Agency for Healthcare Research and Quality
Advancing Excellence in Health Care–•–www.ahrq.gov

Patient Self-Management Support

A Chronic Conditions Practice Improvement Activity

User Guide

Resources

To use a screen reader application with this module, please change your Acrobat reading preferences under the Screen Reader Options to “Only read the currently visible pages.” Then close and re-open the PDF; you do not have to download it again. Instructions on how to change the setting are in Accessing PDF Documents with Assistive Technology.

If you have difficulty after changing your assistive technology settings or need help making the changes, contact our technical assistance number at 301-427-1600. Please specify the module you are trying to use and the nature of your concern.

Start

Welcome

This educational module provides clinicians with a quality improvement activity around **self-management support (SMS) for patients with one or more chronic conditions**. Self-management support is:

- A set of tools that help patients choose healthy behaviors and
- A fundamental transformation of the patient–caregiver relationship into a collaborative partnership.

Engaging patients in their own self-care improves clinical outcomes. This file provides all of the **step-by-step guidance and tools** you need to:

- Learn the essentials of SMS principles, as well as goal-setting and action-planning strategies.
- Focus on a population of your patients with one or more chronic conditions.
- Survey a small sample of your patients (or their parents) about how they have experienced two self-management support techniques: shared decisionmaking about prescription medications and talking about specific patient health goals.
- Design and implement a rapid-cycle quality improvement activity.

Completing this activity should enhance your skills for helping patients with chronic conditions while improving your patients' experience and health. Although you can work independently, you may have a richer learning experience by working with other clinicians (e.g., NPs) to complete this activity. Physicians who complete this activity may receive credit for Maintenance of Certification (MOC) Part IV; PAs may receive performance improvement continuing medical education (PI-CME) credit. This module is directed at English-language users. Spanish-language self-management support resources are available in the resources section.

Watch this optional Webinar about engaging patients with chronic conditions in SMS.

Educational Objectives

After this MOC / CE Activity, you will be able to:

1. Define self-management support (SMS) and its role in patient care.
2. Describe the benefits of SMS for patients with chronic conditions.
3. Identify resources for SMS.
4. Assess your current performance on supporting your patients' self-management.
5. Improve your skills by composing and implementing a quality improvement (QI) activity.
6. Attest and submit this activity for credit from your certifying Board or organization.
   For more details on how to submit this activity, please see the User Guide.

> *"Coordination of diplomates' pursuit of quality improvement activities at the organizational level can extend individual clinicians' certification exercises into a quality improvement enterprise."*
>
> ~ Jonathan Tobin, PhD, Director,
> Clinical Directors Network

The American Academy of PAs has approved the activity for a maximum of 20 Category 1 PI-CME credits; PAs will need to log credits with National Commission on Certification of PAs (NCCPA). Please see the User Guide for more details and instructions on how to obtain credit from your Board. Physicians certified through the American Boards of Family Medicine or Pediatrics must submit as a self-directed activity (please see the User Guide for instructions).

There is no cost to download, use, or copy this toolkit. You will be responsible for paying any fees that may be required by the certifying Board(s) to receive credit for your completed MOC Part IV improvement activity. This activity is open to anyone. Completion of this MOC/CE/CME activity will be documented in this PDF document. All the required sections must be completed to receive credit. The U.S. Department of Health and Human Services is not collecting or maintaining any information you enter into this module.

Continue

Instructions and Requirements

You will need to select a board or organization to display specific activity requirements and estimates of the time needed to complete this activity. We recommend reading the User Guide designed for this activity. You can access the User Guide at any time by using the "User Guide" link at the top of every page in this PDF.

Links to additional, optional resources are provided for those who want more in-depth information, ideas, or tools for SMS. These optional links are identified with ⓘ. For your reference, an acronym list is also available.

This file and the data in the file are stored on your computer. If you enter any patient data into the forms, ensure that you store the file in accordance with HIPAA privacy regulations. You may find that you need to install a more recent version of Adobe Acrobat Reader. You can download the latest version of Acrobat Reader at no cost.

This PDF file provides the necessary tools and information to complete the MOC Part IV/CE practice improvement activity. You will use this PDF file to:

- Work sequentially through each section.
- Enter required information (identified with ⊛).
- Enter patient survey data and document your QI activity.
- Generate summary data reports.
- Review and reflect on your baseline and followup survey data.
- Complete the activity and submit for credit.

The following data will be stored in this PDF file on your computer:

- Your Board ID or organization membership number and information.
- Answers to quizzes.
- Baseline survey data on your patients.
- QI activity plans.
- Followup survey data on your patients.
- Your reflections on your QI activity.
- Your attestation to meaningful participation.

You can print paper forms to simplify data collection and QI activity planning; however, **all performance data and QI plans must be entered into this PDF** document to meet completion requirements.

When you are ready to start this activity, **save this file** to your computer:

- Save in a secure location that is backed up regularly.
- Save the file periodically as you progress.

Select the Appropriate Board or Organization

✱ **Select your primary Board or organization** for which you are seeking MOC Part IV practice improvement credit or Continuing Education credit. (You can select only **one** for this activity.)

○ American Board of Family Medicine (ABFM)
○ American Board of Pediatrics (ABP)
○ American Board of Medical Specialties (ABMS)
○ National Commission on Certification of PAs (NCCPA)
○ Other (please specify): ____________________

Continue

Before you continue.
When you identify your Board or organization, the requirements of that Board (e.g., minimum number of patients, number of observations) will be shown in your copy of the PDF file.

Completion Requirements for

There are 11 steps in this activity. You must complete the following sequentially:

Step	What to Expect	Estimated Effort
1. Review instructions and requirements	Review the basic requirements of your participation, and attest that you have read and understand the requirements.	10-20 mins
2. Enter your information	Enter basic information about yourself to create an interactive version of the module that meets your needs.	10 mins
3. Learn about self-management support	Complete brief readings. Complete pre- and post-tests of self-management support knowledge.	30-90 mins
4. Collect baseline survey data	Survey your patients (or their parents) about their experience with self-management support. Use the included questionnaire to document your baseline performance using self-management support techniques.	2-3.5 hrs
5. Plan your QI activity	This section creates tables and graphs of your baseline performance data. Based on these data, you will develop and compose a QI activity with your clinic team.	1-2 hrs
6. Implement your QI activity	Write down your QI plan and put that plan into action in your clinic. Before you can enter followup performance data, you must test for a minimum of 14 calendar days.	3-8 hrs
7. Collect followup survey data	Use the same questionnaire to survey your patients (or their parents) about their experience with self-management support after your QI plan is implemented.	2-3 hrs
8. Reflect on your QI activity	Write brief reflections about what you learned and what your next steps are.	30-60 mins
9. Attest to your active participation	Formally attest that you had a substantive role in the improvement activity.	10 mins
10. Review and submit	Ensure that all sections are complete and that your name and other information are correct. Print a CE certificate. Review the User Guide for Board submission requirements.	10 mins
11. Save and retain a copy of this file	Save and retain a copy of this completed file in a location that is safe and can be easily retrieved, if needed.	10 mins

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4. Collect baseline survey data	Survey your patients about their experience with self-management support. Use the included questionnaire to document your baseline performance using self-management support techniques.	2-5 hrs
5. Plan your QI activity	This section creates tables and graphs of your baseline performance and guides you through developing a QI activity with your clinic team.	1-2 hrs
6. Implement your QI activity	Put your QI plan into action in your practice. Before you can enter followup performance data, you must test for a minimum of 14 calendar days.	3-8 hrs
7. Collect followup survey data	Use the same questionnaire to survey your patients about their experience with self-management support after your QI plan is implemented.	2-4.5 hrs
8. Reflect on your QI activity	Write brief reflections about what you learned and your next steps.	30-60 mins
9. Attest to your active participation	Formally attest that you had a substantive role in the improvement activity.	10 mins
10. Review and submit	Ensure that all sections are complete and that your name and other information are correct. Print a CE certificate. Review the User Guide for Board submission requirements.	10 mins
11. Save and retain a copy of this file	Save and retain a copy of the completed file in a location that is safe and can be easily retrieved, if needed.	10 min

Completion Requirements for

There are 13 steps in this activity. You must complete the following sequentially:

Step	What to Expect	Estimated Effort
1. Review instructions and requirements	Review the basic requirements of your participation, and attest that you have read and understand the requirements.	10-20 min
2. Enter your information	Enter basic information about yourself to create an interactive version of the module that meets your needs.	10 min
3. Learn about self-management support	Complete brief readings. Complete pre- and post-tests of self-management support knowledge.	30-90 mins
4. Collect baseline survey data	Survey your patients about their experience with self-management support. Use the included questionnaire to document your baseline performance using self-management support techniques.	2-5 hrs
5. Plan your QI activity	This section creates tables and graphs of your baseline performance and guides you through developing a QI activity with your clinic team.	1-2 hrs
6. Implement your QI activity	Put your QI plan into action in your practice. Before you can enter followup performance data, you must test for a minimum of 14 calendar days.	3-8 hrs
7. Collect followup survey data	Use the same questionnaire to survey your patients about their experience with self-management support after your QI plan is implemented.	2-4.5 hrs
8. Plan and implement a revised QI activity	Review your first followup data. Write down your new QI plan and put that into action in your clinic. Before you can enter followup performance data, you must test for a minimum of 14 calendar days.	3-7 hrs
9. Repeat the followup survey data collection	Once more, use the same questionnaire to survey your patients about their experience with self-management support after implementing the revised QI plan.	1-2 hrs
10. Reflect on your QI activity	Write two brief paragraphs about what you learned and what your next steps are to continue improving.	30-60 mins
11. Attest to your active participation	Formally attest that you had a substantive role in the improvement activity.	10 mins
12. Review and submit	Ensure that all sections are complete and that your name and other information are correct. Print a CE certificate. Review the User Guide for Board submission requirements.	10 mins
13. Save and retain a copy of this file	Save and retain a copy of the completed file in a safe location from which the file can be easily retrieved, if needed.	10 mins

Additional Activity Requirements

Your certifying Board requires that you:

- Complete the activity within 12 months of starting.
- Comply with HIPAA privacy rules.
- Attest to your meaningful and substantive participation.
- Submit the appropriate documentation to receive credit.
- Pay any appropriate fees to the certifying Board or organization.
- Maintain a copy of this completed file. Your Board may conduct audits of completed MOC activities to ensure compliance with data collection and participation requirements.

Before You Begin This Activity

⊛ Please acknowledge that you have read the Completion Requirements from the previous page and the Additional Activity Requirements on this page for this MOC/CE/CME activity. Please note that you cannot move forward in this module until this box is checked:

☐ I have read the Completion Requirements and the Additional Requirements.

Your Information

Board or Organization Membership Information

⊛ ENTER your personal information, which will identify you with the Board or organization for which you are seeking MOC Part IV credit or Continuing Education credit. This information is required by your Board or organization to appropriately assign credit and to print a certificate upon completion of the activity.

⊛ **First Name:** ☐

⊛ **Last Name:** ☐

⊛ **Credentials** (e.g., MD, DO, NP, PA, other): ☐

⊛ **Board ID#/NCCPA ID#** [##########]: ☐

⊛ **Re-enter your Board ID#/NCCPA ID#** [##########]: ☐

Activity Start Date

if you are ready to start this MOC/CE/CME activity

As of today, you will have 12 months to complete this activity. You cannot change the start date once you have begun; it was automatically noted when you opened this module. There is no penalty for not completing the activity, but you will not receive credit from your certifying Board if you do not complete it within 12 months.

Today's date is: ☐

You must complete the activity within 12 months of today's date to receive credit. ☐

Learn About Self-Management Support (SMS)

SMS Knowledge Pre-Test

This brief quiz will test your knowledge of patient SMS. Please answer each question. ⊛

A. The definition of patient SMS includes which of the following? (Choose all that apply.)

☐ Giving patients handouts about their disease.
☐ Clinicians using techniques and tools that help patients choose healthy behaviors.
☐ A clinician telling the patient with diabetes to check his or her blood glucose level every day.
☐ A transformation of the patient-clinician relationship into a collaborative partnership.

B. Which of the following is a cornerstone of patient SMS? (Select one.)

○ Clinician's knowledge of lifestyle changes.
○ Patient's knowledge of need for lifestyle changes.
○ Collaborative decisionmaking and agenda setting between the clinician and the patient.
○ Having medical assistants in the office conduct diabetic foot checks.

C. Compared to patient education, SMS emphasizes which of the following for patients with chronic conditions? (Choose all that apply.)

☐ Patients learn to identify and solve problems themselves.
☐ Patients and care teams work to improve the patient's own self-efficacy.
☐ Patients develop skills that are generalizable to multiple health concerns.
☐ All of the above.

D. Which of the following are essential elements of supporting patient self-management? (Choose all that apply.)

☐ Clinicians gathering clinical and patient experience data before a visit.
☐ Prescribing appropriate medications.
☐ Working collaboratively with patients to set health goals.
☐ Reporting errors.
☐ Developing action plans.

E. SMS can be delivered only by clinicians, such as physicians, PAs, or nurse practitioners.

○ True
○ False

ⓘ The next few pages highlight important considerations about SMS in your clinical setting, based on AHRQ's Self-Management Support Resource Library. You will find basic information about SMS on the Web site, plus links to a wide range of practical tools, techniques, instruments, and guidance for you and your practice. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Improvement Guide at AHRQ provides additional guidance for quality improvement related to improving the patient experience.

What Is Self-Management Support?

Self-management support is the help that enables people with chronic conditions to manage their conditions on a daily basis. It is also a portfolio of **tools and techniques** that help patients become more active in the management of their illness, transforming the patient–caregiver relationship into a **collaborative partnership**. Beyond patient education, SMS skills and tools enable primary care teams to help people:

- Manage their chronic conditions.
- Develop the confidence to make healthy choices on their own.

ⓘ What is SMS? Watch a 4-minute AHRQ video to find out what clinicians and staff say—in their own words—about what SMS is for their practice and their patients.

Self-management support includes:

- Providing empathic, patient-centered care.
- Involving the whole care team in planning, carrying out, and following up on a patient visit.
- Planning patient visits that focus on prevention and care management, rather than on acute care.
- Involving the patient in decisionmaking and goal setting.
- Providing tailored education and skills training using materials appropriate for different cultures and health literacy levels.

- Making referrals to community-based resources, such as programs that help patients quit smoking or follow an exercise plan.
- Contacting patients regularly to follow up via email, phone, text messaging, and mailings to support them in maintaining healthy behaviors.

How Does Patient Education Compare to Self-Management Support?

Patient Education	Comparison	Self-Management Support
Teaches information and skills		Teaches skills to solve patient-identified problems
Skills are usually disease-specific		Skills are generalizable to one or more chronic condition
Assumes that knowledge creates behavior change		Assumes that confidence yields better outcomes
Goal is patient compliance		Goal is increased patient self-efficacy
Teachers are health care professionals		Teachers can be professionals or peers

You may read this short article from *Family Practice Management* about how this new model of patient care can work in primary care practice.

Why Is Self-Management Support Important?

An increasing number of people have at least one chronic illness that requires them to take an active role in its day-to-day management, whether that is medication adherence or lifestyle change. Yet only 29% of diabetics have well-controlled lipid levels and only 26% have well-controlled blood pressure. Just 27% of people with high blood pressure are adequately treated. Helping them become more active in self-care can improve outcomes for these patients with complex needs.

ⓘ How does SMS help my patients? Watch a 5-minute AHRQ video to hear from clinicians and staff about how SMS helps their patients.

Evidence

Self-management support improves patients' health-related behaviors and results in improved clinical outcomes. The California HealthCare Foundation found a "significant association between improved information given by the physician, more participatory decisionmaking, enhanced self-efficacy, healthier behaviors, and better outcomes in patients with diabetes."[1] Evidence from controlled clinical trials suggests:

- Programs that address self-management skills are more effective than information-only patient education in improving clinical outcomes. In some circumstances, SMS can improve outcomes and reduce costs for patients with arthritis and adult asthma.
- In initial studies, an SMS program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.[2]

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[1] Kanaan SB. *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned*. Oakland: California HealthCare Foundation; 2008. Accessed April 1, 2015

[2] Bodenheimer T, Lorig K, Holman H, et al. Patient self-management of chronic disease in primary care. JAMA 2002 Nov 20;288(19):2469-75.

Incentive and Quality Programs

Gathering patient-reported outcomes is becoming increasingly important. In its National Quality Strategy, the U.S. Department of Health and Human Services highlighted **patient-reported outcomes measures, including measures of shared decisionmaking and patient engagement**.[3]

Practices may be able to leverage learnings from this module for other activities, such as:

- NCQA's PCMH Recognition Program, 2014 Standards, Elements 4B and 4E[4]
- Centers for Medicare and Medicaid Service's (CMS) *Annual Wellness Visit* for Medicare beneficiaries[5]
- The Physician Quality Reporting System (PQRS), CAHPS PQRS Survey[6]
- CMS Meaningful Use Electronic Health Record Incentive Program, Stage 2, Objective 6.[7]

Who Benefits from Self-Management Support?

Patient Benefits

Many patients can benefit from SMS, especially patients with chronic conditions such as:

- Diabetes
- Heart disease
- Asthma

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[3] Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013;309(21):2215-2216.

[4] *Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2014.* Washington, DC: National Committee for Quality Assurance (NCQA); 2014.

[5] Medicare Learning Network. *The ABCs of the Annual Wellness Visit (AWV)*. Baltimore, MD: Centers for Medicare & Medicaid Services, Department of Health and Human Services; 2015.

[6] *CAHPS® for Physician Quality Reporting System*. Centers for Medicare & Medicaid Services, Baltimore, MD.

[7] *EHR Incentive Programs. 2016 Program Requirements*. Centers for Medicare & Medicaid Services, Baltimore, MD.

While there is stronger evidence of SMS efficacy for the previously mentioned conditions, the principles apply to other chronic conditions, as well, such as:

- Arthritis
- Chronic obstructive pulmonary disease (COPD)
- Obesity
- Depression[8]

Clinician Benefits

Clinicians can benefit when implementing SMS by minimizing their time burden through the following strategies:

- Working collaboratively with a patient to set an agenda at the start of a visit to organize the patient's visit without increasing visit length or the number of problems addressed per visit.[9]
    - » This may also reduce the likelihood of "oh, by the way" concerns surfacing late in the encounter.[10]
- Clinicians may also be able to make better use of their time by seeing multiple patients through group visits.
- Getting help from support staff with systematic approaches for completing paperwork before a visit, talking with patients about next steps, and efficiently following up with patients between office visits can help ease the burden of SMS on clinicians.

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[8] Houle J, Gascon-Depatie M, Belanger-Dumontier G, Cardinal C. Depression self-management support: a systematic review. Patient Educ Couns. 2013;91(3):271-279.

[9] Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA. 1999;281(3):283-287.

[10] Brock DM, Mauksch LB, Witteborn S, Hummel J, Nagasawa P, Robins LS. Effectiveness of intensive physician training in upfront agenda setting. J Gen Intern Med. 2011;26(11):1317-1323.

How Do You Implement Self-Management Support?

The primary care clinician—supported by members of the practice care team—can work SMS into daily practice with a few approaches.

Employ new skills such as motivational interviewing *and* reflective listening

SMS is a collaboration between the clinician and the patient.[11] Motivating, listening, and coaching are important SMS skills that can strengthen the clinician-patient interaction. Through ongoing training and practice, supporting patients and their families in self-care will become part of day-to-day care.[12]

ⓘ Learn more about motivational interviewing. AHRQ's resource, *Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity*, provides a quick review of motivational interviewing along with an easy-to-use tool for using motivational techniques in your clinical practice.

ⓘ How do I implement SMS in my practice? Watch a 6-minute AHRQ video on how clinicians and staff implement key SMS components.

Clinicians can ease the transition of implementing an SMS program by learning how to use tools, such as action plans, goal-setting worksheets, and problem-solving techniques, to support and motivate patients.

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[11] Bodenheimer, T, MacGregor K, Sharifi, C. Helping Patients Manage Their Chronic Conditions. Oakland: California HealthCare Foundation; 2005. Available at: http://www.chcf.org/publications/2005/06/helping-patients-manage-their-chronic-conditions. Accessed March 29, 2016.

[12] Rollnick S, Butler CC, Kinnersley P, et al. Motivational interviewing. BMJ. 2010 Apr;340:c1900.

Action planning is a collaborative, clinician/patient SMS process to:

- Identify the patient's health priorities and preferences.
- Identify and select health goals that matter to the patient.
- Discuss potential barriers to reaching the goal.
- Assess the patient's confidence in reaching the goal.
- Refine the goal to be realistic and achievable, which can help to build patient confidence and motivation.

It might be helpful to use the shared decisionmaking checklist to understand some of the techniques you and your care team can use when talking with patients about their care options.

ⓘ Watch a Webinar on SMS goal setting and action planning tools, created by communities of patients working together with providers.

Use goal-setting and action-planning tools

SMS tools can help simplify the steps for clinicians, staff, patients, and family members. Such tools can provide an easy-to-follow and systematic process for addressing single or multiple chronic conditions by:

- Identifying patient and family priorities and preferences
- Setting an agenda based on patient priorities and preferences
- Setting goals
- Assessing patient readiness and confidence
- Action planning

ⓘ There are two printable tools in the Supporting Materials section of this file:

- For your patients: The patient goal-setting worksheet is a one-page tool for patients to think about and write down a personal health goal.
- For clinicians and staff: The shared-decisionmaking checklist is a short set of reminders to help you and your team talk with patients to engage them in sharing decisions about their care.

ⓘ If you want more detailed information and tools used for goal setting, shared decisions, and action planning, these resources are specifically designed for clinicians and their staff:

- *Institute for Healthcare Improvement (IHI)* offers tools in its “Partnering in Self-Management Support: A Toolkit for Clinicians.” NOTE: Web site requires free registration.
- *The California Health Foundation’s* “Helping Patients Manage Their Chronic Conditions” includes sample dialogues of talking with patients about agenda setting and action planning.

Use the practice care team. Understand how roles and responsibilities can be defined and shared.

To provide effective SMS, a team of clinicians and administrative staff needs to coordinate closely to provide care before, during, and after the patient visit. Successful teams are composed of clinical and administrative staff whose roles are assigned in advance. Roles include:

- Gathering clinical data and information on patients' priorities before a visit
- Helping patients set health goals
- Developing action plans
- Following up on action plans
- Linking patients with community programs
- Tracking health outcomes

Sustaining SMS may require additional training for practice team members or new employees, partnerships with community resources to support patients outside of the practice, and strengthening partnerships with patients and families.

Additional guidance is available in Section 4 of this module.

What Do Patients Expect?

Remember that patients want to feel better and improve their health. When they engage more in their own care, they also expect that there will be follow-through and support from their practice. You can provide the support patients expect by checking in with them between visits and by sharing their goals and action steps with their entire care team.

ⓘ Resources designed for patients and their families are available, including the following:

- The *Institute for Healthcare Improvement* developed a toolkit for patients and families: *Self-Management Toolkit for People with Chronic Conditions and Their Families*.
  NOTE: Web site requires free registration. The document includes definitions, guidance, patient examples, and links to more patient and family resources.
- The "Connection to Health Patient Self-Management Support System," created to support a study, provides patient-focused tips and resources for patients wishing to address a number of health behaviors. To access the site without providing information about your practice, select "Other/None" in the "Select a State" field.

Summary

Self-management support is a portfolio of tools and techniques that help patients take care of themselves. Here's a short list of principles to keep in mind when **implementing** SMS in your clinical setting for patients with chronic conditions:

- Engage patients in shared decisionmaking, guided by evidence.
- Ask patients about their health priorities and preferences.
- Listen to patients and reflect back to them to confirm what you heard and understand.
- Collaboratively set health goals with patients.
- Use goal-setting and action-planning tools to create realistic, focused goals.
- Work together to solve problems in reaching those goals.

Remember, it does not need to be a clinician who does all of this; your practice team can help implement SMS.

ⓘ For a concise list of external tools and resources on SMS for clinicians, staff, and patients, go to the Supporting Materials section.

Select "Continue" to take the SMS post-test.

Continue

Self-Management Support Knowledge Post-Test

Please complete this brief quiz to test what you learned about SMS. Please answer each question. ⊛
You must answer at least four of the questions correctly to pass the quiz. You may retake the quiz, if needed.

A. The definition of patient SMS includes which of the following? (Choose all that apply.)

- ☐ Giving patients handouts about their disease.
- ☐ Clinicians using techniques and tools that help patients choose healthy behaviors.
- ☐ A clinician telling the patient with diabetes to check his or her blood glucose level every day.
- ☐ A transformation of the patient-clinician relationship into a collaborative partnership.

B. Which of the following is a cornerstone of patient SMS? (Select one.)

- ○ Clinician's knowledge of lifestyle changes.
- ○ Patient's knowledge of need for lifestyle changes.
- ○ Collaborative decision making and agenda setting between the clinician and the patient.
- ○ Having medical assistants in the office conduct diabetic foot checks.

C. Compared to patient education, SMS emphasizes which of the following for patients with chronic conditions? (Choose all that apply.)

- ☐ Patients learn to identify and solve problems themselves.
- ☐ Patients and care teams work to improve the patient's own self-efficacy.
- ☐ Patients develop skills that are generalizable to multiple health concerns.
- ☐ All of the above.

D. Which of the following are essential elements of supporting patient self-management? (Choose all that apply.)

- ☐ Clinicians gathering clinical and patient experience data before a visit.
- ☐ Prescribing appropriate medications.
- ☐ Working collaboratively with patients to set health goals.
- ☐ Reporting errors.
- ☐ Developing action plans.

E. SMS can be delivered only by clinicians, such as physicians, PAs, or nurse practitioners.

- ○ True
- ○ False

Score Quiz | Retake Quiz

Collect Baseline Performance Data

For this MOC/CE activity, you will survey your patients about how they experience SMS in your practice. The short survey in this activity asks patients about talking with providers about medication decisions (if applicable) and talking with anyone in your practice about their health goals. The questions are based on the CAHPS© Clinician & Group Surveys maintained by AHRQ.

You are required to collect baseline performance data on your patients seen in the past 12 months. You may collect the data on paper or electronically but **you must enter the data in this PDF file** to count toward completion of this section of the MOC activity. You will use the same data collection process for both baseline and followup surveys. (Surveys do ***not*** need to be on the same patients at baseline and followup.)

Data Collection Overview

You will be guided through a series of prompts to help focus your QI activity and select your performance measures:

A. **Prepare.**
B. Select a **target population** for your baseline data collection.
C. Review the **data collection requirements**.
D. Print your **data collection forms.**
E. **Collect data** on patients through chart review.
F. **Enter your data** into the form in this file.

Select Continue to start the data collection and improvement process.

Continue

Prepare

Quality improvement efforts most often succeed as a result of a team effort. Because clinicians, staff, and managers often have some role in implementing SMS, you will benefit from their involvement, especially when you consider improvements that affect the office workflow. You can choose to work alone or with other clinicians in your practice for this activity. To make some of the work easier, consider obtaining help from:

- Medical staff (e.g., nurses and medical assistants)
- Clerical staff (e.g., front desk or billing staff)
- Administrative staff (e.g., clinic manager or office manager)
- Other staff (e.g., care coordinators or health information technology support)

Many organizations use Plan-Do-Study-Act (PDSA) cycles to implement changes and then test them. Here are the basic steps:

- *Plan* — state an objective for the change and then make an actual plan about what will be changed, by who, and when.
- *Do* — try out the change in your practice, documenting any troubles you have or unexpected outcomes.
- *Study* — review your data to see how it went.
- *Act* — refine your change based on your findings and then get ready for the next cycle.

The following pages will walk you through the steps to first collect and review your baseline data, plan a change, implement the change, and then study your followup data to act on what you have learned.

ⓘ If you are new to PDSAs or want more information and tools, The *Institute for Healthcare Improvement*'s Web site on "How to Improve" provides basic tools and guidance.

AHRQ provides a reference set and video on Using Rapid-Cycle Research to Reach Goals: Awareness, Adaptation, Acceleration to help "team plan rapid-cycle studies that are practical and actionable."

The Web site *Improving Primary Care* includes several resources on training for staff in the "Tools and Resources" tab.

Select Your Target Population

The best way to make improvements is to start small. First, select the patient age group in your practice on which you want to focus, and then select a chronic condition (or conditions). You will use this information to determine which patients (or parents of pediatric patients) you will survey regarding their experiences with shared decisionmaking, including discussions about prescription medication and patients' specific health goals.

⊛ Select **one** age group that will be the focus of this practice improvement activity. A focused target population will help to keep the scope of your improvement efforts manageable and will ensure that the population of patients fits your practice and interests.

○ [1] Children (ages 0-12)

○ [2] Adolescent patients (ages 13-18)

○ [3] Adult patients (ages 19-64)

○ [4] Seniors (ages 65 and above)

⊛ Enter which chronic condition(s) will be the focus of this practice improvement activity in the following space.

Example 1: "Diabetes"

Example 2: "Diabetes or Hypertension"

Chronic conditions to consider:

- Diabetes
- Heart disease
- Asthma
- Arthritis
- COPD
- Obesity
- Depression

Review The Data Collection Sample Requirements

You must complete patient surveys that meet the following parameters:

- You will need surveys from at least of your patients (or their parents).
- Patients must be in the age range you selected.
- Patients must have at least one of the selected chronic health condition(s).
- Patients must have been seen at least once in the past 12 months in your practice.

Patient Sample

Help surveying your patients

Surveying your patients can take time because patient surveys are required, at a minimum. You will likely need to identify more than patients who meet the above criteria, since some patients may choose not to respond to the survey or may not be reachable. Here are some ways you can collect patient surveys:

Seen at least once in past 12 months

- Clinicians or staff ask patients to complete the survey during their clinic visit.
- The patient (or parent of pediatric patient) can be directed to return the completed survey to the front desk, a medical assistant or nurse, or to put them in a designated box in the exam room before they leave the clinic.
- Staff contact patients and complete the survey by telephone.
- Patients (or parents of pediatric patients) complete the survey electronically:
  - » Clinicians or staff hand patients a flyer containing a link to a Web site.
  - » Staff send surveys to your patients using secure email.
  - » Patients are directed to your electronic health record (EHR) patient portal to complete the questions.

Whatever method you use to survey your patients, the patients must meet the sample requirements.

You will use the survey results to calculate the percentage of patients in the relevant age group about their experience. This is your baseline SMS performance measure. For example, if you are a family physician, your baseline performance data calculation might look like the following:

Example Of Numerator And Denominator For Calculation Of Baseline Performance Measure

Numerator	The numerator counts those among the 10 patients you have selected to survey who indicated that they were asked about a specific health goal.	**Example performance calculation:** 5 patients in the baseline sample responded that they were asked about a specific health goal.	5 patients who were asked about a health goal divided by the 10 diabetic patients surveyed = 0.50 This is a **50% performance rate** for asking patients about health goals
Denominator	The denominator is the total number of patients you have selected to survey. (In this example, 10 patients aged 18-64 with a diabetes diagnosis.)		

Because one set of questions asks patients about their experience discussing prescription medications, the sample of patients you choose may or may not have high percentages of patients for whom medication discussions are appropriate. It may be difficult to observe meaningful improvements if the number of patients that provide data on medication decisions is small.

Print Your Baseline Surveys

Based on your target population and selected chronic condition(s), print the surveys to capture your baseline performance data from your patients or their parents.

⊛ **Please confirm** that this is the correct target population and chronic condition(s) you wish to address for your QI activity.

1. Patients between the ages of
   with
2. ☐

No. Re-select | Yes. Print Surveys

You will need to print at least copies of the form.

NOTE: A generic survey cover is provided for the patient survey. You may create your own or modify the generic survey cover sheet to suit your specific needs. Do not modify survey questions.

Collect Your Baseline Data

Once you have printed the data collection forms, you are ready to survey your patients about their health goals and shared decisionmaking. When you are done recording the information, return to this file to enter the data.

Important: After you have printed the surveys and conducted the chart review of patients, return to this file to enter the data.

⊛ Baseline Data Entry

When you have completed your survey of at least patients, you are required to enter baseline performance data in this form to complete this section of the activity. After you enter the data completely, **summary charts and tables** will be generated for you to review in Section 5.

Data for patients 1 to 5

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 6 to 10

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 11 to 15 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 16 to 20 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 21 to 25 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Review the Baseline Performance Data and Plan a QI Activity

Review Your Performance Data—Patient Experience Survey

Your Baseline Patient Survey Data

SMS care planning patient reporting rates among patients in target population

Baseline Performance Measure Results (% reporting "Yes" or "No")		
Medication decisions	**Yes**	**No**
Talked about reasons for taking meds	NaN% (0/0)	NaN% (0/0)
Talked about reasons for NOT taking meds	NaN% (0/0)	NaN% (0/0)
Asked what you thought was best for you?	NaN% (0/0)	NaN% (0/0)
Goals and barriers	**Yes**	**No**
Asked about specific goals	NaN% (0/0)	NaN% (0/0)
Asked about barriers to care	NaN% (0/0)	NaN% (0/0)

Show Chart

Patient experience benchmarks from national CAHPS data

National benchmark data from the *CAHPS Physician & Group Surveys (2014)*

Patients Responding "Yes" or "A lot"			
Medication decisions	**Family medicine benchmark**	**Internal medicine benchmark**	**Pediatric benchmark***
Talked about reasons for taking meds	67%	68%	74%
Talked about reasons for NOT taking meds	49%	50%	59%
Asked what you thought was best for you?	84%	82%	92%

Patients Responding "Yes"			
Goals and barriers	**Family medicine benchmark**	**Internal medicine benchmark**	**Pediatric benchmark**
Asked about specific goals	62%	63%	54%
Asked about barriers to care	42%	42%	27%

* Limited comparative benchmark data available on medication decisions only from the CAHPS Adult Physician and Group Survey for surveys conducted by Pediatric and Internal Medicine Pediatric practices.

Identify Areas For Improvement

How do I identify performance gaps?

Providing SMS requires working with patients on a number of items:

- Asking about health goals.
- Discussing treatment options.
- Listening to your patient's health concerns and ideas.
- Working together to establish agreement on a treatment plan.
- Collaborating to set realistic, small steps to reach a goal.
- Providing tools and resources to help patients meet their goal.

Use the information from the patient survey to help focus on a particular SMS gap to address through your QI activity.

After reviewing your performance data and the national benchmarks, there are four options for setting a goal for your own QI activity:

- Look for items where your percentage of "Yes" or "A lot" responses are **lower than the national data** and select the national rate as your target goal.
- Percentages of "Yes" or "A lot" responses that fall below **your own desired goal** (e.g., "75% of all patients in the target population should respond "Yes" to talking about specific health goals and barriers to own care.")
- Percentages of patients reporting rates of shared decisionmaking or goal setting that fall below a **target you have set for your clinic**.
- Set a goal to increase the percentage of "Yes" or "A lot" responses by a specific percentage from baseline. (e.g., "Increase the percentage of 'Yes' responses from 40% at baseline to 60% at followup.")

Plan For Your Improvements

Remember that this improvement activity is designed to be a small test of changes to improve SMS delivery to your patients with chronic conditions. As you consider what you want to improve, think about:

- What improvements are most important to us now?
- What improvements are achievable?
- Who can help?

Consider the following ideas specifically related to the performance measures you collected:

Talk with patients about their goals — help patients remember to work toward the goals that they set with you or your care team:

- Ask patients about the things they wish they could do (their big goal).
- Ask about why that is important to them as a goal.
- Work on small, achievable steps to reach the goal.
- Ask about their confidence in reaching a goal.
- Ask about what might increase their confidence.
- Document the goal and action steps.
- Give patients a written copy of their goal and action steps.

Shared decisionmaking around medication or treatment options — in addition to naming specific medication or treatment options, ask patients:

- What they understand as the advantages and disadvantages of each option.
- How much the advantages or disadvantages matter to them.
- If they are clear about the benefits and risks of each option.
- If they have enough support and advice to make a choice.

Tools for you and your patients in this document:

- For you and your team — the shared-decisionmaking checklist is a short set of reminders to help you and your team talk with patients to engage them in sharing decisions about their care.
- For your patients — the patient goal-setting worksheet is a one-sheet tool for patients to think about and write down a personal health goal, a first step in an action plan for better health.

ⓘ More external planning resources to help you plan your improvement activities:

- *Improving Primary Care*'s Web pages on Self-Management Support can help you think about what types of improvements you can make. There is even a quick practice assessment to determine what SMS currently exists in your practice.
- The AHRQ CAHPS program can help you think about how to implement shared decisionmaking processes in your practice.

Write Down Your Improvement Plan

On the following pages, several prompts will help you and your team write down specific improvement goals and a plan to achieve those goals. Your goals should focus on improving the patient or parent experience with their health goals or medication decisions.

⊛ Set realistic goals for **improving your SMS** by focusing on one of the survey measures from your baseline data.

- Pick **one** medication shared decisionmaking measure or **one** goal-setting measure to improve.
- Write down your goal below:

⊛ Goal:

Goal Example 1: Absolute Rate (regardless of baseline rate)

> “We want to increase the percentage of patients’ responding ‘Yes’ to discussing **health goals** to at least 75% of our patients in the target population.”

Goal Example 2: Improvement from Baseline Rates

> “We want to improve our patients’ **health goals barriers** ‘Yes’ response rates by at least 20% from baseline.”

> “We want to improve our rate of **parents indicating that they were asked** what they thought was best for their child by at least 50% from baseline.”

⊛ **Describe** *how* you plan to reach the performance goals you have set.

Here are some examples that might help:

- What changes will the team make to help reach your goals?
  - » Medical assistants will add to their diabetes patient workflow checklist a verbal reminder for clinicians to discuss health goals and related barriers during their regular diabetes visits. A printed “health goal statement” will be handed to the patient at the end of the visit.
  - » Clinicians will discuss medication recommendations and options, specifically asking patients (or care-givers) about their preferences and reasons for taking the medication.
- Who on your care team will participate in implementing the change(s)?
  - » Medical assistants, staff, and clinicians.
  - » Specific names of team members.
- When will the changes be tested (provide a specific start date)?
  - » We will start testing this on Monday, July 6, 2015, and end on August 15, 2015.
- What results do you anticipate?
  - » Using the updated workflow checklist will help ensure that patients and providers discuss the patient’s health goals and potential barriers. Discussing medication options will help ensure patients are engaged and understand their reasons for their medication choices.

Select “Continue” to enter your QI plan information.

Continue

⊛ What changes will the team make to help reach your goals?

⊛ Who on your care team will participate in implementing the change(s)?

⊛ When will the changes be tested?

⊛ What results do you anticipate?

⊛ How will you share your experience with colleagues at your practice?

Save & Continue **Save & Exit** **Print QI Plan**

Implement Your QI Activity

Now it is time to implement the QI plan you developed.

Refer to your previously stated improvement goals and plans for who will participate and what each person will do to improve your SMS for your patients. Share the QI plan and start date with your team and discuss with them any concerns to ensure smooth implementation of your planned changes.

After you have completed the QI activity cycle, return to this PDF to collect and upload followup performance measurement data. This will help you to measure how your actions have affected your patients' experience.

Important: You must implement the QI activity over a **minimum of 14 calendar days**. Although 14 days is the minimum, 1 to 3 months may be needed to complete your QI plan and test the improvements you planned.

Although you will not be able enter data in the followup data collection form until **at least 14 days after** baseline performance data were entered, you can return to this PDF at any time to print data collection forms, visit additional tools and resources, or print your QI plan.

Collect Followup Performance Data

At least 14 days must have passed since collecting baseline performance data. Remember, 14 days is the minimum; a good rapid improvement cycle may take longer (from 1 to 3 months).

You will repeat the data collection process with the same data collection tools.

You are required to collect followup performance data through the survey on at least patients. They do not need to be the same patients from the baseline data collection. You may collect the data on paper or electronically but you must enter the data in the following data entry tables to count toward completion of this section of the MOC/CE/CME activity.

For your chosen target population, you must complete a chart review and patient survey meeting the following parameters:

- Surveys of at least of your patients (or their parents)
- Patients must be in the age range of
- Patients must have at least one chronic health condition(s) of interest:
- Patients must have been seen since the quality improvement activity was implemented in your practice

Before You Continue:

⊛ Have at least 14 days passed since you collected your baseline performance data?

You will need to print at least copies of the survey.

Important: After you have printed the followup data collection document, survey patients (or their parents) and return to this file to enter the data.

No. Save & Exit | Yes. Print Surveys

⊛ *Followup Data Entry*

When you have completed your survey of at least patients, you are required to enter followup performance data in this form to complete this section of the activity. After you enter the data completely, summary charts and tables will be generated for you to review.

Select “Continue” to enter your followup performance data.

Continue

Data for patients 1 to 5

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Patient Self-Management Support

A Chronic Conditions Practice Improvement Activity

Data for patients 6 to 10

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 11 to 15 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 16 to 20 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 21 to 25 *(optional for ABFM, required for ABP, NCCPA, and other ABMS boards)*

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Collect Followup Performance Data (Round 2)

At least 14 days must have passed since collecting baseline performance data. Remember, 14 days is the minimum; a good rapid improvement cycle may take longer (from 1 to 3 months).

You will repeat the data collection process with the same data collection tools.

You are required to collect 2 rounds of followup performance data through the survey on at least patients. They do not need to be the same patients from the baseline data collection. You may collect the data on paper or electronically but you must enter the data in the following data entry tables to count toward completion of this section of the MOC/CE activity.

For your chosen target population, you must complete a chart review and patient survey meeting the following parameters:

- Surveys of at least of your patients (or their parents)
- Patients must be in the age range of
- Patients must have at least one chronic health condition(s) of interest:
- Patients must have been seen since the quality improvement activity was implemented in your practice

Before You Continue:

⊛ Have at least 14 days passed since you collected your baseline performance data?

You will need to print at least copies of the survey.

Important: After you have printed the followup data collection document, survey patients (or their parents) and return to this file to enter the data.

Followup Data Entry — Round 2

When you have completed your survey of at least patients, you are required to enter followup performance data in this form to complete this section of the activity. After you enter the data completely, summary charts and tables will be generated for you to review.

Select “Continue” to enter your followup performance data.

Continue

Data for patients 1 to 5 (Round 2)

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 6 to 10 (Round 2)

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 11 to 15 (Round 2)

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 16 to 20 (Round 2)

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Data for patients 21 to 25 (Round 2)

ID	1. Correct Provider	2. Usual Provider	3. Talked About Starting/ Stopping Meds	4. Talked About Reasons for Taking Meds	5. Talked About Reasons for NOT Taking Meds	6. Asked What Was Best For You	7. Asked About Specific Goals	8. Asked About Barriers to Care	Patient Age	Gender	Hispanic /Latino	Race
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Not at all ☐ A little ☐ Some ☐ A lot ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	0–12 ☐ 13–18 ☐ 19–64 ☐ 65+ ☐	Male ☐ Female ☐	Yes ☐ No ☐ Unk. ☐	White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other ☐

Reflect on Your QI Activity

Review The Followup Performance Data

As a next step, review your followup performance data and reflect on how it went.

Your Followup Patient Survey Data

Self-management support care planning patient reporting rates among patients in target population compared to national benchmarks

Follow-up Performance Measure Results (% reporting "Yes" or "A lot")

Medication decisions	Baseline	Follow-up	Benchmark
Talked about reasons for taking meds	NaN% (0/0)	NaN% (0/0)	67%
Talked about reasons for NOT taking meds	NaN% (0/0)	NaN% (0/0)	49%
Asked what you thought was best for you?	NaN% (0/0)	NaN% (0/0)	84%
Goals and barriers	**Baseline**	**Follow-up**	**Benchmark**
Asked about specific goals	NaN% (0/0)	NaN% (0/0)	62%
Asked about barriers to care	NaN% (0/0)	NaN% (0/0)	42%

Show Chart

Reflect on Your QI Activity

You are almost done!

Before you can submit this activity for MOC Part IV or CE/CME credit, you must answer these questions about your improvement activity.

(∗) If you were able to achieve your improvement goals for your planned activity, what helped?

(∗) What barriers or challenges did you encounter?

(∗) What are your next steps for improving or maintaining SMS in your practice?

Please ensure that you have entered all baseline and followup performance data.
The Certificate will not print until you have input the full set of data.

Review, Save, and Print Your File For Credit

After you complete each manual review step, please check all boxes that aren't completed automatically.

⊛ Review this document for completeness:
- ☐ I have completed the CME pre-test and post-test portion.
- ☐ I have completed all of the baseline data entry with the correct number of records.
- ☐ I have completed a written QI activity plan.
- ☐ I have completed the QI activity.
- ☐ I have completed all of the followup data entry with the correct number of records.
- ☐ I have completed a reflection on the QI activity.

⊛ Verify that your Board or organization credentials are correct
- ☐ I have selected the correct Board for which I am seeking credit.
- ☐ My board credentials are correct.

⊛ Save this file
- ☐ This file has been saved.

Congratulations! You are now ready to submit your completion file for credit from your selected Board.

Note: The only information that you will send to the Board or organization when you apply for credit is the data collected in Section 9. All other information, including your performance data, QI activity, and reflection, remains in this PDF file and is not transmitted to any other entity. Please refer to the User Guide for specific instructions regarding how to submit to your Board.

After you print the certificate and submit for credit, you can still return to this file at any time to review your data, review your QI plan, or use any of the tools or resources offered in the file.

Acknowledgements

Faculty for this Course/Activity

The Agency for Healthcare Research and Quality (AHRQ) contracted with Westat and its subcontractor—the University of Colorado School of Medicine—to produce this educational module, and would like to acknowledge key project team members:

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None of the individuals involved in producing this module has any conflicts of interest to disclose.

Certificate of Completion

Please ensure that you have entered all baseline and followup performance data. The Certificate will not print until you have input the full set of data.

Back to Module **Print Certificate**

SUPPORTING MATERIALS

Benefits of Self-Management Support for Patients With Chronic Conditions

Diabetes

The American Diabetes Association found evidence for these benefits from SMS for patients with diabetes:[1]

1. Improved diabetes knowledge and improved self-care behavior
2. Lower HbA1c
3. Lower self-reported weight
4. Improved quality of life
5. Healthy coping
6. Lower costs

Also, better outcomes were reported for DSME interventions that were longer and included followup support.

Back to Patient Benefits — Diabetes

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[1] American Diabetes Association. Standards of medical care in diabetes—2014. Diabetes Care. 2014;37 Suppl 1:S14-80.

Benefits of Self-Management Support for Patients With Chronic Conditions

Heart Disease

The American Heart Association found evidence for these benefits from SMS related to heart disease:[2]

- Improvements in fat intake and serum cholesterol for multicomponent interventions using SMS principles.
- Improvements in physical activity and diet when patients and providers work together using these SMS principles:
  - » Set goals
  - » Use self-monitoring
  - » Frequent and prolonged followup contact
  - » Feedback on progress and reinforcement
  - » Problem solving
  - » Motivational interviewing

Back to Patient Benefits — Heart Disease

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[2] Artinian NT, Fletcher GF, Mozaffarian D, et al. Interventions to promote physical activity and dietary lifestyle changes for cardiovascular risk factor reduction in adults: a scientific statement from the American Heart Association. Circulation. 2010;122(4):406-441.

Benefits of Self-Management Support for Patients With Chronic Conditions

Asthma

A review of SMS for chronic conditions found that, for patients with asthma, using multi-component programs with SMS principles helped increase knowledge; improve medication compliance, symptom management, and lung function; and reduce days hospitalized.[3]

Back to Patient Benefits — Asthma

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[3] Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J. Self-management approaches for people with chronic conditions: a review. Patient Educ. Couns. 2002;48(2):177-187.

Employ New Skills to Implement Self-Management Support

Motivational Interviewing

Motivational interviewing takes practice, but there are four core principles:

1. Express empathy.
2. Support self-efficacy—highlight patient skills and past successes; share examples of how other patients have changed; celebrate successes.
3. Roll with resistance—encourage patients to develop their own ideas for overcoming barriers.
4. Develop discrepancy between where they are and where they want to be.

Back to Employ New Skills — Motivational Interviewing

Employ New Skills to Implement Self-Management Support

Reflective Listening

Reflective listening has two key steps:

1. Seeking to understand a patient's idea.
2. Offering the idea back to the patient to confirm the idea has been understood correctly.

Back to Employ New Skills — Reflective Listening

Acronyms

AAPA: American Academy of PAs

ABFM: American Board of Family Medicine

ABMS: American Board of Medical Specialties

ABP: American Board of Pediatrics

AHRQ: Agency for Healthcare Research and Quality

CAHPS: Consumer Assessment of Healthcare Providers and Systems

EHR: electronic health record

HIPAA: Health Insurance Portability and Accountability Act

IHI: Institute for Healthcare Improvement

MOC: Maintenance of Certification

NCCPA: National Commission on Certification of Physician Assistants

NCQA: National Committee on Quality Assurance

PCMH: Patient-Centered Medical Home

PI-CME: Performance Improvement-Continuing Medical Education

PDSA: “Plan-Do-Study-Act”

QI: quality improvement

SMS: self-management support

Back to Instructions and Requirements

External Resources On Self-Management Support

For Clinicians and Staff

Background, resources, and tools

- AHRQ's Self-Management Support Resource Library has basic information about self-management support plus links to a wide range of practical tools, techniques, instruments, and guidance for you and your practice.

Shared decisionmaking guidance

- The AHRQ CAHPS program can help you think about how to implement Shared Decisionmaking processes in your practice.
- The Mayo Clinic has a national resource center focused on shared decisionmaking, including a number of disease-specific resources.
- The Ottawa Hospital Research Institute offers many disease-specific resources, such as personal decision guides. (Several tools also available in Spanish.)

Goal-setting and other self-management support tools

- *Institute for Healthcare Improvement (IHI)* has tools in its Partnering in Self-Management Support: A Toolkit for Clinicians, which can be downloaded for free. NOTE: quick, free registration with IHI is required for download.
- The U.S. Department of Health and Human Services offers resources related to helping patients manage multiple chronic conditions.
- The Community Health Association of Mountain/Plains States (CHAMPS) offers a number of tools, forms, and flyers for patient self-management support (many are also available in Spanish).
- Improving Primary Care: Self-Management Action Plan (provided by the Neighborhood Family Practice). Under the Resources Available subheading, select "Patient Materials." (Spanish and English on one form.)
- Integrative Medicine for the Underserved: General Goal Setting page includes several goal-setting tools (in English and Spanish).

Motivational interviewing guidance

- AHRQ's resource, Community Connections: Linking Primary Care Patients to Local Resources for Better Management of Obesity, provides a quick review of motivational interviewing along with an easy-to-use tool for using motivational techniques in clinical practice.

Planning for practice improvements

- Improving Primary Care's Web pages on Self-Management Support can help you think about what types of improvements you can make. A quick practice assessment will help you determine what self-management support currently exists in your practice.

For Patients And Families

- *The California Health Foundation* Helping Patients Manage Their Chronic Conditions.
- The Connection to Health Patient Self-Management Support System provides patient-focused tips and resources for patients wishing to address a number of health behaviors (also available in Spanish). (Note: you can access the site without specifying a State or residence or linking to a practice, just select "Other/None" for the State.)

Tools For Specific Chronic Conditions

Asthma

- The American Lung Association: Asthma Action Plan. (Also available in Spanish.)
- The National Heart, Lung, and Blood Institute provides a similar Asthma Action Plan in print or online formats. (Also available in Spanish.)

Chronic Obstructive Pulmonary Disease (COPD)

- The American Lung Association: COPD Action/Management Plan for patients.

Depression

- Community Health Association of Mountain/Plains States (CHAMPS): Depression Self-Management Goals worksheet. (Also available in Spanish.)

Diabetes

- Community Health Association of Mountain/Plains States (CHAMPS): Diabetes Goal Setting tool. (Also available in Spanish.)
- The Diabetes Initiative (a Robert Wood Johnson Foundation program): its Goal Setting Resources page includes goal setting, action planning, and self-management support tools (many available in Spanish).
- National Institute of Diabetes and Digestive and Kidney Diseases: 4 Steps to Manage Your Diabetes for Life includes tips and tracking tools. (Also available in Spanish.)
- Agency for Healthcare Research and Quality: Diabetes Planned Visit Notebook includes the Diabetes Self-Management Goals Worksheet.

Heart Disease

- Community Health Association of Mountain/Plains States (CHAMPS): CVD Self-Management Goals Contract. (Also available in Spanish.)
- Community Health Association of Mountain/Plains States (CHAMPS): Hypertension Goal Contract.

Overweight/Obesity

- United States Department of Agriculture: ChooseMyPlate.gov provides several online and print tools for healthy meal planning (some available in Spanish).
- National Institute on Aging: physical activity goal-setting and monitoring tools in Exercise & Physical Activity: Your Everyday Guide from the National Institute on Aging (Chapter 7). (Also available in Spanish.)

SELF MANAGEMENT GOAL WORKSHEET FOR PATIENTS

The ***Take Charge of Your Health*** **patient worksheet** on the next two pages was developed through a collaborative process that included patients, clinicians, and care coordinators from primary care practices in the State Networks of Colorado Ambulatory Practices and Partners (SNOCAP) practice-based research network (PBRN). The worksheet is designed to help patients set a personal wellness goal and then share it with his or her health care team. The development of the worksheet was supported through an AHRQ grant (Implementing Networks' Self-management Tools Through Engaging Patients and Practices (INSTTEPP); grant #1R18HS022491) and the Meta-LARC PBRN consortium.

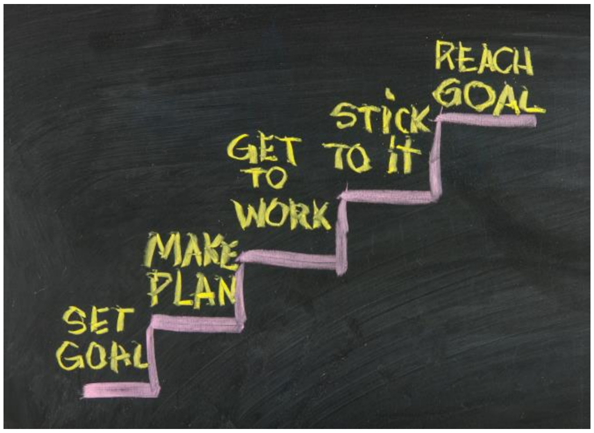
Back to module
Print Worksheet

Take Charge of Your Health

Set a Personal Wellness Goal!

What is a goal? A goal is:

1) Something ***you*** want and think you can do
2) Something with clear steps
3) Something that makes you want to *get to work* and stick to it
4) Something that will make your health and quality of life better



Step 1: Set a Personal Wellness Goal Here:

My goal for better health and better quality of life is:

This goal is important to me because:

Now is the time to take control and make changes for a healthier *you*!

Step 2: My **next step** in reaching this goal is to share it with my doctor or the health care team at [the Clinic].

Example Goals

I will eat one more green vegetable, such as broccoli, spinach, or lettuce per day. I will share my plan with my spouse or partner, who will ask me how it is going at least once a week.

For the next two weeks, I will walk in my neighborhood for 30 minutes on Monday, Wednesday, and Friday. If the weather is too cold, then I will walk in the mall. I will share my plan with my best friend, who will join me on my walks.

I will work on reducing my stress level. I will do relaxation exercises for 20 minutes each day when I get home from work. I will share my plan with my children, who will ask me how it is going daily.

Back to module

Print Checklist

SHARED DECISION-MAKING CHECKLIST

Use this checklist to make sure you and your care team are incorporating elements of the SHARE* Approach with your patients.

☐ **Step 1: *S*eek your patient's participation**
- I invited my patient to participate in the decision-making process.
- I explained the importance of my patient's role in the decision-making process.
- I discussed the essential issues about my patient's condition.

☐ **Step 2: *H*elp your patient explore and compare treatment options**
- I presented all of the reasonable treatment/intervention options to my patient.
- I discussed the risks and benefits of each option with my patient.
- I asked my patient to review relevant decision tools (booklets/videos/Web sites).
- I asked my patient to teach back what was discussed.
- My patient demonstrated an understanding of the options.

☐ **Step 3: *A*ssess your patient's values and preferences**
- I encouraged my patient to talk about what matters most to him or her.
- I listened actively to my patient and asked open-ended questions.
- I asked my patient how his or her decision might impact their daily life.
- I acknowledged and agreed with my patient on what matters most to him or her.

☐ **Step 4: *R*each a decision with your patient**
- I asked my patient what option he or she preferred.
- I asked my patient if he or she needed additional information or wanted to consult others before making a decision.
- My patient and I agreed on the decision.

☐ **Step 5: *E*valuate your patient's decision**
- My patient and I made plans to review their decision in the future.
- I worked with my patient to help them manage barriers to implementing their decision.

*Source: Adapted from The SHARE Approach—Essential Steps of Shared Decision Making: Expanded Reference Guide with Sample Conversation Starters: Workshop Curriculum: Tool 2. July 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-2/index.html

PATIENT/PARENT/CAREGIVER SURVEY

Dear Patient:

This survey is part of a program to help your health care provider and staff improve the care they provide to patients. You can help our office give you the best possible care by completing this survey about your own experience.

The survey will take less than 10 minutes to complete. There is no cost to complete the survey and you can choose not to complete the survey.

To protect your privacy, please do NOT write your name on the survey.

When you are done with the survey, please return it to our office.

Thank you for your help.

Sincerely,

Your primary care practice.

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

To begin the survey, please go to the next page and start with Question 1.

* * * FOR ADULT PATIENTS * * *

Your Provider

1. Our records show that you got care from the provider named below in the last 12 months.

Name of provider label goes here

Is that right?

1☐ Yes
2☐ No → **If No, go to #9 on page 2**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

1☐ Yes
2☐ No

Your Care From This Provider in the Last 12 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

3. In the last 12 months, did you and this provider talk about starting or stopping a prescription medicine?

1☐ Yes
2☐ No → **If No, go to #7**

4. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?

1☐ Not at all
2☐ A little
3☐ Some
4☐ A lot

5. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might **not** want to take a medicine?

1☐ Not at all
2☐ A little
3☐ Some
4☐ A lot

6. When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?

1☐ Yes
2☐ No

7. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health?

1☐ Yes
2☐ No

8. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

1☐ Yes
2☐ No

Please continue to the next page

About You

9. What is your age?

1☐ 18 to 24
2☐ 25 to 34
3☐ 35 to 44
4☐ 45 to 54
5☐ 55 to 64
6☐ 65 to 74
7☐ 75 or older

10. Are you male or female?

1☐ Male
2☐ Female

11. Are you of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino
2☐ No, not Hispanic or Latino

12. What is your race? Mark one or more.

1☐ White
2☐ Black or African American
3☐ Asian
4☐ Native Hawaiian or Other Pacific Islander
5☐ American Indian or Alaska Native
6☐ Other

Thank you.

Please return the completed survey in the postage-paid envelope.

*** * * FOR CHILD PATIENTS * * ***

Your Child's Provider

1. Our records show that your child got care from the provider named below in the last 12 months.

Name of provider label goes here

Is that right?

1☐ Yes
2☐ No → **If No, go to #9 on page 2**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if your child needs a check-up or gets sick or hurt?

1☐ Yes
2☐ No

Your Child's Care From This Provider in the Last 12 Months

These questions ask about **your child's** health care. Do **not** include care your child got when he or she stayed overnight in a hospital. Do **not** include the times your child went for dental care visits.

3. In the last 12 months, did you and this provider talk about starting or stopping a prescription medicine for your child?

1☐ Yes
2☐ No → **If No, go to #7**

4. When you talked about starting or stopping a prescription medicine for your child, how much did this provider talk about the reasons you might want your child to take a medicine?

1☐ Not at all
2☐ A little
3☐ Some
4☐ A lot

5. When you talked about starting or stopping a prescription medicine for your child, how much did this provider talk with you about the reasons you might **not** want your child to take a medicine?

1☐ Not at all
2☐ A little
3☐ Some
4☐ A lot

6. When you talked about starting or stopping a prescription medicine for your child, did this provider ask what you thought was best for your child?

1☐ Yes
2☐ No

7. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your child's health?

1☐ Yes
2☐ No

8. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your child's health?

1☐ Yes
2☐ No

Please continue to the next page

About Your Child

9. What is **your child's** age?

☐ Less than 1 year old

______ YEARS OLD *(write in)*

10. Is your child male or female?

1☐ Male
2☐ Female

11. Is your child of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino
2☐ No, not Hispanic or Latino

12. What is your child's race? Mark one or more.

1☐ White
2☐ Black or African American
3☐ Asian
4☐ Native Hawaiian or Other Pacific Islander
5☐ American Indian or Alaska Native
6☐ Other

Thank you.

Please return the completed survey in the postage paid envelope.