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DIABETES INITIATIVE
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Introduction to the PCRS

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What is PCRS?

Assessment of Primary Care Resources and Supports for Self Management

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

Development process for the tool

- Formation of workgroup
- 2 ½ years of development and testing
  - Workgroup meetings
  - Expert consultation
  - 3 phases of pilot testing
- Use/ spread of the tool
  - Program Use, e.g.,
    - Quality Allies/ New Health Partnerships Program
    - Missouri: DPCP/MPCA
    - California HealthCare Foundation Db Program
  - Journal Articles
  - Health Disparities website

Purpose of the PCRS

- To help primary care settings focus on actions that can be taking 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

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

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

An example…..

3. Goal Setting…

- D: is not done **1**
- C: occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients **2 3 4**
- B: 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**
- A: 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**

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)
  - Finding out where you are now
  - Identifying aspects 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 at http://www.diabetesinitiative.org/build/PCRS.html and http://improveselfmanagement.org