Quality Improvement Instrument Improves Multidisciplinary Approach to Self Management in West Virginia Clinics

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What is PCRS?

Assessment of **P**rimary **C**are **R**esources and **S**upports for Chronic Disease Self Management

- A "drill down" of Self Management Supports in the Chronic Care Model that defines its components
- A self assessment tool for patient care teams in primary care settings
- A quality improvement tool

Who should use it?

- Multidisciplinary patient care teams in primary care settings who are incorporating self management support into chronic illness care
- Teams interested in improving the quality of their self management support systems and service delivery

Purpose of the PCRS

- To help patient care teams in primary care settings *focus on actions that can be taken* to support self management by patients with diabetes and other chronic conditions
- Specifically, the PCRS helps:
  - Define/ describe optimal performance
  - Identify gaps in resources, services and supports for self management
  - Facilitate communication among team members; build consensus for change
  - Provide a mechanism to monitor progress

The components of PCRS

- Patient Support
  - Assessment at the "micro system" level (patient, provider, care team)
  - Addresses characteristics of service delivery found to enhance patient self management

- Organizational Support
  - Assessment at the "macro system" level (clinic or health care system)
  - Addresses characteristics of organizations that support the delivery of self management services

Patient Support

1. Individualized assessment of patient self management educational needs
2. Self management education
3. Goal setting/ action planning
4. Problem solving
5. Emotional health
6. Patient involvement in decision making
7. Social support
8. Links to community resources

Organizational Support

1. Continuity of care
2. Coordination of referrals
3. Ongoing quality improvement
4. System for documentation of SM support services
5. Consumer participation/ patient input
6. Integration of SM support into primary care
7. Patient care team/ team approach
8. Staff education and training

I: PATIENT SUPPORT (circle one NUMBER for each characteristic)				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (=all of B plus these)**
3. Goal Setting	…is not done **1**	…occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients **2 3 4**	…is done collaboratively with all patients/ families and their provider(s) or member of healthcare team; goals are specific, documented and available to anyone on the team; goals are reviewed and modified periodically **5 6 7**	…is an integral part of care for patients with chronic disease; goals are systematically reassessed and discussed with the patient; progress is documented in the patient's chart **8 9 10**
4. Problem-Solving Skills	…are not taught or practiced with patients **1**	…are taught and practiced sporadically or used by only a few team members **2 3 4**	… are routinely taught and practiced using evidence based approaches and reinforced by members of the health care team **5 6 7**	…. is an integral part of care for people with chronic disease; takes into account family, community and environmental factors; results are documented and routinely used for planning with patient \ **8 9 10**
5. Emotional Health	…is not assessed **1**	…is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent **2 3 4**	…assessment is integrated into practice and pathways established for treatment and referral; patients are actively involved in goal setting and treatment choices; team members reinforce consistent goals **5 6 7**	…systems are in place to assess, intervene, follow up and monitor patient progress and coordinate among providers; standardized screening and treatment protocols are used **8 9 10**

Scoring the tool

Letters A-D

- A= (highest level) characteristic is part of a quality improvement **system** that gives feedback to the patient and the health care system
- B= characteristic is consistently well demonstrated in **teams** and services are coordinated
- C= characteristic is demonstrated **inconsistently** or sporadically during patient-provider interaction
- D= characteristic **not** demonstrated

Numbers

- Within a level, the degree to which a characteristic is being addressed

How the PCRS is being used to plan and document Self Management QI in WV Primary Care Centers

Marshall Center for Rural Health

Licensed to disseminate CDSMP in 2003

- 19 leader trainings in WV
- 267 people trained as workshop leaders
- More than 130 6-week CDSMP workshops conducted in WV
- Over 1,032 people participated – learning and practicing self management skills

Primary Care Center Partners

- Offer PCRS as tool to define standards for self management integration
- Clinics' experience and reasons for using PCRS varies
- Used to document where they are and what they need
- A tool for planning self management QI

Clinic Example

- Success with offering CDSMP
- Success with incorporating self management into Medical Group Visits
- Senior management interest in making system change for Self Management Integration
- Standardize user friendly process for self management goal setting
- Need to establish self management baseline for Rural Quality Grant and Medical Home Application
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Self Management QI Team

- Looking for ways to plan and document self management system of care change
- PCRS piloted at 2 of the 4 clinic sites
- Raise awareness, and document baseline and plan next steps
- Decision to invite all care teams to fill out assessment on line

http://improveselfmanagement.org

Team: Scarbro

Assessment: Scrabro Clinical Team Baseline Jan. 2010

Date: 1/14/2010 - 1/29/2010

Category	PCRS Characteristic	Number of Respondents	High Score	Low Score	Mean	Standard Deviation
Patient Support	Individualized Assessment	13	10	2	5.8	2.1
	Self Management Education	13	9	4	5.7	1.8
	Goal Setting	13	9	3	5.3	1.5
	Problem-Solving Skills	13	9	3	5.6	1.8
	Emotional Health	13	10	3	6.2	1.9
	Patient Involvement	13	10	5	6.5	1.5
	Social Support	12	10	4	6.4	1.6
	Links to Community Resources	12	10	4	6.3	1.9
Organizational Support	Continuity of Care	13	10	4	6.2	1.6
	Coordination of Referrals	13	10	5	7.2	1.4
	Ongoing Quality Improvement	13	9	4	6.1	1.7
	System for Documentation	13	9	4	6.3	1.7
	Patient Input	13	10	4	6.8	1.6
	Integration into Primary Care	13	8	3	5.3	1.7
	Patient Care Team	12	9	4	6.7	1.5
	Staff Education and Training	12	10	4	6.6	1.6

What we learned….

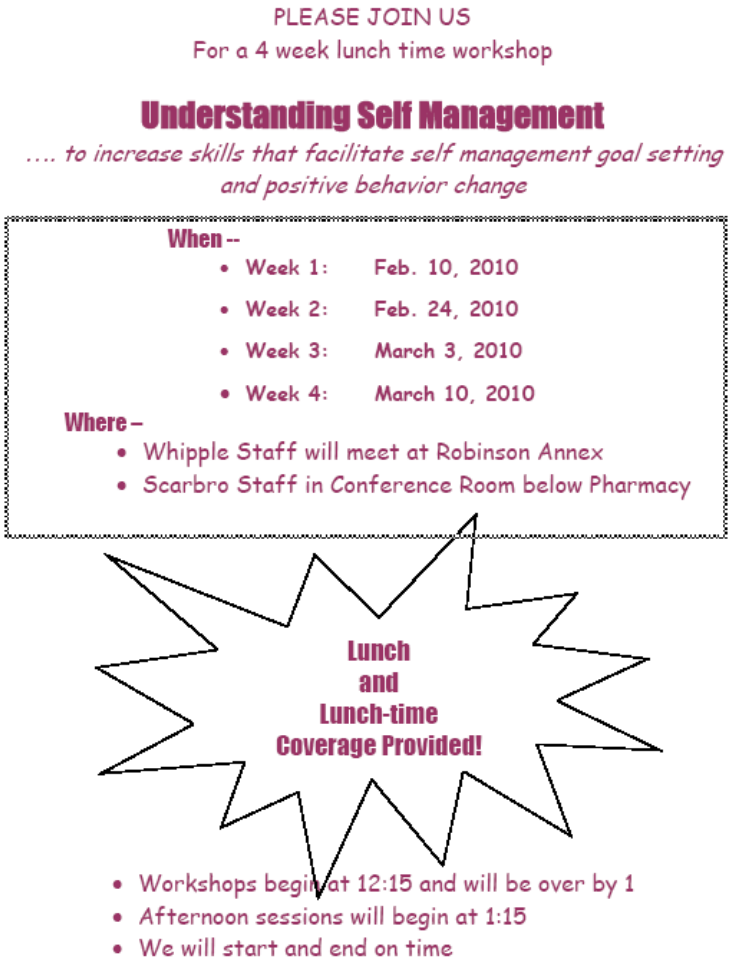
- Understanding about self management support widely varies
- Not everyone had basic self management skills and understanding of key concepts
- Staff are resistant to change and overwhelmed
- Individuals and teams need support to begin from where they are
- Changing the culture of care will take time and require an investment

Plan: Staff training on self-management skills

- Four lunch time sessions over 4 weeks with a healthy lunch provided
- Patient schedules altered to ensure that staff would be able to attend
- Sessions spaced out by one week so that staff can set their own goals and report on them at the next meeting
- Training agenda focus on staff setting personal self management goals and then on how to properly interact with patients using a defined method of self management action planning

Build Excitement about Self Management

- Personal letter of invitation
- Flyers
- Reminders



Evaluation and Self Management Knowledge Survey

- Comments about what they liked:
  - The pace of information
  - Not pressured
  - Time for practicing
  - Helpful personally
  - Helped me to get motivated
  - All “goals” don’t have to be large
  - Talking about everyday health
  - Action plans make changes less overwhelming
- 98% scored 100%

Certificate of Completion

Name

Has successfully completed the 4 hour staff training

Understanding Self-Management And Motivational Interviewing

February 10; February 24; March 3; March 10, 2010
New River Health Association, Scarbro, WV

Marshall University
Center for Rural Health

Yvonne Mims

Susie Criss

Date

Self Management QI Committee

- Summarized and reviewed PCRS data and training process
- Sent out email invitations to PCRS re-assessment
- Plans in place to send PCRS to staff at other 2 clinic sites and repeat training
- Offer another chance for people to do PCRS and training in summer
- On going regular meetings to keep process moving

Chronic Disease Self Management Program Workshops

Outcomes of Interest

- Monitor clinic data for increase in % of patients with documented self management goal
- Ongoing documentation of self management system change
- Improvements in process and outcomes data

"The PCRS tool is helping us plan and document an overall culture change at New River. It helps us define self management standards for our system of care and patient interactions. This change is not going to happen overnight. Using the PCRS can allow us to stay on course as we move forward over the coming years."

- Jennifer Boyd, PA-C, Medical Director

New River Health Association

4/2010

Helpful Resources

- Electronic PRCR: http://improveselfmanagement.org
- Diabetes Initiative website with paper version of PCRS: http://diabetesinitiative.org
- Coming soon! http://selfmanagementonline.org

Thank you!

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