

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

Individuals interested in using the PCRS in quality improvement work or research are free to do so. We request that you not change the wording or content of the questions and that attribution to the Robert Wood Johnson Foundation *Diabetes Initiative* appears prominently on all pages. We would appreciate an e-mail or phone call from users of the tool, so we can track its dissemination. We also ask that users be willing to share results and feedback about the instrument with us so that we can continually update our work. If you need written documentation from us verifying permission to use the PCRS, please contact:

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Background and Rationale

Purpose

This survey was developed by the Advancing Diabetes Self management Program of the Robert Wood Johnson Foundation Diabetes Initiative. The grantees wanted an instrument that would be congruent with the Chronic Care Model, and which would be an expansion of the self management component. Its purpose is to help primary care settings focus on actions that can be taken to support self management by patients with diabetes and other chronic diseases. Specific goals are that it:

1. Function as a self-assessment, feedback and quality improvement tool to help build consensus for change
2. Identify optimal performance of providers and systems as well as gaps in resources, services and supports
3. Help teams integrate changes into their system by identifying areas where self management support is needed

Who should use this tool?

This tool is for providers in primary health care settings that are interested in or working on changes consistent with the Chronic Care Model. It is to be used with multi-disciplinary teams representing front line staff, clinicians and administrative personnel. We suggest that teams use it periodically (e.g., quarterly, semi-annually) as a way to guide the integration of self management into their system of health care.

Why another assessment tool?

This tool can be used along with other tools such as the Assessment of Chronic Illness Care (ACIC) (Bonomi, Wagner et al. 2002). It focuses on key characteristics of good patient self management at the process level (how well the system is performing) and at the structural level (what systems need to be in place). When appropriate, it looks at these characteristics at the patient, clinical team (microsystem) and organizational (macrosystem) levels. The changes suggested should lead to improved patient and staff competence in self management processes and improved behavioral and clinical outcomes.

How is it used?

This tool is intended for use by teams interested in improving the quality of their self management support systems and service delivery. Each member of the team should fill out the assessment independently over an agreed upon timeframe (e.g., last quarter). When all members have completed the tool, it is recommended that the team meet to discuss their scores and any discrepancies among scores. Discrepancies in scores offer an important opportunity for discussion that can lead to improved communication and team function. The value of this tool is not in the number each member assigns, but in the improvement process that is initiated by discovery of discrepancies or improvements warranted.

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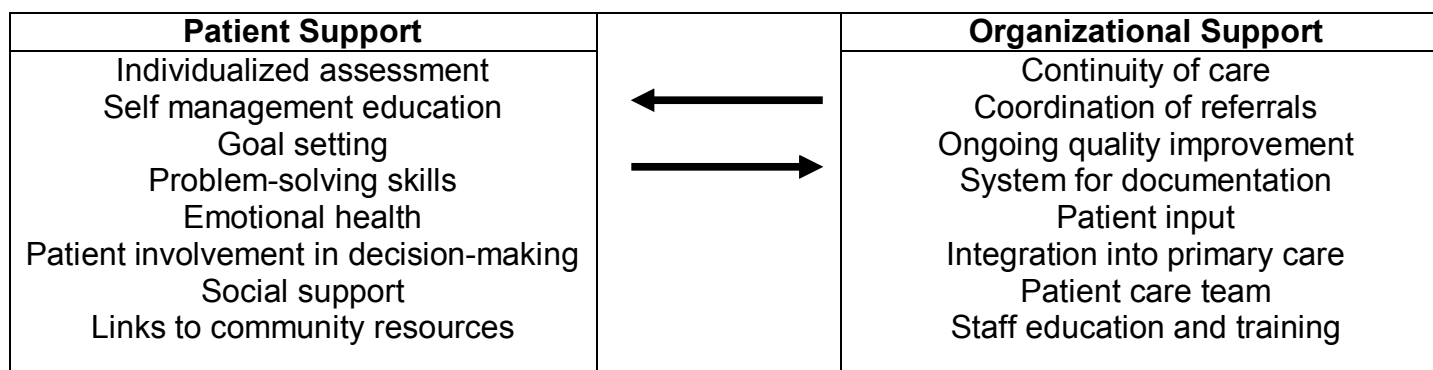
Definitions and Scoring

This tool will help clinics assess the level to which self management is integrated into their practice. It is divided into two components (Patient Support and Organizational Support) followed by a score sheet.

Patient Support: The first section includes eight characteristics of service delivery found to enhance patient self management in the areas of physical activity, healthy eating, emotional health, medication management, and managing daily activities and roles.

Organizational Support: The second section includes eight system design issues that primary care organizations must address in their planning, resource allocation, and evaluation to support the delivery of self management services.

Both components are needed. Just as tools must be in place to assess individuals' self management needs and work with them to achieve their goals, the infrastructure must be in place to document and monitor progress in meeting those needs. The following diagram lists the characteristics of each of the two components and reflects their interface.



Ratings: Each characteristic listed has 4 levels of performance, from a low level of development (D) to a level that reflects strong systems integration (A). The levels are progressive. In general, the following criteria were used in listing activities in each of the A-D levels.

Level D: structure and/or process nonexistent or inadequate

Level C: patient/ provider level = addresses issues related to patient-provider interaction

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Level B: microsystem level = addresses issues related to health care teams/ coordination of services of that particular office

Level A: system level = addresses issues in levels B *plus* the health care system, polices, and environmental and/or community supports

With the exception of the D level, each level has a range of 3 numbers from which to select. This allows you to consider to what degree your team is meeting the criteria described for that level and score accordingly. Similar to Likert scales, this is somewhat subjective. Within each level, you can adjust your score up or down depending on *how much* of the criteria you meet and/ or *how consistently* you meet it. Respondents should circle one number (not a letter) for each of the 16 characteristics in the survey.

As in school, the best grade is an “A”. In general, to get an A-level rating (8, 9 or 10), clinics should be consistently using systematic, integrated approaches that incorporate follow up support and are sustainable. It is important to note that the highest level, the system level (A), assumes the microsystem components in B *plus* the items specifically listed.

Scoring: There is an optional Individual score sheet attached to each survey. You/ the team may also want to devise a sheet on which to aggregate scores for ease of comparison and to facilitate discussion among team members.

Bonomi, A. E., E. H. Wagner, et al. (2002). "Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement." Health Serv Res 37(3): 791-820.

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Individual Instructions for Completing the Survey

Although the survey can be answered regarding any of a number of chronic illness conditions, for today we would like you to rate the care your team provides for your panel of _____ patients only.

Please rate **your care team** or 'microsystem' on the extent to which it does each of the activities listed for those patients under your care. By patient care team we mean the clinical staff that work together to manage a panel of patients. This often, but not always, involves a physician and the nurse(s), technician(s), and possibly educators and front office staff who work with that physician.

When considering your responses to each characteristic, use the **previous 3 months** as the timeframe.

Using the 1 – 10 scale in each row, give **one numeric rating** for each of the 16 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side (or in the comment section of the score sheet) any comments or feedback you would like to give regarding that item. NOTE: There are no right or wrong answers and each members of the team's perspective is different and important. For this reason, please first rate each item without talking with or discussing your rating with other team members.

After team members have completed their surveys individually, have one team member collect scores from all respondents and aggregate the scores for discussion (it may help to write scores on a chalk board or flip chart for each question). Meet and share comments, insights and rationale for scores. Discussion should NOT be focused on who is right or wrong, but rather *why* various ratings were given. If time permits, it may also be valuable to discuss ideas about specific actions that the team could take to enact strategies described at the higher levels.

If your team uses this method, please answer these "group discussion questions" on a separate sheet and submit responses with the surveys.

- a. How was the discussion useful?
- b. What items did you spend most time on?
- c. Was there anything about which the group was confused?
- d. Were the examples under the various levels helpful for generating improvement ideas? If yes, can you share an example?

Teams can also opt to complete the group discussion on their own after the surveys have been submitted.

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Return the survey and the score sheet (or copy of both) to the survey administrator by _____.
Please make sure your team designation and role on the team are filled in on the front page.

If you have any questions, need assistance or clarification, please contact your survey administrator
_____ (name) at _____ (contact info)

Thank you!

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To be filled in by your survey administrator:

Site/ Location: _____

Team: _____

Focus of assessment or patient population under consideration (e.g., those with specific condition, those seen by certain patient care teams): _____

Has this team had past experience in systematic QI initiatives, e.g., collaboratives? Yes _____ No _____

To be completed by respondent: My role in team: _____ **My profession:** _____

I: PATIENT SUPPORT (circle one NUMBER for each characteristic)				
Characteristic	Quality Levels			
	D	C	B	A (=all of B plus these)
1. Individualized Assessment of Patient's Self management Educational Needs	...is not done 1	...is not standardized and or does not consistently include most self management components* 2 3 4	...is standardized, fairly comprehensive and documented prior to initial goal setting; takes into account language, literacy and culture; assesses patient's self management knowledge, behaviors, confidence, barriers, resources, and learning preferences 5 6 7	...is an integral part of planned care for chronic disease patients; results are documented, systematically reassessed, and utilized for planning with patient 8 9 10
2. Patient Self management Education	...does not occur 1	...occurs sporadically or without tailoring to patient's skills, culture, educational needs, learning styles or resources 2 3 4	...plan is developed with patient (and family if appropriate) based on individualized assessment, is documented in the patient's chart, and all team members generally reinforce same key messages 5 6 7	...is documented in patients' charts, is an integral part of the care plan for patients with chronic diseases; involves family and community resources; and is systematically evaluated for effectiveness 8 9 10

*e.g., for diabetes: physical activity, healthy eating, emotional health, medication management, monitoring, reducing risks and managing daily roles and activities

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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 (i.e., problem identification, listing of possible solutions, selection of one to try, assessment of the results)	...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 (e.g., depression, anxiety, stress, family conflicts)	...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

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I: PATIENT SUPPORT (circle one NUMBER for each characteristic)				
Characteristic	Quality Levels			
	D	C	B	A (=all of B plus these)
6. Patient Involvement	...does not occur 1	...is passive; clinician or educator directs care with occasional patient input 2 3 4	...is central to decisions about self management goals and treatment options and encouraged by health care team and office staff 5 6 7	... 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 8 9 10
7. Patient Social Support	...is not addressed 1	...is discussed in general terms, not based on an assessment of patient's individual needs or resources 2 3 4	...is encouraged through collaborative exploration of resources available, (e.g., significant others, education groups, support groups) to meet individual needs 5 6 7	... systems are in place to assess needs, link patients with services and follow up on social support plans using household, community, or other resources 8 9 10
8. Linking to Community Resources	...does not occur 1	...is limited to a list or pamphlet of contact information for relevant resources 2 3 4	...occurs through a referral system; team discusses patient needs, barriers and resources before making referral 5 6 7	...system in place for coordinated referrals, referral follow up and communication among practices, resource organizations and patients 8 9 10

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II. ORGANIZATIONAL SUPPORT (Circle one NUMBER for each characteristic)					
Characteristic	Quality Levels				
	D	C			B
4. System for Documentation of Self management Support Services	...does not exist 1	...is incomplete or does not promote documentation (e.g., no forms in place) 2 3 4	...includes charting of care plan and self management goals; is used by the team to guide patient care 5 6 7	... is an integral part of the patient's medical record; is easily accessible to all team members and organized to see progression; charting includes care provided by all care team members and referral specialists 8 9 10	
5. Patient Input	... does not occur 1	... mechanisms exist, but are not promoted; input solicited sporadically 2 3 4 is solicited through focus groups, surveys, suggestion boxes, etc. for both service and service delivery improvements under consideration; patients are made aware of mechanisms for input and invited or encouraged to participate 5 6 7	...is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery and evidence that management acts on the information 8 9 10	
6. Integration of Self management Support into Primary Care does not exist 1	...is limited to special projects or to select teams 2 3 4	...is routine throughout the practice; team members reinforce consistent strategies 5 6 7	...is built into the practice's strategic plan, is routinely monitored for quality improvement and visibly supported by leadership 8 9 10	

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Site/ Location: _____ Team: _____
 Focus of assessment or patient population under consideration (e.g., those with specific condition, those seen by certain patient care teams): _____
 Has this team had past experience in systematic QI initiatives, e.g., collaboratives? Yes _____ No _____

Score Sheet (Optional)

If you plan to meet as a group to discuss your results, you may elect to transfer the rating (1-10) that you gave each characteristic onto this sheet. If you use this option, please make sure the survey and this score sheet are attached when turned in to the survey administrator.

I. Patient Support.....Score (number selected)	II. Organizational Support.....Score (number selected)
1. Individualized assessment..... _____	1. Continuity of care..... _____
2. Self management education..... _____	2. Coordination of referrals..... _____
3. Goal setting..... _____	3. Ongoing quality improvement _____
4. Problem-solving skills..... _____	4. Systems for documentation of SMS _____
5. Emotional health..... _____	5. Patient Input..... _____
6. Patient involvement _____	6. Integration of SMS into primary care. _____
7. Patient social support _____	7. Patient care team..... _____
8. Link to community resources..... _____	8. Education and training..... _____
Total Score _____	Total Score _____

Comments: (use reverse side if needed and/or write directly on the survey and return it the survey administrator)