



Oregon Heart Disease & Stroke and Diabetes Rural Collaborative

Goal: To enhance quality of care for patients with cardiovascular disease and diabetes in rural northeast Oregon

Objectives:

- Improve outcome measures: blood pressure, cholesterol, and HbA1c (an indicator of long-term blood glucose management)
- Increase number of patients in registry with documented self-management goals
- Increase collaboration between clinic staff and community partners

Strategies:

- Conducted five monthly distance-learning meetings to teach quality care improvement to learning teams comprised of rural clinicians and their community partners. Through lecture, discussion and group activities, meetings used the Collaborative Learning Model to implement facets of the (chronic) Care Model in rural clinics.
 - Topics included research vs. quality improvement, clinical information systems, self-management support and community resources, the Model for Improvement, community partnerships, PDSA cycles, reframing the patient-provider relationship, planned visits, and final progress reports from participating clinics.
- Assisted each clinic in setting up a stand-alone CDEMS registry, populated with data from at least 50 patients with diabetes and/or heart disease

Partners & Roles:

- The Oregon Heart Disease and Stroke Prevention Program and the Oregon Diabetes Prevention Program (lead partners)
 - Funding source, planning and technical assistance to lead contractor; guest faculty; evaluation
- OMPRO (Oregon's Quality Improvement Organization/QIO) (contractor)
 - Planning, coordination and logistics; faculty; evaluation
- Oregon Rural Practice Research Network (subcontractor)
 - Recruit clinics for participation; provide technical assistance for registry setup; assistance with evaluation
- Five rural community clinics from eastern Oregon: Union Family Health Care, Union; Pine Eagle Clinic, Halfway; Elgin Family Health Care, Elgin; Mid-Columbia Medical Center, The Dalles; Gilliam County Medical Center, Condon

(see reverse for program contact information)



Living Well with Chronic Conditions: The Oregon Chronic Disease Self-Management Network

About Living Well:

Living Well with Chronic Conditions (the Stanford Chronic Disease Self-Management Program/CDSMP) is a six-week workshop that teaches practical self-management skills for people with chronic health conditions. Interactive sessions encourage participants to share their successes and create a common source of support as they build confidence for managing health, staying active and enjoying life. Participants include people with different chronic conditions and their family or friends. Two trained leaders teach the workshop; one or both may have a chronic condition.

Strategies for Promotion of Living Well in Oregon:

- Sponsor representatives of state agencies, health systems and community organizations to become master (leader) trainers and train local workshop leaders
- Develop and provide resources to promote systematized offering of the program in a variety of settings, including community health and social service organizations, health systems, and long-term care facilities.
Resources include:
 - Leader/master trainer listserv and web site (in development)
 - Promotional materials for workshops and leader trainings
 - Technical assistance regarding training, certification, recruitment of leaders and participants, and identification of referral networks
 - Continuing education and networking opportunities for leaders and master trainers

Partners:

- Oregon Heart Disease & Stroke Prevention Program
- Oregon Diabetes Program
- Oregon Asthma Program
- Oregon Arthritis Program
- Oregon Department of Human Services/Seniors & People with Disabilities

Contact:

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