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DIABETES INITIATIVE
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Measuring and improving delivery of patient support at the health services level

4th International DAWN Summit

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Overview

- Setting the context: the *Diabetes Initiative*
- Defining core elements of patient-centered self-management support in primary care
- Developing the PCRS: A measurement model and quality improvement process for widespread use in practices
  - How it works and how it is scored
  - Using the measurement and team sharing to improve patient support
- Experience to date and next steps

New Approaches Are Needed …

	Traditional Patient Education	Self Management Education
What is taught	Information and technical skills about the disease	Skills on how to act on problems
How problems formulated	Problems reflect inadequate control of disease	Patient identifies problems; may or may not be disease related
Relationship of education to the disease	Education is disease specific and teaches information and skill related to the disease	Education teaches problem solving skills that are relevant to the consequences of chronic conditions
Underlying theory	Knowledge leads to behavior change which leads to better clinical outcomes	Greater patient confidence in his/her capacity to make life-improving changes leads to better clinical outcomes
The goal	Compliance with behavior changes to improve clinical outcomes	Increased self-efficacy to improve clinical outcomes
The educator	A health professional	A health professional, peers, other patients, lay health workers; may be in group settings

Bodenheimer, JAMA, November 20, 2002—Vol. 288, no 19

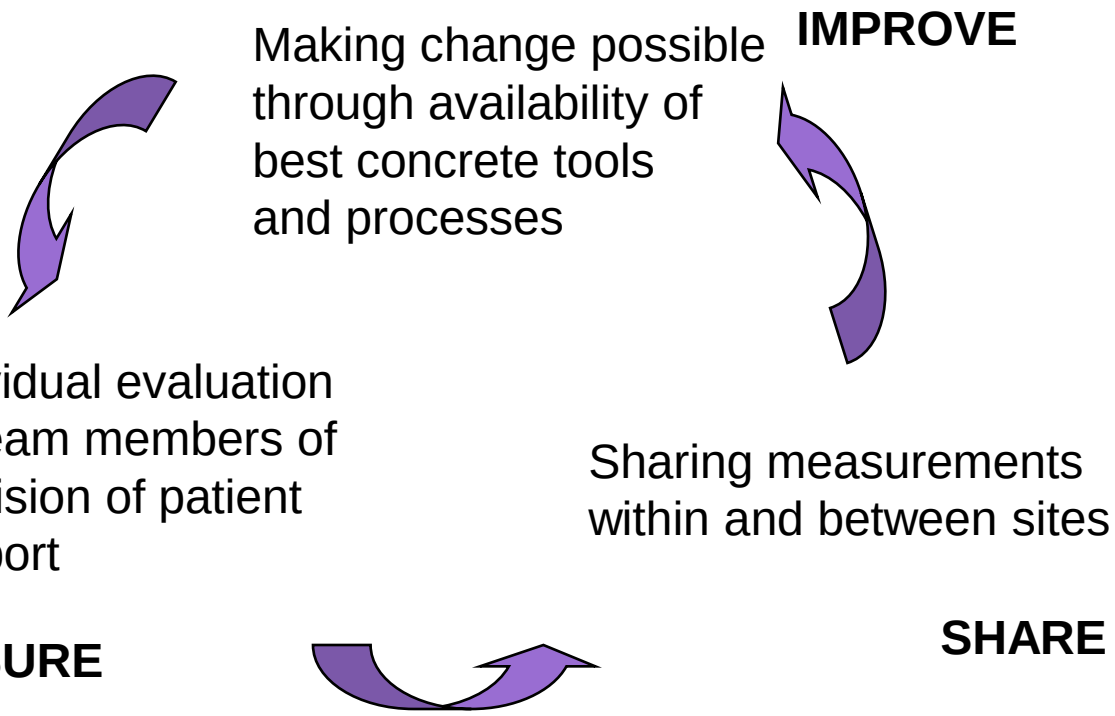
Diabetes Initiative o*f the Robert Wood Johnson Foundation*

To demonstrate feasible, sustainable, successful self management programs as part of high quality diabetes care in primary care and community settings

What Individuals Need: Resources and Supports for Self Management

- Regular, safe, high-quality clinical care
- Individualized assessment of educational needs
- Patient-centred, collaborative goal setting and problem solving that result in a shared management plan
- Education and skills for managing diabetes
- Ongoing follow-up and support
- Community resources and policies that support health

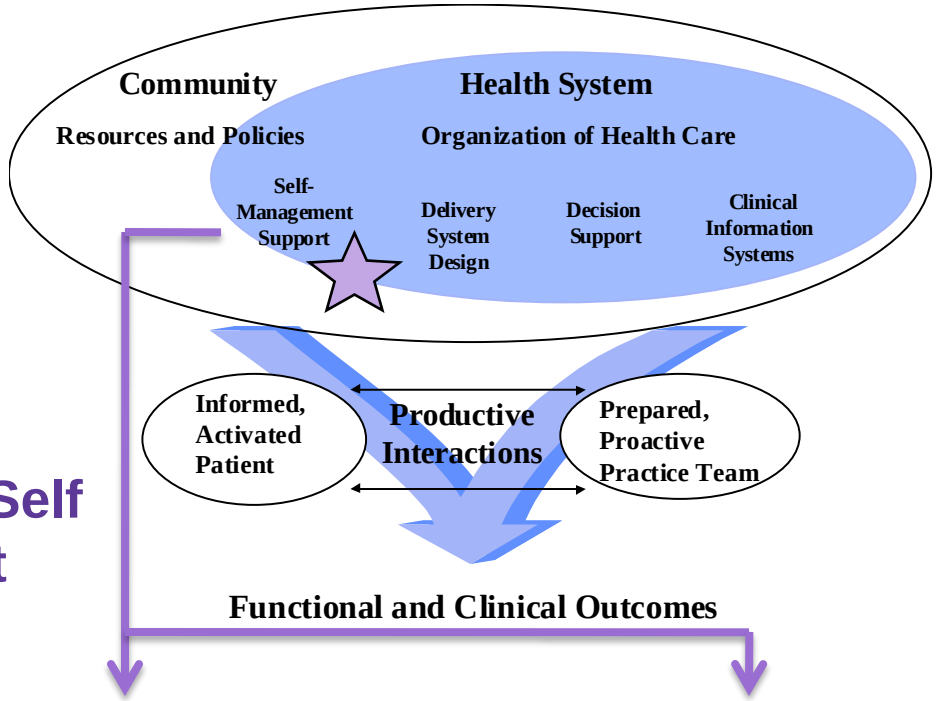
Improving Delivery of Patient-centered Diabetes Management in Primary Care



Guiding Questions

- What constitutes support for patient centered self management?
- What benchmarks can we use to monitor improvements in our capacity to provide self management support?
- How can we facilitate a multi-disciplinary process for ongoing improvement of diabetes care?

Chronic Care Model



Domains of Self Management Support

Patient Support		Organizational Support
Individualized assessment Self management education Goal setting Problem-solving skills Emotional health Patient involvement in decision-making Social support Links to community resources	⟷	Continuity of care Coordination of referrals Ongoing quality improvement System for documentation Patient input Integration into primary care Patient care team Staff education and training

The PCRS

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

- A tool developed by primary care projects of the *Diabetes Initiative* to facilitate assessment and improvement of support for patient self management

How Does the PCRS Help?

- Defines current healthcare system capacity for patient support at a delivery and organizational level.
- Provides a way for team members to assess current capacity to support patient self management (measure)
- Helps identify specific gaps in capacity -- or lack of agreement about capacity -- so that team members know where to focus their improvement efforts (improve)
- Promotes discussion among patient care teams that can help build consensus for change and initiate plans for improvement (share and improve)
- Gives teams benchmarks against which to measure progress over time

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

Domains of Patient Support

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

Scoring the Tool – Examples

PATIENT SUPPORT (How well is your team doing? Circle one NUMBER.)

Characteristic**: Goal setting**

D	C	B	A
...is not done	...occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients	...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	...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
1	2 3 4	5 6 **7**	8 9 10

Scoring the Tool

PATIENT SUPPORT (How well is your team doing? Circle one NUMBER.)

Characteristic**: Emotional Health**

...is not assessed	...is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent	...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	...systems are in place to assess, intervene, follow up and monitor patient progress and coordinate among providers; standardized screening and treatment protocols are used
1	2 3 4	5 6 7	8 9 10
D	C	B	A

Scoring the Tool

PATIENT SUPPORT (How well is your team doing? Circle one NUMBER.)

Characteristic**: Patient Involvement**

…does not occur	…is passive; clinician or educator directs care with occasional patient input	…is central to decisions about self management goals and treatment options and encouraged by health care team and office staff	… is an integral part of the system of care; is explicit to patients; is accomplished through collaboration among patient, team members and physician, and takes into account environmental, family, work or community barriers and resources
1	2 3 4	5 6 7	8 9 10
D	C	B	A

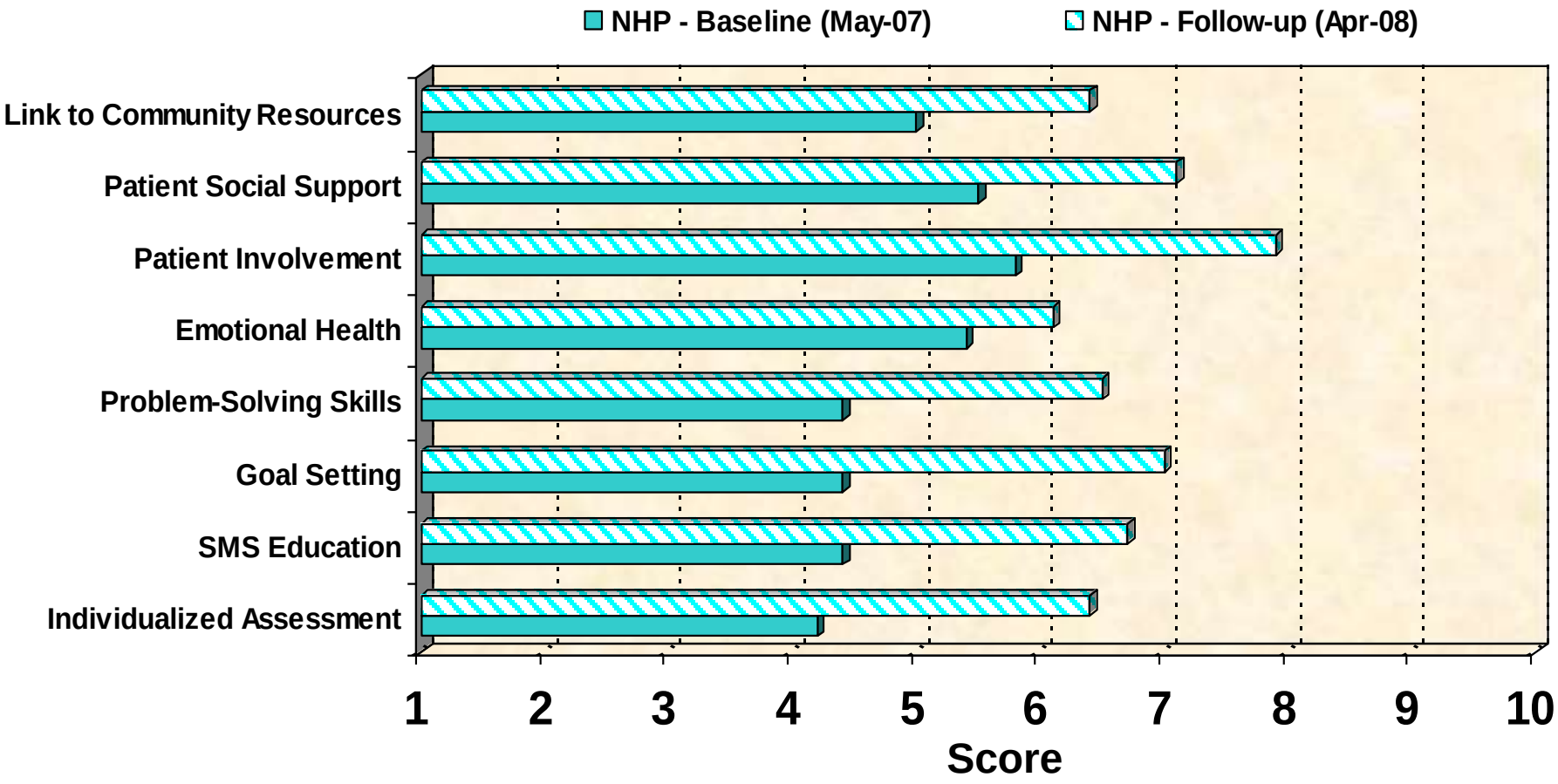
Starting the Improvement Process

- Each provider/ team member completes the PCRS independently
- A member of the team compiles the scores for use in team discussions
- The team meets to discuss the results
- Based on what is learned, the team selects
  - a characteristic(s) for improvement
  - a strategy/ process for improvement
  - a timetable for reassessment
- The cycle repeats…

PCRS and Quality Improvement

- What it's NOT about
  - Absolute numbers
  - Averages
- What it IS about
  - Increasing team members' understanding of everyone's role and how they complement each other
  - Getting a current picture of the system of patient-centered self management support at your setting, including
    - Aspects of self management support that are working well that might serve as models to share with others
    - Gaps in capacity or service that suggest areas for focused, measurable improvement
  - Making improvements in patient care and support
  - Team-building

Changes in Patient Support Scores Following Participation in a Virtual Learning Community..*



* n=9 sites at baseline; n=8 sites at follow-up

Note: All pre/post changes significant at p<.05 except for "Emotional Health"

Change Summary Report*

for **the Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)**

Please answer the following questions for each change addressed. (**If you addressed more than one component in a category, please use a separate report form for each).

Site / Location: _____ For the Time Period: _____

Disease or condition of focus (e.g. diabetes, CVD, depression, asthma): _____

1. Check the component of Patient Support chosen for improvement**	☐ **Individualized Assessment** ☐ **Self Management Education** ☐ **Goal Setting** ☐ **Problem Solving Skills** ☐ **Emotional Health** ☐ **Patient Involvement** ☐ **Patient Social Support** ☐ **Link to Community**
2. Describe your team's rationale for choosing this component.	
3. Describe major steps taken to make improvements.	
4. Were there things that really helped you as you went through your processes?	
5. What barriers/obstacles did you encounter? How did you overcome them?	
6. Outcome (status at this point)	

*** to be completed at the end of the each improvement period, e.g., quarterly or semi-annually, as a summary of quality improvement processes initiated by the first PCRS assessment and before re-assessment**

Examples from the Field….
Strategies for Improving Goal Setting

- Education/ increased awareness
  - Discussion at provider meetings
  - In-service training
- Improved processes
  - Better documentation of patient progress toward goals
  - Reminders on patient charts
  - Copies for patients to take home and post
  - Faxing goals to doctor for feedback
- Improved practice
  - Open ended inquiry; patient centered approach
  - Self management goals addressed at every visit
  - Active follow up with patients between visits, and over longer time period
  - More team members involved in reinforcing patient goals

In Summary…

We have developed a tool for measuring and improving delivery of patient support at the health services level that is:

- User friendly
- Consistent with the five goals of DAWN
- Consistent with current best practices in quality improvement and chronic illness care
- Broadly applicable (i.e., settings and conditions)
- Publicly available at http://diabetesinitiative.org and electronically at http://improveselfmanagement.org

Next Steps: International version of PCRS and resources to facilitate improvement