Robert Wood Johnson Foundation

Washington University in St. Louis
School of Medicine

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

# *The Road to Effective Patient Self Management*

**NACHC's 2007 Community Health Institute**

**Carol Brownson, Deputy Director**
**RWJF Diabetes Initiative**
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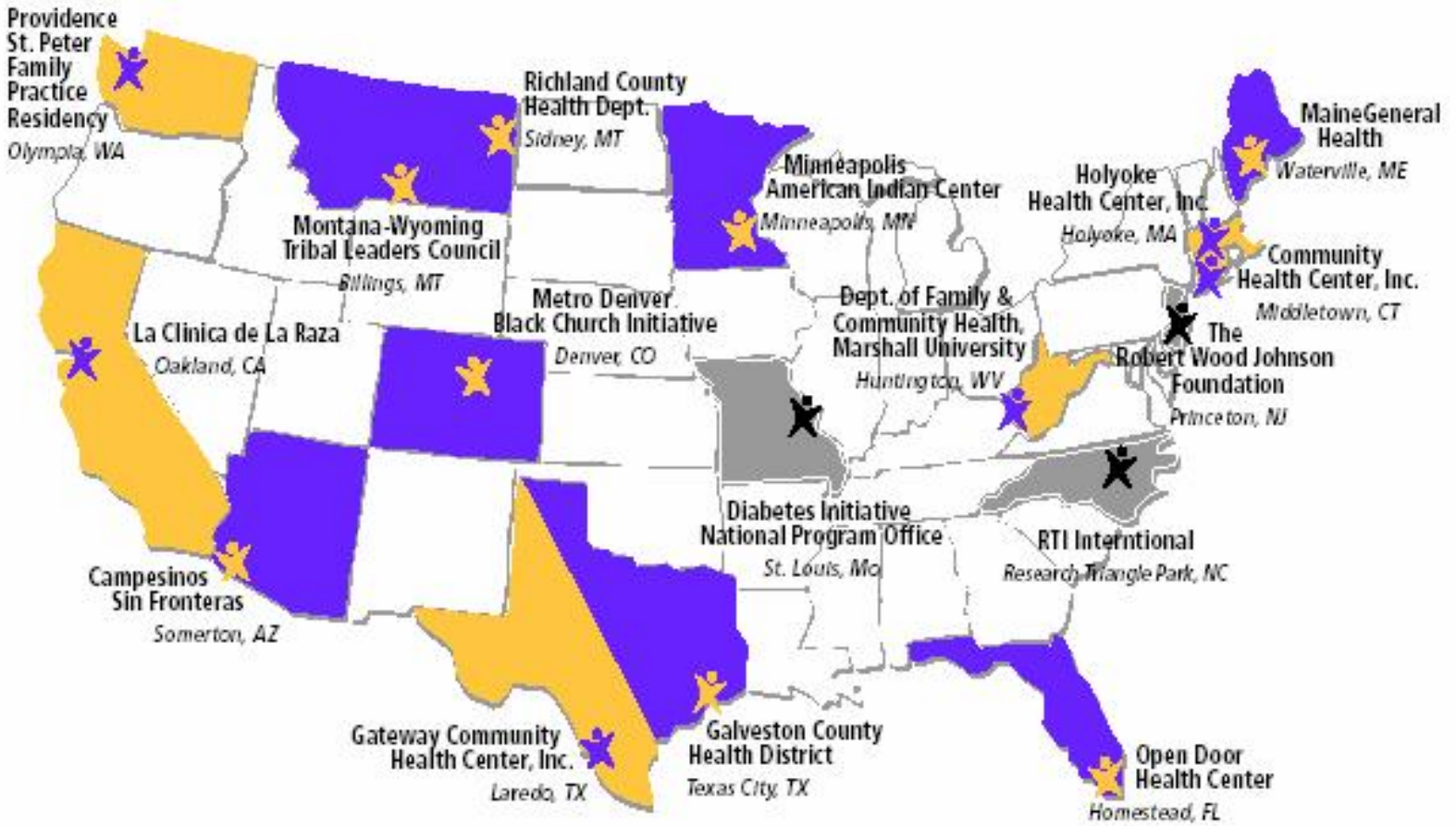
This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

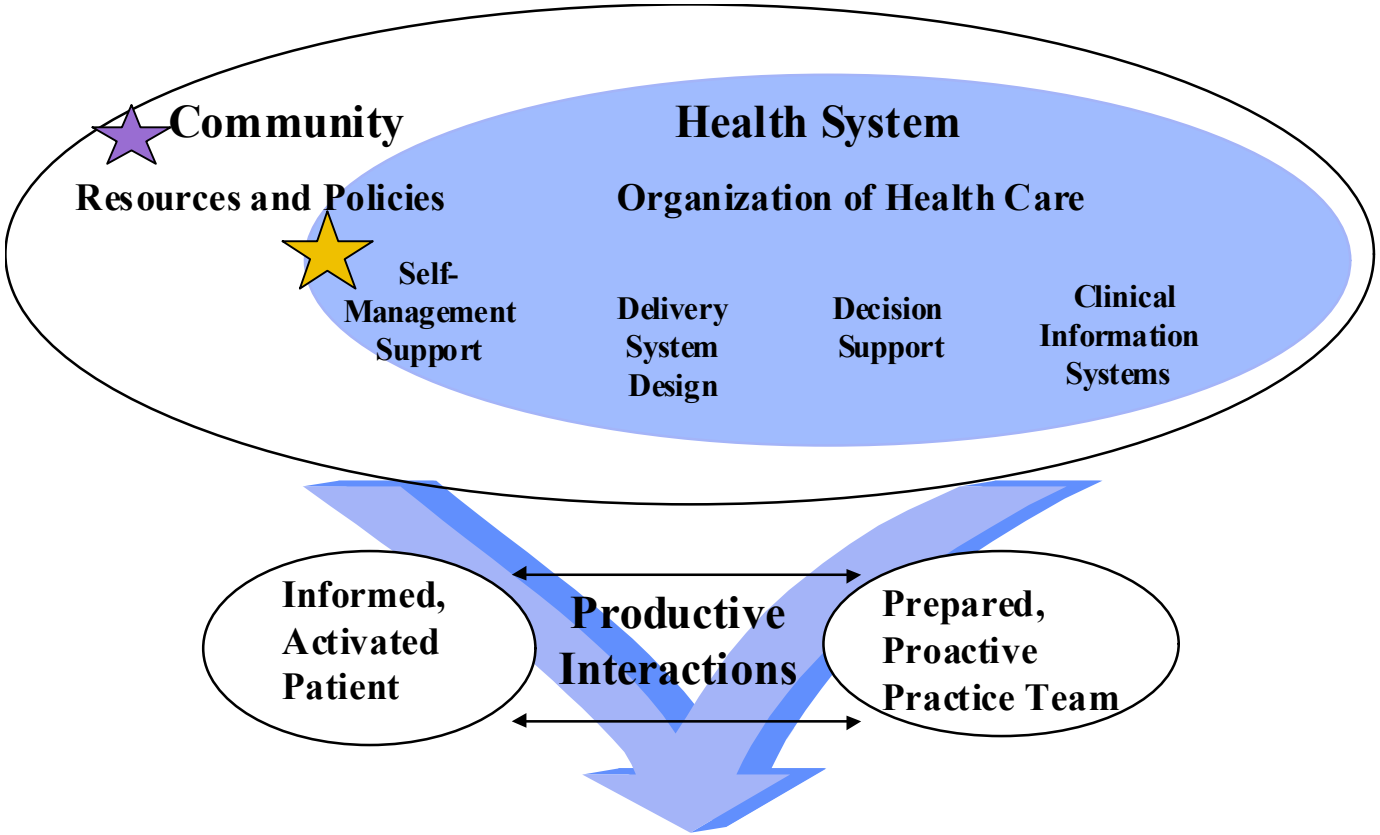
# *Objectives:*

- Provide an overview of the PCRS, an assessment tool develop by the Diabetes Initiative (DI) to facilitate quality improvement of self management support in primary care
- Showcase approaches to improving self management in primary care clinics from three sites of the (DI)
- Describe a project involving HDC sites in MO that used the PCRS and learnings from the DI to further enhance self management support in their settings

# Robert Wood Johnson Foundation Diabetes Initiative



# *Chronic Care Model*




**Functional and Clinical Outcomes**

# *Advancing Diabetes Self Management (ADSM)*


**Demonstrating and evaluating programs to promote self management of diabetes in primary care settings**

# *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
- A self assessment tool for patient care teams in primary care settings
- A quality improvement tool

# *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
- Specific goals are that it:
  - Function as a self assessment, feedback and QI tool to help build consensus for change
  - Identify optimal performance of providers and systems as well as gaps in resources, services and supports
  - Help teams integrate changes into their systems by identifying areas where SM support is needed

# *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
4. Problem solving skills
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

# *Scoring the tool*

Two levels:

- 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

| 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<br>**1** | …occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients<br>**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<br>**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<br>**8 9 10** |
| 4. Problem-Solving Skills | …are not taught or practiced with patients<br>**1** | …are taught and practiced sporadically or used by only a few team members<br>**2 3 4** | … are routinely taught and practiced using evidence based approaches and reinforced by members of the health care team<br>**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<br>**8 9 10** |
| 5. Emotional Health | …is not assessed<br>**1** | …is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent<br>**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<br>**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<br>**8 9 10** |

# *Starting the improvement process*

- Each member of the team gets a copy to fill out independently for a specific condition
- After scoring individually, a member of the team compiles/organizes the scores
- The team meets to discuss their scores
- Based on what is learned, the team selects
  - a characteristic(s) for improvement
  - a strategy/ process for improvement
  - a timetable for reassessment, etc
- The cycle continues….

# *Team work after the scoring*

- What it's NOT about
  - Absolute numbers
  - Averages

- What it IS about
  - Understanding why people gave the scores they did
  - Increasing team members' understanding of everyone's role and how they complement each other (i.e.., seeing the whole elephant)
  - Getting a current picture of the system of self management support at your setting
  - Identifying aspects of self management support that are working well that might serve as models for others
  - Identifying areas for focused, measurable improvement

- Improvement and "teamness" is the goal

# *In summary, the PCRS tool is….*

- User friendly
- Consistent with current best practices in quality improvement and chronic illness care
- Broadly applicable (i.e., works in different types of settings as well as for different chronic conditions)
- Publicly available under "Lessons Learned" on the **Diabetes Initiative** website http://diabetesinitiative.org

# *Today's presenters……..*

Intervention Approaches From 3 DI Sites:

- Lourdes Rangel
  Director of Special Projects
  Gateway Community Health Center, Inc., Laredo, TX
- Jon Liebman, MSN, MSPH
  Holyoke Health Center, Inc., Holyoke, MA
- Daren R. Anderson, MD
  Chief Medical Officer
  Community Health Center, Inc., Middletown, CT

A Model for Collaboration and Spread:

- Angela Herman, MPA
  Clinical Program Manager
  Missouri Primary Care Association, Jefferson City, MO

Gateway Community Health Center, Inc.


Empowering Communities for Better Health

# *The Role of Lay Health Workers in Managing Diabetes*

This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

**Presented By:**
**Lourdes Rangel**
**Director of Special Projects**

**2007 NACHC Community Health Institute**
**August 27, 2007**
**Dallas, Texas**

# Demographics



- **Gateway is located in Laredo, Texas (along the U.S.-Mexico Border)**
- **Began operations in 1963**
- **Center offers a wide array of medical care services provided by physicians and/or mid-level practitioners**
- **Over 84,000 medical, dental, and specialty care patient visits were provided in 2006**

**Mission Statement**

"To improve the health status of the people we serve in Webb County and surrounding areas by striving to provide high quality medical, mental and dental care; **health promotion and disease management services** in a professional, personal, and cost effective manner."

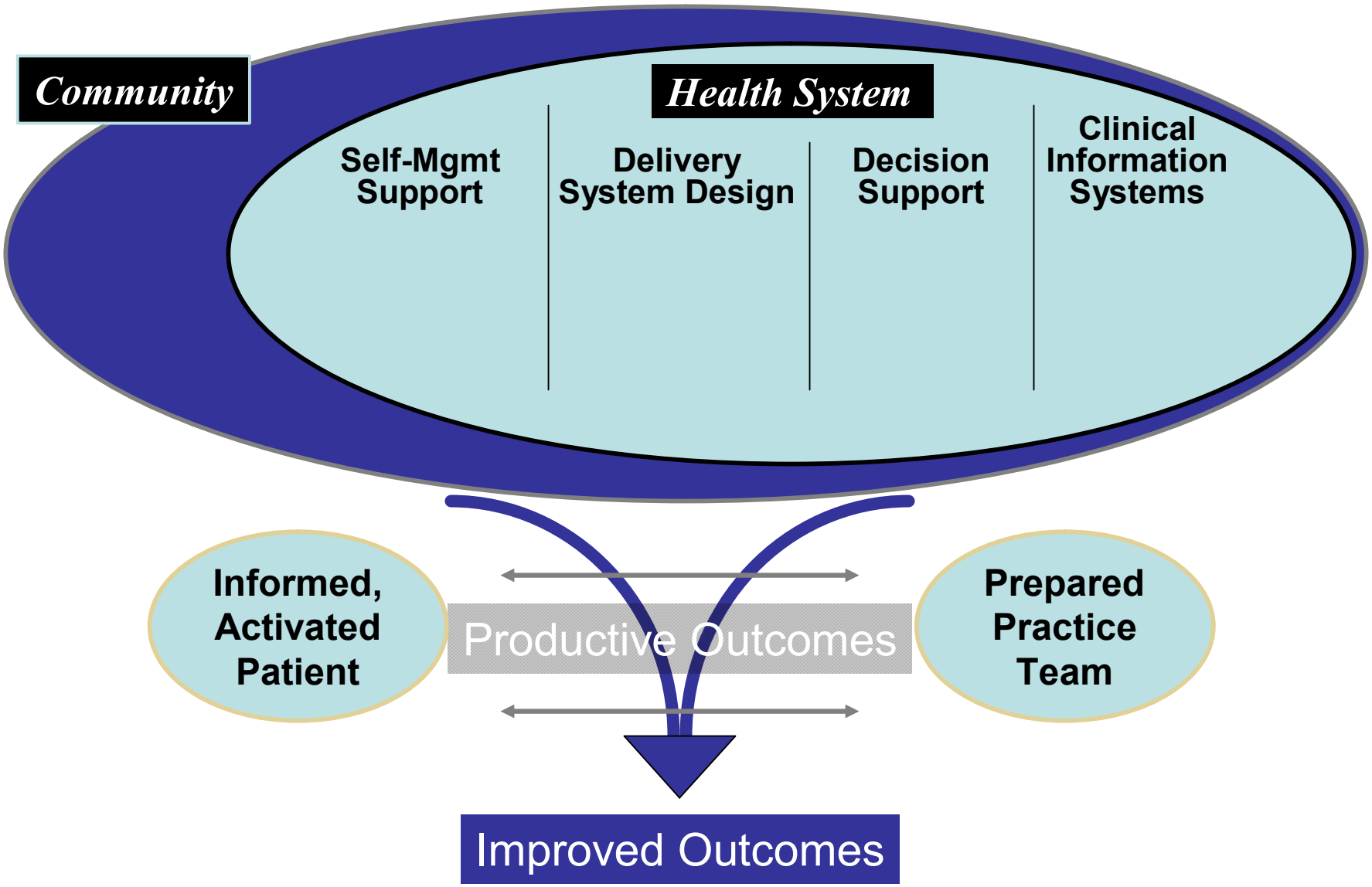
| Gateway | Texas | U.S. |
|---|---|---|
| 99% Hispanic | 32% Hispanic | 13% Hispanic |
| 65% Uninsured | 25% Uninsured | 16% Uninsured |
| 27% of the adult patient population (18+) has diabetes | 8% of Hispanic adults have diabetes | 13.6% of Hispanic adults have diabetes, almost twice that for non-Hispanic whites |

**2005-07 Diabetes Risk Assessment Results (20,000):**

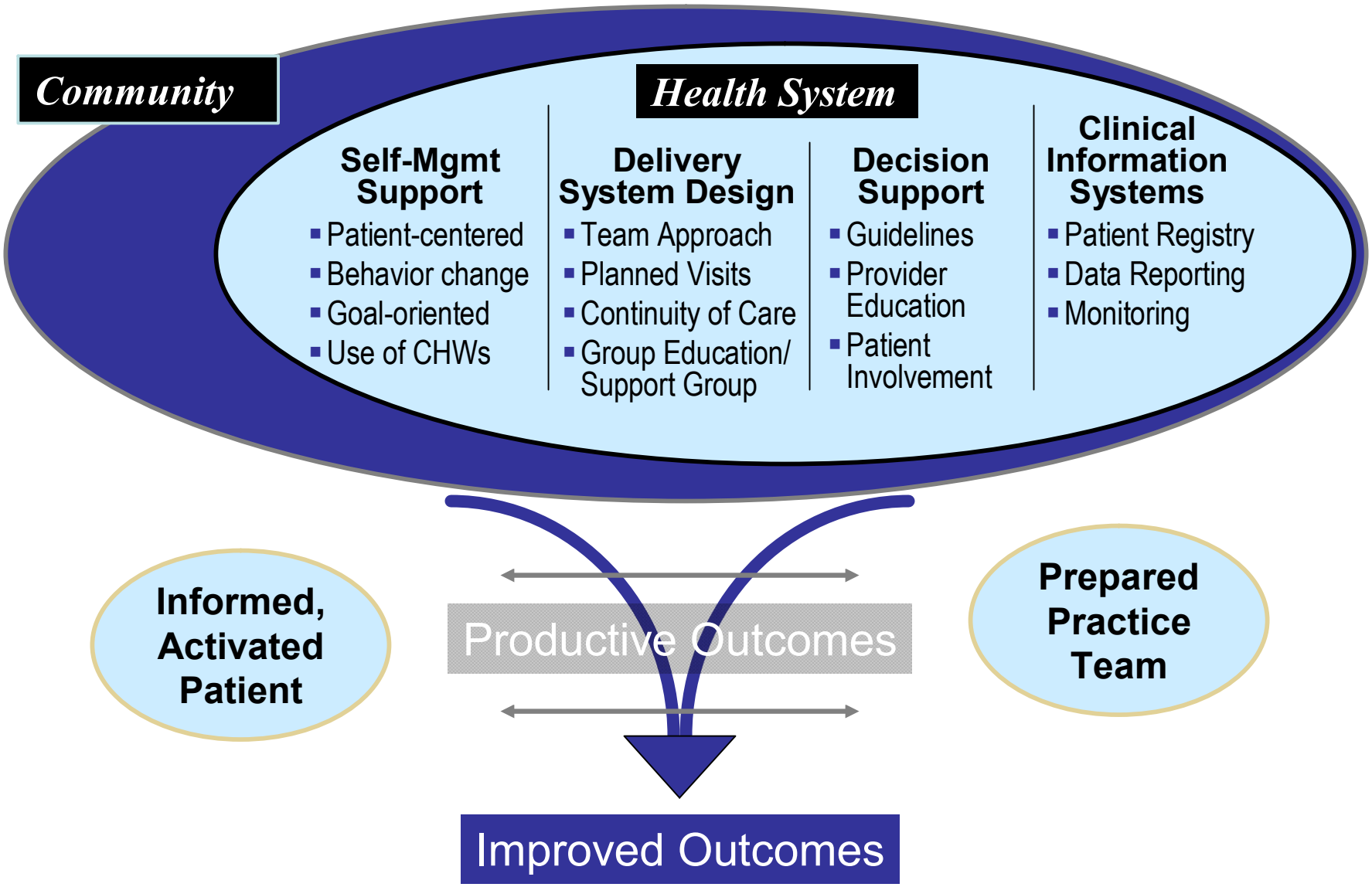
- 42% at risk of developing diabetes due to family history;
- 47% BMI higher than normal;
- 42% do not exercise according to the recommended time and duration;
- 65% were women; 35% were men;
- 17% had diabetes.

Source: UDS Report; Census 2000; Kaiser Family Foundation; American Diabetes Association Assessment Tool

# Chronic Care Model



# Chronic Care Model – Gateway Approach



**Gateway's Diabetes self-management Program is a culturally-relevant program that assists patients and their family members to understand and self-manage diabetes through trained Community Health Workers (Promotoras).**

## Program Goals

- Increase awareness of diabetes
- Improve diabetes clinical care through adherence to national guidelines
- Demonstrate behavioral change and self-management skills
- Achieve high satisfaction with care received

# Promotora Program

## Topics Include

**Diabetes/CVD Group Classes**

***10 week curriculum***

- Understanding diabetes and CVD
- Strategies and benefits of good diabetes control
- Importance of blood sugar monitoring
- Nutrition
- Lifestyle behaviors (physical activity, weight management, smoking cessation)
- Problem solving
- Medication
- Goal Setting
- Partnership with healthcare team
- Identifying and avoiding diabetes complications
- Social support
- Preventive care
- Community resources

**Support Groups**

***On-going***


Promotoras:

- *Assess patient needs*
- *Individual contacts, as needed*
- *Patient advocate*
- *Liaison to healthcare Team*
- *Documentation*
  - *-Progress*
  - *-Outcomes*

# Promotora Training-Topics and Evaluation

**300 Hours of Training**

- ✓Clinic Site Orientation
- ✓Medical Records
- ✓Diabetes Self-management
- ✓Leadership
- ✓Time Management
- ✓Listening Skills
- ✓How To Make a Home Visit and Referrals
- ✓Advocacy
- ✓Promotora Safety
- ✓Goal Setting
- ✓Problem Solving
- ✓Mental Health Training
- ✓Stress Management
- ✓Support Group Facilitation
- ✓Community Resources
- ✓Communication Skills

**Evaluation**

- ➢Skills List
- ➢3-month
- ➢12-month
- ➢Patient

# Routine Care

Appt scheduled

MD Visit → Assessment → MD Education (verbal and printed handouts) → Treatment Plan (Labs Medication Care Plan)

MD Follow up
1 month:
Review labs
& initial
treatment plan

MD Follow up
x 3 months,
as needed

# Care that Includes Promotoras

Appt scheduled

MD Visit → Assessment → MD Education (verbal and printed handouts) → Treatment Plan Labs Medication Care Plan

Referral to Promotora program

*Promotoras*

**Group classes and individual support**

***Extensive Education***

- Using glucometer
- Medication use
- How to check feet
- How to identify complications
- Support for lifestyle changes

**MD Follow up 1 month:** Review labs & initial treatment plan

**Patient educated and more informed**

**MD Follow up x 3 months, as needed**

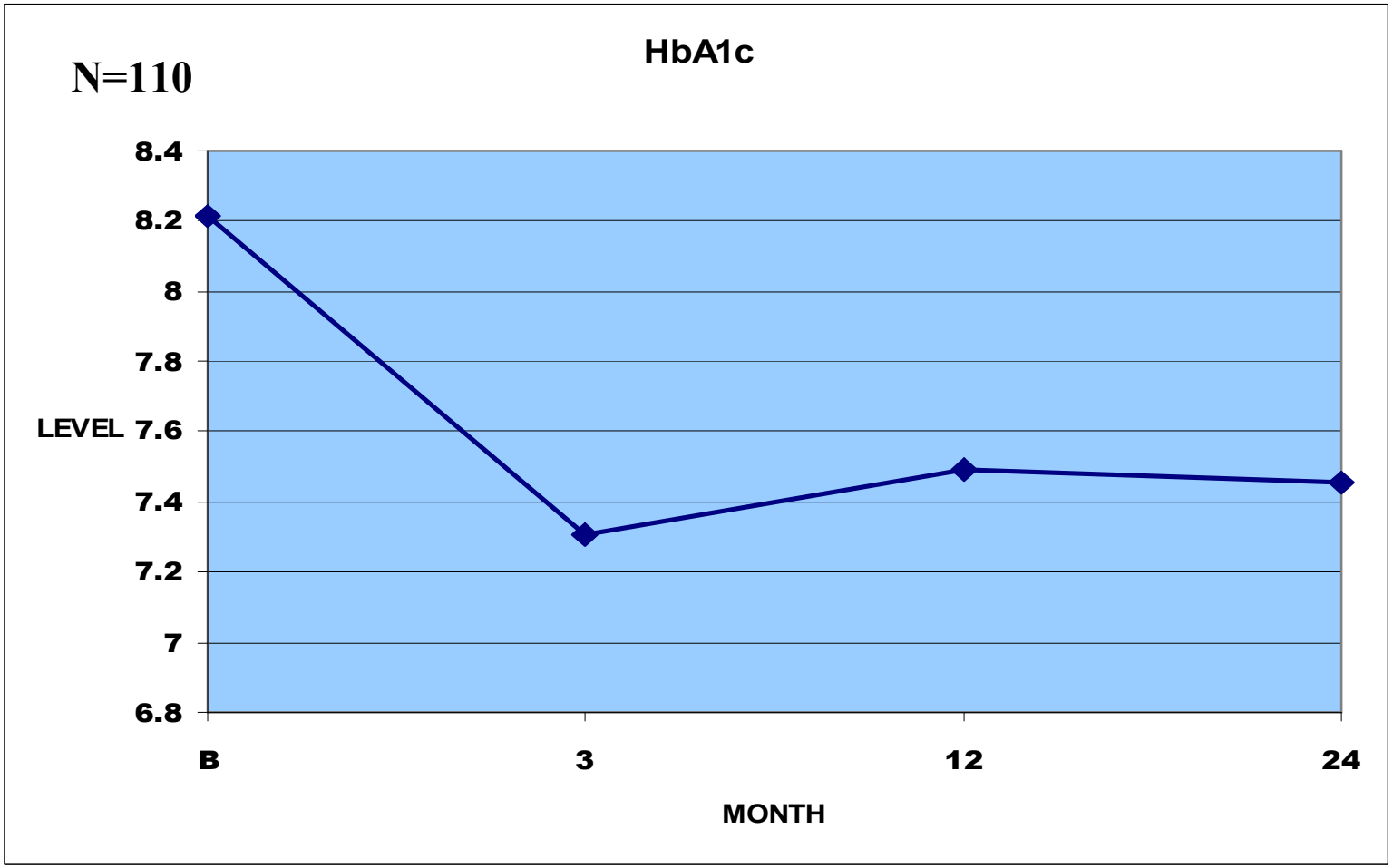
**MD visits are more focused, less follow up required**

# Benefits of the Integration of the Promotora Program

| To Providers | | To Patients |
|---|---|---|
| More efficient use of time | ⟷ | More time spent on education |
| Improved diabetes control | ⟷ | Improved health outcomes |
| Assess of social needs/concerns | ⟷ | Individualized care |
| Reinforce treatment plan | ⟷ | Better self management |
| Extension of MD services | ⟷ | Improved access to care |
| Health advocate / additional clinic services and referrals identified | ⟷ | Specific needs met by appropriate referrals |
| Implement clinical protocols | ⟷ | Improved quality of care |

# Results

***Goal: A1c levels below 7.5 over an extended period of time***




**65% of the patients maintain their A1c at or below 7.5 over an extended period of time**

# Sustainability Strategies

***Proposed Changes within the Organization***

- Explore the possibility to increase the cost per office visit;
- Expand services to the private sector;
- Offer services to worksites.

***Training Program***

- **Promotora training to facilitate self-management classes;**
- **Self-management curriculum;**
- **Bilingual training;**
- **Train-the-trainer sessions for local sustainability.**

***Effective Promotora Training is critical for the continued growth, respect, credibility and sustainability of this model in the public health field.***

# Thank You!

**Self Management is the key to good control of diabetes and**

**Promotoras play an important role.**

**Lourdes Rangel**
**Director of Special Projects**
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www.gatewaychc.com

This product was developed by the Proyecto Vida Saludable at the Holyoke Health Center, Inc. in Holyoke, MA. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

# Diabetes Self Management in a Community Health Center

Jon Liebman, MSN, MS
Adult Nurse Practitioner
Dawn Heffernan, MSN
Diabetes Program Manager
Holyoke Health Center

# Holyoke, Massachusetts

- Small industrial city in Western Massachusetts
- Population 39,000
- Service area 75% Latino
- 50% of residents Medicaid recipients
- 46% below 200% of federal poverty level

# Holyoke Health Center

- Two main clinic sites
- Migrant clinics and county jail sites
- 20,000 patients
- 76,000 annual visits
- 18.6 FTE MD and NP medical providers

# Comprehensive Services

- Adult, Pediatric, Family Medicine
- Urgent Care
- Dental
- Pharmacy
- Addiction treatment (Suboxone)
- Migrant Health Program
- Mental Health Services
- Support for patients with chronic diseases
- Participation in Health Disparities Collaboratives

# Implementation of the Chronic Care Model, 1999

- Key Program Elements at HHC:
  - Team Approach
  - Electronic registry
  - Key clinical information at time of visit
  - Clinician training – treat to target
  - Exercise and Nutrition programs

- Outcomes

  Generated data to track progress

  Staff became invested

  Outcomes improved a little

# The Missing Piece: Self-Management Support

- 2003 – present
- RWJF supported
- Goals:
  - Increased patient knowledge
  - Increased self efficacy and problem solving
  - Peer support/role modeling/mentoring
  - Linkages to community supports
  - Continued involvement in medical care
  - Goal setting
  - Physical activity and nutrition

# Self-Management Activities

- Weekly breakfast club
- Weekly afternoon snack club
- Supermarket tours
- Diabetes education classes
- Individual diabetes teaching with RN
- On-site Exercise class
- Community Health Workers
- Volunteers/Mentors

# Community Health Workers

- CHWs:
  Outreach to at-risk patients
  Home visits
  Phone contact
  Clinic visits
  Attend medical visits
  Help with group activities.

- Mentors assist with group activities.

Role Modeling; Mentoring; Peer Education/Support

# Patient Participation

- 580 individuals participated in self-management over 3 years (49%)

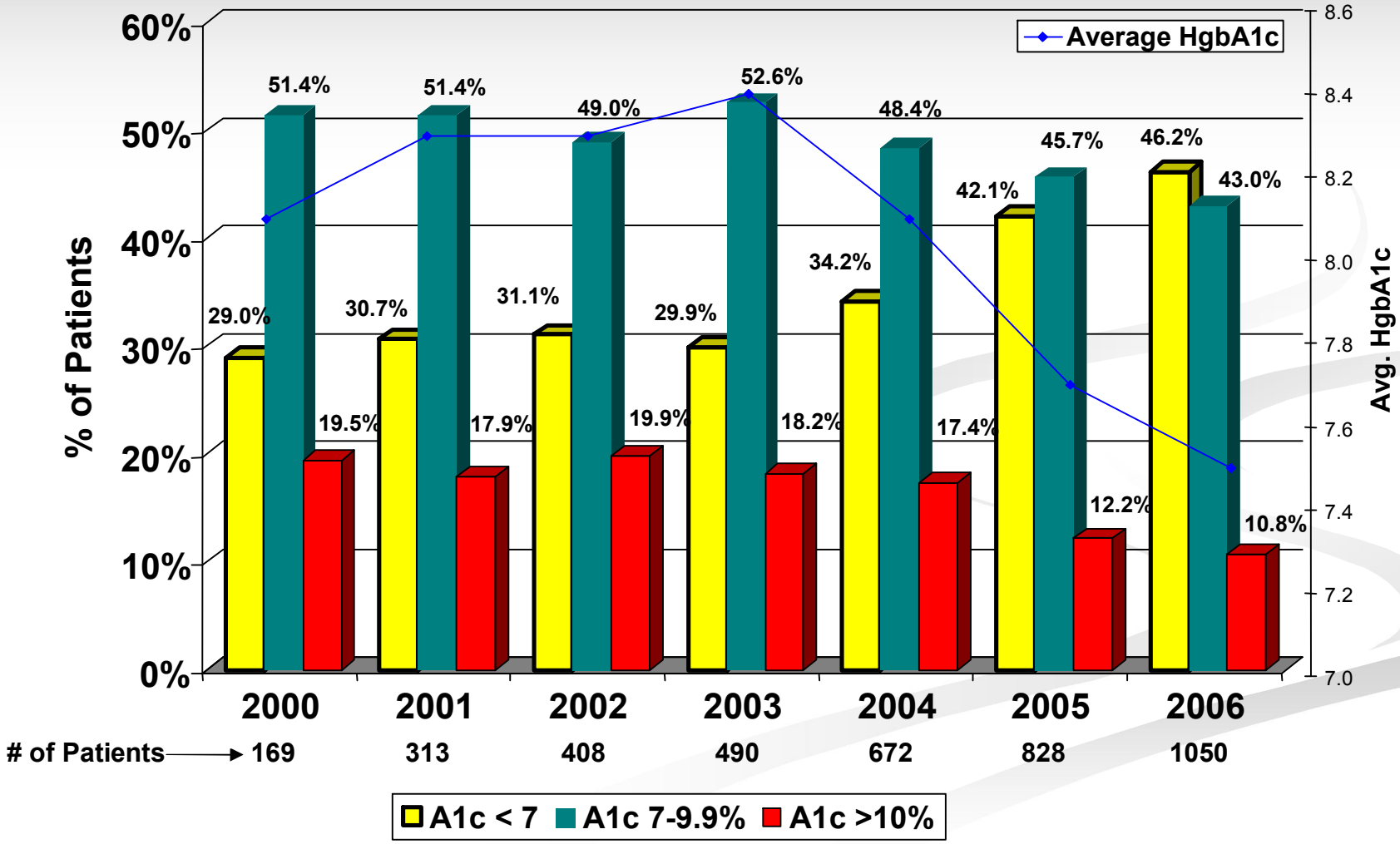
- Diabetes educator: 439
- Breakfast club: 147
- Snack club: 162
- Diabetes class: 146
- CHW interaction: 136

# Clinical Outcomes

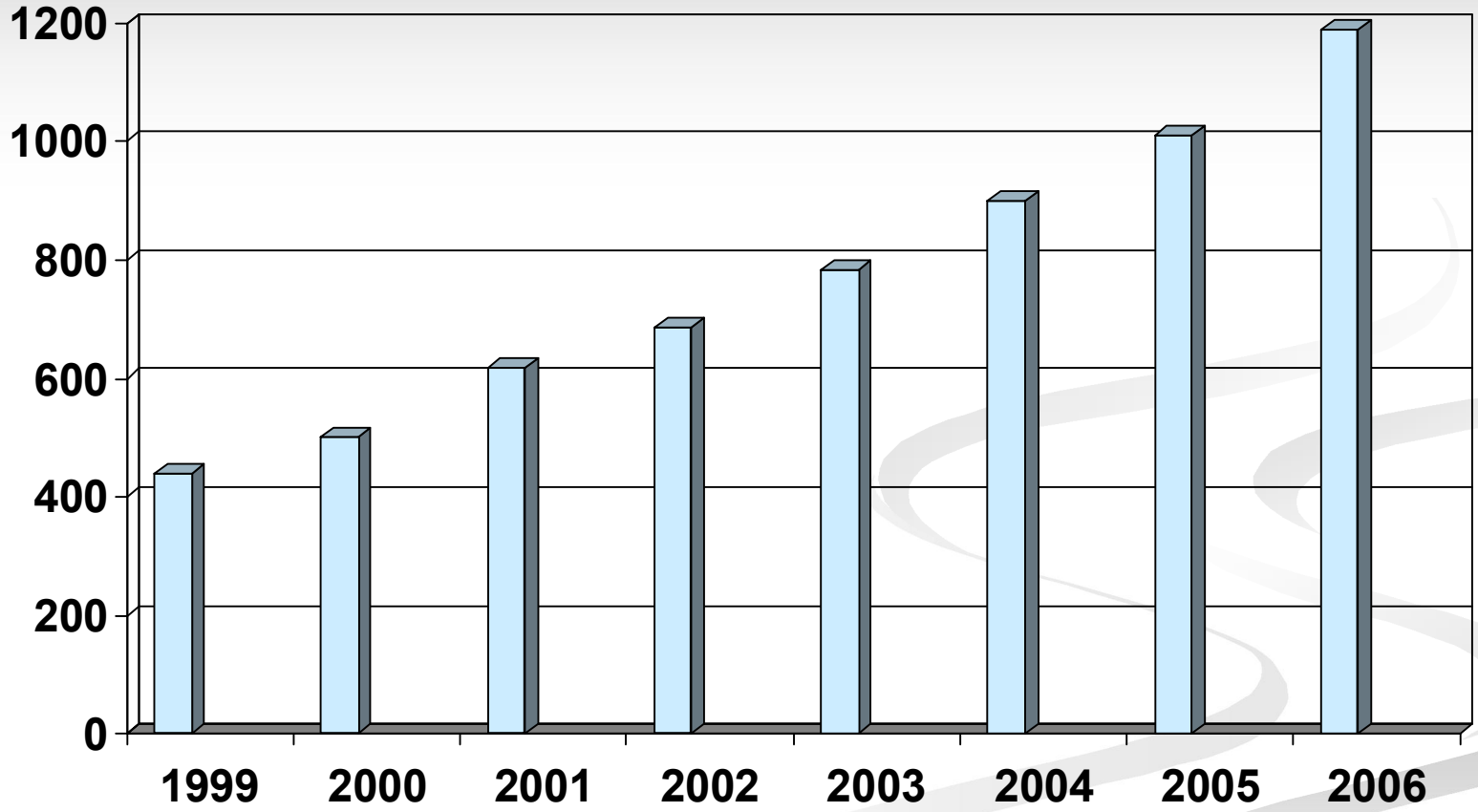
- Prior to 2003
- Average A1C from 8.1 to 8.4
- Proportion with A1c < 7.0 about 30%
- Proportion with A1c > 10.0 remained 18-20%

- 2003-2006
- Average A1c dropped to 7.5
- Proportion with A1c <7.0 increased to 46%
- Proportion with A1c > 10.0 dropped to 10.8%

# Improvements in Glycemic Control Years 2000-2006



# Growth in the Number of Patients



# Now… More Patients with Diabetes

- January 2006: 1188 patients
- January 2007: 1456 patients
- August 2007: 1642 patients

- Average A1c has remained 7.5
- Proportion of patients not seen > 1 year is increasing
- Proportion with uncontrolled diabetes is increasing
- The model works, but the numbers are overwhelming

# Where Do We Go From Here?

- Maintain existing program; expand as able
- Obesity Programming:  Healthy Weight for Women
- Community Prevention
- Chronic Disease Self Management

# Chronic Disease Self-Management

- Model developed at Stanford (Lorig et al)
- Group sessions, not disease specific
- Focus on problem solving skills, self-efficacy
- Led by paraprofessional staff (MAs)
- Program run in clinic, and outside sites

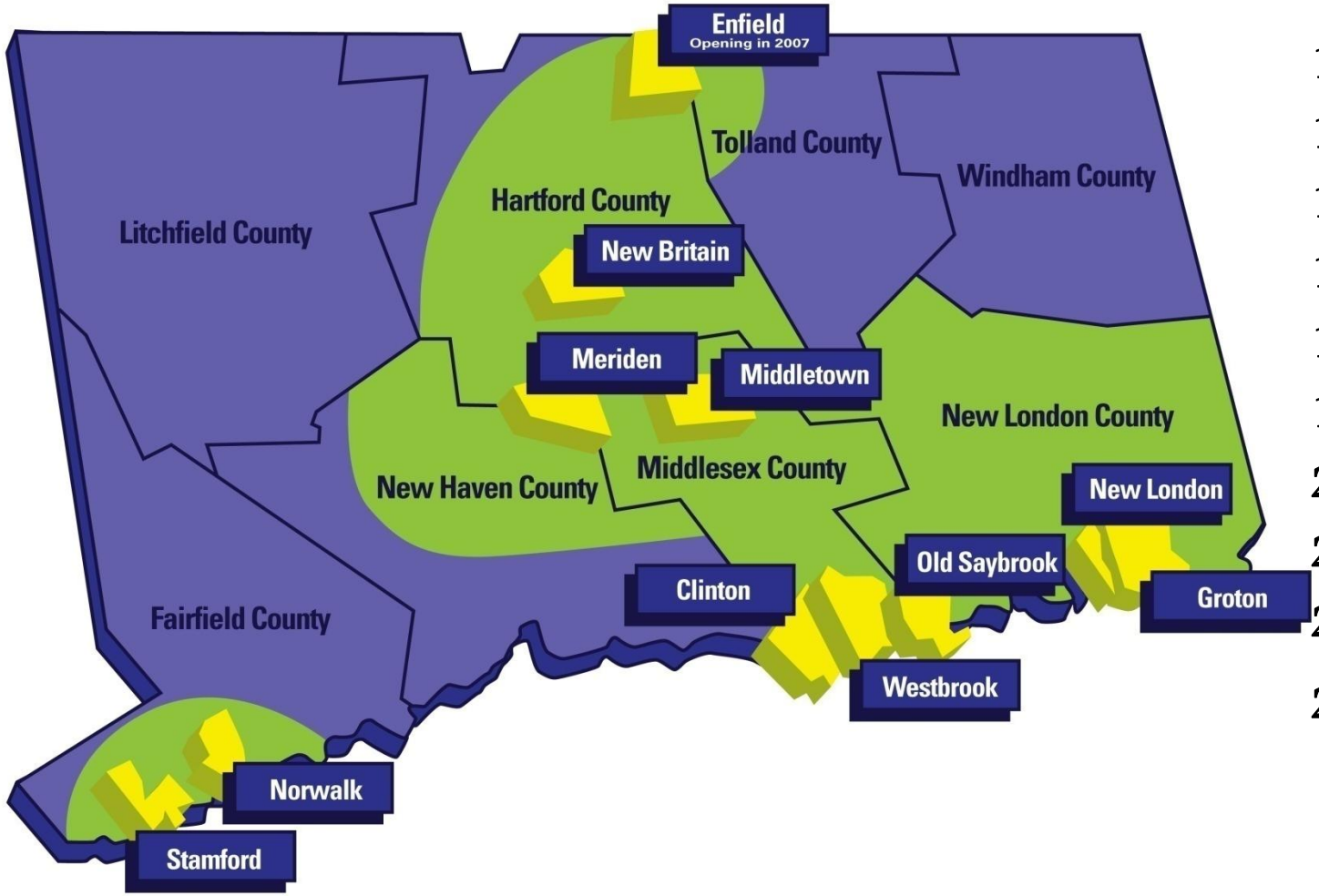
This product was developed by the RWJ Diabetes Self Management Program at Community Health Center, Inc. in Middleton, CT. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

# Improving Diabetes Care

Daren R. Anderson, MD
Chief Medical Officer
Community Health Center, Inc.

2007 NACHC Community Health Institute
August 27, 2007
Dallas, Texas

# Community Health Center, Inc.




1972- Middletown
1980- Old Saybrook
1990- Meriden
1992- New London
1994- Groton
1995- New Britain
2001- Clinton
2005- Norwalk
2005- Stamford
2007- Enfield*

# CHC Inc. Services



**Health Care Services:** **Ages: ALL**

- Medicine
- Dentistry
- Behavioral Health

**Locations:**

Primary care offices, schools, and shelters

**Specialties**: OB, HIV/AIDS, and chronic diseases

**Other Services:**

- Eligibility Assistance and Outreach
- Language Line interpretation Services
- Domestic Violence Services
- Vinnie's Jump & Jive (Community Dance Studio)

Where health care is a right, not a privilege, since 1972
Community Health Center, Inc.

# 2006 in Review

**Patients Consider CHC their Health Care Home: 70,000**

| **Patients by Practice** (2006) | |
|---|---|
| Medical Care | 30432 |
| Dental Care | 21581 |
| Mental Health Care | 3192 |

| **Patients by Condition** (2006) | |
|---|---|
| Chronic Disease | 11244 |
| Psychiatric Disorder | 3192 |
| Pediatric and Adolescent Care | 19642 |

# Innovations in Healthcare Delivery

- Advanced Access Scheduling
  - Increase capacity and timeliness
  - Decrease waste and delay
- 340B Pharmacy program
  - 50% decrease in drug cost for uninsured
- Weitzman Center for R&D
  - Research, Publication, Consulting, and Symposium
- Electronic Health Record: wireless, fully electronic system in all CHC sites
- Integrated Diabetes Self Management

# Main Conclusions/Lessons Learned from RWJF SM Project

I. Underserved patients with diabetes can successfully take part in diabetes self management and improve their clinical outcomes

II. Depression is extremely prevalent and must be dealt with in an integrated fashion

III. Patients choose to engage in SM in different ways. Programs must be flexible and offer varied options

IV. Creative solutions are needed to maintain engagement over the long term

# I. Clinical/Behavioral Outcomes

## Over 2300 self management goals have been set by 489 patients enrolled in RWJ. Change among these patients:

- Average A1C: –0.7666
- Average LDL: – 23.3
- Average HDL: + 1.4
- Average overall cholesterol: – 28.8 pts
- 42.3% of the 489 patients now have BP <130/80 compared to only 26.9% upon enrolling in RWJ
- 60% of goals were attained (attainment score of 3-4 on a four point scale

# II. Depression and Diabetes

- Integration of care
- Key elements of the models:
  - All diabetic patients screened for depression with PHQ9
  - Using available resources
  - Self management and depression care were complementary
  - Primary care delivery
  - Emphasis on non-pharmacologic treatments
  - Cultural factors
  - Group sessions
  - Lay-health workers

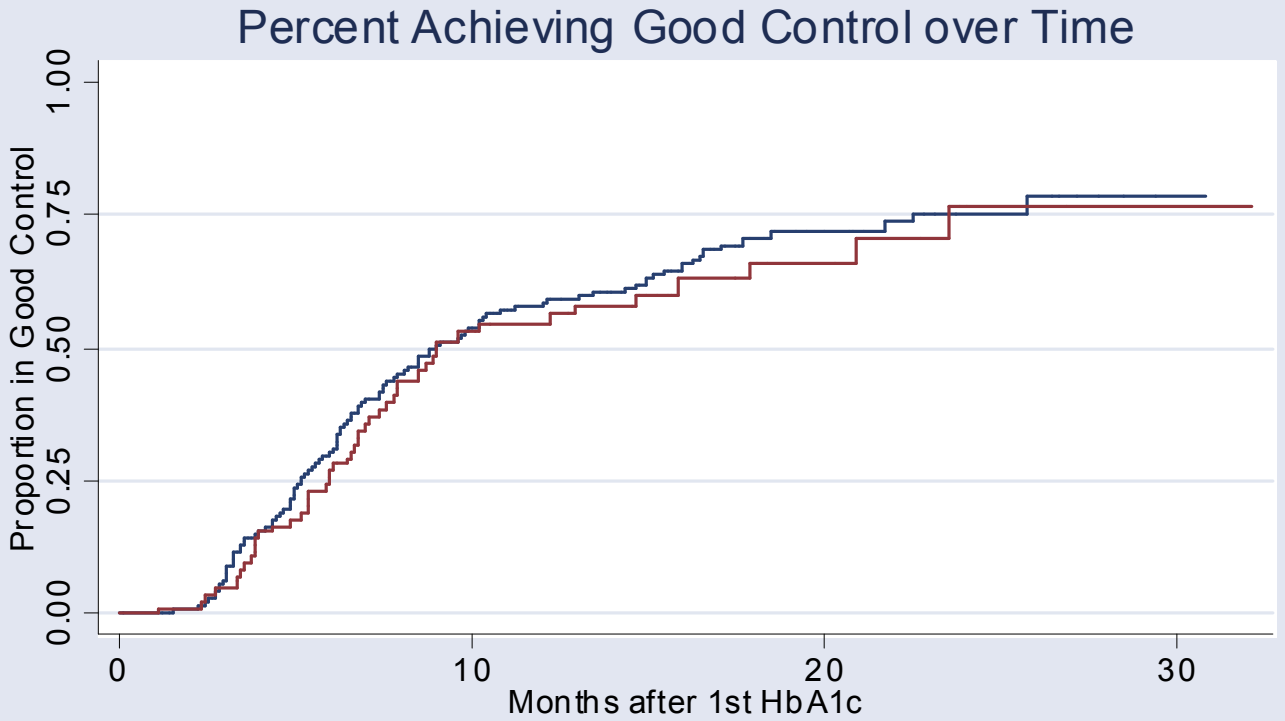
# Screening Results

- 739 patients screened
- 31% had PHQ9 score $\geq$ 10 (moderate to severe depression)
- Range 30-70%

# Key Characteristics Of Integrated Models

- Emphasize primary care-based treatment of depression
- Promotoras: Peer coaches, focused on behavior change
- Culturally focused models: i.e. incorporating Native American beliefs and traditions into counseling program
- Mind-body focus: Relaxation, inter-relationship of physical and psychological symptoms, emotional and spiritual factors, yoga sessions
- Integrated MH/DM care: Coordinated treatment between on-site primary care, behavioral health, and self management educator

# $HbA_{1c}$ over Time: Patients in Poor Control



# III. Providing Options for SM

I. **CDE individual session**

- Initial contact with bilingual, empathetic CDE's
- Roughly six 30 minute sessions covering a defined curriculum
- Emphasis on individual goal setting
- SM goals recorded, tracked, and attainment score recorded at each follow up
- Quarterly CDE follow-up (visit/phone)

II. **Group sessions**

- 6 sessions, 2 hours, didactic/participatory
- Special activities (cooking clubs, salsa, DM bingo, walking)

III. **Needed a 3rd way:**

- Events such as cooking clubs or exercise groups attracted a relatively small number of participants, usually female
- Complex and fragmented lives contributed to patients' keeping medical visits but not "extra" visit
- Only about 1/3 of diabetic patients engaged in DM self management

# Expand the Reach with Teamwork: Planned Care

- Conduct morning team huddles to review charts of patients coming in
- Review EHR and address needs using PCP, RN and MA (i.e., foot check, A1C, review SM goals)
- Utilize nurses trained in SM to facilitate goals before or after the patient's visit with the provider
- Provide separate nursing visits for education and self management goal setting

# IV. Maintaining Engagement Over the Long Term

- Evidence shows that duration of contact is associated with improved SM outcomes
- Diabetes self management is for the long term
- Patients who "graduate" or lose contact with SM team often revert to old behaviors

# New Strategies

- How to provide SM education to a large population of patients, and maintain contact over the long term?
- Maintenance sessions (quarterly)
- Drop in sessions
- Telephone
- Internet/email

Where health care is a right, not a privilege, since 1972
Community Health Center, Inc.

# Thank you

# PCRS Use in Missouri Community Health Centers


**Presented by:**

**Angela Herman, MPA**

**Clinical Program Manager**

Missouri Primary Care Association

**2007 NACHC Community Health Institute**

**August 27, 2007**

# Missouri Primary Care Association

- MPCA is a nonprofit corporation founded in November 1984 as an alliance of Community and Migrant Health Centers.
- Member centers have 19 Main Health Center Sites with over 110 Delivery Sites
- All 19 CHCs are participating in One or more National Health Disparities Collaboratives

# Disease Collaboratives in Missouri

- Missouri CHCs are currently participating in the following Disease Collaboratives:
  - Asthma: 3,596 Patients in Registries
  - Cancer: 18,451 Patients
  - CVD: 20,080 Patients
  - Depression: 1,582 Patients
  - Diabetes: 11,940 Patients
  - Total in All Registries: 56,089 Patients

# Partners Involved in PCRS Project in Missouri

- Partners:
  - Washington University in St. Louis School of Medicine
  - The Robert Wood Johnson Foundation Diabetes Initiative
  - Missouri Department of Health and Senior Services-Diabetes and CVD Programs
  - Missouri Primary Care Association
  - Missouri Community Health Centers

# PCRS Implementation in MO

- Funding for the Implementation of the PCRS in Missouri was provided in part from the following federal sources:
  - U32/CCU722693-04 Systems-Based Diabetes Prevention & Control Program
  - U50/CCU721332-04 Cardiovascular Health Programs
  - U58/CCU722795 Consolidated Chronic Disease Prevention and Health Promotion Programs

# PCRS Implementation in Missouri Timeline

- September 2005: National Program Office of the Diabetes Initiative began discussions with MO Diabetes Prevention and Control Program
- December 2005: First planning meeting of the partners involved at which time decided to add a train the trainer component and quality improvement tracking tool
- February 2006: Conducted focus group with CHC personnel to develop train the trainer session
- May 2006: Train the Trainer session for all CHCs on self-management, PCRS, reporting processes, and forms
- June 2006: Start of One Year PCRS Project in MO
- May 2007: Preliminary PCRS Data Available

# Train the Trainer Session

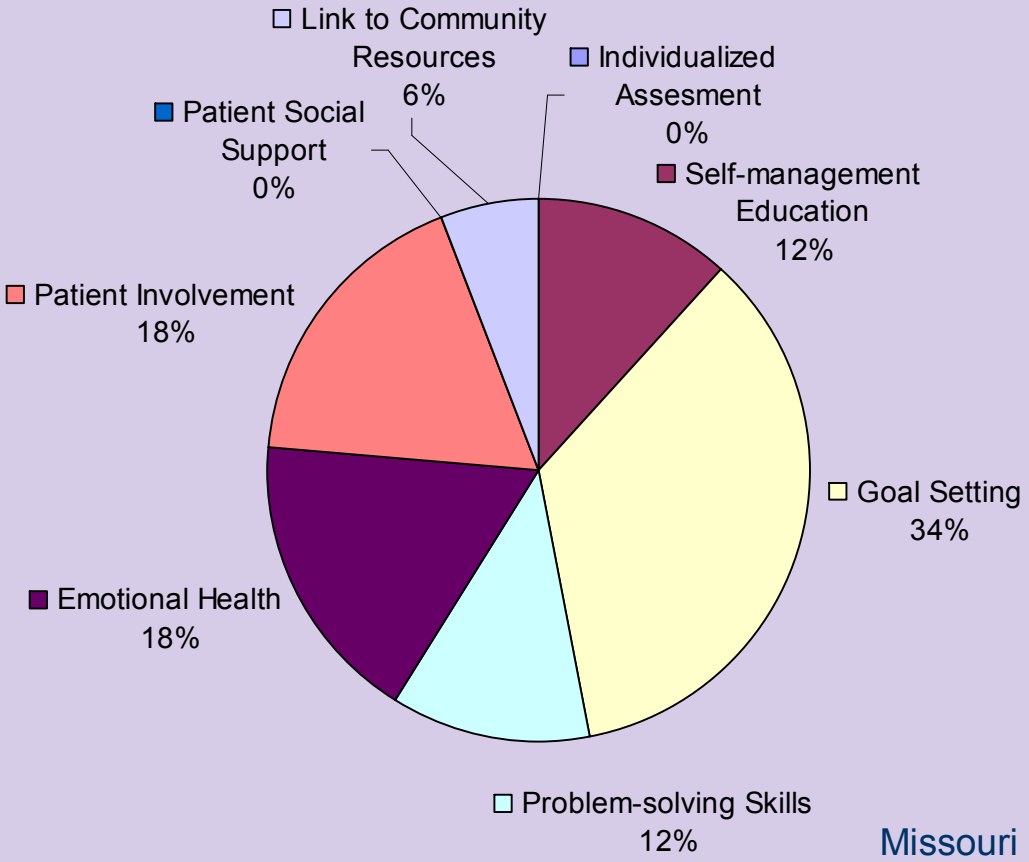
- Self-management 101
  - Opportunity to provide CHC staff with training on self-management support
  - Development of action plans
  - Acquire skills needed to assist patients with problem solving skills
  - Learn the difference between self-management education and self-management support
- Overview of PCRS Tool
- Quality Improvement Tracking Tool
- Reporting Requirements

# Quality Improvement Tracking Tool

- Asked centers to identify patient support characteristic chosen and organizational support characteristic chosen
- For each area asked the centers to provide the following:
  - Rationale for choosing components
  - Describe major steps taken to make changes in chosen components
  - Were there things that really helped you as you went through your processes?
  - Barriers/obstacles encountered? If so, how did you overcome?
  - Outcome of the change
- Please let me know if you would like a copy of the Quality Improvement tracking tool

# Data: Patient Support

**Patient Support - Characteristic Selected**

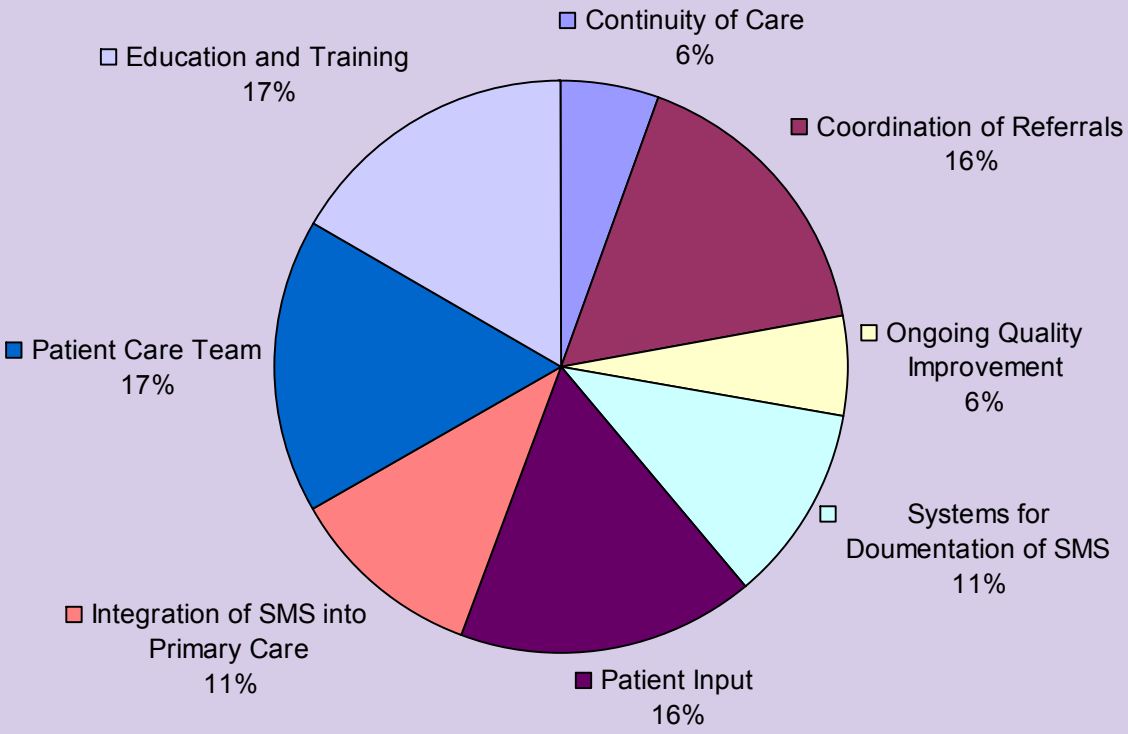


# Some Observations from the Patient Support Component

- 12 of 16 sites recorded improvement in the characteristic chosen; 2 of those reported major improvement (≥ 3 points)
- 3 of 16 sites recorded major improvement (≥ 3 points) in ANY characteristic
- 5 of 16 recorded major improvement (≥ 5 points) in Patient Support total score; 2 accomplished a major improvement in one characteristic and 3 made small improvements in multiple characteristics

# Data: Organizational Support

**Organizational Support - Characteristic Selected**



# Some Observations from the Organizational Support Component

- 9 of 16 reported improvement in the characteristic chosen; one reported *major* improvement (≥ 3 points)
- 4 of 16 sites reported major improvement (≥ 3 points) in ANY characteristic
- 7 of 16 sites recorded major improvement (≥ 5 points) in Organizational Support total score; 3 accomplished a major improvement in one characteristic that accounted for the score, and four made small improvements in multiple characteristics

# Lessons Learned in Missouri

- At the provider level, self management is enhanced overall when the patient care team functions as a team (patient care team)
- At the level of patient services, self management is enhanced overall by a patient-centered approach (patient involvement)
- What they have in common:
  - working together in partnership (“teamness”)
  - improved communication
  - role clarification
- Good relationships help improve the capacity for self management support!

# Example QI Strategies in Goal Setting

- Education/ awareness
  - Provider meetings
  - In-service on goal setting
- Improved processes
  - New forms
  - Better tracking of patient progress toward goals
  - Reminders on patient charts
- Focused on a subset of patients
  - Collaboration with Behavioral Health (for staff training on goal setting and on depression)
- Improved practice
  - Address SM goals at every visit

# Example QI Strategies in Patient Involvement

- More information
  - Tracking form revised; 1 copy to patient
  - Educational information in multiple languages
- More services
  - New diabetes educator—more one on one and follow up
  - New classes
- More opportunities for patient input into decision making
  - Patient made captain of healthcare team
  - Invited patients to be on advisory board

# Example QI Strategies in Patient Care Team

- Planned and conducted staff in-services
- Defined specific tasks for team members
- Worked on re-designing visit
- Included all staff in collaborative meetings; oriented all staff to the collaborative
- Published monthly newsletter
- Hired new nurse; defined her role on the team

# Documentation of Self-management Goal Setting

- Documentation of Self-management goal setting for Diabetes in August 2006 was at **43.2%**
- Documentation of Self-management goal setting in May 2007 at the conclusion of the one year PCRS project was **51.5%**
- Increases in the aggregate level was seen even when adding over 1600 patients over the course of the project

# In Summary

- Real change takes time; trends are in the right direction
- PCRS is one piece of the story; each site has unique resources and challenges
- Next Steps
  - Continue to monitor documentation of self-management goal setting to see if improvements can be maintained
  - Continue to share lessons learned

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# Questions

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