- 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.

Organizational Capacity for Self Management in Primary Care
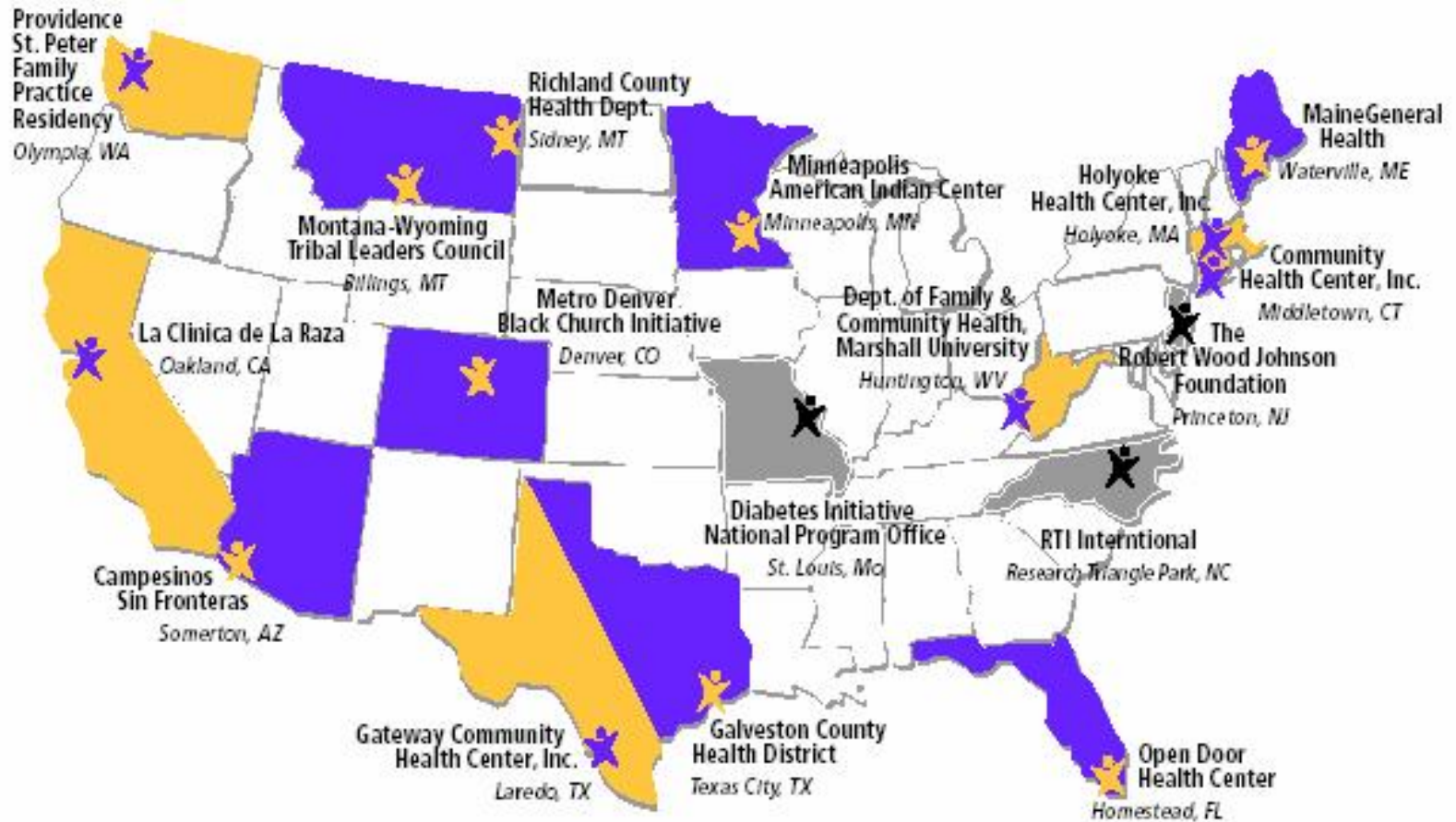
Carol Brownson, Joan Thompson, Joe Wall, Sally Neuner, Richard Crespo, Russ Glasgow, Doriane Miller

CDC Diabetes Translation and Obesity Conference

May 16 -19, 2006

Robert Wood Johnson Foundation Diabetes Initiative

Advancing Diabetes Self Management

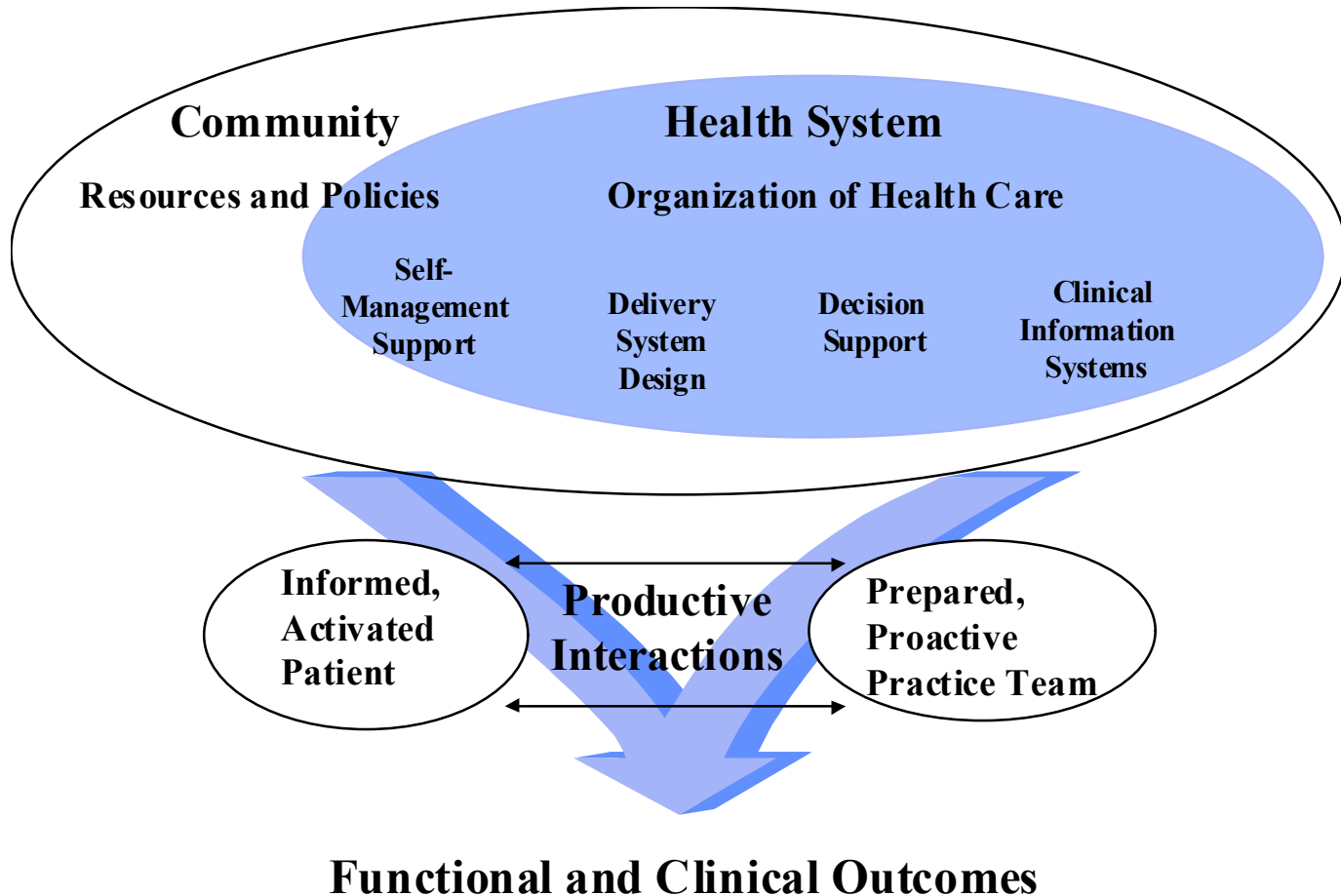Demonstrating and evaluating programs to promote self management of diabetes in primary care settings

Building Community Supports for Diabetes Care

Demonstrating and evaluating clinic-community partnerships to support self management of diabetes and diabetes care

Chronic Care Model

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

Resources and Supports for Self Management (RSSM)

- Individualized assessment
- Collaborative goal setting
- Skills for key self management behaviors (e.g., AADE7 for diabetes)
- Ongoing follow up and support
- Continuity of quality clinical care
- Access to community resources

Assessing Organization Capacity for Self Management

- Formation of a Workgroup
- 2 ½ years of development and testing
  - Workgroup meetings
  - Expert consultation
  - 3 phases of pilot testing
    - Clarity, completeness, etc. of the tool
    - Self assessment by teams in the workgroup
    - Use by external teams

What is PCRS?

Assessment of <u>P</u>rimary <u>C</u>are <u>R</u>esources and <u>S</u>upports 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

Purpose of the PCRS

- To help primary care settings focus on actions that can be taken to improve self management support for 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 existing self management support systems and service delivery

- Systems interested in identify exemplars who can assist other teams

- Researchers who are interesting in linking organizational characteristics and patient outcomes

The components

- Patient Support
  - Assessment at the "micro system" level (patient, provider, care team)
  - Addresses <u>characteristics of service delivery</u> found to enhance patient self management

- Organizational Support
  - Assessment at the "macro system" level (clinic or health care system)
  - Addresses <u>characteristics of organizations</u> 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 self management 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

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….

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
  - 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**

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://diabetesinitiative.org

- THANK YOU! -