Development and validation of a Japanese version of the Patient Centred Assessment Method and its user guide: a cross-sectional study

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ABSTRACT

Objectives The primary objective of this study was to develop the Japanese version of the Patient Centred Assessment Method (PCAM) and its user guide. The secondary objective was to examine the validity and reliability in the primary care setting.

Design Cross-sectional study.

Setting Three family physician teaching clinics located in urban residential areas in Tokyo, Japan.

Participants Patients who were aged 20 years or older, and who had an appointment with physicians at the three participating clinics.

Main outcome measures Patient complexity measured by PCAM and complexity/burden level measured by a Visual Analogue Scale (VAS).

Results Although confirmatory factor analysis using a model described in a previous study revealed that the indices did not meet the criteria for good fit, exploratory factor analysis revealed a new three-factor structure of ‘Personal well-being,’ ‘Social interaction’ and ‘Needs for care/service.’ Cronbach’s alpha of PCAM was 0.86. Spearman’s rank correlation coefficients between PCAM scores and VAS scores were 0.51 for complexity (p<0.001) and 0.41 for burden (p<0.001). There were 42 patients (14.3% of total patients) with PCAM scores greater than its mean of 16.5 but with complexity VAS scores less than its mean of 20.8.

Conclusions The Japanese version of PCAM and its user guide were developed through Japanese translation and cultural adaptation by cognitive debriefing. PCAM is a valid and reliable tool to assess patient complexity in the primary care settings in Japan. Additionally, although the correlation between total PCAM scores and complexity/burden as assessed by VAS was moderate, PCAM can more precisely identify patient complexity than skilled physician’s intuition.

INTRODUCTION

Social and economic conditions are associated with human health and have been termed social determinants of health.1 Developed countries are now increasingly facing many obstacles caused by changes in the population pyramid, declining birthrates and ageing populations.2 These demographic shifts are leading to a growing number of people with diverse and complex backgrounds, such as multimorbidity,3,4 neuropsychiatric diseases including dementia5,6 and depression,7,8,9 less involvement in social networks10 and living alone.11 Therefore, the role of primary care providers in addressing these patients’ biopsychosocial complexities is becoming more important.

INTERMED14–16 is an instrument that was developed to assess patient complexity in secondary care settings, and the validity and reliability of the Japanese version have been verified.12 Based on INTERMED, the Minnesota Complexity Assessment Method (MCAM)18 was developed for use in the primary care settings, which led to an advanced version of MCAM, called the Minnesota Edinburgh Complexity Assessment Method (MECAM),19 for the assessment of patients’ biopsychosocial needs.

The Patient Centred Assessment Method (PCAM)20 is an improved version of MECAM that can be applied to long-term conditions such as chronic obstructive pulmonary...
Research Task Force for Translation. First, the International Society Pharmacoeconomics and Outcomes Research, Inc. adapted to Japanese with the original author’s permission. The PCAM and its user guide were translated into and culturally adapted into Japanese, and four researchers (RM, MM, SY, HW) discussed cultural adaptation to Japanese and completed the provisional versions. 

METHODS

This study consisted of two phases. In the first phase, the Japanese version of PCAM and its user guide were developed. In the second phase, the validity and reliability of the Japanese version of PCAM were evaluated in the primary care setting. In this study, we examined the structure and criterion validity and internal consistency as reliability.

First phase: development of the Japanese version of PCAM and its user guide

PCAM and its user guide were translated into and culturally adapted to Japanese with the original author’s permission in accordance with the guidelines of the WHO and International Society Pharmacoeconomics and Outcomes Research Task Force for Translation. First, the primary investigator (RM), who was a native speaker of Japanese, translated the original PCAM and its user guide into Japanese, and four researchers (RM, MM, SY, HW) discussed cultural adaptation to Japanese and completed the provisional versions. Next, a bilingual medical doctor (DH), who was not familiar with the original PCAM and its user guide, back-translated the provisional versions into English. Then, discrepancies between the original and back-translated English version were reviewed and revised by the original authors and three of the authors of this study (RM, MM, SY). Thus, we completed the prototype versions. Next, cognitive debriefing on the prototype version was conducted in a small group to check alternative wording and to confirm the understandability, interpretation and cultural relevance of the translation. Five Japanese physicians were recruited from primary care clinics in Tokyo, Japan by means of snowball sampling considering age, sex and years of experience, and were interviewed to check and confirm each of the points described above.

Second phase: evaluation of validity and reliability

Study design and setting

This was a cross-sectional study reported in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology Statement. This study was conducted at three family physician teaching clinics located in urban residential areas in Tokyo, Japan that were responsible for primary care with group practice: Kitaadachi-seikyo Clinic, Seikyo-ukima Clinic and Musashikoganei Clinic affiliated with Japanese Health and Welfare Co-operative Federation.

Patient participants

Patients who were aged 20 years or older, and who had an appointment with physicians at the three participating clinics were consecutively included. Exclusion criteria were patients for a general check-up, patients who had difficulty communicating in Japanese, patients who were too sick to complete the questionnaire or patients who declined to participate in this study.

Data collection

Data were collected by five physicians: two at Kitaadachi-seikyo Clinic, one at Seikyo-ukima Clinic and two at Musashikoganei Clinic, Japanese Health and Welfare Co-operative Federation. The period for data collection was between 5th January 2018 and 25th July 2018 in consideration of the physicians’ and the principal investigator’s schedule: 5 days at Kitaadachi-seikyo Clinic, 15 days at Seikyo-ukima Clinic and 12 days at Musashikoganei Clinic. In advance of the data collection, the principal investigator explained the Japanese version of the PCAM to the five physicians using the user guide to standardise the criteria of evaluation. Patients were asked to complete a self-administered questionnaire on demographic characteristics while waiting for a consultation at the clinic; furthermore, physicians evaluated the degree of complexity and burden using a Visual Analogue Scale (VAS). During or after a consultation, physicians...
used the Japanese version of the PCAM user guide and completed a PCAM form.

**Outcome measures**

**Patient Centred Assessment Method**

PCAM consists of 12 items across four categories: 'Health and well-being' (four items: ‘Physical health needs’, ‘Physical health impacting mental well-being’, ‘Lifestyle impacting mental well-being’ and ‘Other mental well-being’), ‘Social environment’ (four items: ‘Home environment’, ‘Daily activities’, ‘Social network’ and ‘Financial resources’), ‘Health literacy and communication’ (two items: ‘Health literacy’ and ‘Engagement in discussion’) and ‘Service coordination’ (two items: ‘Other services’ and ‘Service coordination’). Each item is scored from 1 to 4 points, with total scores ranging from 12 to 48 points. The higher the score, the more complex the patient.

**Complexity/burden level measured by VAS**

Physicians possibly misperceive the psychological ‘burden’ of caring for a patient with complex needs as intuitive patient ‘complexity.’ Therefore, patient complexity and psychological burden were measured separately, enabling the physicians to be aware of the difference between them and to evaluate them precisely. Measurements were performed by using a VAS. The VAS for ‘complexity’ comprised a 10 cm long horizontal line with a starting point of ‘not complex’ (0 point) and an ending point of ‘the most complex’ (100 points). The VAS for ‘burden’ similarly comprised a 10 cm long horizontal line with a starting point of ‘no burden’ (0 point) and an ending point of ‘the heaviest burden’ (100 points). A person who was blinded to the patients’ information measured the length marked on the VASs.

There are currently no external criteria for examining criterion validity for which the validity and reliability have been established in the primary care setting. Therefore, a VAS, which is a practical tool, was substituted for external criteria.

**Patient characteristics**

Demographic characteristics including sex, age, marital status, household composition, household size, home ownership, years of residence, employment status and educational background were obtained from a self-administered questionnaire, whereas main diseases, Charlson Comorbidity Index (CCI) and copayment (the proportion of individual payment of medical expense depending on age and income) were obtained from medical records. Physicians chose one main disease from all of a patient’s diseases for that patient’s regular clinical visits.

**Sample size calculation**

The recommended subjects-to-variables ratio is from 3:1 to 20:1 when conducting exploratory factor analysis. Because a larger sample size has been reported to provide more precise results in factor analysis, the ratio of 20:1 was employed in this study. Therefore, because PCAM includes 12 items, the sample size was determined to be 300 in consideration of at most 60 participants having missing values.

**Statistical analysis**

Confirmatory factor analysis with the robust maximum likelihood estimation was conducted to assess structural validity, assuming a two-factor model of medicine-oriented and patient-oriented complexity, which was derived from our previous study. The model fit was judged to be good if the comparative fit index (CFI) was ≥0.90, standardised root mean residual (SRMR) was ≤0.08 and root mean squared error of approximation (RMSEA) was ≤0.08.33 When the model fit was insufficient, exploratory factor analysis with the robust maximum likelihood estimation and CF-Equamax rotation was performed. Parallel analysis was conducted to determine the number of common factors and factor loading ≥0.4 was adopted to determine which items to include.

Internal consistency was considered adequate if Cronbach’s alpha was between 0.70 and 0.95. Spearman’s rank correlation coefficient between total PCAM scores and complexity/burden as measured by VAS examined criterion validity and how closely the scale correlated with the physicians’ general impressions.35

All statistical analyses were performed using Stata/SE V.14.0 and Mplus V.8.4. P values of <0.05 were considered statistically significant.

**RESULTS**

**Japanese translation and cultural adaptation by cognitive debriefing**

After the Japanese forward and backward translation process, cultural adaptation was conducted by interviewing one female physician and four male physicians between 27th April and 18th May 2017. These five physicians’ median (IQR) age and years of experiences as a primary care physician were 37 (34–38) and 12 (10–14) years, respectively. The median interview time (IQR) was 51 (17–55) min. The physicians pointed out 34 parts that required improvement; modification of these parts was subsequently discussed by the researchers. For example, the wording of the sample questions to patients in the user guide was changed from a literary to a colloquial style to make them easier to understand. Terms with the same pronunciation but different Chinese characters with different meanings were changed to avoid confusion. Twelve of the 34 modified parts were back-translated to minimise possible loss of the original meaning caused by the modification. Three were back-translated into exactly
the same as the original English text; four in the PCAM; and five in the user guide were confirmed and accepted by the original authors. Finally, the Japanese version of PCAM (see online supplemental file 1) and its user guide (see online supplemental file 2) were developed.

**Evaluation of validity and reliability**

A total of 298 eligible patients were recruited: 100 at Kitaadachi-seikyo Clinic, 101 at Seikyo-ukima Clinic and 97 at Musashikoganei Clinic. Physicians missed out the entire PCAM in four patients and part of it in one patient, which led to a total of 293 patients included in the final analysis. Patient characteristics and main diseases are shown in tables 1 and 2.

The mean (SD) PCAM score was 16.5 (5.1) and the median (IQR) score was 15 (13–18). As shown in figure 1, the distribution of total PCAM scores was skewed to the right with a floor effect.

**Confirmatory and exploratory factor analysis**

Confirmatory factor analysis using the model described in our previous study revealed the following indices for model fit: CFI=0.663, SRMR=0.104 and RMSEA=0.134.

Because the indices did not meet the criteria of good fit, exploratory factor analysis was performed. Parallel analysis suggested a maximum of six common factors.
However, because the four-factor to six-factor models included a common factor that comprised one item, a three-factor model was employed. The items ‘Physical health needs,’ ‘Physical health impacting mental well-being,’ ‘Other mental well-being concerns’ and ‘Daily activities,’ which focus on physical and mental well-being, contributed to the first factor, termed ‘Personal well-being.’ The items ‘Social network,’ ‘Health literacy’ and ‘Engagement in discussion,’ which focus mainly on interaction with social networks and healthcare professionals, contributed to the second factor, termed ‘Social interaction.’ The items ‘Home environment,’ ‘Other services’ and ‘Service coordination,’ which focus on patients’ needs arising in the home environment and satisfied with social services, contributed to the third factor, termed ‘Needs for care/service.’

However, the two items ‘Lifestyle impacting mental well-being’ and ‘Financial resources’ were not included due to a factor loading less than 0.4 (table 3).

Cronbach’s alpha of PCAM was 0.86, and that of the three factors: ‘Personal well-being,’ ‘Social interaction’ and ‘Needs for care/service’ were 0.77, 0.78 and 0.89, respectively.

The correlation between PCAM and VAS (complexity and burden) is shown in figure 2. Spearman’s rank correlation coefficients between PCAM scores and VAS were 0.51 for complexity (p<0.001) and 0.41 for burden (p<0.001). There were 42 patients (14.3% of total patients) with PCAM scores more than the mean score of 16.5 but with complexity scores less than the mean score of 20.8. Moreover, Spearman’s rank correlation coefficient between complexity and burden was 0.77.

**DISCUSSION**

In this study, a Japanese version of the PCAM and its user guide were developed through a process of translation, back-translation and cognitive debriefing. Then, the structural validity of the Japanese version of the PCAM was assessed through exploratory factor analysis, which revealed the three new factors of ‘Personal well-being,’ ‘Social interaction’ and ‘Needs for care/service,’ although confirmatory factor analysis using the model described in our previous study showed the model fit to be poor. Cronbach’s alpha of PCAM, ‘Personal well-being,’ ‘Social interaction’ and ‘Needs for care/service’ were all high. Additionally, the total PCAM score was moderately correlated with complexity and burden as assessed by VAS, indicating that criterion validity was established to some extent.

**Table 3 Exploratory factor analysis of the Japanese version of the Patient Centred Assessment Method**

<table>
<thead>
<tr>
<th>Health and well-being</th>
<th>First factor</th>
<th>Second factor</th>
<th>Third factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health needs</td>
<td>0.527</td>
<td>0.165</td>
<td>0.017</td>
</tr>
<tr>
<td>Physical health impacting mental well-being</td>
<td>0.622</td>
<td>0.009</td>
<td>0.114</td>
</tr>
<tr>
<td>Lifestyle impacting mental well-being</td>
<td>0.099</td>
<td>0.144</td>
<td>0.083</td>
</tr>
<tr>
<td>Other mental well-being concerns</td>
<td>0.667</td>
<td>–0.022</td>
<td>0.094</td>
</tr>
<tr>
<td>Social environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home environment</td>
<td>0.327</td>
<td>0.111</td>
<td>0.433</td>
</tr>
<tr>
<td>Daily activities</td>
<td>0.659</td>
<td>0.010</td>
<td>0.084</td>
</tr>
<tr>
<td>Social network</td>
<td>0.369</td>
<td>0.426</td>
<td>0.094</td>
</tr>
<tr>
<td>Financial resources</td>
<td>0.307</td>
<td>0.120</td>
<td>0.236</td>
</tr>
<tr>
<td>Health literacy and communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health literacy</td>
<td>0.063</td>
<td>0.862</td>
<td>0.015</td>
</tr>
<tr>
<td>Engagement in discussion</td>
<td>–0.141</td>
<td>0.806</td>
<td>0.099</td>
</tr>
<tr>
<td>Service coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>0.020</td>
<td>0.056</td>
<td>0.915</td>
</tr>
<tr>
<td>Service coordination</td>
<td>0.014</td>
<td>0.086</td>
<td>0.885</td>
</tr>
</tbody>
</table>
This study showed a three-factor structure that differed from that of our previous study, this difference presumably being attributable to differences between the clinical settings. Our previous study was conducted in the secondary care setting and the participants were inpatients of an acute hospital, whereas the current study was in the primary care setting. For example, one difference was that the mean (SD) CCI score was 0.9 (1.4) in the present study, which was lower than that of 2.0 (2.2) in our previous study with higher biomedical complexity. Furthermore, the mean (SD) age of patients in our previous study, 77.4 (11.9) years, was higher than that of the current study. In terms of factor structure, patients with greater physical health-related needs are likely to have greater needs for care and services, which could result in hospitalisation in the secondary care setting. Thus, the ‘Medicine-oriented’ factor in the previous study includes both the item ‘Physical health needs’ and items that are included in the ‘Needs for care/service’ factor in the present study. Conversely, in the primary setting, such needs for care and services may not be identified because the patients have fewer physical health-related needs. Therefore, the

Figure 2  Correlation between PCAM scores and complexity/burden level measured by VAS. PCAM, Patient Centred Assessment Method; VAS, Visual Analogue Scale.
item ‘Physical health needs’ was not included in the same factor as items that are included in the ‘Needs for care/service’ factor. Rather, the item ‘Physical health needs’ was treated as a component of physical well-being and therefore included in the ‘Personal well-being’ factor in the present study. Additionally, the ‘Patient-oriented’ factor in the previous study includes the items ‘Physical health impacting mental well-being,’ ‘Other mental well-being,’ ‘Daily activities,’ ‘Social network,’ ‘Health literacy’ and ‘Engagement in discussion,’ whereas these items were divided into two factors, ‘Personal well-being’ and ‘Social interaction,’ in the present study. This is probably because primary care physicians take care of people in the community and focus more on assessing their patients from social perspectives. In contrast, social aspects of hospitalised patients are less important in the secondary setting, where social aspects are combined with biopsychosocial factors in the ‘Patient-oriented’ factor in the previous study.

The extraction of ‘Social interaction’ and ‘Needs for care/service’ from ‘Personal well-being’, which is mainly related to physical and psychological well-being, was of particular importance. ‘Social interaction’ includes items regarding ‘Social network’ and ‘Health literacy and communication.’ Health literacy is the cognitive and social ability to obtain, understand, assess and use information that is essential for good health, and consists of basic/functional, communicative/interactive and critical literacy; in particular, communicative/interactive literacy is necessary for active participation in social networks. Therefore, it was consistent and reasonable to extract issues related to both social network and health literacy/communication as a common factor. On the other hand, ‘Needs for care/service’ includes items regarding ‘Home environment’ and ‘Service coordination.’ The PCAM evaluates ‘Home environment’ in terms of safety and stability. In Japan, the population is rapidly ageing, causing many related problems. For example, older adults are obliged to take care of their old spouses. The numbers of households with a single older adult and solitary deaths are increasing. These problems that are attributable to an unsafe or unstable home environment, which may be solvable with nursing care and social welfare interventions, are assumed to be strongly associated with ‘Service coordination.’

However, two items, ‘Lifestyle impacting mental well-being’ and ‘Financial resources’, had insufficient factor loading less than 0.4 and were not included in the three factors. The exclusion of the former item presumably resulted from the fact that 60% of all patients had lifestyle diseases such as diabetes mellitus, dyslipidaemia and hypertension, which were generally well controlled at the participating clinics; therefore, the impact of a patient’s lifestyle on these diseases might have been underestimated. Additionally, severely alcoholic patients and drug misusers were possibly referred to specialised facilities, which could also have resulted in underestimation of this item. The exclusion of the latter item presumably resulted from the fact that copayment of medical expenses is at most 30% under the Japanese universal health insurance coverage system and 0% under the welfare system; hence, few patients were likely troubled with financial problems due to healthcare. Moreover, previous research revealed that financial topics are taboo and inappropriate for discussion with healthcare providers; therefore, this question might not have been answered accurately. In the Japanese version of PCAM, these items were not intentionally excluded in consideration of the fact that the overall Cronbach’s alpha was 0.86, which indicates a high internal consistency without exclusion of these items. The fact that lifestyle-related and economic problems negatively influence physical and psychological conditions is established. These two items should therefore not be excluded at this stage; further cautious and prudent research is required to determine how best to accurately score and include them.

This study also showed a floor effect in the distribution of PCAM scores, whereas our previous study did not. The large number of patients, in fact, had low patient complexity; however, physicians might not be able to distinguish detailed factors related to subtle patient complexity due to limited consultation time.

The correlation between total PCAM scores and complexity/burden as assessed by the VAS was found to be moderate. Although complexity and burden were separately assessed to prevent physicians from confusing these two variables, Spearman’s rank correlation coefficient between complexity and burden was high. This indicates that physicians do not regard complexity as an objective index, but rather handle it as subjective feeling, or burden. Furthermore, patients that physicians regarded as being not complex were found to have somewhat high PCAM scores, even though physicians working at family physician teaching clinics are generally well trained to see patients from biopsychosocial perspectives. Accordingly, PCAM can more objectively and precisely identify patient complexity than skilled physician’s intuition.

There are some limitations in this study. First, only three clinics in urban areas in Tokyo were included as study settings, which could have limited the generalisability of our findings. Second, inter-rater variability of PCAM scores was not evaluated. Patients were not assessed by two physicians because they usually visited the same primary care physician. We considered it would be unethical to force them to see an unfamiliar physician and undergo another PCAM assessment due to their temporal, economic and psychological burden. Moreover, some of the clinics had only one physician on service at a time. As a result, PCAM scores might have been overestimated or underestimated. However, a Japanese version of PCAM is necessary for healthcare providers to address biopsychosocial problems without language barriers, which outweighs the above study limitations.
CONCLUSION
The Japanese version of PCAM and its user guide were developed from the original English version. PCAM was found to be a valid and reliable tool to assess patient complexity in the primary care setting in Japan. Additionally, the correlation between total PCAM scores and complexity/burden as assessed by the VAS was moderate, PCAM can more precisely identify patient complexity than skilled physician’s intuition.

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Contributors RM designed the study; collected, analysed and interpreted the data; and prepared and reviewed the manuscript. MM designed the study; analysed and interpreted the data; and prepared and reviewed the manuscript. SY designed the study; collected and interpreted the data; and reviewed the manuscript. HS designed the study; analysed and interpreted the data; and reviewed the manuscript. MK, TW and TT designed the study; collected the data and reviewed the manuscript. DH back-translated PCAM and its user guide and reviewed the manuscript.

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Competing interests MM received lecture fees and lecture travel fees from the Centre for Family Medicine Development of Japanese Health and Welfare Co-operative Federation. MM is an adviser of the Centre for Family Medicine Development practice-based research network. MM is a program director of The Jikei Clinical Research Program for Primary-care. YS, SY, MK, TW and TT are former trainees of The Jikei Clinical Research Program for Primary-care. TW currently is and SY, MK and TT used to be family physicians at the Centre for Family Medicine Development of Japanese Health and Welfare Co-operative Federation. RM, RH and DH have nothing to disclose.

Patient consent for publication Not required.

Ethics approval The research protocol for the first phase was approved by the Ethics Committee of The Jikei University School of Medicine (ethics number: 28-365 (8608)). The research protocol for the second phase was approved by the Ethics Committee of The Jikei University School of Medicine (ethics number: 29-229 (8845)) and Tokyo Hekuto Health Co-operative (ethics number: 89). The principal investigator (RM), who was not associated with any of the three family physician teaching clinics, fully explained the content of this study to all subjects; they then provided written informed consent to participate.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available.

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日本語版

Patient Centered Assessment Method (PCAM)

医師/看護師：

実施上の注意点：この評価シートをガイドとして使用し、あなたが各質問に答えやすいように、面談の際にあなたの自身の言葉で患者に質問してください。この患者に関連した複雑性のレベルを反映させるように各項目を選択肢一つに丸をつけてください。面談の間か、もしくはその後に完成させてください。

身体の健康と心の安寧

1. 患者の身体の健康についてどのようなニーズがあるかを考えた場合、更に精査が必要と思われる不確かな症状や問題（危険因子）があるか？

| 診断 | 軽度の漠然とした身体的状態あるいは問題がある；しかし日常生活に影響を及ぼさないか、患者の心配事ではない | 日常生活に影響を及ぼす中等度から重度の症状あるいは問題がある | 日常生活に重大な影響を及ぼす重度の症状あるいは問題がある |

2. 患者の身体の健康が心の安寧に影響しているか？

| 患者の身体の健康が心の安寧に影響しているか？ | 心の安寧に軽度の影響を与えている（例：“うんざりする感じ”、“楽しみが減っている”） |

3. 身体の健康や心の安寧に影響するような生活習慣（アルコール、薬、食事、運動）に伴う問題があるか？

| 患者の身体の健康や心の安寧に影響するよう生活習慣に伴う問題があるか？ | 身体の健康や心の安寧に軽度の影響を与える可能性がある軽度の問題を認める |

4. 患者の心の安寧について他に何らかの懸念される問題があるか？その深刻さや患者に与える影響をどのくらいと評価するか？

| 患者の心の安寧について他に何らかの懸念される問題があるか？その深刻さや患者に与える影響をどのくらいと評価するか？ | 中等度から重度の問題があり日常生活を妨げている |

社会的環境

1. 安全性、安定性の点（家庭内暴力、安全でない家、隣人の嫌がらせを含む）から住居環境をどのよう評価するか？

| 安全性、安定性の点（家庭内暴力、安全でない家、隣人の嫌がらせを含む）から住居環境をどのよう評価するか？ | 安全/安定しているか疑問がある |

2. 日常の活動は患者の事、介護、その他を含む？

| 日常の活動は患者の事、介護、その他を含む？ | 時々、気分の落ち込みやストレスの一因となっている |


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### 社会ネットワーク

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<thead>
<tr>
<th>社会ネットワークに十分に参加している</th>
<th>社会ネットワークに不足なく参加している</th>
<th>ある程度、社会的に孤立し、参加が制限されている</th>
<th>孤独で社会的に孤立し、ほとんど参加していない</th>
</tr>
</thead>
<tbody>
<tr>
<td>金銭面（すべての必要な医療ケアを受ける余裕があることを含む）についてはどう評価するか？</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>金銭的に安定し、十分な収入があり、問題は見いだされない</td>
<td>金銭的に安定しているが、収入にいくつかの問題がある</td>
<td>金銭的に不安定で、収入にいくつかの問題がある</td>
<td>金銭的に不安定で、収入は極端に少なく、問題に直面している</td>
</tr>
</tbody>
</table>

### 健康リテラシーとコミュニケーション

| 自分の健康・安寧（症状、徵候、危険因子）と健康管理に必要なことを、患者は今、どの程度よく理解しているか？ |
| 合理的によく理解している | 合理的によく理解しているが、現時点ではアドバイスを受け入れられない | より良い管理を可能にするような理解を少しずつしていらない | 健康管理をするための重要なことを理解していないうち |
| 患者はどのくらいヘルスケアの話し合いに参加することができるか（言語の壁、聴覚欠如、失語症、アルコールや薬物問題、学習困難、集中力）？ |
| 妨げがなく、率直なコミュニケーションで、障壁は見出されない | むずかしい障壁があるものの、不必要なコミュニケーションである | 中等度の障壁があり、コミュニケーション上のいくつかの困難がある | 重度な障壁を伴うコミュニケーション上の深刻な困難がある |

### サービスコーディネーション

| 患者を支援するために必要な他のサービスはあるか？ |
| 現時点では他のケア/サービスは必要としていない | 他のケア/サービスはすでに受けており、不足はないと考えられるが、十分ではありません | ケア/サービスを受けておらず、受ける必要がある |
| 現在、患者に関わっているサービスは良く調整されているか（あなたが今薦めている他のサービスとの調整も含む）？ |
| すべての必要なケア/サービスをすでに受けており、良好に調整されている | 必要なケア/サービスをすでに受けており、不足なく調整がなされている | 必要なケア/サービスはすでに受けてだが、いくらかの調整に妨げがある | 必要なケア/サービスが欠如している、かつ/あるいは調整が断片的である |

<table>
<thead>
<tr>
<th>通常のケア</th>
<th>経過観察</th>
<th>プラン作成</th>
<th>すぐに実施</th>
</tr>
</thead>
<tbody>
<tr>
<td>どんな行動が必要か？</td>
<td>難に協力を求めるべきか？</td>
<td>行動のための妨げは何か？</td>
<td>どんな行動をとるか？</td>
</tr>
</tbody>
</table>

備考：
日本語版 Patient Centered Assessment Method (PCAM)
評価実施のためのユーザーガイド

＜身体の健康と心の安寧＞

項目１：身体の健康についてのニーズ

<table>
<thead>
<tr>
<th>1. 患者の身体の健康についてどのようなニーズがあるかを考えた場合、更に精査が必要と思われる不確かな症状や問題（危険因子）があるか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>不確かな問題は見出されない、あるいは問題はすでに吟味されているかもれない。軽度の漠然とした身体的症状あるいは問題がある。しかし日常生活に影響を及ぼさないか、患者の心配事ではない。日常生活に影響を及ぼす中等度から重度の症状あるいは問題があるが、日常生活に重大的な影響を及ぼす重度の症状あるいは問題がある。</td>
</tr>
</tbody>
</table>

この項目では、健康診断の際に行われた身体的な検査の結果として見出された危険因子（血圧、血糖値）を含めてください。さらに、患者が自発的に挙げた問題、また、自身に影響を及ぼしている健康問題があるか尋ねてください。患者はすでにケアを受けているかもしれませんが、症状が変化していたり、持続して日常生活に影響を与えているかもしれません。

尋ねたらよいと思われる質問項目サンプル：
- 現時点でのあなたの健康状態について述べてください。
- 身体の健康についてはいかがでしょうか。
- もし、診療所以外（非医療機関）でPCAMによる評価が行われている場合、あなたは医者にかかる必要が最近ありましたか？それは何のためですか？

項目２：身体の健康が心の安寧に与える影響

<table>
<thead>
<tr>
<th>2. 患者の身体の健康が心の安寧に影響しているか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>懸念される問題は見出されない</td>
</tr>
<tr>
<td>心の安寧に中等度から重度の影響を与えており、日常生活の楽しみを妨げている</td>
</tr>
</tbody>
</table>

ここでは、項目１で挙げられた問題や、生活習慣上の問題による身体の症状を考慮することになるでしょう。

尋ねたらよいと思われる質問項目サンプル：
- 私たちがあなたの身体の症状や状態について話し合っている時、どのように感じますか？
- Xという状態は現時点であなたにどのように影響していますか？
- あなたの心の状態はいかがですか？
- あなたはストレスを感じたり、うんざりする感じが少しでもありますか？
項目3：ライフスタイルが身体の健康と心の安寧に与える影響

<table>
<thead>
<tr>
<th>3</th>
<th>身体の健康や心の安寧に影響するような生活習慣（アルコール、薬、食事、運動）上の問題があるか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>懸念される問題は見出されない</td>
<td>身体の健康や心の安寧に悪影響を与える可能性がある軽度の問題を認める</td>
</tr>
<tr>
<td></td>
<td>身体の健康や心の安寧に中等度から重度の影響を与えおり、日常生活の楽しみを妨げている</td>
</tr>
<tr>
<td></td>
<td>身体の健康や心の安寧に重度の影響を与えおり、他者にも影響する可能性がある</td>
</tr>
</tbody>
</table>

この項目では、アルコール、薬物使用、食事、運動のような生活習慣による影響と、それらが身体と心の健康の両方にどのように影響を及ぼしているかを考慮しましょう。

尋ねたらよいと思われる質問項目サンプル：
・あなたはアルコールや薬物使用について、何か気になることがありますか？
・健康を維持するためにあなたがしていることはどんなことですか？運動や食事？

項目4：その他の心の安寧の問題

<table>
<thead>
<tr>
<th>4</th>
<th>患者の心の安寧について他に何らかの懸念される問題があるか？その深刻さや患者に与える影響をどのくらいと評価するか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>懸念される問題は見出されない</td>
<td>軽度な問題－日常生活の機能を妨げない</td>
</tr>
<tr>
<td>軽度な問題－日常生活の機能を妨げない</td>
<td>中等度から重度の問題がある日常生活の機能を妨げている</td>
</tr>
<tr>
<td>中等度から重度の問題がある日常生活の機能を妨げている</td>
<td>ほとんどの日常生活の機能を妨げる重度の問題がある</td>
</tr>
</tbody>
</table>

ここでは、上記で考慮されたこと以外の心の安寧について考慮しましょう。ここでは統合失調症等のような厳しい状況に加えて、不安、うつ、自尊心、死別、虐待、人間関係、雇用問題が含まれるかもしれません。あなたは時間制限のある面談中に“パンドラの箱を開ける”ことを心配するかもしれません。このことは経験、訓練、サービスプランニングによってしばしば軽減することができます。（例：さらに案件を話し合うために、再度患者に来てもらえるようにすること）

時々、患者は希死念慮を表現するかもしれません。リスク評価を訓練することがこの問題に対処するのに役立つでしょう。こういう思いを訴える患者は、またに差し迫った危険な状態ではないでしょう。そして、会話がその危険を軽減することに役立つかもしれません。

尋ねたらよいと思われる質問項目サンプル：
・生活において、あなたの健康に影響を及ぼしているかもしれません、他のことはありませんか？
・個人的な人間関係が失われた、変化したりしましたか？
・あなたは生活をどのくらいうまく管理できていると感じますか？
＜社会的環境＞
項目1：居住環境

<table>
<thead>
<tr>
<th>1.</th>
<th>安全性、安定性の点（家庭内暴力、安全でない家、隣人の嫌がらせを含む）から住居環境をどのように評価するか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>一貫して安全で、支援的、安定している状態で、問題は見受けられない</td>
<td>安全で、安定しているがやや一貫性に欠け、問題がある</td>
</tr>
<tr>
<td>安全/安定しているか疑問がある</td>
<td>安全でなく、安定していない</td>
</tr>
</tbody>
</table>

この質問項目では（患者と）話し合うには困難でやりがいがある領域になりますが、経験上、このツールを試しに使用した看護師は非常に有益であると見出しています。心の安寧についての話し合いを通じて、問題が浮かび上がってくるかもしれません。患者が言ったことをそのまま受け売りで環境を評価することはできませんが、ここでは報告したことを記録することになるでしょう。この時点で、危険にさらされている患者はこの問題について打ち明けることはできないかもしれません。しかし、患者と普段通りに自然な態度で話し始めると、いずれ打ち明けてくれるかもしれません。

尋ねたらよいと思われる質問項目サンプル：
・お家ではいかがですか？
・お家やご近所は安全だと感じていますか？
・あなたは自分の住んでいるところについて満足と感じていますか？なぜそう感じますか？/感じないのはなぜですか？

項目2：日常の活動

<table>
<thead>
<tr>
<th>2.</th>
<th>日常の活動は患者の（心の）安寧にどう影響を与えているか？（現在失業中か予想される失業、仕事、介護、その他を含む）</th>
</tr>
</thead>
<tbody>
<tr>
<td>問題は見いだされないか、あるいは恩恵があると感じている</td>
<td>ある程度ありきたりの不満があるが、気気がしていない</td>
</tr>
<tr>
<td>ある程度ありがたくありがたい</td>
<td>時々、気分の落ち込みやストレスの一因となっている</td>
</tr>
<tr>
<td>心の安寧に重度の悪影響を与えている</td>
<td></td>
</tr>
</tbody>
</table>

仕事のストレス、失業、責任のある介護はすべて安寧を著しくする可能性があります。

尋ねたらよいと思われる質問項目サンプル：
・現在、日常の活動をいつも通りに送れていますか？それはなぜ？/なぜできないのですか？
・（もし、雇用されているなら）毎日仕事に行くことを楽しんでいますか？または仕事によってストレスが生じていますか？
・日常生活や（心の）安寧に影響を与えるような責任を抱えていますか？
項目3:社会ネットワーク

<table>
<thead>
<tr>
<th>3. 社会ネットワーク（家族、仕事、友人）についてどのように評価するか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>社会ネットワークに十分に参加している</td>
</tr>
</tbody>
</table>

適切な社会ネットワークはうつ、不安、自殺を予防できます。

尋ねたらよいと思われる質問項目サンプル:

・もしあなたが問題や気分の落ち込みを感じたら、だれに話せますか?
・あなたは友達や家族から良く支えられていると感じますか?なぜそう感じますか?   /感じないのはなぜですか?
・他にどのような支えが必要ですか?

項目4:金銭的な収入

<table>
<thead>
<tr>
<th>4. 金銭面（すべての必要な医療ケアを受ける余裕があることを含む）についてはどう評価するか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>金銭的に安定し、十分な収入があり、問題は見いだされない</td>
</tr>
</tbody>
</table>

借金や金銭面についての心配は心の安寧にとって、重大な危険因子となります。初めはこのことを話すのは難しい話題になり得ますが、現在の経済状況や増大する収入格差という文脈のなかで、“多くの人々は今、職を失うことや、収入の範囲内でやっていけるかを心配していますが、あなたはどうですか？”というように質問を一般化して始めることが有用かもしれません。

追加して尋ねたらよいと思われる質問項目サンプル:

・あなたは金銭的にゆとりがあると感じていますか?
・あなたは健康管理に関連した費用を支払えると感じていますか?

＜健康リテラシーとコミュニケーション＞

項目1:健康リテラシー

<table>
<thead>
<tr>
<th>1. 自分の健康・安寧（症状、徵候、危険因子）と健康管理に必要なことを、患者は今、どの程度よく理解しているか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>合理的によく理解していて、すでに健康管理をしているか、あるいはより良い管理をすることをいまとわない。</td>
</tr>
</tbody>
</table>

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この項目は援助を受ける際の障害を明らかにすることを意図しています。これを文書化しておくと、今後のコンサルテーションに対しての情報提供や、さらに患者と話し合う機会を持つための理由として役立つかもしれません。患者は健康の一つの側面は理解していますが、他の側面は理解していないかもしれません（例えば、喫煙量を減らす必要性は理解しているかもしれませんが、自宅での怒りが健康問題であるとは理解していないかもしれません）。ここでのあなたの記録は全体像を反映しているべきです。もし患者に前向きに進み始めるための理解が十分にあれば、緑か黄色につけるとよいでしょう。

尋ねたらよいと思われる質問項目サンプル:
・あなたは医療者にまだ質問があると感じていますか？他に知りたいことは何でしょうか？
・あなたは健康、診断、問題について必要な情報をすべて持っていると感じますか？
・あなたの生活を、医療者が提案したように変えるという準備ができていると感じていますか？（食事、運動、健康管理）

項目２：話し合いへの参加

<table>
<thead>
<tr>
<th>2. 患者はどのくらいヘルスケアの話し合いに参加することができるか？（言語の壁、聴覚欠如、失語症、アルコールや薬物問題、学習困難、集中力）</th>
</tr>
</thead>
<tbody>
<tr>
<td>妨げがなく、率直なコミュニケーションが、中等度の障壁があり、コミュニケーション上のいくらかの困難がある 重度の障壁を伴うコミュニケーション上の深刻な困難がある</td>
</tr>
</tbody>
</table>

上記のように、この項目では必要とされる治療よりも、話し合いに参加するための障壁を強調することを意図しています。このことは、患者にもう一度戻ってきてもらって、通訳者のような援助を提供できたり、学習困難者を援助するための資源を紹介できるかもしれません。

尋ねたらよいと思われる質問項目サンプル:
・医療者はあなたが理解しやすい方法で彼らの考えをあなたに説明をしますか？
・どうしたら医療者により理解してもらいやすくなりますか？

＜サービスコーディネーション＞

項目１：その他のサービス

<table>
<thead>
<tr>
<th>1. 患者を支援するために必要な他のサービスはあるか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>現時点では他のケア/サービスは必要としない</td>
</tr>
</tbody>
</table>

この項目は、あなたが勘ぐる（他のサービスへの）紹介と、あなたの載めに対して従うことへの患者の関心と意思を評価するために使ってください。たくさんの紹介があるかもしれませんが。その中のいくつかは患者を受けていたと思っているでしょうし。他、現時点では解決しようとしていないかもしれませんが。この紹介ということは、行動の必要性についてのあなたの意見を反映しているものです。実際に
行われた紹介はあなたの意見と患者の希望を反映しています。患者は現時点ではこの紹介は適切でないと判断するかもしれません。

尋ねたらよいと思われる質問項目サンプル：
・あなたは医療者やケアに関わっているその他の人々から、現時点で必要なすべてのケアを受けていると感じていますか？
・あなたは私が提案した薦めについてどのくらい満足していますか？
・あなたが経過を見たい、解決したい最重要課題のように感じているものは何でしょう？

項目2: サービスコーディネーション

<table>
<thead>
<tr>
<th>2.</th>
<th>現在、患者に関わっているサービスは良く調整されているか？（あなたが今薦めている他のサービスとの調整も含む）</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>すべての必要なケア/サービスをすでに受けており、良好に調整されている</td>
</tr>
<tr>
<td></td>
<td>必要なケア/サービスをすでに受けており、不足なく調整がなされている</td>
</tr>
<tr>
<td></td>
<td>必要なケア/サービスはすでに受けているが、調整にいくらかの妨げがある</td>
</tr>
<tr>
<td></td>
<td>必要なケア/サービスが欠如していて、（かつ/あるいは）調整が断片的である</td>
</tr>
</tbody>
</table>

この項目は、すべてのケアとサービス（あなたが評価する前にすでに受けていることも含めて）がどの程度うまく調整できているかを示すために使用してください。もし、サービスとケアが断片的で、患者が利用することが難しい場合は、例え患者がやると決めて、良く参加していても、やり遂げることができないかもしれません。

尋ねたらよいと思われる質問項目サンプル：
・あなたが利用しているすべてのサービスはどのくらいうまく組み立てられましたか？
・あなたが利用しているサービスは簡単にアクセスすることができて、あなたが利用できる時に提供されているか？
・サービスやケアを受ける準備や、そこにアクセスすることが困難で、それら（サービスやケア）を受けられないことがありますか？

このセクションは、あなたが薦めている行動、誰に紹介するか、妨げになるものの、そして、患者が何をしたいかという意思表示を要約するために使います。

<table>
<thead>
<tr>
<th>どんな行動が必要か？</th>
<th>誰に協力を求めるべきか？</th>
<th>行動のための妨げは何か？</th>
<th>どんな行動をとるか？</th>
</tr>
</thead>
<tbody>
<tr>
<td>備考：</td>
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