

Measure #21. Resources and Support for Self-Management (RSSM)

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility			
Communicate			
<i>Interpersonal communication</i>	□		
<i>Information transfer</i>	□		
Facilitate transitions			
<i>Across settings</i>	□		
<i>As coordination needs change</i>			
Assess needs and goals	■		
Create a proactive plan of care	□		
Monitor, follow up, and respond to change	■		
Support self-management goals	■		
Link to community resources	■		
Align resources with patient and population needs			
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			
Care management	■		
Medication management	□		
Health IT-enabled coordination			

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Resources and Support for Self-Management (RSSM)

Purpose: To measure the receipt of self-management support for chronically ill patients.

Format/Data Source: Adapted the 20-item Patient Assessment of Chronic Illness Care (PACIC) survey, adding new items that addressed domains (including followup and support for community resources) and removing others, for a finalized 17-item instrument. The RSSM portion of the survey contains 17 items spanning 5 areas: (1) individualized assessment, (2) collaborative goal setting, (3) enhancing skills, (4) ongoing followup and support, and (5) community resources.

Date: Measure published in 2008.¹

Perspective: Patient/Family

Measure Item Mapping:

- **Communicate:**
 - Interpersonal communication:
 - *Between health care professional(s) and patient/family:* 10, 15
 - Information transfer:
 - *Between health care professional(s) and patient/family:* 14
- **Facilitate transitions:**
 - Across settings: 9
- **Assess needs and goals:** 1, 2, 4, 5
- **Create a proactive plan of care:** 3, 4
- **Monitor, follow up, and respond to change:** 1, 2, 5, 9-15
- **Support self-management goals:** 1, 6-8, 11
- **Link to community resources:** 11, 16, 17
- **Care management:** 1-15
- **Medication management:** 12, 13

Development and Testing: Two rounds of cognitive testing on 14 participants pilot-tested the RSSM questionnaire. Further testing was performed on a sample of 957 patients with diabetes. Cronbach's alpha coefficients supported construct validity. The RSSM tool exhibited good psychometric properties and was used successfully by respondents of varying education levels.¹

Link to Outcomes or Health System Characteristics: Patients with diabetes who reported higher RSSM scores also reported better self-management behaviors (more frequently checking blood sugar and feet, greater program participation, better diet and nutrition behaviors, and greater physical activity).¹

Logic Model/Conceptual Framework: The Chronic Care Model provided the framework for construction of the RSSM. The model identifies 6 elements of a delivery system that lead to improved care for the chronically ill, including: (1) organization of care within the health system,

(2) clinical information systems, (3) decision support, (4) delivery system design, (5) self-management support, and (6) community resources and policies.¹

Country: United States

Past or Validated Applications*:

- **Patient Age:** Not Age Specific
- **Patient Condition:** Combined Chronic Conditions, General Chronic Conditions
- **Setting:** Primary Care Facility

*Based on the source listed below and input from the measure developer.

Notes:

- All instrument items are located in Table 2 of the source article.¹
- This instrument contains 17 items; all 17 were mapped.

Source:

1. McCormack LA, Williams-Piehotu PA, Bann CM, et al. Development and validation of an instrument to measure resources for chronic illness self-management: a model using diabetes. *Diabetes Educator* 2008;34(4):707-18.