



*From WReN to WREN - Celebrating 25 years of practice-based research success!*

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# The Reach of Research

- It is estimated that it takes an average of 17 years for 14% of original research to reach practice(s) and benefit the patients they care for.

(Balas and Boren. *Yearbook of Medical Informatics* 2000:65-70)

- A 1998 review of published studies on the quality of care found that only 3 of 5 patients with chronic conditions receive recommended care.

(Schuster M, McGlynn E, Brook R. How good is the quality of health care in the United States? *Milbank Quarterly* 1998;76:517-63)

# Where Care Happens

113 : 1



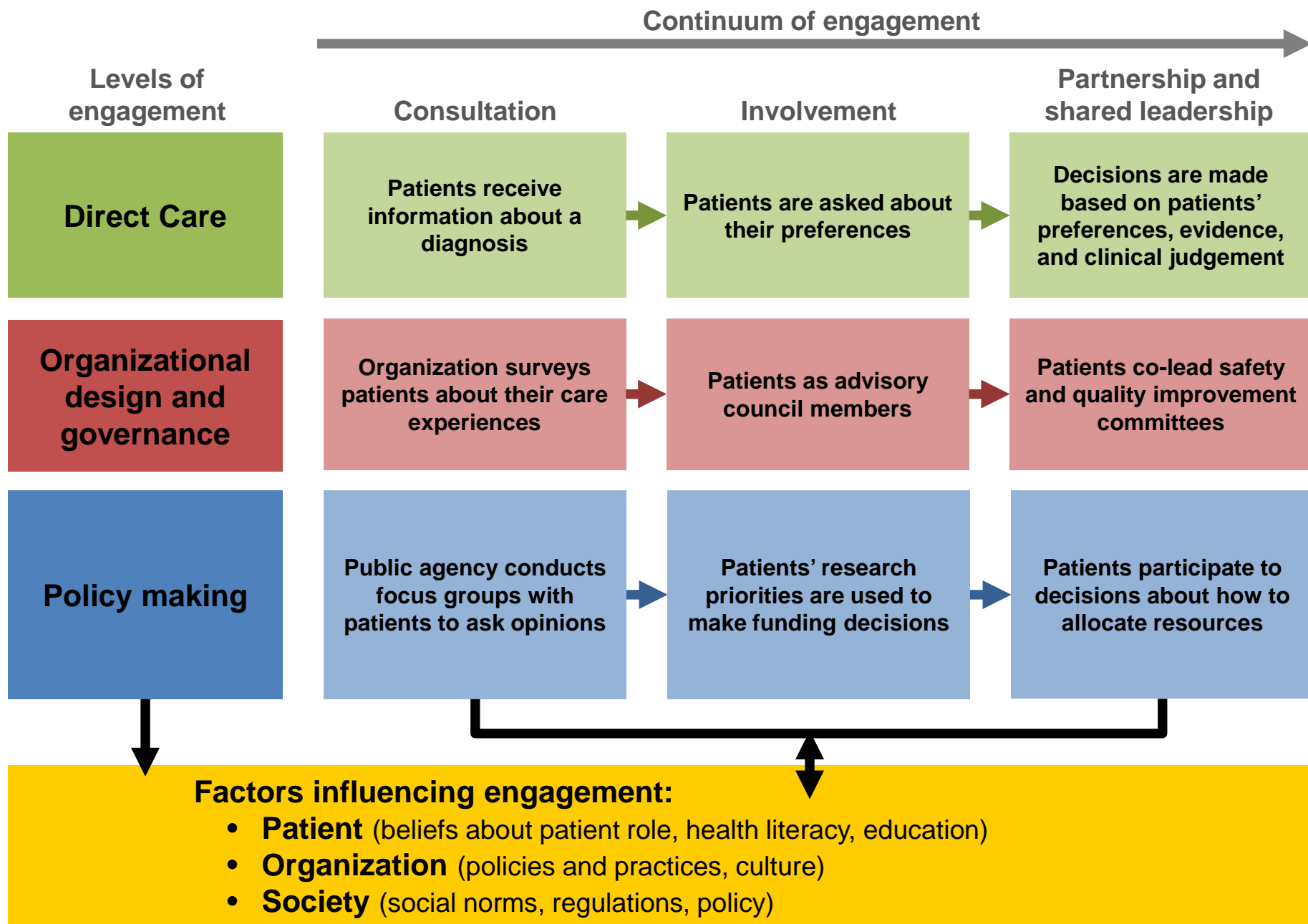
# Continuum Strategies to Support Self-Management



# Questions for WREN Practices

- Who is primarily responsible for driving SMS in your practice?
- What SMS tools are you using?
- How are you using HIT to facilitate SMS?
- How are patients informing you about SMS?

# Multidimensional Framework For Patient And Family Engagement In Health





- Family takes care of family
- Staying healthy
- Pilot things as a practice
- Man does not live by acronym alone
- Take charge

- You can't fix everybody, fix what you can

- Keep it simple
- Trust your team

- Empowering Patient
- Doctor Buy-in
- Share Successes
- Doc & Pt. meeting in the middle
- Hold each other accountable

- Experience-based care not just evidence-based

- We know the doctor can't do it (all)

• Peer support groups

How do we go beyond the numbers?

- Integrate mind & body & make that normal

- Tools are of no use by themselves

- Just sending someone to the internet isn't enough

• It starts with relationship

- trust - home

- \* Get down on my level
- \* The doctor doesn't assume
- I want to know that you know ~~that you~~

How to start a peer support group

- Any can come
- Based on solutions
- Experts available to educate

INSTTEPP  
Boot Camp  
March 21, 2014  
Portland, Oregon

I 'N 'S 'T 'T 'E 'P 'P

# Four SMS tools produced

Patient Name: \_\_\_\_\_  
Date: \_\_\_\_\_

## PROBLEM-SOLVING WORKSHEET

1. Problem:

2. Achievable goal:

3. How convinced are you that this is the right goal for you?

⊕ 0 1 2 3 4 5 6 7 8 9 10 ⊖  
Totally Unsure Somewhat Very Extremely  
unconvinced convinced convinced convinced

4. Solutions:

Pros (+)

Cons (-)

a)

b)

c)

5. Choice of solution:

6. Steps to achieve solution:

a)

b)

c)

Confidence ruler: How confident are you that you can reach your goal?

⊕ 0 1 2 3 4 5 6 7 8 9 10 ⊖  
Totally Unsure Somewhat Very Extremely  
unconvinced convinced convinced convinced

Notes:



MERCY EMPLOYEE HEALTH CENTER  
788 8<sup>th</sup> AVENUE SE  
CEDAR RAPIDS, IA 52401

## PERSONAL ACTION PLAN

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Goals: Something you WANT to do: 2. Positive Outcomes for my life:

3. Describe Action Plan (steps to achieve goal):

What:

When:

Where:

How often:

Start date:

4. Challenges/Obstacles:

5. Plans to overcome challenges:

6. Support and resources to achieve goal:

7. How sure are you



0 1 2  
Totally unsure

8. Follow-Up: \_\_\_\_\_

700 10<sup>th</sup> Street SE

## 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].

## Your Diabetes Health Guide

Blood Pressure

Last visit: \_\_\_\_\_ Today: \_\_\_\_\_  
Recommended: Less than 140/80 mm Hg

Total Cholesterol

At least once a year  
Next due: \_\_\_\_\_

	Total Cholesterol	LDL	HDL	Triglycerides
Result				
Recommended Men	Less than 200	Less than 100	Greater than 40	Less than 150 mg/dl
Recommended Women	Less than 200	Less than 100	Greater than 50	Less than 150 mg/dl

Dilated Eye Exam

Last Exam date: \_\_\_\_\_  
Next Due: \_\_\_\_\_  
Once a year

Weight Check

Last visit: \_\_\_\_\_ Today: \_\_\_\_\_  
Goal Weight: \_\_\_\_\_ Lbs.

HbA1c

Result: \_\_\_\_\_ Next Due: \_\_\_\_\_  
Recommended: Less than 7%  
Every 3-6 months

Microalbumin/Creatine (kidney)

Result: \_\_\_\_\_ Next due: \_\_\_\_\_  
Recommended: Less than 30 mg/dl  
At least once a year

Foot Exam for Nerves

Last Exam: \_\_\_\_\_ Next Due: \_\_\_\_\_  
At least once a year  
Foot check at each diabetes visit

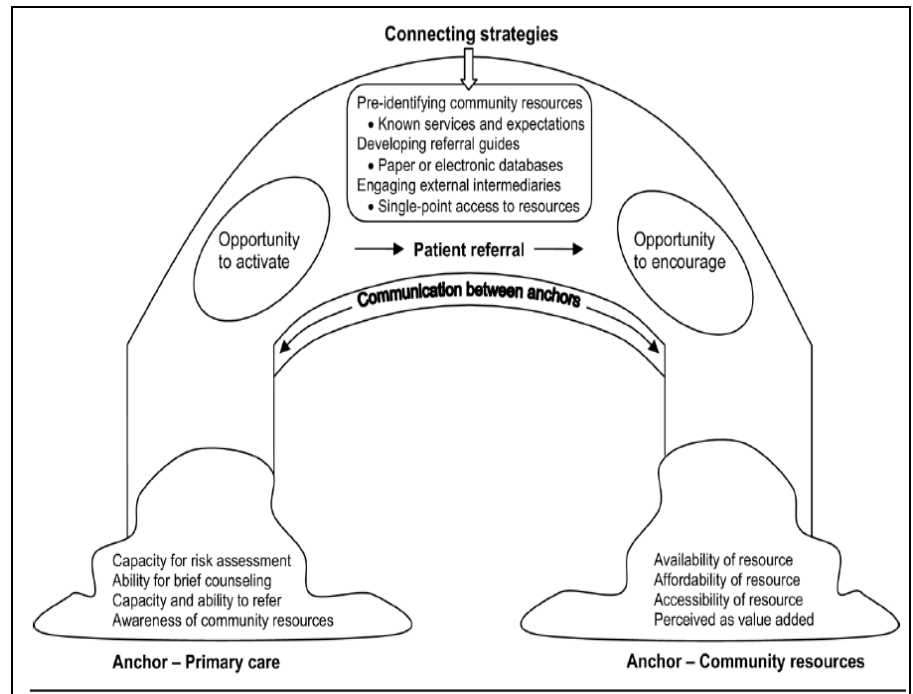
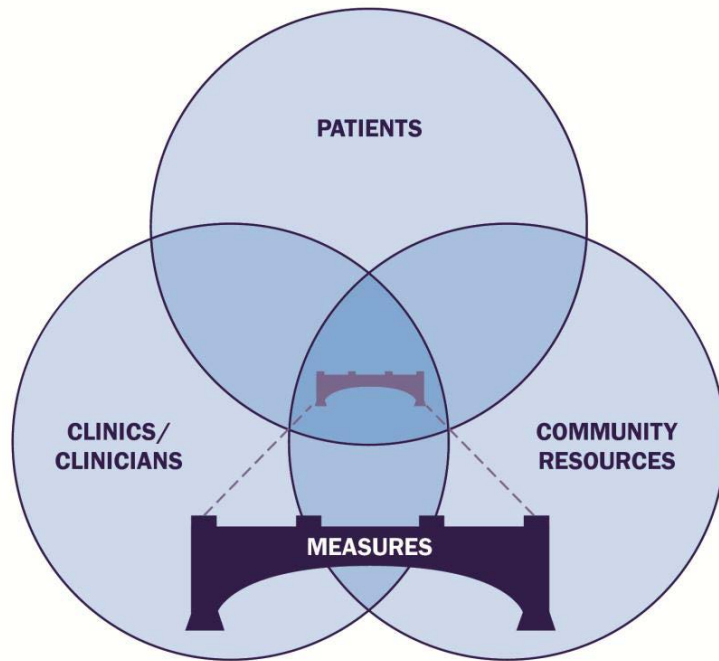
- \_\_\_\_ Did you get your yearly flu vaccine?
- \_\_\_\_ Did you get your pneumonia vaccine?
- \_\_\_\_ Are you taking aspirin?
- \_\_\_\_ Are you taking ACE or ARB medication for kidneys or blood pressure?
- \_\_\_\_ Are you taking any statins for cholesterol?

When was the last time I reviewed my care plan with my doctor? \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10



# Patient referral to community resources, a conceptual framework



Etz RS. *AM J Prev Med*. 2008

<http://www.ahrq.gov/professionals/prevention-chronic-care/resources/clinical-community-relationships-eval-roadmap/index.html#>

# Priority Questions

- How do the characteristics of primary care clinics, patients and community resources influence the effectiveness of linkages for the delivery of patient self-management support?
- What are the best methods, strategies, and settings for studying and improving clinical-community resource relationships for the delivery of patient self-management support?
- What are the best measures for evaluating the effectiveness of clinical-community resource relationships for the delivery of patient self-management support?