

# Quality Improvement Instrument Improves Multidisciplinary Approach to Self Management in West Virginia Clinics



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# Marshall Center for Rural Health



Developing partnerships  
with a Self Management focus since 2003

- WVBPH Diabetes Prevention and Control
- WV Health Care Improvement Initiative
- Communities Putting Prevention to Work Initiative



- Primary Care Centers
- Churches
- Community Organizations
- Senior Centers



# Stanford Chronic Disease Self Management Programs

- ❖ 267  
workshop  
leaders
- ❖ 130  
workshops
- ❖ 1,032  
participants



# Challenge



**HOW DO PRIMARY CARE  
ORGANIZATIONS  
INTEGRATE SELF MANAGEMENT  
INTO THEIR DAY-TO- DAY  
DELIVERY OF PATIENT CARE?**

# Primary Care Resources and Supports



## PCRS Assessment

- A self assessment tool for patient care teams in primary care settings
- Based on the Chronic Care Model it “drills down” to defines the support components of self management
- 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
- Specifically, the PCRS helps:
  - Define/ describe optimal performance
  - Identify gaps in resources, services and supports for self management
  - Facilitate communication among team members; build consensus for change
  - Provide a mechanism to monitor progress

# 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

# Components of Self Management Support



## Patient

1. Individualized assessment of self management educational needs
2. Self management education
3. Goal setting/ action planning
4. Problem solving
5. Emotional health
6. Patient involvement in decision making
7. Social support
8. Links to community resources

## Organization

1. Continuity of care
2. Coordination of referrals
3. Ongoing quality improvement
4. Documentation of SM support services
5. Patient participation and input
6. Integration of SM support
7. Patient care team/ team approach
8. Staff education and training

**I: PATIENT SUPPORT** (circle one NUMBER for each characteristic)

Characteristic	Quality Levels									
	D	C			B			A (=all of B plus these)		
<b>Goal Setting</b>	...is not done  <b>1</b>	...occurs but goals are established primarily by member(s) of the health care team rather than developed collaboratively with patients  <b>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  <b>5 6 7</b>			...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  <b>8 9 10</b>		
<b>Problem-Solving Skills</b>	...are not taught or practiced with patients  <b>1</b>	...are taught and practiced sporadically or used by only a few team members  <b>2 3 4</b>			... are routinely taught and practiced using evidence based approaches and reinforced by members of the health care team  <b>5 6 7</b>			.... 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  <b>8 9 10</b>		
<b>Emotional Health</b>	...is not assessed  <b>1</b>	...is not routinely assessed; screening and treatment protocols are not standardized or are nonexistent  <b>2 3 4</b>			...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  <b>5 6 7</b>			...systems are in place to assess, intervene, follow up and monitor patient progress and coordinate among providers; standardized screening and treatment protocols are used  <b>8 9 10</b>		

# Scoring the tool



## 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

# Who should use it?

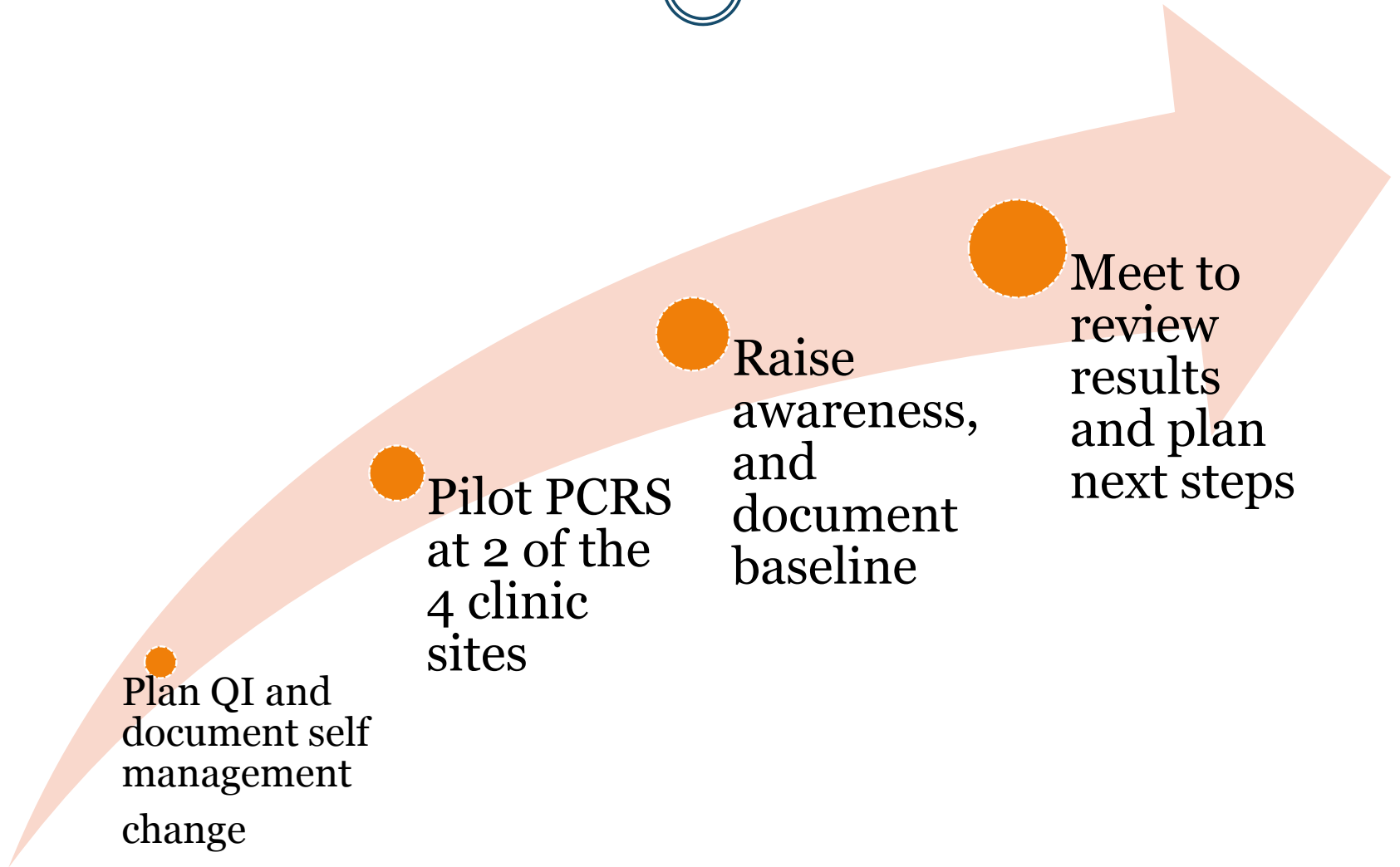


- Multidisciplinary patient care teams in primary care settings who are incorporating self management support into system of care
- Teams interested in improving the quality of their self management support systems and service delivery

# The PCRS Story at New River Health Association

- 
- Success with offering Stanford CDSMP
  - Success with incorporating Self Management in Medical Group Visits
  - Senior management interest in making system change for Self Management Integration
  - Standardize a “user friendly” process for self management goal setting
  - Need to establish self management baseline for Rural Quality Grant and Medical Home Application

# Self Management QI Team



**Team:** Scarbro  
**Assessment:** Scarbro Clinical Team Baseline Jan. 2010  
**Date:** 1/14/2010 - 1/29/2010

Category	PCRS Characteristic	Number of Respondents	High Score	Low Score	Mean	Standard Deviation
Patient Support	Individualized Assessment	13	10	2	5.8	2.1
	Self Management Education	13	9	4	5.7	1.8
	Goal Setting	13	9	3	5.3	1.5
	Problem-Solving Skills	13	9	3	5.6	1.8
	Emotional Health	13	10	3	6.2	1.9
	Patient Involvement	13	10	5	6.5	1.5
	Social Support	12	10	4	6.4	1.6
	Links to Community Resources	12	10	4	6.3	1.9
Organizational Support	Continuity of Care	13	10	4	6.2	1.6
	Coordination of Referrals	13	10	5	7.2	1.4
	Ongoing Quality Improvement	13	9	4	6.1	1.7
	System for Documentation	13	9	4	6.3	1.7
	Patient Input	13	10	4	6.8	1.6
	Integration into Primary Care	13	8	3	5.3	1.7
	Patient Care Team	12	9	4	6.7	1.5
	Staff Education and Training	12	10	4	6.6	1.6

# What we learned....



- Understanding about self management support widely varies
- Not everyone had basic self management skills and understanding of key concepts
- Staff are resistant to change and overwhelmed
- Individuals and teams need support to begin from where they are
- Changing the culture of care will take time and require an investment

# Plan: Staff self-management skills training



- Four lunch time sessions over 4 weeks with a healthy lunch provided
- Patient schedules altered to ensure that staff would be able to attend
- Sessions spaced out by one week so that staff can set their own goals and report on them at the next meeting
- Training agenda focus on staff setting personal self management goals and then on how to properly interact with patients using a defined method of self management action planning and motivational interviewing



## Build Excitement about Self Management

- Personal letter of invitation
- Flyers
- Reminders

PLEASE JOIN US  
For a 4 week lunch time workshop

### **Understanding Self Management**

*.... to increase skills that facilitate self management goal setting  
and positive behavior change*

**When --**

- Week 1: Feb. 10, 2010
- Week 2: Feb. 24, 2010
- Week 3: March 3, 2010
- Week 4: March 10, 2010

**Where --**

- Whipple Staff will meet at Robinson Annex
- Scarbro Staff in Conference Room below Pharmacy



**Lunch  
and  
Lunch-time  
Coverage Provided!**

- Workshops begin at 12:15 and will be over by 1
- Afternoon sessions will begin at 1:15
- We will start and end on time

# Self Management Knowledge Survey



- 98% scored 100%
- Comments about what they liked:
  - The pace of information
  - Not pressured
  - Time for practicing
  - Helpful personally
  - Helped me to get motivated
  - All “goals” don’t have to be large
  - Talking about everyday health
  - Action plans make changes less overwhelming

# Certificate of Completion

*Name*

Has successfully completed the 4 hour staff training

## **Understanding Self-Management And Motivational Interviewing**

February 10; February 24; March 3; March 10, 2010  
New River Health Association, Scarbro, WV

Marshall University  
Center for Rural Health



\_\_\_\_\_  
Yvonne Mims

\_\_\_\_\_  
Susie Criss

\_\_\_\_\_  
Date

# Self Management QI Committee



- Summarized and reviewed PCRS data and training process
- Repeat process and training with staff at other 2 clinic sites
- Plans to repeat PCRS assessment in workgroups
- Continue to meet regularly to keep QI planning process moving
- Incorporate Action Planning/Feedback and Problem Solving into meeting structure

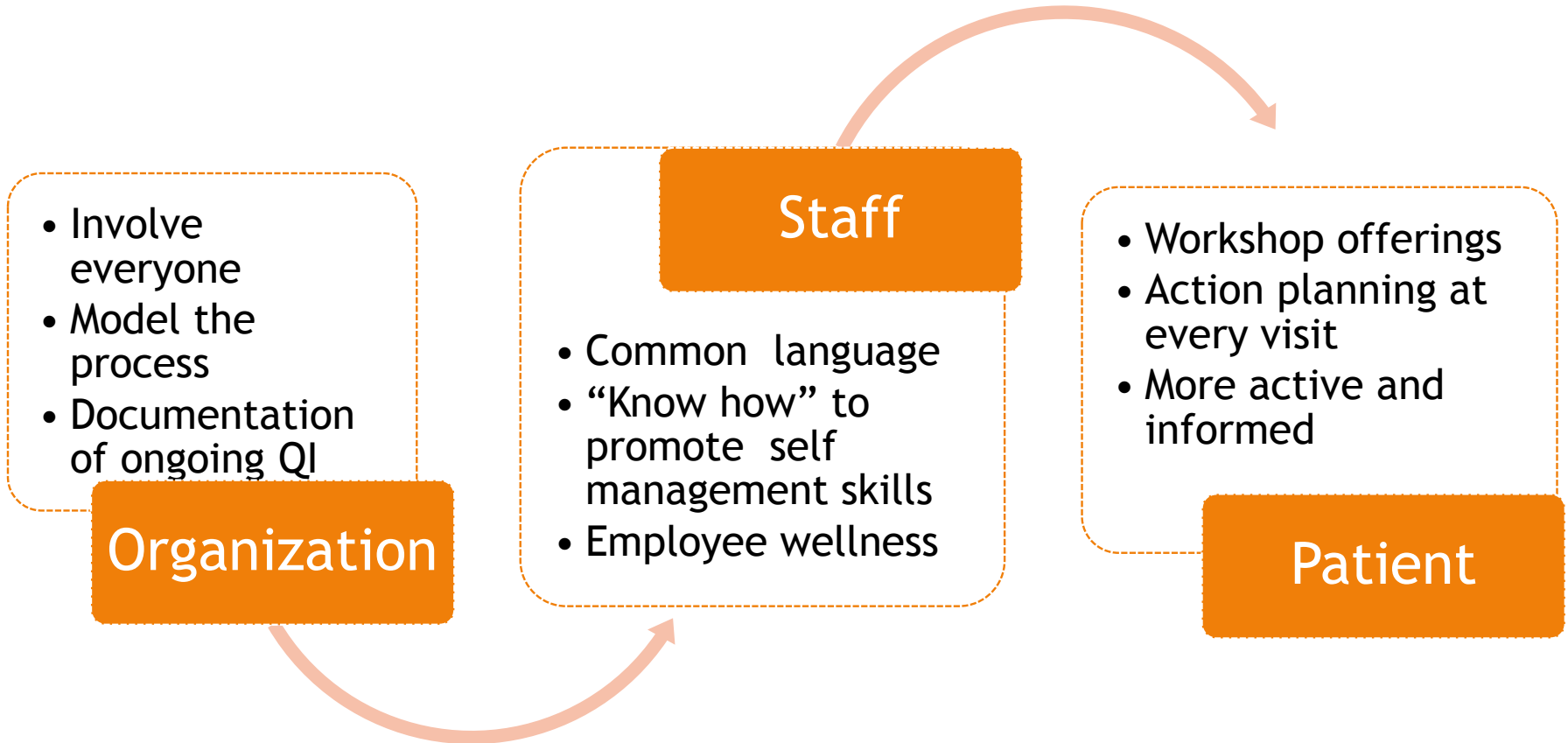
# In Summary.....



What worked?

- PCRS raised awareness about Self Management
- Forming a Self Management QI Team that meets regularly
- Organization showed respect to staff by investment of food and adjusting schedule
- Careful attention to creating a BUZZ
- Acknowledgement of participation and recognition of small steps
- Commitment to Self Management for the long haul

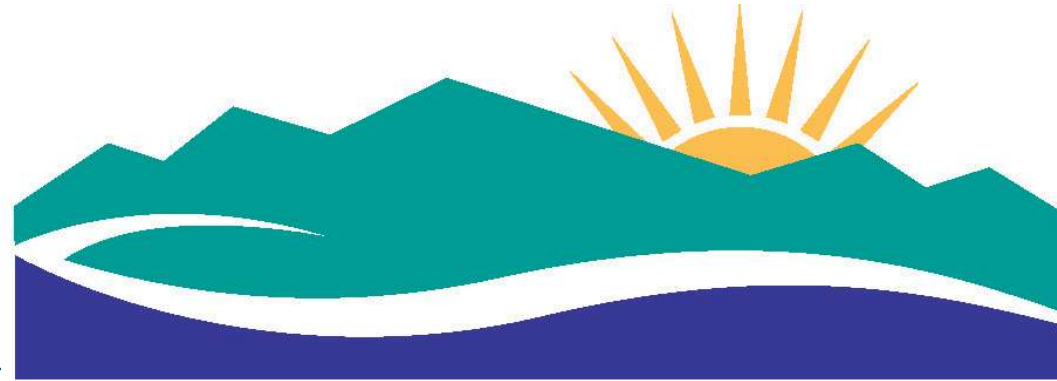
# Beginning a Cultural Shift



# Outcomes of Interest



- Monitor clinic data for increase in % of patients with documented self management goal
- Continued use of PCRS assessment and comparison of responses overtime
- Ongoing documentation of self management system change
- Improvements in outcomes data



West Virginia  
**Diabetes**  
Prevention & Control Program  
WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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# Helpful Resources



- Electronic PRCR:  
<http://improveselfmanagement.org>
- New Marshall Self Management Website  
<http://selfmanagementonline.org>

*Thank you!*

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304-574-3384

# Upcoming CDSMP Leader Trainings



## Martinsburg

### Consecutive Tues/Weds

Day 1 - June 22

Day 2 - June 23

Day 3 - June 29

Day 4 - June 30

## Charleston

### Consecutive Tues/Weds

Day 1 - July 20

Day 2 - July 21

Day 3 - July 27

Day 4 - July 28

**To Register - Call Sally @ 304-574-3384**