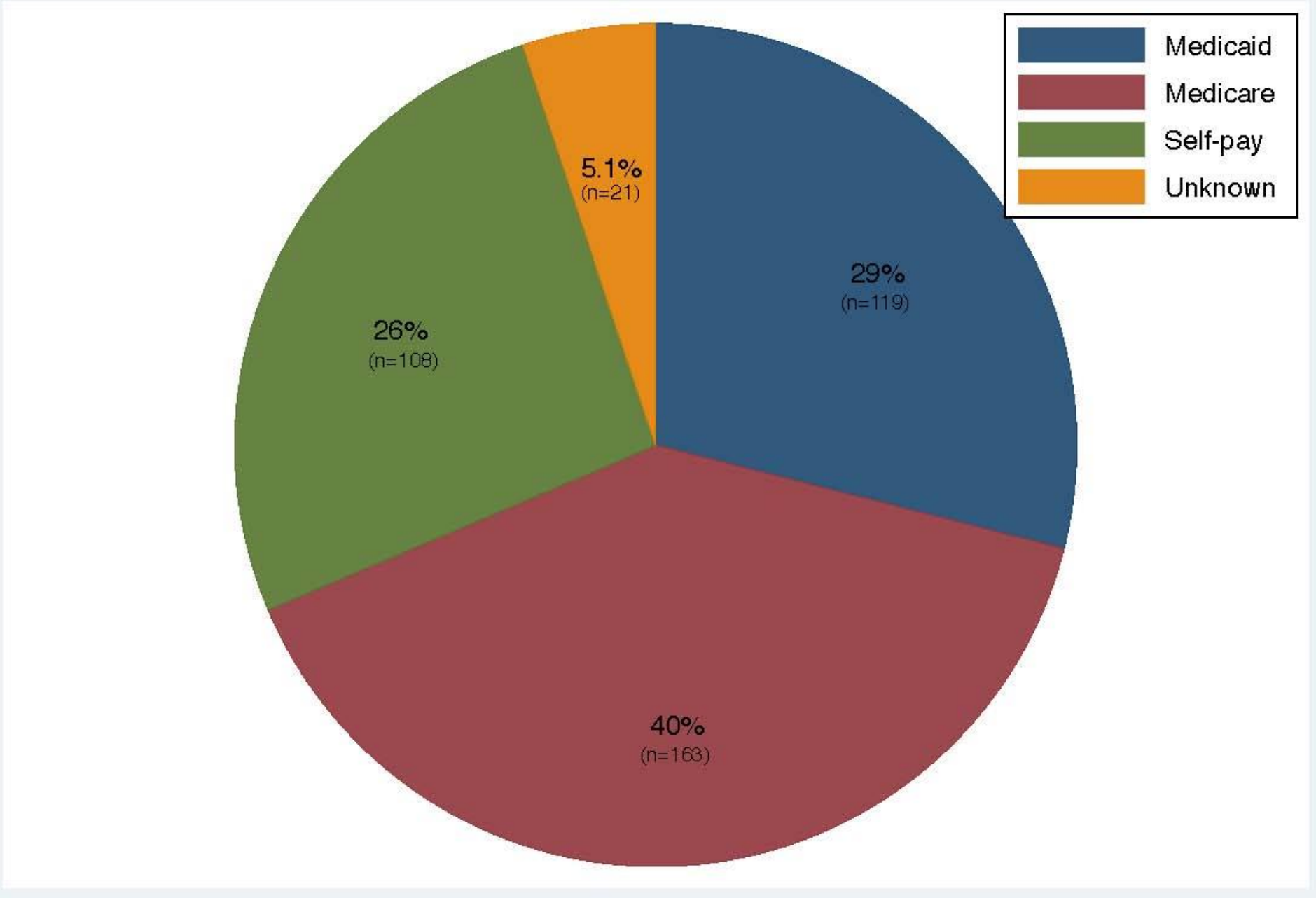
# Be very careful to state your assumptions clearly and openly.

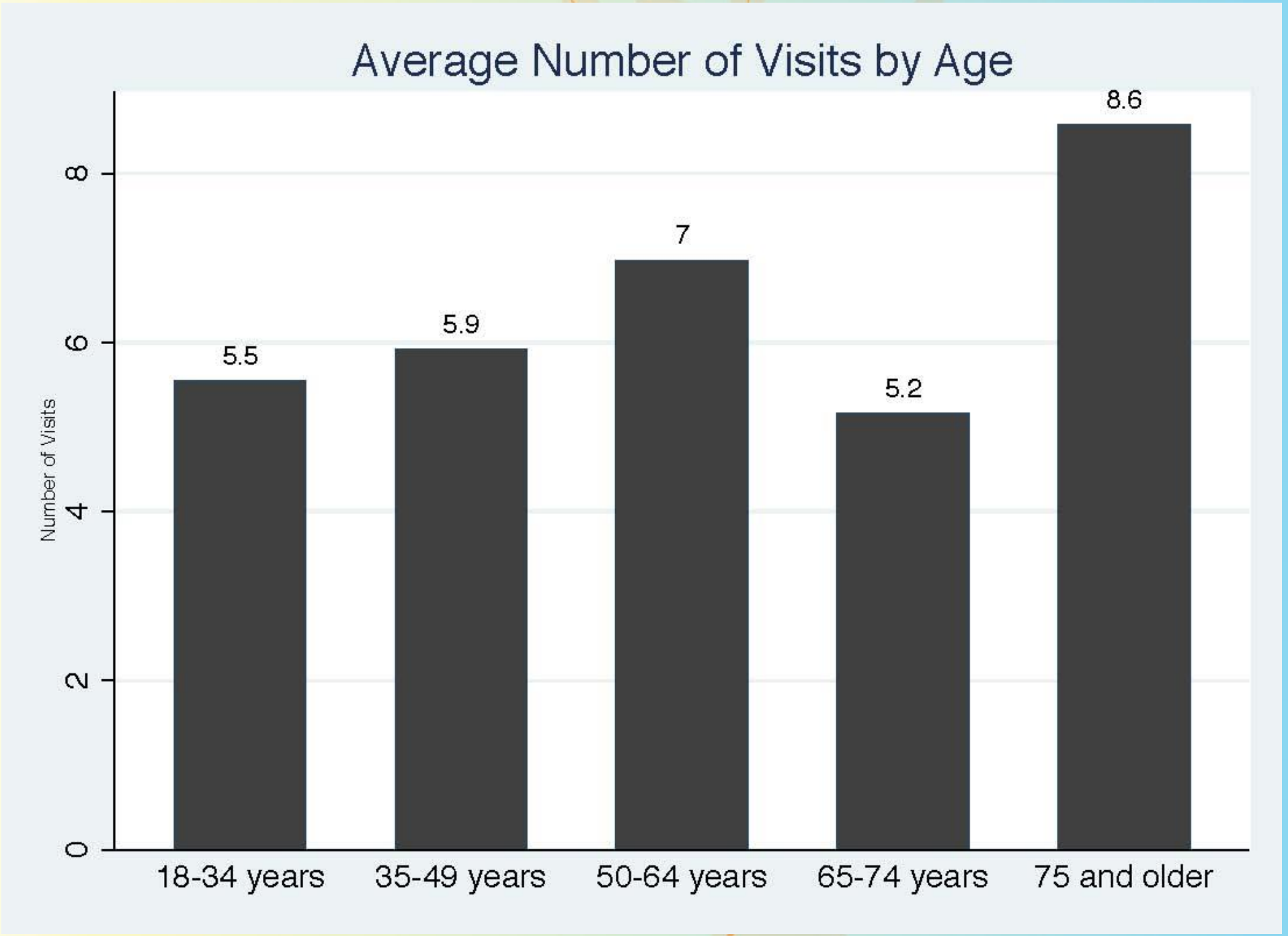


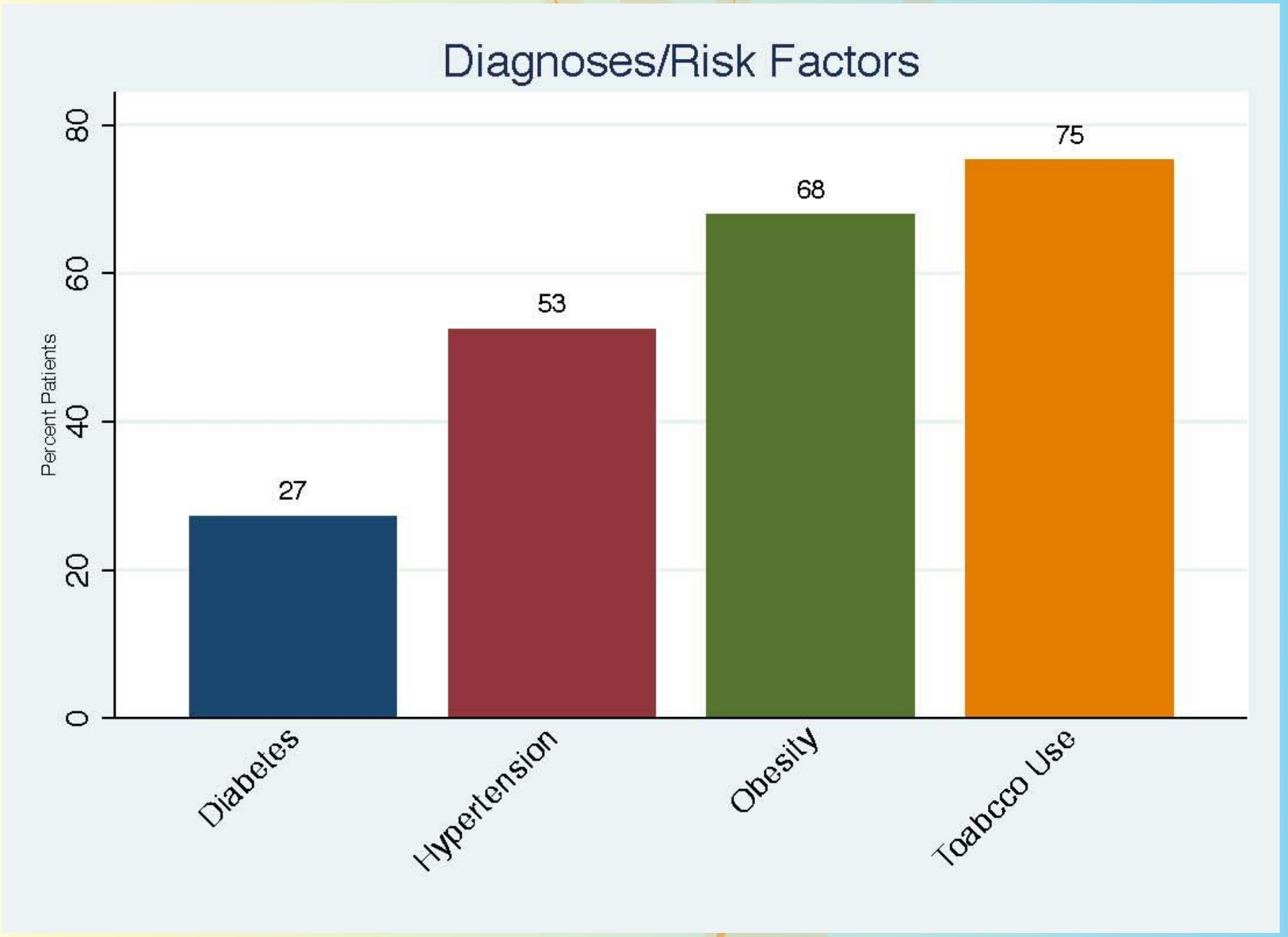
# Age Groups

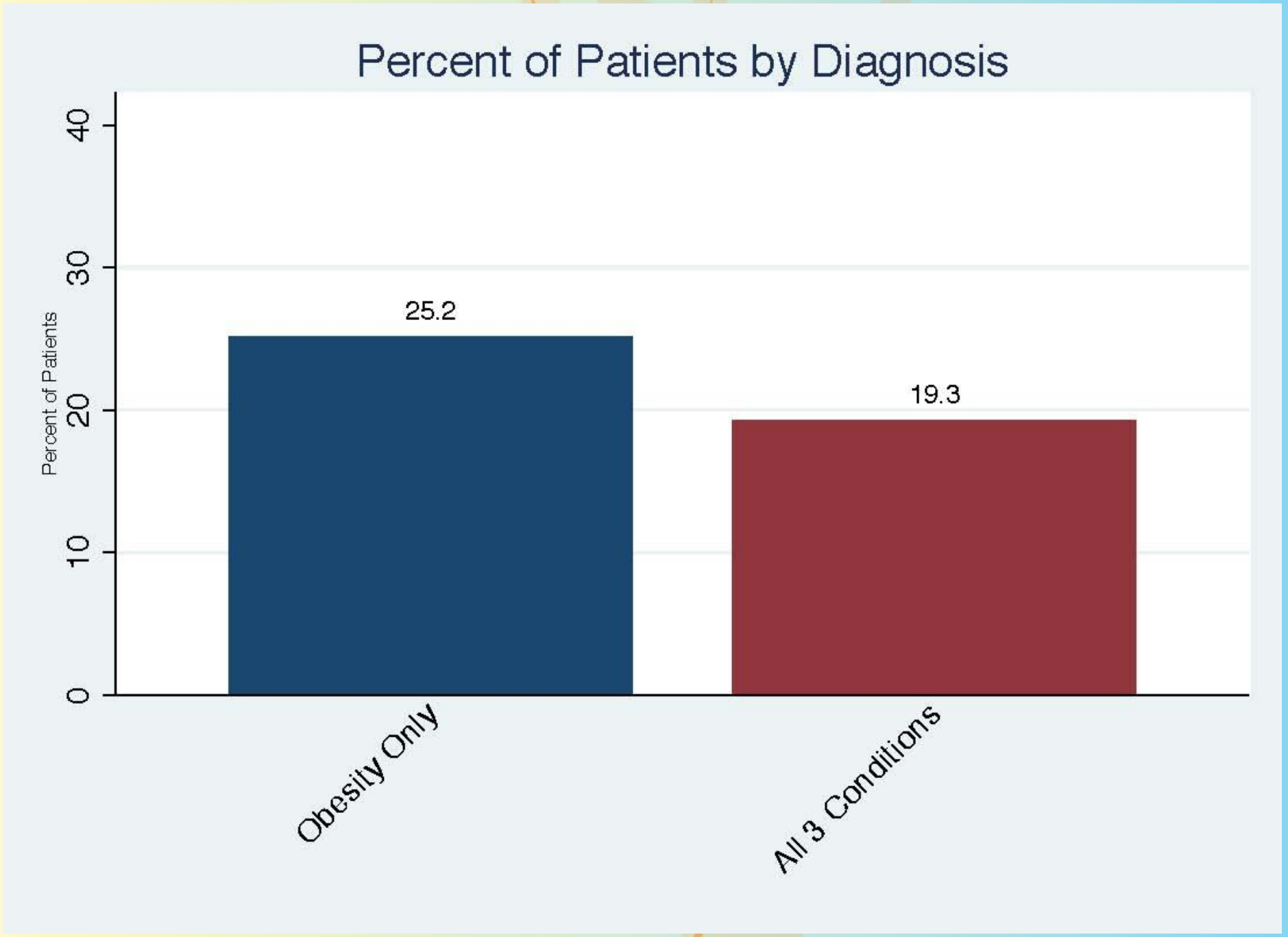

18-34 years
35-49 years
50-64 years
65-74 years
75 and older
17%
(n=68)
18%
(n=73)
37%
(n=152)
19%
(n=80)
9.2%
(n=38)

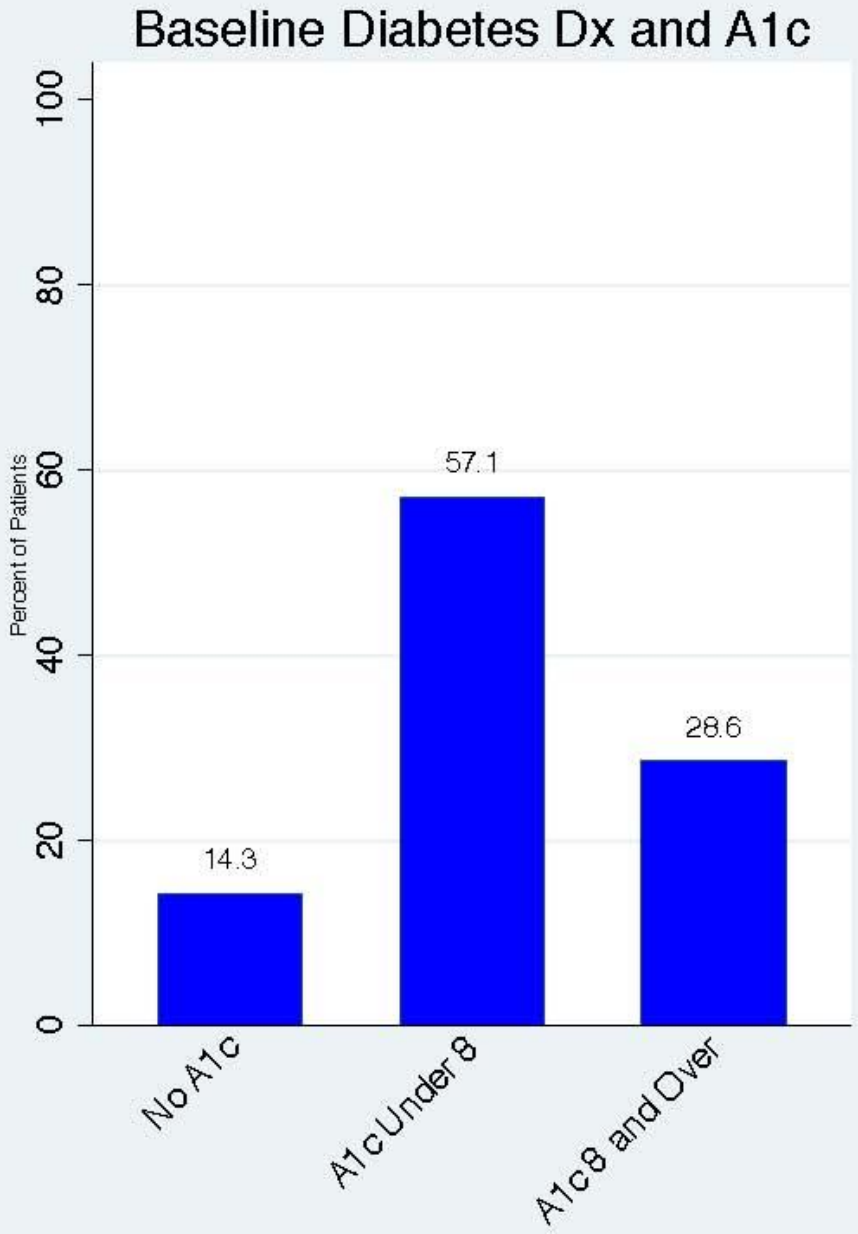
# Payer Mix

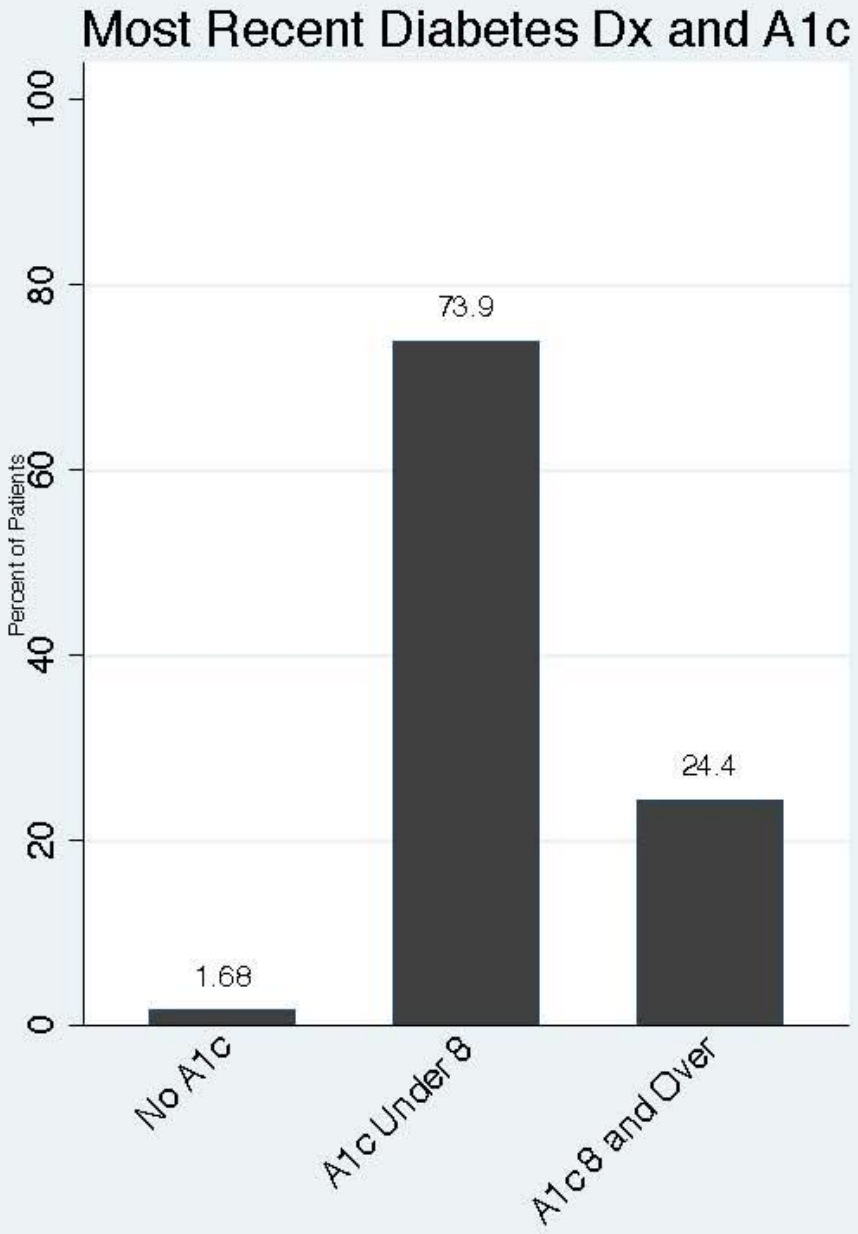

Medicaid
Medicare
Self-pay
Unknown
29%
(n=119)
40%
(n=163)
26%
(n=108)
5.1%
(n=21)

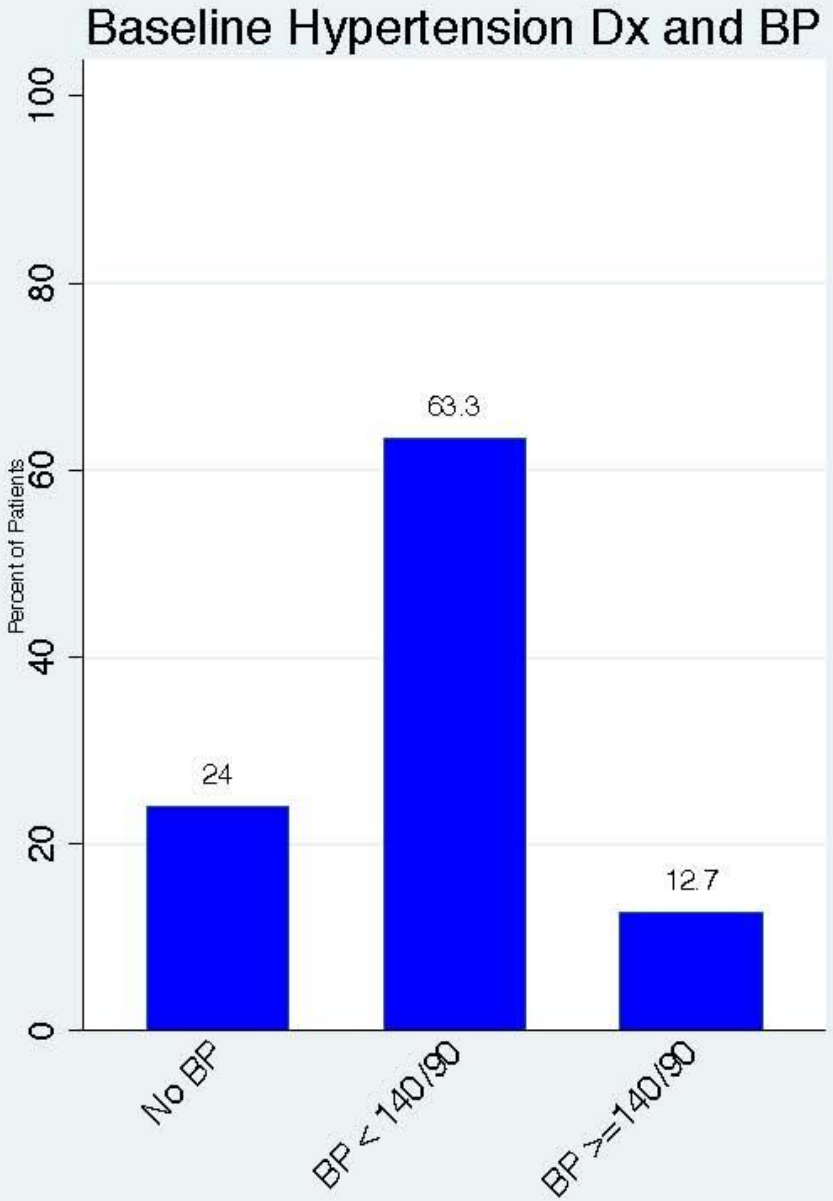

Average Number of Visits by Age
Number of Visits
0
2
4
6
8
5.5
5.9
7
5.2
8.6
18-34 years
35-49 years
50-64 years
65-74 years
75 and older

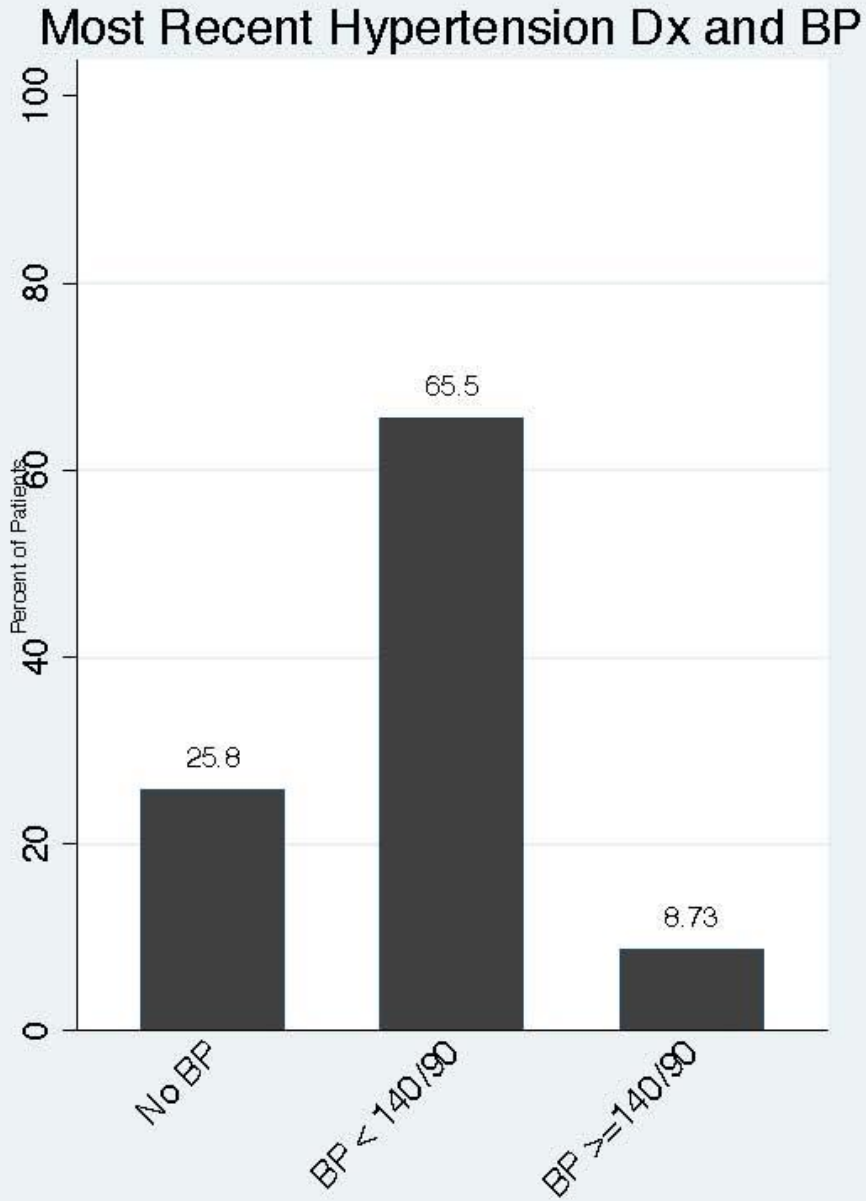

Diagnoses/Risk Factors
Percent Patients
0
20
40
60
80
27
53
68
75
Diabetes
Hypertension
Obesity
Toabcco Use

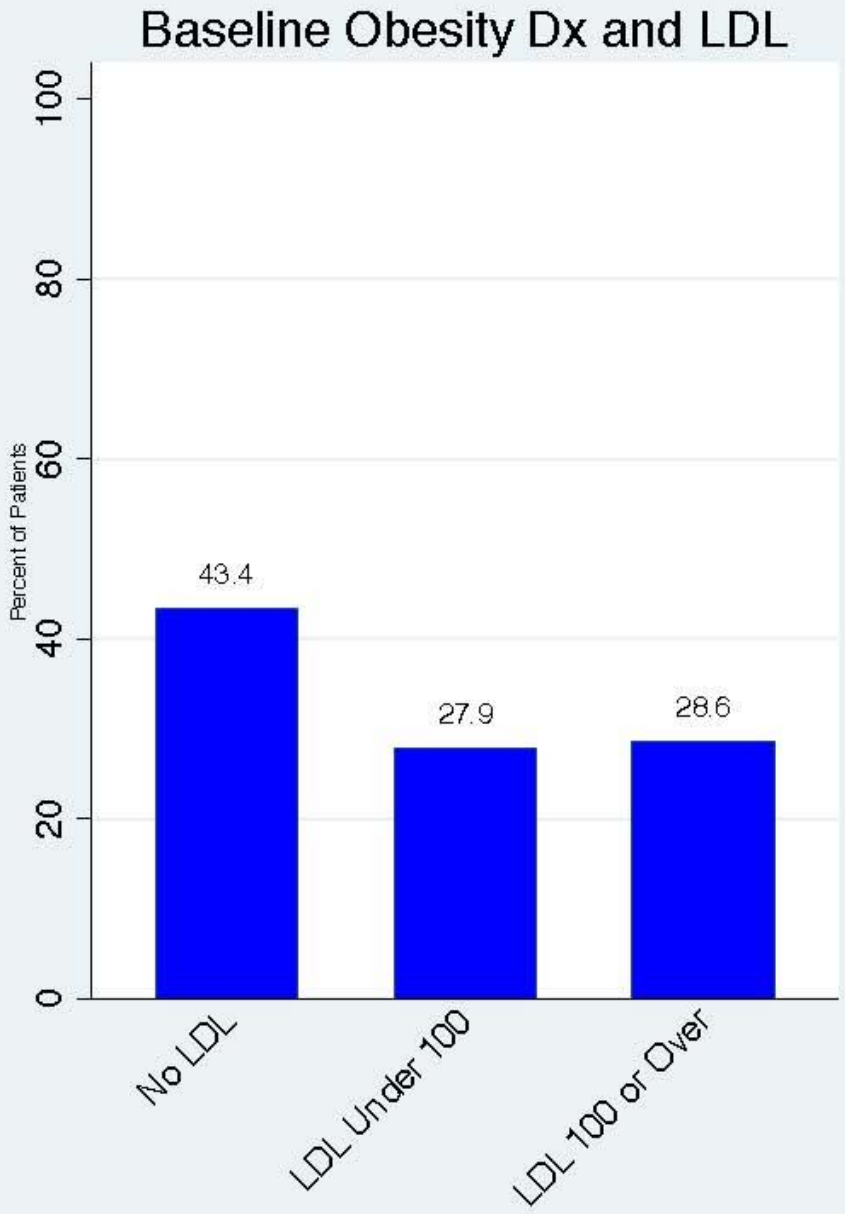

Percent of Patients by Diagnosis
Percent of Patients
0
10
20
30
40
25.2
19.3
Obesity Only
All 3 Conditions

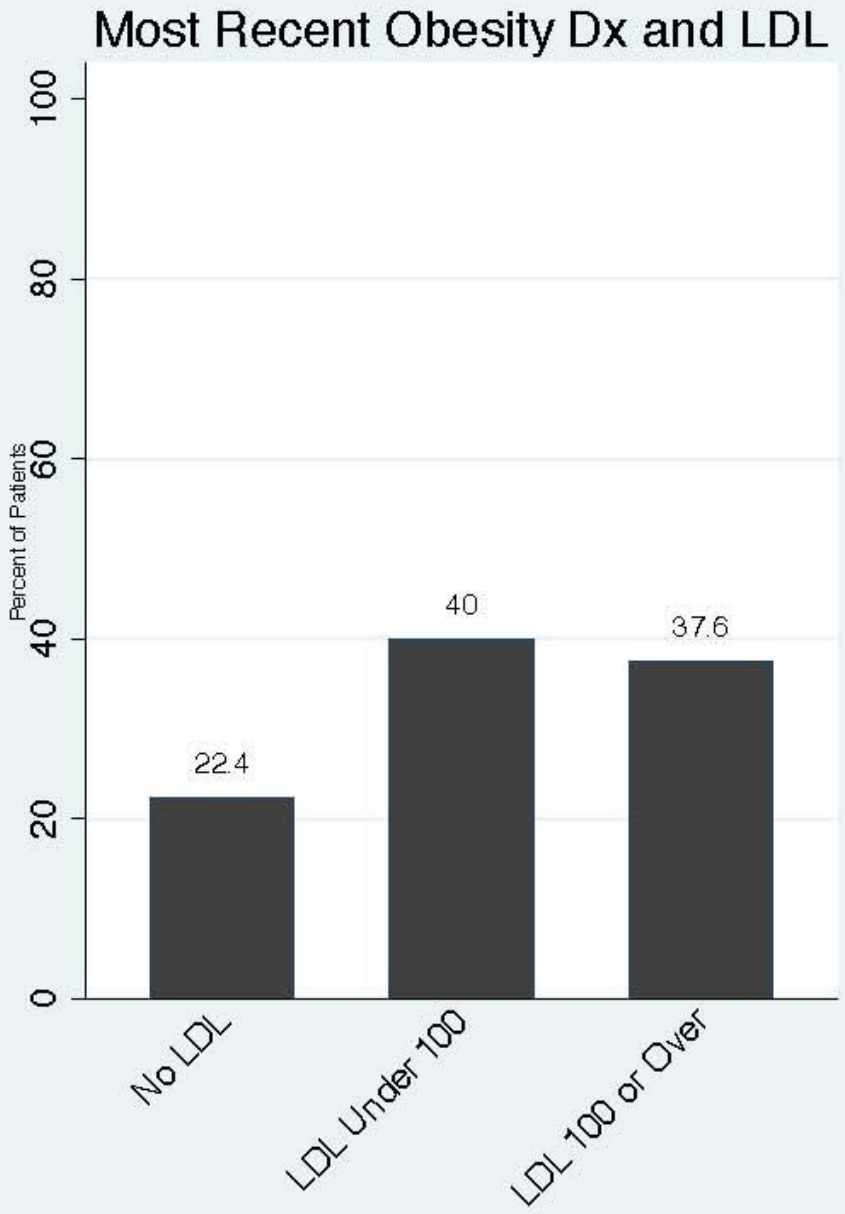

Baseline Diabetes Dx and A1c
Percent of Patients
0
20
40
60
80
100
14.3
57.1
28.6
No A1c
A1c Under 8
A1c 8 and Over

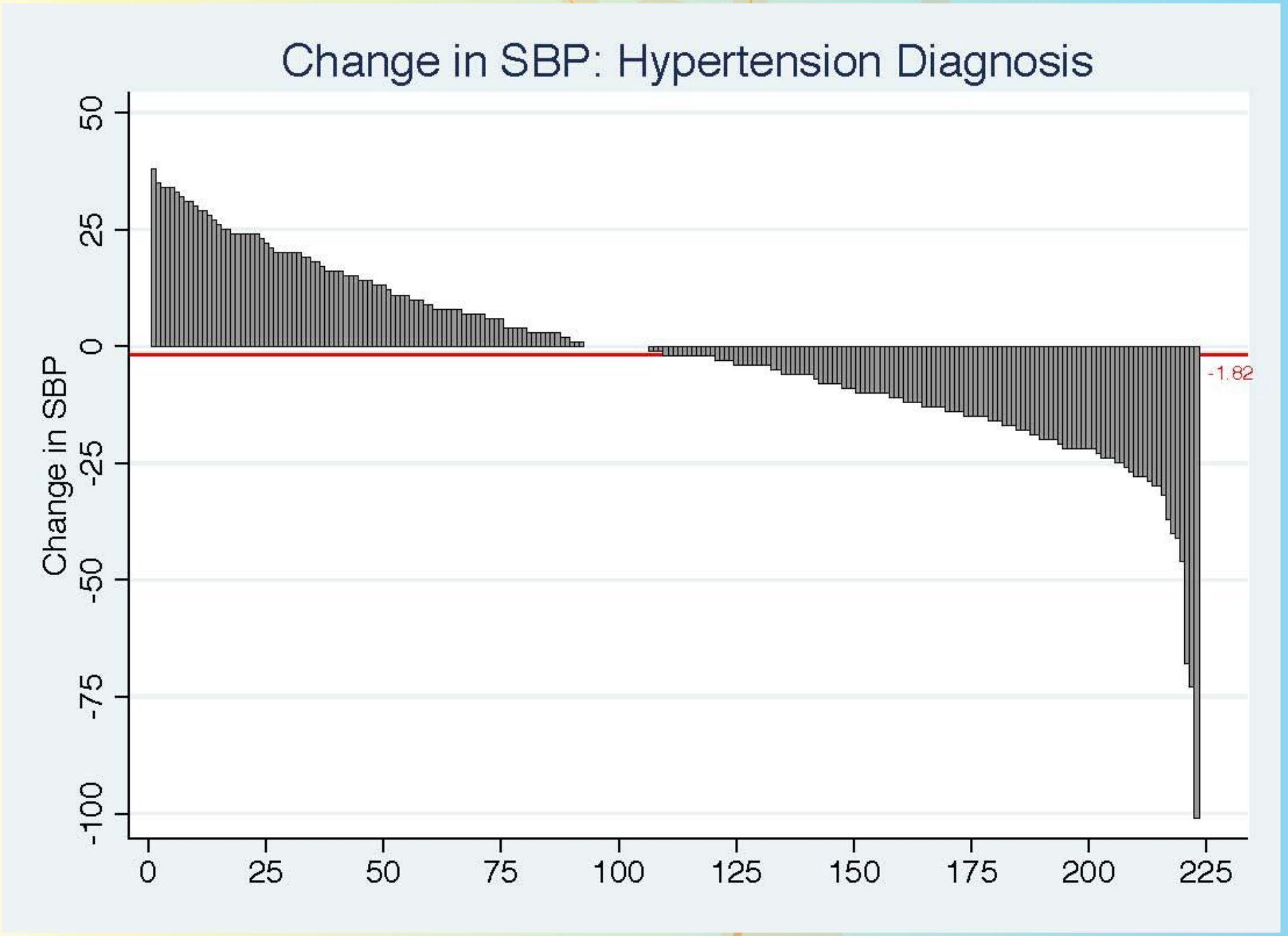

Most Recent Diabetes Dx and A1c
Percent of Patients
0
20
40
60
80
100
1.68
73.9
24.4
No A1c
A1c Under 8
A1c 8 and Over


Baseline Hypertension Dx and BP
Percent of Patients
0
20
40
60
80
100
24
63.3
12.7
No BP
BP < 140/90
BP >=140/90


Most Recent Hypertension Dx and BP
Percent of Patients
0
20
40
60
80
100
25.8
65.5
8.73
No BP
BP < 140/90
BP >=140/90


Baseline Obesity Dx and LDL
Percent of Patients
0
20
40
60
80
100
43.4
27.9
28.6
No LDL
LDL Under 100
LDL 100 or Over


Most Recent Obesity Dx and LDL
Percent of Patients
0
20
40
60
80
100
22.4
40
37.6
No LDL
LDL Under 100
LDL 100 or Over


Change in SBP: Hypertension Diagnosis
Change in SBP
50
25
0
-25
-50
-75
-100
-1.82
0
25
50
75
100
125
150
175
200
225

# What Comes Next?

- More questions, of course!
- We are two months into year three and we know the project intervention will permanently sustain.
- Working on expanding the collaboration to include higher education partner to obtain research funding to answer those questions.

# The End