



**Physician resource guide to patient  
self-management support**

**AMA**  
AMERICAN  
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ASSOCIATION



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## Introduction

The American Medical Association (AMA) is committed to helping doctors help their patients. To fulfill this goal, the AMA produces innovative resources designed to bridge gaps in the delivery of medical care. The “Physician resource guide to patient self-management support” introduces patient self-management support concepts and presents selected resources and practice implementation tools. The resource guide builds on existing information in the field of patient self-management. It is organized to direct physicians to resources that will help them implement cost-effective techniques at various levels of the health care system in order to help patients achieve better health outcomes and increase their quality of life.

## What do I expect from my patients?

### 1. Follow health behavior recommendations to achieve and maintain a healthy lifestyle.

- Americans continue to engage in risky health behaviors. Seventy-two million adults, approximately 34 percent of the U.S. population, are obese.<sup>1</sup> Forty-five million, 20.8 percent of the adult population, smoke tobacco cigarettes. Smoking is the No. 1 preventable cause of death in this country, taking about 438,000 lives per year.<sup>2</sup> Sixty-one percent of the population had at least one alcoholic drink within the past year and 32 percent had five or more drinks in a day within the past year.<sup>3</sup>
- Approximately 25 percent of patients do not adhere to physician recommendations.<sup>4</sup> Disease-specific studies have found even higher non-adherence rates. A study of diabetes patients revealed that only 60 percent adhered to a diabetic diet and only 19 percent followed regular exercise recommendations.<sup>5</sup>
- Medication therapy adherence rates are usually higher among patients with acute conditions compared to those with chronic conditions. Adherence among patients with chronic conditions is low, dropping most dramatically after the first six months of therapy.<sup>6</sup> Adherence rates average approximately 75 percent for short-term self-administered medication regimens,<sup>7</sup> while adherence rates to long-term self-administered medication regimens are approximately 50 percent for those who remain in care.<sup>8</sup>

### 2. Follow chronic condition treatment plans.

- A total of 125 million individuals are coping with chronic medical conditions, affecting almost 50 percent of the U.S. population and touching every sector of society.<sup>9</sup> Nearly 80 percent of Medicare recipients have at least one chronic condition and 50 percent have more than one.<sup>10</sup> Although rates are high among the elderly, younger populations are also significantly affected by these conditions. Research has shown that 25 percent of children, 40 percent of adults aged 20 to 44 years and 67 percent of adults aged 45 to 64 years live with at least one chronic condition.<sup>9</sup>

- Fifty-three percent of Medicare recipients with a serious chronic condition receive more than one diagnosis for the same problem within a one-year period.<sup>11</sup>
- Sixty percent of caregivers caring for patients with a serious chronic condition report receiving conflicting advice from physicians.<sup>11</sup>
- Twenty-eight percent of patients reported receiving physician advice to increase physical activity levels, of which only 38 percent received help formulating specific activity plans and 42 percent received follow-up support.<sup>12</sup>
- Patient self-reports conclude that only approximately 40 percent of patients feel confident that they can successfully make health behavior changes.<sup>13</sup> Confidence is a strong predictor of successful behavior change.
- The majority of patients can recall only about 50 percent of the information communicated to them by their physician.<sup>14</sup>
- Patients vastly prefer that when a doctor asks the patient to describe his or her understanding of conditions or treatments, the physician tells the patient additional necessary information, then asks what the patient understands and feels about the information given (the “Tell Back–Collaborative Inquiry” method). This method of information-sharing is not only preferred by patients but is also more effective in achieving understanding.<sup>15</sup>

## What challenges do my patients face when making behavior changes for a healthier lifestyle?

1. What are patients' conceptions about improving and maintaining health? [The American Academy of Family Physicians](#) commissioned a survey in 2002 to answer this question. The *FP Report* article, "Changing health behaviors can be tricky, survey shows,"<sup>16</sup> explains why Americans continue to engage in risky health behaviors and discusses how to apply this information in clinical practice to encourage patients to make healthy lifestyle choices. Survey results confirm what some physicians have learned in clinical practice: To engage a patient in successful behavior change, interventions must be tailored to complement the patient's lifestyle.

Visit the AAFP Web site to [view the article](#).

2. Patients with more than one chronic condition often engage in a number of tasks to manage their health. An article in [Annals of Family Medicine](#), "Descriptions of Barriers to Self-Care by Persons with Comorbid Chronic Diseases,"<sup>17</sup> discusses the findings of a qualitative analysis of barriers to patient self-care when coping with more than one chronic condition. Survey results indicate that many barriers are associated with having multiple medical conditions; therefore, self-management interventions need to address interactions between chronic conditions as well as skills necessary to treat individual diseases.

[Click here](#) to view the article.

## Have I noticed any red flags in my practice indicating my patients are having problems maintaining a healthy lifestyle?

### Ask myself:

1. Are my patients meeting their health goals?
2. Are my patients following health behavior recommendations?
3. Am I frustrated with my patients' ability to make lifestyle changes?

4. Am I using an accurate method to assess my patients' motivation level to make lifestyle changes?
5. Do my patients understand each step they need to take to improve their health?
6. Do my patients understand how to properly take their medications?

Review resources and tools included within this guide to address these red flags.

## Why is managing my patients' chronic conditions to improve their health a challenge to me?

1. "[Helping Patients Take Charge of Their Chronic Illnesses](#),"<sup>18</sup> an article in *Family Practice Management*, discusses the many challenges physicians and patients may face while managing chronic conditions. This article reviews the "old health care model" framework and discusses how this model produces inefficient care for patients coping with chronic disease. The article outlines the patient and physician role in managing chronic conditions and suggests a shift toward patient-centered, collaborative interventions to improve care.
2. [The California HealthCare Foundation's Better Chronic Disease Care program](#) is improving clinical outcomes and quality of life for Californians with chronic disease through the application of innovative programming and models of care. This organization developed a report to identify barriers inherent in the health care system that impede care of chronic conditions. "Challenging the Status Quo in Chronic Disease Care: Seven Case Studies"<sup>19</sup> reviews barriers to effective health care; identifies models of care for chronic conditions such as disease management, case management and the Chronic Care Model; and discusses implementation themes of seven practices that are attempting to systematically improve chronic care. "Challenging the Status Quo in Chronic Disease Care: Appendix with Detailed Case Studies"<sup>20</sup> provides a detailed overview of the seven case-study sites, including a discussion of lessons learned from implementing these programs.

[Click here](#) to view both the report and the appendix with case studies.

3. The Chronic Care Model provides a framework for system redesign to deliver effective chronic condition care. This model promotes change through provider groups to support evidence-based clinical care and quality improvement across health care settings.<sup>21</sup> It identifies the essential elements in a health care system actively engaged in treatment to provide optimal care.

[Click here](#) to access this resource.

[Click here](#) for additional information.

## What do I need to know about the behavior change process and how do I engage my patients in making healthy lifestyle choices?

1. Behavior is only one aspect in the process of behavior change. To understand the change process, there are depth (psychoanalytic, object relations, intrapsychic humanism, etc.) and non-depth psychologies (behavior modification, social cognitive, motivational interviewing, etc.), which attend to the psychological, cognitive and social aspects of the mind and behavior. Some of the psychology theories have specific interventions to help people change behavior; however, others do not. For example, “[A ‘Stages of Change’ Approach to Helping Patients Change](#),” an article in the journal *American Family Physician*<sup>22</sup>, reviews the five stages of change and discusses their application within clinical practice. Other theories—some of which include object relations, social cognitive and intrapsychic humanism—identify the key depth and non-depth psychological constructs that address the behavior change process.

Object relations:

Visit the [Sonoma State University Web site](#) to learn more about this perspective.

Social cognitive theory:

[Learn more about this perspective.](#)

Intrapsychic humanism:

[Learn more about this perspective.](#)

2. Developed by the Institute for Healthcare Improvement, [New Health Partnerships](#) is an online community working to improve care for those coping with chronic conditions. This community is supported by individuals and orga-

nizations that believe collaborative partnerships among patients, families and providers can transform care for long-term conditions. New Health Partnerships brings together a variety of resources for patients and providers to aid communication, facilitate patient development of self-management skills and promote systemic changes to support patient self-management. In the excerpt “[Collaborative Self-Management: What Is It?](#),”<sup>23</sup> New Health Partnerships defines self-management support and recognizes its value within clinical care.

[Click here](#) to view the excerpt.

3. [Educating Physicians on Controversies and Challenges in Health](#) is a series of brief, informational [Web-streaming programs](#) developed by the American Medical Association (AMA) for primary care physicians. These programs inform physicians about the challenges and controversies at the interface of clinical medicine and public health and offer strategies to address these issues in practice. The short video “[Self-management strategies for vulnerable populations](#)”<sup>24</sup> focuses on strategies for physicians to assist their patients in managing chronic conditions. After completing this segment the viewer should be able to: (1) define self-management and self-management support; (2) recognize the value of self-management in chronic conditions; and (3) apply self-management support strategies to improve the care of patients with chronic conditions.

[Click here](#) to watch the video.

4. [The Joint Commission Journal on Quality and Patient Safety](#) discusses one model of patient self-management support across chronic conditions and health care systems in the article “[Implementing Practical Interventions to Support Chronic Illness Self-Management](#).”<sup>25</sup> This article reviews the “five A’s” model of self-management support, provides recommendations to health care professionals on making changes at varying levels of the health care system and identifies tips and lessons learned when implementing this model.

5. [New Health Partnerships](#) summarizes the components necessary to support behavior change within clinical practice. “[Partnering in Self-Management Support: A Toolkit for Clinicians](#)”<sup>26</sup> identifies and explains each component of the patient-physician collaborative process for successfully making behavior change.

[Click here](#) to view toolkit.

## How can I work more effectively with my patients with chronic conditions to achieve better health outcomes?

1. The AMA developed the “[Physician tip sheet for self-management support](#)”<sup>27</sup> (see Appendix A), designed to guide the physician through a patient conversation about behavior change. This tip sheet provides the physician with patient self-management worksheets and questions to initiate the physician-patient discussion and establish a collaborative relationship.

2. “[Focusing on Today’s Visit](#),” which appears online in *Family Practice Management*,<sup>28</sup> provides a resource to improve care and reduce physician frustration with patient visits. This resource includes a form that allows patients to reflect on and document their reasons for visiting their physician. The form takes a patient a few minutes to complete while waiting in the physician office and allows the physician to easily identify topics the patient would like to address during their time together.

[Click here](#) to access this resource.

[Click here](#) for a downloadable form.

3. [New Health Partnerships](#) discusses the disconnect between provider expectations and patient values, priorities and preferences. The excerpt “[Exploring Patient Values](#)”<sup>29</sup> reviews the extent in which competing interests can hinder a patient’s ability to successfully make behavior changes and offers simple solutions to overcome such barriers.

[Click here](#) to view this excerpt.

4. Steven Cole, MD, professor of psychiatry at Stony Brook University Medical Center, developed Ultra-Brief Personal Action Planning, or UB-PAP<sup>30</sup> (see Appendix B), a highly focused, three-question tool that allows physicians to support patients’ self-management within the constraints of limited time. This patient-centered technique encourages the patient to develop his or her own behaviorally specific action plan, allowing the physician to effectively apply the spirit of motivational interviewing to efficiently move the patient from contemplation or preparation into action.

[Click here](#) to access this resource.

5. The AMA has developed the Healthier Life Steps<sup>®</sup> program<sup>31</sup> to help physicians support patients who are actively trying to make health behavior changes. The program includes a toolkit that targets four primary areas: alcohol use, smoking, physical activity and nutrition. This toolkit provides planning tools for making behavior changes, including exploring the patient’s motivation and confidence in making these changes, identifying goals and specific action plans and providing helpful information for patients.

[Click here](#) to access this resource.

6. The AMA created *The Physician’s Role in Medication Reconciliation*<sup>32</sup> to increase physicians’ awareness of the integral role of medication reconciliation. This monograph provides a framework for physicians to understand their personal roles and clarify medication risks for themselves and their patients and provides a tool to improve medication management.

Visit the [AMA Web site](#) for more information.

## How do I prepare my office to address my patients' healthier lifestyle goals?

1. In 2006 the California HealthCare Foundation's Better Chronic Disease Care program commissioned a report to summarize general issues facing clinical teams in primary care and to highlight lessons learned during implementation. "[Building Teams in Primary Care: Lessons Learned](#)"<sup>33</sup> reviews why teams are needed within primary care, identifies features of successful teams, describes problems and barriers and provides a method for introducing teams into primary care practice. "Building Teams in Primary Care: 15 Case Studies"<sup>34</sup> presents a range of team-building case examples.

[Click here](#) to view this report and the case examples.

2. [The National Council on Aging](#) developed the MD Link: Partnering Physicians with Community Organizations<sup>35</sup> toolkit, which provides a step-by-step approach to increase physician and community-based organization (CBO) understanding of their roles along the continuum of care and facilitates collaboration and communication between these entities. This toolkit offers physicians a method to identify CBOs in their locale and develop lasting relationships to improve linkage and coordination of care between service providers.

[Click here](#) to access this resource.

## Is there a way to track patient changes in meeting their healthier lifestyle objectives?

1. [The Ideal Medical Home](#) provides physician tools to ensure that patient care practices permit unfettered access, high continuity and efficient care that moves beyond compliance to reveal barriers to positive patient outcomes. With free registration, this Web site provides assessment tools for practice employees and patients. Physicians can customize survey questions and change questions over time.

## Where do I send my patients for more information?

1. [Eldercare Locator](#) is a public service of the U.S. Administration on Aging. The Eldercare Locator is the first stop for finding resources for older adults in any U.S. community. This service connects those who need assistance from state and local area agencies on aging and community-based organizations that serve older adults and their caregivers. Information resources can be accessed on the Web site or by calling (800) 677-1116 (9 a.m.–8 p.m. EST weekdays). Spanish-speaking information specialists are available.
2. [How's Your Health](#) is an online resource for physicians and patients to improve communication. Developed by the board of trustees of Dartmouth College, this patient Web site is divided into two parts: (1) patients are asked questions to obtain information in order to better care for themselves and (2) patients receive information to address health conditions based on answers from the questions. This site provides resources for additional disease-specific information and calculators and patient action planning.
3. [New Health Partnerships](#) works to bring together patients, family members and health care providers to promote collaborative self-management. Developed by the Institute for Healthcare Improvement, New Health Partnerships offers a variety of resources for patients and providers to aid communication, facilitate patient development of self-management skills and promote systematic changes to support patient self care.

## If my patient depends on a caregiver, where do I send the caregiver to get support?

1. The AMA developed the “Caregiver self-assessment tool”<sup>36</sup> (see Appendix C) to help caregivers identify their own behavior and health risks. This 16-question tool is designed to aid the caregiver and the physician attempting to identify and provide appropriate preventive services that directly or indirectly affect the caregiver and patient. It is available with instructions in both English and Spanish.

[Click here](#) to access these resources.

2. [The Family Caregiver Alliance](#) is an information center to support and provide information for those caring for a loved one. Resources include information on hiring in the home, relocating parents, coordinating elder care and other topics. The Web site also has links to online support group, policy and advocacy information.
3. [The Health and Aging Caregiver Center](#) provides information to help caregivers deal with day-to-day problems. This Web site contains articles, news, digests and other items that help caregivers with both practical and emotional issues they may encounter.

## When I reflect on the simple strategies I have tried to reduce red flags, do I notice any changes?

### Ask myself:

1. Were my patients aware of their treatment plan health goals?
2. Were my patients more successful in following healthy behavior recommendations?
3. Were my patients able to successfully take all their medications?
4. Did my patients and I identify more successful interventions to manage their chronic conditions?
5. Were my patients more confident in their ability to attain their health goals?
6. Did I receive fewer follow-up phone calls and/or e-mails from patients?
7. Do I feel less frustrated with my patients?

## I have tried self-management support techniques, and I have specific questions. Whom can I contact for answers?

1. Both New Health Partnerships “Idea Exchange”—an online center equipped with a blog, discussion forums and Wiki tools—and the Ideal Medical Home Web site offer online technical assistance and support for health care professionals implementing patient self-management support techniques within a practice or at a system level.

[Click here](#) to join the online discussion at New Health Partnerships.

[Click here](#) to access the Ideal Medical Home Web site

## Now that I have opened the door, how can I build on the changes I have made in my practice?

1. [The Robert Wood Johnson Foundation Diabetes Initiative](#) developed the “Assessment of Primary Care Resources and Supports for Chronic Disease Self Management”<sup>37</sup> (see Appendix D) to aid primary care settings in supporting patients’ self-management of their chronic conditions. This tool has three functions: (1) to act as a self-assessment, feedback and quality improvement tool to help build a consensus for change; (2) to identify optimal performance of providers and systems as well as gaps in resources, services and supports; and (3) to aid team members integrating changes into their system by identifying areas where self-management support is needed. This tool can be used by multidisciplinary teams working with front-line staff, clinicians and administrative personnel. Although this tool was designed for diabetes care, it can be applied to improve care for other chronic conditions.

[Click here](#) to access this resource.

[Click here](#) for PowerPoint® instructions and a complimentary worksheet.

2. The Dartmouth-Hitchcock Medical Center and collaborating professionals developed the materials in the [Clinical Microsystems Web site](#). Establishing the premise of clinical microsystems as the front-line units of the health care system where the majority of patient care is provided, the developers created a series of workbooks to improve and maintain clinical microsystems’ quality, safety and efficiency. The “Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice”<sup>38</sup> workbook provides tools and methods for clinical teams to improve the quality and value of patient care in the primary care setting.

[Click here](#) to access this resource.

3. [The Improving Chronic Illness Care organization](#) focuses on improving chronic illness care at a systems level through implementation of the Chronic Care Model. “Assessment of Chronic Illness Care”<sup>39</sup> rates the degree to which each component of the Chronic Care Model is being implemented within a system or practice. Subscale scores are provided for each component of the model, including for self-management support.

[Click here](#) to access the survey.

[Click here](#) for scoring instructions.

4. [The National Quality Forum](#) is dedicated to measuring the impact of patient care and health care delivery on improving the quality of care. It has endorsed a “Definition and Framework for Measuring Care Coordination.”<sup>40</sup> This framework provides a concise description of each component of care coordination.

[Click here](#) to access this resource.

## Other resources

1. [The Center for Medical Home Improvement](#) works to establish support networks of parent and professional teams to improve the quality of primary care medical homes. This organization's target audience is the practices serving families and children with chronic conditions, but medical home principles can be adapted to practices serving other patient populations. The organization's Web site offers comprehensive information on medical home services, resources and tools to improve quality of care to patients and their families. Tools are designated within one of three main areas: medical home toolkit, medical home measures and beyond the medical home.
  2. [The Health Research and Educational Trust](#) developed both the "Collaboration Primer"<sup>41</sup> and the "Public-Private Partnerships to Improve Health Care." These tools are designed to help physicians develop networks with community-based organizations to improve service delivery systems, advance policy, address reimbursement issues and more.
- [Click here](#) to access the primer.
3. The Patient Education Department of the Stanford School of Medicine is at the forefront of programming for individuals with chronic conditions. Their [Patient Self-Management Education programs](#) have been rigorously evaluated and shown to achieve improved health outcomes for patients coping with chronic conditions. This Web site provides an overview of patient self-management programs and educational opportunities for both patients and professionals.
  4. [Health Information Translation](#) has developed common signs and other resources for hospitals, clinics and emergency response teams to aid clinician-patient communication in times of emergency and throughout treatment. These signs, checklists and other resources cover a range of topics from diet and exercise, to surgeries and treatments. All resources have been translated into multiple languages.

5. [The American Geriatrics Society](#) is a nonprofit organization of health care professionals dedicated to improving the health, independence and quality of life of all older adults. This Web site offers links and resources for policy and program advocacy, journals, public education and other information. In addition, the organization's [Foundation for Health in Aging](#) presents a wide variety of information on aging topics, how patients and caregivers can communicate with their physician, current research and more.
6. [The Alzheimer's Association](#), [the American Diabetes Association](#), [the American Cancer Society](#) and [the American Heart Association](#) all support Web sites equipped with tools and resources for patients, caregivers and health care professionals. These Web sites provide information on local resources, including support groups, activities and meetings, advocacy opportunities and current research.
7. [Healthfinder](#) is the federal government's main Web site for consumer health. It contains extensive information on preventive medicine, health organizations, drug interactions and more. Physician tools to improve care are also available.
8. [Medfusion](#) contains information for medical providers along the continuum of care. Patients have access to the online medical library and can search by topic on diseases and conditions, life stages, treatments, and other information. Medfusion's learning center provides links to information from various medical centers. The Web site also presents some information on self-management and caregiving.
9. [The Institute for Healthcare Improvement \(IHI\)](#) works to improve the lives of patients and health care communities. To accomplish this goal, IHI provides a number of resources to cultivate, evaluate and implement innovative practice improvement ideas. This Web site organizes information around specific health care topics, such as chronic conditions and patient-centered care, and provides tools to assess clinical practice, learn new techniques and implement advances in patient care.

Visit the IHI Web site for more on [chronic conditions](#) and [patient-centered care including self-management support](#).

10. [The Partnership for Solutions](#) works to improve the quality of care for individuals coping with chronic conditions. This Web site defines a chronic condition, identifies who is affected, discusses the variety of problems associated with chronic conditions within the current health care system and provides information on ways to improve care to this population.
  
11. [The U.S. Office of Minority Health](#) provides health statistics on minority populations and resources to improve the health of racial and ethnic minorities.

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## Appendix A: Physician tip sheet for self-management support



# Use the 5 A's—**Assess, Advise, Agree, Assist, Arrange**—a conversation about

These techniques can be used for patients with chronic conditions or for prevention. Remember, you **do not** have to touch on every A at every visit; some visits will just use Assess and Advise, and some Assess, Agree and Arrange, etc. Any member of your health care team can learn and use these techniques.

### **Assess—determine whether your patient is adopting healthier behaviors.**

- Use a “bubble diagram” (see “Health concerns of older adults” panel) to elicit your patient’s concerns.
- Use a pre-visit or waiting room questionnaire to focus the examination. Visit [www.howsyourhealth.com](http://www.howsyourhealth.com) to view examples.
- Ask your patient questions that focus on health behaviors.
  - “Most of the patients I work with have trouble [taking medications regularly, living with pain, etc.]. What trouble are you having?”
  - “Of all that I have asked you to do, what is the hardest?”
  - “Is there anything you have been thinking about doing to improve your health? Have you tried anything?”
  - “How important on a scale of 1 to 10 is it for you to [quit smoking, control your blood sugar, lose weight, exercise more, etc.]?” “Why is it a 4 and not a 1?” Try to get your patient to tell you why change is good for him or her.

### **Advise—provide brief information without medical jargon.**

- Find out what your patient understands about his or her illness or treatment before you give advice. This will save you from repeating what your patient already knows and allow you to clarify his or her misunderstandings.
- Have a key message for each diagnosis or symptom.
- Make the source of the advice (medical literature, your opinion, other patients you work with) clear.
- Ask your patient to repeat what you told him or her so you know if you made your advice understandable. (“Closing the loop” is a proven technique to improve health literacy.)

# Assess, Advise, Agree, as a framework to guide out behavior change.

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## **Agree—collaborate to develop a specific, actionable plan that describes:**

- *What.* Identify the specific tasks your patient will perform before your next meeting.
- *When.* Designate a specific time when your patient will perform tasks.
- *How often.* Specify how often your patient should do the task, keeping in mind what suits and what is realistic for his or her lifestyle.
- *Where.* Designate a specific location where your patients will carry out tasks.
- *Which problems.* Help your patient identify and problem-solve through barriers to carrying out plans.
- Check your patient's level of confidence in his or her ability to actually make changes.
  - "On a scale of 1 to 10, how confident are you that you can [walk three times this week, do relaxation exercises five evenings a week, skip dessert]?"
- Schedule a check-in date by e-mail, phone or another office visit.

## **Assist—help your patients when they have problems until they learn to help themselves.**

- Teach basic problem-solving skills. (Identify the problem, brainstorm solutions, pick one, try it, pick another, try it, find a resource; consider that the problem isn't solvable now.)
- Refer your patient to a problem-solving Web site such as [www.howsyourhealth.com](http://www.howsyourhealth.com) for further tips.

## **Arrange—follow up to check on progress or match the patient to community resources.**

- Use phone, e-mail or office staff your patient is familiar with to follow up on plans.
- Keep a list of helpful resources, such as local community agencies, exercise programs, weight loss programs and caregiver support groups.
- Document referrals and recommendations.



## Ultra-Brief Personal Action Planning (UB-PAP)

### The Ultra-Brief Personal Action Plan has five core elements:

1. The plan must be truly patient-centered, focused on what the patient himself or herself actually wants to do, not on what the doctor tells him or her to do.
2. The plan must be behaviorally specific—that is, very concrete and specific about what, when, where, how long, etc.
3. The patient should restate the complete plan (i.e., make a “commitment statement”).
4. The plan should be associated with a level of confidence (on a scale of 1 to 10) of 7 or greater. If the confidence level is less than 7, the clinician and patient should begin problem-solving on strategies to modify the plan.
5. There should be a specific date and mechanism for follow-up (or accountability).

### Ultra-Brief Personal Action Planning is structured around three core questions:

#### 1. Elicit patient preferences/desires for behavior change.

“Is there anything you would like to do for your health over the next few days (weeks) before I see you again?”

- What?
- Where?
- When?
- How often?
- Elicit commitment statement (e.g., “I will walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner”).

#### 2. Check confidence level.

“That sounds like a great plan. But changing behavior and sticking with a plan is actually very hard for most of us. If you consider a confidence scale of 1 to 10, where ‘10’ means you are very confident you will carry out the plan and ‘1’ means you are not at all confident, about how confident are you?”

If confidence level is less than 7, then problem-solve to identify solutions.

“That’s great that you feel a confidence level of 5. That’s a lot higher than 1. I wonder if there are some ways we could modify the plan so you might get to a confidence level of 7 or more. Perhaps you could choose a less ambitious goal, ask for help from a friend or family member, or think of something else that might help you feel more confident about carrying out the plan?”

#### 3. Arrange follow-up.

“Great, then let’s make a date for our next appointment, so we can check on how you’re doing with your plan.”

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## Health concerns of older adults

Here are some things older adults have told us they think about. Maybe some of these things concern you. You may add your concerns in the empty bubbles. Would you like to talk today about the one that matters to you the most? Would you like to make a change in one of them?

Medications

Preventing falls

Healthy eating

Staying independent

Memory

Exercise

Managing pain

Anger

Making the health care system work better for me

Managing stress

Finances



## Appendix B: Ultra-Brief Personal Action Planning

### Ultra-Brief Personal Action Planning\* (UB-PAP)

#### The Ultra-Brief Personal Action Plan has 5 core elements:

1. The plan must be truly patient-centered, that is what the patient himself/herself actually wants to do, not what the doctor told him/her to do.
2. The plan must be behaviorally specific – that is very concrete and specific about what, when, where, how long, etc.
3. The patient should re-state the complete plan (i.e. “commitment statement”).
4. The plan should be associated with a level of confidence (on a 1 to 10 scale) of 7 or greater. If the confidence level is <7, the clinician and patient should begin problem-solving on strategies to modify the plan.
5. There should be a specific date and mechanism for follow-up (or accountability).

#### Ultra-Brief Personal Action Planning is structured around 3 core questions:

##### 1. \_\_\_ Elicit patient preferences/desires for behavior change

*“Is there anything you would like to do for your health over the next few days (weeks) before I see you again?”*

\_\_\_ What?

\_\_\_ Where?

\_\_\_ When?

\_\_\_ How often?

\_\_\_ Elicit commitment statement (e.g. “I will walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner”)

##### 2. \_\_\_ Check confidence level

*“That sounds like a great plan. But changing behavior and sticking with a plan is actually very hard for most of us. If you consider a confidence scale of 1 to 10, where ‘10’ means you are very confident you will carry out the plan and ‘1’ means you are not at all confident, about how confident are you?”*

##### If confidence level <7, problem solve solutions

*“That’s great that you feel a confidence level of 5. That’s a lot higher than 1. I wonder if there are some ways we could modify the plan so you might get to a confidence level of 7 or more. Perhaps you could choose a less ambitious goal, ask for help from a friend or family member, or think of something else that might help you feel more confident about carrying out the plan?”*

##### 3. \_\_\_ Arrange follow-up

*“Great, so let’s make a date for our next appointment, so we can check on how you’re doing with your plan.”*

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# Caregiver self-assessment questionnaire

## How are YOU?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have ...

- |  |   |
|--|---|
| 1. Had trouble keeping my mind on what I was doing ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          | 13. Had back pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 2. Felt that I couldn't leave my relative alone ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                             | 14. Felt ill ( <i>headaches, stomach problems or common cold</i> )..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                  |
| 3. Had difficulty making decisions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 15. Been satisfied with the support my family has given me..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 4. Felt completely overwhelmed ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 16. Found my relative's living situation to be inconvenient or a barrier to care..... <input type="checkbox"/> Yes <input type="checkbox"/> No                    |
| 5. Felt useful and needed..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress.<br>_____                     |
| 6. Felt lonely..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____ |
| 7. Been upset that my relative has changed so much from his/her former self ..... <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 8. Felt a loss of privacy and/or personal time ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              |   |
| 9. Been edgy or irritable..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 10. Had sleep disturbed because of caring for my relative ..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |   |
| 11. Had a crying spell(s)..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 12. Felt strained between work and family responsibilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   |   |

**Comments:**

*(Please feel free to comment or provide feedback.)*

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# Auto-evaluación de cuidadores

## Caregiver self-assessment questionnaire

# ¿Cómo esta usted?

## How are you?

Los cuidadores de familia se encuentran tan involucrados en el cuidado de sus seres queridos que se olvidan de su propio bien estar. Por favor tome un momento para responder a las preguntas siguientes. Después de responder a las preguntas, pase la página para hacer la evaluación personal.

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

### Durante la última semana yo he ...

During the past week or so, I have ...

- |  |   |
|--|---|
| 1. Tenido dificultad concentrándome en lo que estaba haciendo ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Had trouble keeping my mind on what I was doing | 7. Estado triste que mi pariente ha cambiado tanto ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Been upset that my relative has changed so much from his/her former self        |
| 2. Sentido que no podía dejar a mi pariente solo/a..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt that I couldn't leave my relative alone                | 8. Sentido una pérdida de tiempo personal ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt a loss of privacy and/or personal time  |
| 3. Tenido dificultad tomando decisiones..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Had difficulty making decisions  | 9. Estado irritable y tenso/a ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Been edgy or irritable   |
| 4. Me sentí frustrado/a, agobiado/a... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt completely overwhelmed  | 10. Tenido el sueño perturbado por cuidar a mi pariente ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Had sleep disturbed because of caring for my relative                      |
| 5. Me sentí útil y que se me necesitaba/a..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt useful and needed   | 11. Quería llorar..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Had a crying spell(s)   |
| 6. Me sentí solo/a y aislado/a ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt lonely  | 12. Me sentí atrapado/a entre el trabajo y las responsabilidades familiares ..... <input type="checkbox"/> Sí <input type="checkbox"/> No<br>Felt strained between work and family responsibilities |







# 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:

Robert Wood Johnson Foundation *Diabetes Initiative* National Program Office  
Washington University in St. Louis School of Medicine  
Division of Health Behavior Research  
4444 Forest Park Avenue Suite 6700  
St. Louis, MO 63108-2212  
Phone: 314-286-1900  
E-mail: [diabetes@im.wustl.edu](mailto:diabetes@im.wustl.edu)

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

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

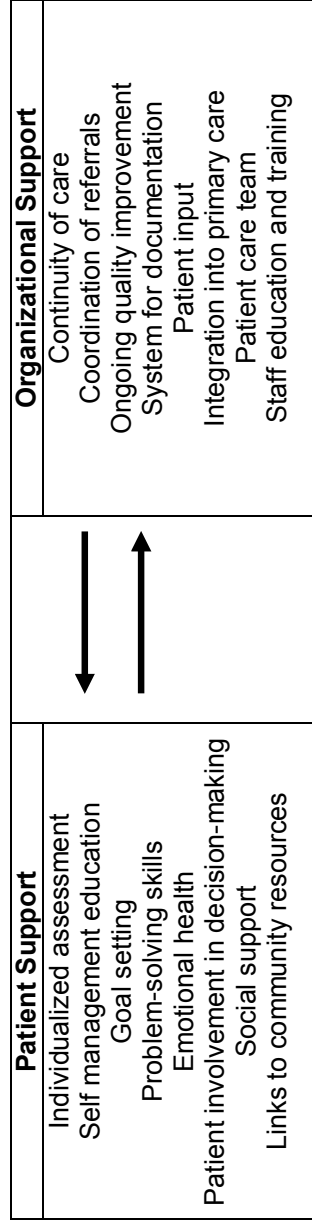
### Definitions and Scoring

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

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

### 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 member 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.

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

**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!

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

**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  <b>1</b>	...is not standardized and or does not consistently include most self management components*  <b>2 3 4</b>	...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  <b>5 6 7</b>	...is an integral part of planned care for chronic disease patients; results are documented, systematically reassessed, and utilized for planning with patient  <b>8 9 10</b>
2. Patient Self management Education	...does not occur  <b>1</b>	...occurs sporadically or without tailoring to patient's skills, culture, educational needs, learning styles or resources  <b>2 3 4</b>	...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  <b>5 6 7</b>	...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  <b>8 9 10</b>

\*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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## Assessment of Primary Care Resources and Supports for Chronic Disease Self management (PCRS)

I: PATIENT SUPPORT (circle one NUMBER for each characteristic)		Quality Levels			
Characteristic	D	C	B	A (=all of B plus these)	
3. Goal Setting	...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>	
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  <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>	
5. Emotional Health (e.g., depression, anxiety, stress, family conflicts)	...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>	

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

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

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

II. ORGANIZATIONAL SUPPORT (Circle one NUMBER for each characteristic)		Quality Levels				
Characteristic	D	C	B	A (=all of B plus these)		
1. Continuity of Care	...does not exist  <b>1</b>	...is limited; some patients have an assigned primary care provider (PCP); planned visits and routine lab work occur on a sporadic basis  <b>2 3 4</b>	...is achieved through assignment of patients to a PCP, scheduling routine planned visits with appropriate members of the team, and involvement of most team members in ensuring patients meet care guidelines  <b>5 6 7</b>	...systems are in place to support continuity of care, to assure all patients are assigned to a provider, to schedule planned visits and to track and follow up on all patient visits and labs  <b>8 9 10</b>		
2. Coordination of Referrals	...does not exist  <b>1</b>	... is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care  <b>2 3 4</b>	...occurs through team and office staff working together to document, completed referrals and coordinate with specialists in adjusting the patient's care plan  <b>5 6 7</b>	...is accomplished by having systems in place to track incomplete referrals and follow-up with patient and/ or specialist to complete referral  <b>8 9 10</b>		
3. Ongoing Quality Improvement (QI)	... does not exist  <b>1</b>	...is possible because organized data are available, but practice has not initiated specific QI projects in this area  <b>2 3 4</b>	...is accomplished by a patient care team that uses data to identify trends and launches QI projects to achieve measurable goals  <b>5 6 7</b>	... uses a registry or EMR to routinely track key indicators of measurable outcomes; is done through a structured and standardized process with administrative support and accountability to management  <b>8 9 10</b>		

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Characteristic	Quality Levels				
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4. System for Documentation of Self management Support Services	... does not exist  <b>1</b>	...is incomplete or does not promote documentation (e.g., no forms in place)  <b>2 3 4</b>	...includes charting of care plan and self management goals; is used by the team to guide patient care  <b>5 6 7</b>	... 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  <b>8 9 10</b>	
5. Patient Input	... does not occur  <b>1</b>	... mechanisms exist, but are not promoted; input solicited sporadically  <b>2 3 4</b>	.... 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  <b>5 6 7</b>	...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  <b>8 9 10</b>	
6. Integration of Self management Support into Primary Care	.... does not exist  <b>1</b>	...is limited to special projects or to select teams  <b>2 3 4</b>	...is routine throughout the practice; team members reinforce consistent strategies  <b>5 6 7</b>	...is built into the practice's strategic plan, is routinely monitored for quality improvement and visibly supported by leadership  <b>8 9 10</b>	

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Quality Levels			
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<p>7. Patient Care Team (<u>internal</u> to the practice)</p> <p>... does not exist</p> <p style="text-align: center;"><b>1</b></p>	<p>...exists but little cohesiveness among team members</p> <p style="text-align: center;"><b>2    3    4</b></p>	<p>...is well defined, each member has defined roles and responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills</p> <p style="text-align: center;"><b>5    6    7</b></p>	<p>...is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences are regularly scheduled</p> <p style="text-align: center;"><b>8    9    10</b></p>
<p>8. Physician, Team and Staff Self management Education &amp; Training</p> <p>... does not occur</p> <p style="text-align: center;"><b>1</b></p>	<p>...occurs on a limited basis without routine follow up or monitoring</p> <p style="text-align: center;"><b>2    3    4</b></p>	<p>...is provided for some team members using established and standardized curricula; practice assesses and monitors performance</p> <p style="text-align: center;"><b>5    6    7</b></p>	<p>...is supported and incentivized by the practice for all key team members; continuing education is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to self management</p> <p style="text-align: center;"><b>8    9    10</b></p>

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

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..... _____
<b>Total Score</b> ..... _____	<b>Total Score</b> ..... _____

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

**For more information contact:**

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