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

4th International DAWN Summit

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

Making change possible through availability of best concrete tools and processes

Individual evaluation by team members of provision of patient support

Sharing measurements within and between sites

MEASURE

SHARE

IMPROVE
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?
Informed, Activated Patient Productive Interactions Prepared, Proactive Practice Team Functional and Clinical Outcomes

Chronic Care Model

Domains of Self Management Support

<table>
<thead>
<tr>
<th>Patient Support</th>
<th>Organizational Support</th>
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<tbody>
<tr>
<td>Individualized assessment</td>
<td>Continuity of care</td>
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<td>Self management education</td>
<td>Coordination of referrals</td>
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<tr>
<td>Goal setting</td>
<td>Ongoing quality improvement</td>
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<td>Problem-solving skills</td>
<td>System for documentation</td>
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<td>Emotional health</td>
<td>Patient input</td>
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<td>Patient involvement in decision-</td>
<td>Integration into primary care</td>
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<td>Emotional health</td>
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<td>Social support</td>
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<td>Links to community resources</td>
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The PCRS

Assessment of **Primary Care Resources and Supports 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

...occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients

1 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

D C B A
### Scoring the Tool

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

**Characteristic: Emotional Health**

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- ...systems are in place to assess, intervene, follow up and monitor patient progress and coordinate among providers; standardized screening and treatment protocols are used

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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): __________________________

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<th>1. Check the component of Patient Support chosen for improvement**</th>
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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)

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