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.

Working Together to Improve Self Management Support in Missouri Community Health Centers

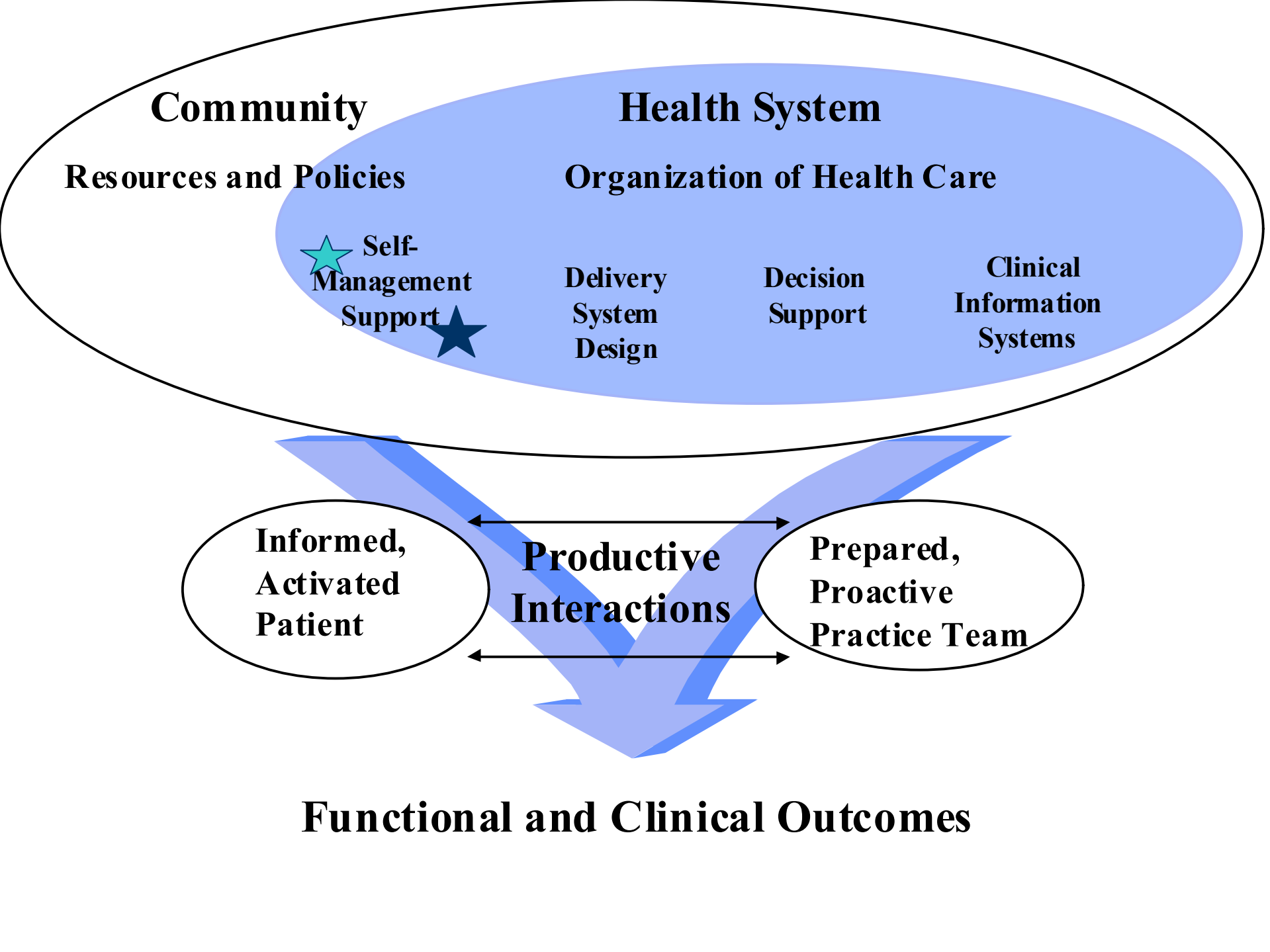
Presented by:
Angela Herman, MPA
Clinical Program Manager
Missouri Primary Care Association

Collaborators:
Carol Brownson, MSPH
Victoria Fehrmann Warren, MS

Partnership to Achieve Health Equity
November 1, 2007

Objectives:

- Demonstrate a model of collaboration and teamwork for improving self management in primary care settings
- Use a quality improvement tool to assess and monitor improvements in self management support


Community
Resources and Policies
Health System
Organization of Health Care
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Functional and Clinical Outcomes

The Tool: Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)

- 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
- Two components Patient Support and Organizational Support

Patient Support Component

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 Component

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

PCRS 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

Sample PCRS section

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**

Methods:
Train the Trainer Course

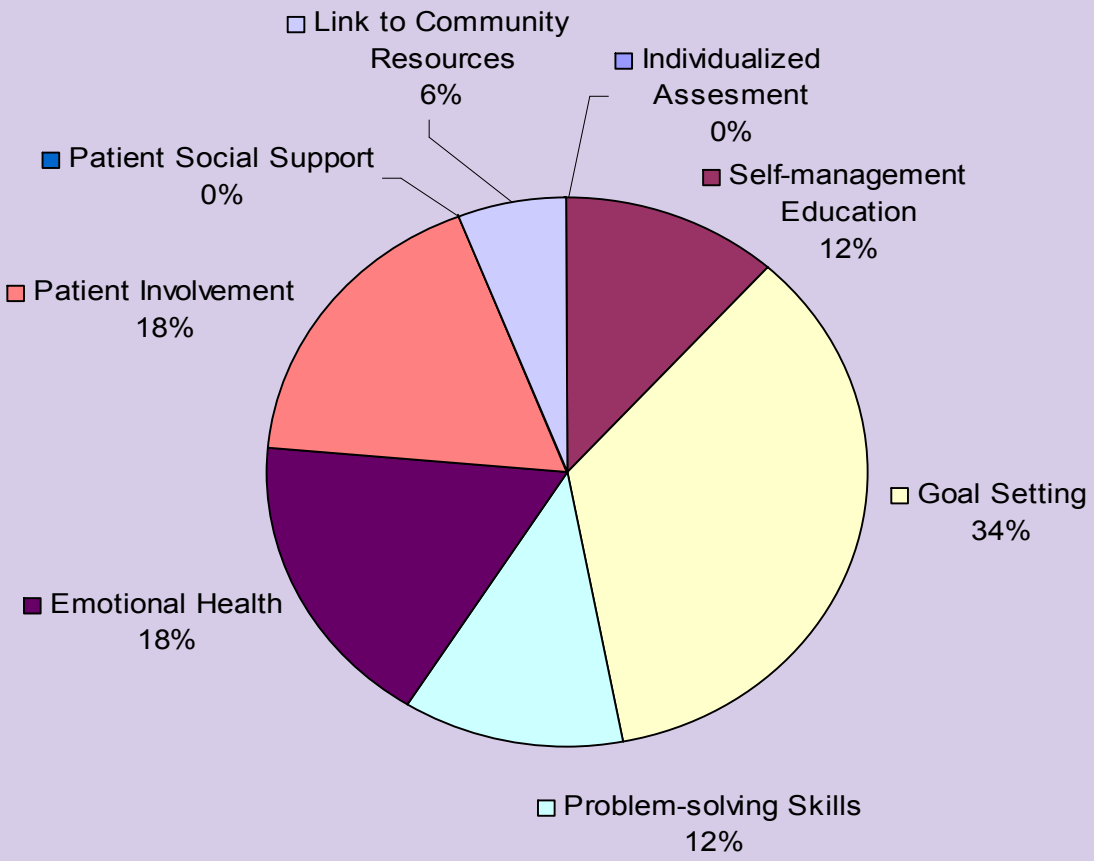
Self-management 101 for CHC staff included:

- training on self-management support
- practice developing action plans
- skills needed to assist patients with problem solving skills
- the difference between self-management education and self-management support

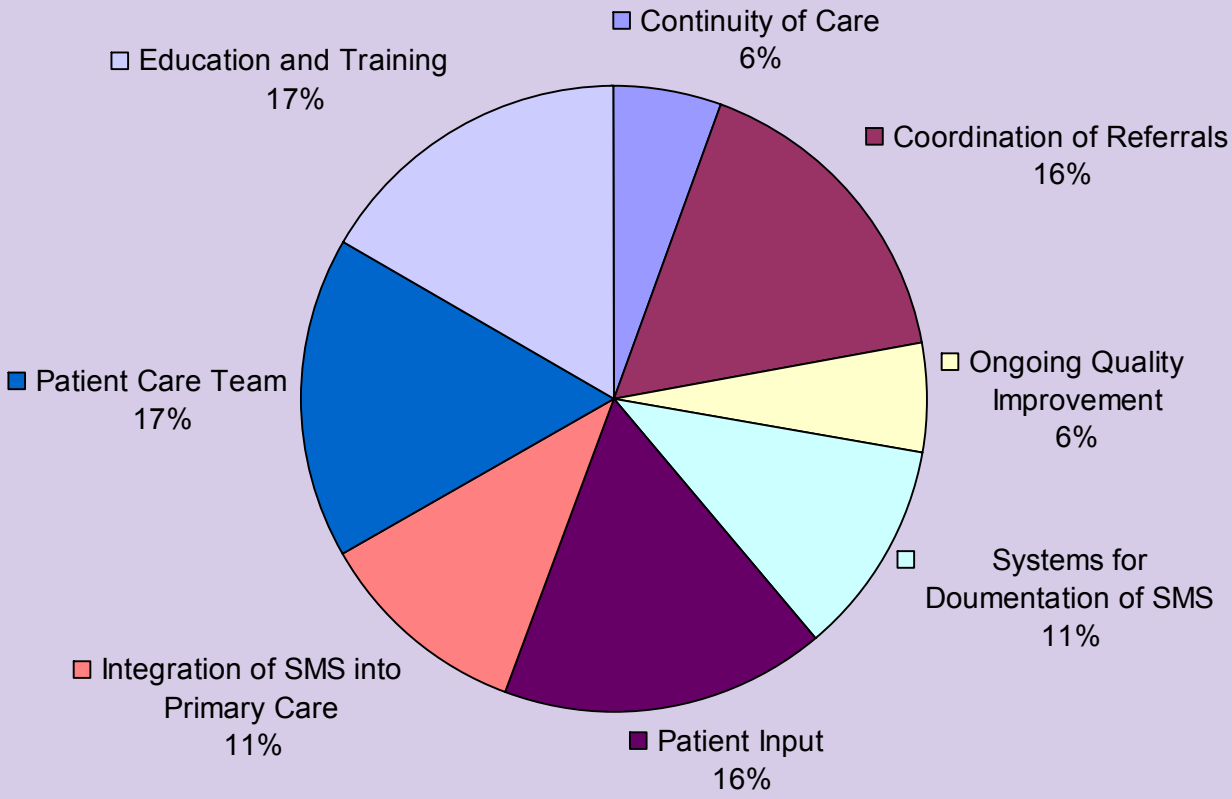
Methods: Quality Improvement Tracking

- Centers identified 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

Results
Patient Support - Characteristic Selected



Results:
Organizational Support - Characteristic Selected



Example QI Strategies for "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

Example QI Strategies for "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
- Improved practice
  - Address SM goals at every visit

Example QI Strategies for "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
- Patient input into decision making
  - Patient made captain of healthcare team
  - Invited patients to be on advisory board

Lessons Learned in Missouri

- FQHCs improved functioning of the patient care team
- Enhanced ability to provide more patient-centered care
- Good relationships help improve the capacity for self management support!