Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS)[1,2,3]

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:

Robert Wood Johnson Foundation *Diabetes Initiative* National Program Office
E-mail: cbrownson2@gmail.com

http://diabetesinitiative.org

[1] http://diabetesinitiative.org/lessons/tools.html

[2] Brownson CA, Miller D, Crespo R, Neuner S, Thompson JC, Wall JC, Emont S, Fazzone P, Fisher EB, Glasgow RE. Development and Use of a Quality Improvement Tool to Assess Self-Management Support in Primary Care. *Joint Commission Journal on Quality and Patient Safety*. 2007 Jul;33(7):408-16.

[3] Shetty G, Brownson CA. Characteristics of Organizational Resources and Supports for Self Management in Primary Care. *The Diabetes Educator*. 2007 Jun;33(Suppl 6):185S-192S.

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

Background and User Guide

Purpose

This survey was developed by the Advancing Diabetes Self Management (ADSM) Program of the Robert Wood Johnson Foundation *Diabetes Initiative*. The ADSM grantees wanted an instrument that would further delineate and facilitate assessment of the self-management component of the Chronic Care Model. The purpose of the PCRS is to help primary care settings focus on actions that can be taken to support self management by patients with diabetes and/ or other chronic conditions. Specific goals are that it:

1. Function as a self-assessment, feedback and quality improvement tool
2 Characterize optimal performance of providers and systems as well as gaps in resources, services and supports
3. Promote discussion among patient care team members that can help build consensus for change and plans for improvement
4. Give teams a way to measure progress over time.

Who should use this tool?

This tool was developed for primary health care settings interested in improving self-management support systems and service delivery. It is to be used with multi-disciplinary teams (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that work together to manage patients' health care. We suggest that teams use it periodically (e.g., quarterly, semi-annually) as a way to monitor their progress and guide the integration of self-management supports into their system of health care.

Why another assessment tool?

The PCRS can be used along with other tools such as the Assessment of Chronic Illness Care (ACIC).[4] While it is consistent with and complementary to the ACIC, the PCRS focuses exclusively and more comprehensively on self-management support. Using the PCRS to initiate quality improvement processes should lead to improved patient and staff competence in self-management processes and improved behavioral and clinical outcomes among patients.

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[4] Bonomi AE, Wagner EH, Glasgow RE, VanKorff R. Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement. *Health Services Research.* 2002 Jun;37(3):791-820.

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How is the PCRS organized?

This survey tool consists of 16 characteristics of self-management support that are separated into two categories: patient support and organizational support. (Definitions provided in the Appendix). Below the characteristic name are descriptions of four levels of performance from lowest on the left (D) to highest on the right (A).

- D is the lowest level; it is an indication of inadequate non-existent activity.
- C pertains to the patient-provider level. At this level, implementation is sporadic or inconsistent; patient-provider interaction is passive.
- B pertains to the team level. At this level, implementation is done in an organized and consistent manner using a team approach; services are coordinated.
- A is the highest level; it assumes the B level **plus** system-wide adoption and integration of that aspect of self-management support.

With the exception of level D, each level has three numbers from which to select. This allows team members to consider *to what degree* their team is meeting the criteria described for that level; that is, *how much* of the criteria and/ or *how consistently* their team meets this criteria.

Completing the PCRS:

- Each member of the team fills out the assessment independently, reflecting a specified period of care delivery (e.g., last quarter) for a specific group of patients (e.g., those with specific condition, those seen by certain patient care teams, etc.).
- Using the 1 – 10 scale provided, respondents circle one numeric rating for each of the 16 characteristics.
- There are no right or wrong answers; scores are based on individuals' knowledge, experience and observation of how well the team is addressing the characteristic shown.
- When finished, team members may transfer their numeric answers onto the score sheet at the end of the survey. The score sheet can be returned to the person coordinating the assessment so scores can be compiled for team review and discussion.

Using the results:

- When all members have completed the tool, it is recommended that the team meet to share comments, insights and rationale for scores. To facilitate the discussion, the person coordinating the assessment may want to prepare a summary list of the results so that team members can easily see the range of scores on each item, the average score for each item or other helpful

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information. (Note: if the assessments are being filled out *during* a team meeting, results can be recorded in real time as part of the discussion.).

- Discussion should NOT be focused on "right" or "wrong", but rather *why* various ratings were given. 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 gaps in capacity. Discrepancies in scores offer an important opportunity for discussion that can lead to improved communication and team function.
- Based on the discussion and consensus among members, teams may chose to develop quality improvement plans in one or more areas of self-management support.
- Using the PCRS periodically gives teams a way to measure the impact of their improvement processes and facilitates the integration of self-management supports into their system of care.

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Individual Instructions for Completing the PCRS *

We are using this tool, the Assessment of Primary Care Resources and Supports for Chronic Disease Self Management (PCRS), to help us monitor and improve our support for patient self management. 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** _____**patients** only.

Each team member's perspective is unique and valuable. For this reason, please **complete the survey independently,** before discussing your ratings with other team members.

When considering your responses to each item, **use the previous** ____ **months** as the timeframe.

Using the 1 – 10 scale in each row, **give one numeric rating** for each of the 16 characteristics. Please rate your patient care team on the extent to which it addresses each self-management characteristic for those patients specified above. (Definitions of characteristics are provided in the Appendix following the survey).In general, to warrant a rating in the highest category (8, 9 or 10), that characteristic of self-management support should be consistently and systematically integrated into care in a way that is sustainable.

There are no right or wrong answers. If you are unsure or do not know, please give your best guess, and make notes on the side (or in the comment section of the score sheet) regarding any thoughts or questions you have about that item.

Transfer your scores to the score sheet and return the score sheet (or a copy of it) to the person coordinating the assessment, _____ (name), by _____ (date). Please make sure you also complete the descriptive information in the box at the top of the page.

After all team members have completed their surveys individually, scores will be aggregated and the team will meet to discuss the results. Feel free to **bring your completed assessment to the meeting** for reference.

If you have any questions, need assistance or clarification, please contact_____ (name) at _____ (contact info). Thank you.

** The team leader or designated assessment coordinator should complete this form and distribute it with the PCRS to team members. The instructions may be tailored as appropriate for your setting.*

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To be filled in by the assessment coordinator:

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

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 patients **8 9 10**
2. Patient Self-Management Education	…does not occur **1**	…occurs sporadically or without tailoring to patient 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 patient chart; all team members generally reinforce same key messages **5 6 7**	…is documented in patient charts; is an integral part of the care plan for patients with chronic diseases; involves family and community resources; 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/ Action Planning	…is not done **1**	…occurs but goals are established primarily by health care team rather than developed collaboratively with patients **2 3 4**	…is done collaboratively with all patients/ families and member(s) of their health care team; goals are specific, documented and available to any team member; goals are reviewed and modified periodically **5 6 7**	…is an integral part of care for patients with chronic diseases; goals are systematically reassessed and discussed with patients; progress is documented in patient charts **8 9 10**
4. Problem-Solving Skills	…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 diseases; takes into account family, community and environmental factors; results are documented and routinely used for planning with patients **8 9 10**
5. Emotional Health	…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 patients' 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; is 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 patients and team members; 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 to meet individual needs (e.g., significant others, education groups, support groups) **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**	…systems are 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**	**A (=all of B plus these)**
1. Continuity of Care	…does not exist **1**	…is limited; some patients have an assigned primary care provider (PCP); planned visits and routine lab work occur sporadically **2 3 4**	…is achieved through assignment of patients to a PCP or designated primary care team member, scheduling of routine planned visits with appropriate team members, and involvement of most team members in ensuring patients meet care guidelines **5 6 7**	…systems are in place to support continuity of care, to assure all patients are assigned to a provider or team member, to schedule planned visits and to track and follow up on all patient visits and labs **8 9 10**
2. Coordination of Referrals	...does not exist **1**	... is sporadic, lacking systematic follow-up, review or incorporation into the patient's care plan **2 3 4**	…occurs through team and office staff working together to document, track and review completed referrals and coordinate with specialists in adjusting the patient's care plan **5 6 7**	…is accomplished by having systems in place to track incomplete referrals and follow up with patients and/ or specialists to complete referrals **8 9 10**
3. Ongoing Quality Improvement (QI)	… does not exist **1**	...is possible because organized data are available, but practice has not initiated specific QI projects in this area **2 3 4**	…is accomplished by a patient care team that uses data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	… uses a registry, electronic medical record or other system to routinely track key indicators of measurable outcomes; is done through a structured and standardized process with administrative support and accountability to management **8 9 10**

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II. ORGANIZATIONAL SUPPORT (Circle one NUMBER for each characteristic)				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (=all of B plus these)**
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 or documentation of care plan and self-management goals; is used by the team to guide patient care **5 6 7**	... is an integral part of patient medical records; information is easily accessible to all team members and organized to see progression; charting or documentation 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, or other means 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 an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; there is 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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II. ORGANIZATIONAL SUPPORT (Circle one NUMBER for each characteristic)				
Characteristic	**Quality Levels**			
	D	**C**	**B**	**A (=all of B plus these)**
7. Patient Care Team (internal to the practice)	… does not exist **1**	…exists but little cohesiveness among team members **2 3 4**	...is well defined; each member has defined roles and responsibilities; there is good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	...is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences or team reviews are regularly scheduled **8 9 10**
8. Physician, Team and Staff Self-Management Education & Training	… does not occur **1**	...occurs on a limited basis without routine follow-up or monitoring **2 3 4**	…is provided for some team members using established and standardized curricula; practice assesses and monitors performance **5 6 7**	...is supported and incentivized for all key team members; continuing education is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to self management **8 9 10**

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Site/ Location: _____ Team: _____
Focus of assessment or patient population under consideration: _____
My role on the team: _____ My profession: _____
Date: _____

Summary Score Sheet

Please transfer the rating (1-10) that you gave each characteristic onto this sheet. The person who coordinated the assessment may ask for a copy of this sheet or your survey so that team results can be aggregated and presented for discussion at a team meeting.

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/ action planning…… _____	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 comments directly on the survey and provide a copy to the assessment coordinator)

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Appendix: Definitions of self-management support characteristics in the PCRS

PATIENT SUPPORT

1. **Individualized assessment of patient's self-management educational needs:** The process of determining patient-specific educational needs, barriers, skills, preferences, learning styles and resources for self management.

2. **Self-management education:** An interactive, collaborative and ongoing process of providing information and instruction to support people's ability to successfully manage their health condition, their daily life activities, and the emotional changes that often accompany having a chronic condition.

3. **Collaborative goal setting:** The process of providers and patients working together on identifying something the patient wants to accomplish and agreeing on a plan for getting started. Well formulated goals are "SMART" (Specific, Measurable, Action-oriented, Realistic, and Time-limited).

4. **Problem solving skills:** Skills patients can learn and use to overcome barriers to healthy self management. The process involves a series of steps: identifying the problem or barrier, identifying possible solutions, selecting and implementing the one that seems best, evaluating the results, and planning next steps accordingly.

5. **Emotional health:** Mental or emotional health generally refers to an individual's thoughts, feelings and moods. Good mental health is defined in the Surgeon General's report as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." Difficult emotions, on the other hand, run the gamut from stress and anxiety to depression and psychopathology and can be a barrier to healthy self management.

6. **Patient involvement in decision making:** Patient involvement means that patients--and their families--are involved in planning and making decisions about the patient's health care. In this approach, patients are viewed as key members of the health care team and have access to useful information to promote health and manage disease. Patient involvement implies shared decision making about care and ensuring that the patient's values guide all clinical decisions.

7. **Patient social support:** The assistance or help that is accessible to a patient through their social ties to others including family, friends, neighbors and peers. Social support can take many forms such as emotional support, tangible assistance, information or helpful feedback.

8. **Link to community resources:** Community resources include programs, services, and environmental features that support self-management behaviors. Programs and services that support self management may be available through community agencies, schools, faith-based organizations or places of work. Examples of environmental supports include safe, accessible and affordable places for physical activity and for buying healthy foods.

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ORGANIZATIONAL SUPPORT

1. **Continuity of Care:** The coordination and smooth progression of a patient's care over time and across disciplines. Continuity of care is supported by systems that use a team approach to care, schedule planned visits and follow up on visits and lab work.

2. **Coordination of referrals:** Effective collaboration and communication among primary care providers and specialists. Coordination of referrals is supported by systems that track referrals, monitor incomplete referrals, and ensure follow-up with patients and/or the specialists to complete referrals.

3. **Ongoing Quality Improvement:** The process of using data on a regular basis to identify trends, undertake processes to improve aspects of service delivery, and measure the results. Patient care teams often use the Plan, Do, Study, Act (PDSA) rapid cycle improvement process to facilitate the improvement process.

4. **System for Documentation of Self-Management Support Services:** Standardized processes used by members of the patient care team to record patient self-management goals and progress notes into patient charts (or electronic medical records) and routinely monitor their progress.

5. **Patient Input:** The ideas, suggestions and feedback from patients about the services and quality of care provided by your team or health care setting. This occurs when there are systems or procedures in place to solicit input thought such mechanisms as focus groups, surveys, suggestion boxes, or patient advisory committees.

6. **Integration of Self-Management Support into Primary Care:** Integration occurs when self-management support is a fundamental and routine part of all chronic illness care.

7. **Patient Care Team:** A patient care team is a multidisciplinary group (e.g. physicians, mid-level practitioners, nurses, educators, medical assistants, behavioral health specialists, social workers, dieticians, community health workers or others) that works together to manage a patient's health care.

8. **Physician, Team and Staff Self-Management Education & Training:** Opportunities for members of the patient care team to increase their knowledge and improve skills and practices for improving self-management support. Health care systems can support continuing education and training by setting an expectation for excellence, offering training to all team members, ensuring that new team members have access to orientation and training, assessing and monitoring performance and providing incentives for the adoption of new practices and skills.

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