Example: Results sharing pilots North Tyneside General Hospital

Results sharing sheet

These are some questions you might like to think about before the appointment:

What aspects of your diabetes you would like to discuss?
What aspects of diabetes would you like more information about?
These are some of the things we know have an effect on you and your diabetes control. Which are most relevant to you?

Medical check-ups	Eating the right amount
Taking medication	Giving up smoking
Avoiding sugary foods	Alcohol within limits
Monitoring sugar levels	Foot care
Healthier eating	Regular physical activity

Diabetes Care Planning Interim Results

Name

Address

D O B
Trust No:
NHS No:
GP:

You have recently had a number of tests done, looking at your diabetes. The results from some of these tests are enclosed. Please take time to read these results and have a think about what they mean to you. Any other results (including foot and eye screening) can be discussed at your appointment.

An appointment has been made for you to discuss these results and any other things that you may like to talk about regarding your diabetes:

20th July 2006 at 10.30 at the Diabetes Resource Centre

If this appointment is inconvenient for you, or if you feel you need to discuss these results more urgently, please contact …… at the Diabetes Resource Centre on Tel No……

Please feel free to write down any questions or issues that you might like to discuss at this appointment in the space provided and bring this along to your appointment.

Care Planning Results - Interim

	Your result was:	Please feel free to write any questions or comments you may like to discuss
Diabetes control Your HbA_{1c} is an overall measure of glucose control over the past 8-10 weeks. A level of between 6 and 7% is associated with the lowest risk of complications.	HbA_{1c} 6.6%	
Blood pressure (BP) A target blood pressure of below 130/80 lowers the risk of complications (a target of below 125/75 is used if you have kidney disease).	BP125/72	
Cholesterol and blood fats Lowering your cholesterol can reduce the risk of complications such as heart attacks and strokes. Whether or not you need treatment depends on your overall risk. If you are on treatment the target cholesterol is less than 5.	Cholesterol 4.2	
Kidney tests Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein in your urine.	Creatinine 146 Urine: Normal	This result is stable but may indicate some kidney problems. This can be discussed in more detail at your appointment.
Weight & body mass index Being overweight increases the risk of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control. The body mass index (BMI) is another way to look at your weight by adjusting for your height. A BMI between 19 and 25 is associated with the lowest risk to your health.	Weight 104.6kg BMI 34.9	
Smoking Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.	You are an ex-smoker	

Name: Date of Birth: Date sheet completed:

Further details of the consultation or plan:

Your current treatments are:

Glicazide 80mg am, 40mg pm (reduced from 80 today) – for your diabetes)
Rosiglitazone 8mg daily (for your diabetes)
Simvastatin 10mg daily (for cholesterol)
Aspirin 75mg daily (to thin blood)
Omeprazole
Metodopramide
Coodamol
GTN

Report completed by Doctor Nurse A on 20th July 2006.

Signed:

Diabetes Care Planning Summary 2006

Name

Address

D O B
Trust No:
NHS No:
GP:

This is the summary of the care planning Consultation on 20th July 2006 with Doctor/Nurse A

The tests results and comments are overleaf along with more details of the consultation where necessary.

This is the plan we agreed for your diabetes over the next year:

1. You aimed to lose further weight (see below)
2. Reduce the evening Glicazide aiming to keep morning sugars above 4.0
3. Clinic review in 12 months and keep in touch with practice nurse in meantime.
4. I would suggest a further HbA1c in 4-6 months to make sure hasn't crept up with less tablets.

Care Planning Results

	Your result was:	Comment
Diabetes control Your HbA_{1c} is an overall measure of glucose control over the past 8-10 weeks. A level of between 6 and 7% is associated with the lowest risk of complications.	HbA_{1c} 6.6%	This shows good control but you are getting sugars frequently below 4 in the morning. We agreed to reduce your evening Glicazide to 40mg (half a tablet) or perhaps even stop it.
Blood pressure (BP) A target blood pressure of below 130/80 lowers the risk of complications (a target of below 125/75 is used if you have kidney disease).	BP 125/72	Excellent
Cholesterol and blood fats Lowering your cholesterol can reduce the risk of complications such as heart attacks and strokes. Whether or not you need treatment depends on your overall risk. If you are on treatment the target cholesterol is less than 5.	Cholesterol 4.2	Excellent
Kidney tests Your kidneys are tested by looking at a blood test (creatinine) and the leak of protein in your urine.	Creatinine 146 Urine: Normal	Your creatinine is slightly high (eGFR 45) but this has been stable since at least 2001. I explained this does demonstrate some damage to the kidneys but suggested I was not too worried about this at the moment
Weight & body mass index Being overweight increases the risk of many medical conditions including heart disease, arthritis and premature death. It can also make your diabetes and blood pressure more difficult to control. The body mass index (BMI) is another way to look at your weight by adjusting for your height. A BMI between 19 and 25 is associated with the lowest risk to your health.	Weight 104.6kg BMI 34.95	We discussed this in some detail today and used the action planning approach sheet. You have already made some changes such as cutting down portion sizes and avoiding fatty foods which seem to be working (you have lost some weight since the last appointment). You are quite confident you will be able to keep these up.
Smoking Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.	You are an ex-smoker	Excellent

Name: Date of Birth: Date sheet completed:

Action planning proforma

Use this sheet to record what actions you are going to take. Ensure that your action plan is SMART:

S - Specific
M - Measurable
A - An Action
R - Realistic
T - Time-scaled

NB ensure that you include WHEN you are going to take the action, also that if any barriers exist which might prevent you acting, include a plan of how to overcome them. You might also like to give yourself a score between 0-10 as to how likely it is that you will undertake your action. If your score is 7 or less, you may need to 'smarten' it up!

Action I am going to take: **confidence level**

Is this action plan SMART?

Potential barriers to success

Revised action plan **confidence level**

Is this action plan SMART now?

Example: Action plan

Action Plan

1. Goals: *Something you WANT to do:*

_____

_____

_____

_____

2. Describe

How: _____

Where: _____

What: _____ **Frequency:** _____

When: _____

3. Barriers: _____

4. Plans to overcome barriers: _____

5. Conviction ___ & Confidence ___ratings (0 - 10)

6. Follow-Up: _____

Action Plan *(Example)*

1. **Goals:** *Something you WANT to do:*
   Begin exercising

2. **Describe:**
   How: Walking
   Where: Around the block
   What: 2 times **Frequency:** 4 x/wk
   When: after dinner, with husband

3. **Barriers:** have to clean up; bad weather

4. **Plans to overcome barriers:**
   ask kids to help clean up; get rain gear

5. **Conviction** 8 **& Confidence** 7 **ratings (0 - 10)**

6. **Follow-Up:** next visit – 2 months

Example: Results sharing pilots North Tyneside General Hospital

Results sharing sheet

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What aspects of diabetes would you like more information about?
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Taking medication	Giving up smoking
Avoiding sugary foods	Alcohol within limits
Monitoring sugar levels	Foot care
Healthier eating	Regular physical activity

Diabetes Care Planning Interim Results

Name

Address

D O B
Trust No:
NHS No:
GP:

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Cholesterol and blood fats Lowering your cholesterol can reduce the risk of complications such as heart attacks and strokes. Whether or not you need treatment depends on your overall risk. If you are on treatment the target cholesterol is less than 5.	Cholesterol 4.2	
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Name: Date of Birth: Date sheet completed:

Further details of the consultation or plan:

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Simvastatin 10mg daily (for cholesterol)
Aspirin 75mg daily (to thin blood)
Omeprazole
Metodopramide
Cocdamol
GTN

Report completed by Doctor Nurse A on 20th July 2006.

Signed:

Diabetes Care Planning Summary 2006

Name

Address

D O B
Trust No:
NHS No:
GP:

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3. Clinic review in 12 months and keep in touch with practice nurse in meantime.
4. I would suggest a further HbA1c in 4-6 months to make sure hasn't crept up with less tablets.

Care Planning Results

	Your result was:	Comment
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Smoking Smoking causes problems with your health in many ways but is particularly damaging in people with diabetes.	You are an ex-smoker	Excellent

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Action I am going to take: **confidence level**

Is this action plan SMART?

Potential barriers to success

Revised action plan **confidence level**

Is this action plan SMART now?

Example: Community Health Center of Burlington

Depression Self-Care Action Plan

Name of Patient: _____
Clinician initiating plan: _____
Date: _____

Here are some ideas to help you take some steps toward managing your depression:

- **Stay Physically Active**
  Make sure you make time to address your basic physical needs, for example, get out and walk a little or engage in some other way of moving around.

- **Make Time For Pleasurable Activities**
  Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some activity each day that gives you pleasure. For example, doing a hobby, listening to music, watching a video, going outside, looking at pictures of loved ones, playing with a pet.

- **Practice Relaxing**
  Physical relaxation can lead to mental relaxation, can help with anxiety, and can increase positive mood. Try deep breathing; meditation; a warm bath; or just go to or think about a quiet, peaceful place. Practice saying comforting things to yourself (like "It's OK").

- **Simple Goals and Small Steps.**
  It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down into small steps. Give yourself credit for each step you accomplish.

During the next _____week(s), I will practice the following self management goal(s):

_____

_____

_____

Where: _____

When: _____

How often: _____

How Likely Are You to Follow Through With These Activities Prior To Your Next Visit?
Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

Plan reviewed in follow up by (write name and date):

Social Work: _____ Medical Provider: _____ Nurse: _____

Example: Depression self-care action plan

Improving Depression Care

Depression Self-Care Action Plan

NAME: _____

1. Stay Physically Active!

✓ Every day during the next week I will spend at least ___ minutes (make it easy/reasonable) doing_____.

2. Make Time for Fun Activities!

✓ Every day during the next week I will spend at least ___ minutes (make it easy/reasonable) doing_____.

3. Spend Time with People Who Can Support You!

✓ During the next week I will make contact for at least ___ minutes (make it easy/reasonable) with:
- _____ (name) doing/talking about _____.
- _____ (name) doing/talking about _____.

4. Practice Relaxing!

Every day during the next week I will practice relaxing by (☒ one or two):
- ❑ Deep breathing
- ❑ Warm bath
- ❑ Finding a quiet, peaceful place for reflection/thought
- ❑ Talk positive messages to myself (like…"it's OK")
- ❑ Other_____.

5. Simple Goals and Small Steps!

✓ The problem is:_____
✓ My goal is:_____
- Step 1 _____
- Step 2 _____
- Step 3 _____

Adapted from: "Self Care Action Plan" developed by T. Amann, RN, C. (Group Health Cooperative of Puget Sound) Property of CareOregon, Inc.

Improving Depression Care *The MaineHealth® Family* *July, 2002*

Example: Holyoke Health Center Inc

Holyoke Health Center, Inc.

Affix label here

Last Name: _____ First Name: _____ MI: ___

Date of Birth: ___/___/___ Date: ___/___/___ Medical Record #: _____

My Personal Goals

I _____ have agreed that to improve my health I will:

☐ Work on something important to me:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

☐ Improve my food choices:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

☐ Get more active (walk, exercise):

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

☐ Reduce my stress:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

☐ Take care of my health needs (Take my medications and keep my Appointments):

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

☐ Cut down on smoking, alcohol or drugs:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ Date_____
Modification: _____

Signature/Date_____

Health Care Worker
Signature/Date_____

Date	Goal	Complete	Modify	Cancel	Initial

Holyoke Health Center, Inc.

Affix label here

Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: ___/___/___ **Date:** ___/___/___ **Medical Record #:** _____

Mis Metas Personales

Yo, _____, estoy de acuerdo que para mejorar mi salud haré lo siguiente:

☐ Haré algo importante para mí:

Qué haré _____
Cuándo lo haré _____
Cuánto: (si aplica) _____
Cuán frecuente lo haré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____
_____

☐ Reduciré mi estrés:

Qué haré _____
Cuándo lo haré _____
Cuánto: (si aplica) _____
Cuán frecuente lo haré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____
_____

☐ Aumentaré mi Actividad Física:

Qué haré _____
Cuándo lo haré _____
Cuánto: (si aplica) _____
Cuán frecuente lo haré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____
_____

☐ Disminuiré el uso de sustancias tóxicas (cigarillo, alcohol, drogas)

Qué voy a disminuir: _____
Cómo lo voy a disminuir: _____
Cuándo comenzaré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____
_____

☐ Cuidaré de mi Salud, tomando las Medicinas y asistiendo a las citas médicas:

Qué haré _____
Cuándo lo haré _____
Cuánto: (si aplica) _____
Cuán frecuente lo haré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____

☐ Haré los siguientes Cambios en mí Alimentación:

Qué haré _____
Cuándo lo haré _____
Cuánto: (si aplica) _____
Cuán frecuente lo haré: _____
Nivel de confianza____ Fecha_____
Modificación_____
_____
_____

Firma: _____Fecha:_____

Firma del Proveedor de Salud: _____
Fecha: _____

Fecha	Meta	Completó	Modificó	Canceló	Inicial

Example: United Community Health Center - Self-management goals

Date of Service:

Patient Name:
Date of Birth:
Medical Record #:

United Community Health Center
Self-Management Goals

I,_____, have agreed that to improve my health I will do my part of the following goal(s):

	I will:	1) **Describe it** (How, where, what, when, frequency):
	Do something good for me	
	Increase my physical activity	
	Cut down or stop smoking	2) **Barriers** (What might get in the way?):
	Improve my food choices	3) **Plans to overcome barriers** (What could you do to handle the barriers?):
	Enhance my spiritual well-being	4) **On a scale of 1 – 10** (if either is less than 6 start over) Importance level:_____ Confidence level:_____
	Reduce my stress level	5) **Follow-Up** (Who are you going to talk to about the plan and when?)
	Take these steps to better manage my health: See Eye Specialist See Foot Specialist See Dentist Attend Classes Take Medications Consistently Follow up with PCP as indicated DEXA scan, GI-colonoscopy, etc? _____	Signature:_____ Signature of Clinician:_____

Self Care Action Plan

Depression is Treatable!

Relationships: Spend time with people who can be supportive to you.

It's easy to avoid contact with people when you're depressed, but you need the support of friends and loved ones. Explain to them how you feel, if you can. If you can't talk about it, that's OK-just ask them to be with you. Try to participate with others in social settings.

Scale 1-10 the degree which depression has affected your relationships:

less 1 2 3 4 5 6 7 8 9 10 more

During the next week, I will make contact for at least _____ minutes with:

1) _____(name) doing or talking about_____

2) _____(name) doing or talking about_____

3)_____(name) doing or talking about_____

Healthy Lifestyle: Healthy lifestyle choices will help you feel better.

Eat well, increase your physical activity, get enough sleep, practice relaxing. The basics of good health are hard to do when you have little energy. Slowly increasing your activity level through activities you enjoy can help other areas of physical wellbeing including rest.

Scale 1-10 the degree your general health has been affected by this illness:

less 1 2 3 4 5 6 7 9 10 more

Every day during the next week I will be active by _____ for ___minutes.

___ I will avoid foods with high fat, high sugar and high caffeine content.

___ I will drink ___ glasses of water each day.

___ I will try to sleep for ___ hours each night.

_____

_____

_____

Spirituality: Spend time doing things that feed your spirit and feel "healing" to you as an individual.

Think about the things that you feel strongly or "passionately" about (or have in the past). What gives your life meaning. Do you feel "connected with others?" Participate in religious activities if this is important to you. Find quiet time for self-reflection and restoring you sense of hopefulness for the future. Nature walks, meditation, music, inspirational reading, or time with a valued friend can be healing to the spirit.

Scale 1-10 the degree which this illness has affected your spirit:

less 1 2 3 4 5 6 7 8 9 10 more

During the next week, I will spend at least _____minutes each day for healing my spirit through self-reflection or other activities:

_____

_____

_____

_____

Recreation/Hobbies: Make time for pleasurable events: Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some *fun activities every day.* Do a hobby, listen to music, go out into nature for a walk, attend a sporting event you enjoy.

Scale 1-10 the degree which this illness has affected your hobbies/leisure life:

less 1 2 3 4 5 6 7 8 9 10 more

Every day I will spend at least ___ minutes each day doing recreational activity.

I will list at least 5 hobbies or recreational activities I enjoy:_____

_____

_____

_____

_____

Productivity can come from work, caring for your home & family and volunteerism: It evolves around that part of life that gives a sense of accomplishment. Depression can take away your energy to be productive and active. You may need to set small goals to get tasks done. It is easy to be overwhelmed. Doing the basic daily tasks can feel exhausting. Start with the tasks that you have enjoyed in the past.

Scale 1-10 the degree which this illness has affected productivity:

less 1 2 3 4 5 6 7 8 9 10 more

One thing I can do to feel productive in the next week is:

_____.

Other Activities that are important for Me to feel productive:

_____

_____

_____

_____

_____

Adherence & Participation in My Treatment Plan: It is important for you to discuss your treatment plan with your doctor. There may be several ways to treat your illness. Taking medication and keeping follow-up appointments can help find the best treatment for you. This action plan provides a guide to help you through the healing process.

Scale 1-10 How likely are you to follow Through with these activities prior to your next visit?

less 1 2 3 4 5 6 7 8 9 10 more

My goal for feeling better is: _____

_____

_____

My plan:

Step 1:_____

_____

Step 2:_____

_____

Step 3:_____

_____

Please Keep this plan where you can refer to it. Bring this action plan with you to your follow-up appointments with your doctor.

Depression Self-Care Action Plan

DEPRESSION IS TREATABLE!

- **Stay Physically Active.**
  Make sure you make time to address your basic physical needs, for example, walking for a certain amount of time each day.

My Plan

I will spend at least _____ minutes (make it easy, reasonable)

doing _____ for _____ days next week.

- **Make Time For Pleasurable Activities.**
  Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day- for example doing a hobby, listening to music, or watching a video.

My Plan

I will spend at least _____ minutes (make it easy, reasonable)

doing _____ for _____ days next week.

- **Spend Time With People Who Can Support You.**
  It's easy to avoid contact with people when you're depressed, but you need the support of friends and loved ones. Explain to them how you feel, if you can. If you can't talk about it, that's OK- just ask them to be with you, maybe accompanying you on one of your activities.

My Plan

During the next week, I will make contact for at least

_____ Minutes (make it easy, reasonable) with

_____(name) doing/talking about _____

_____(name) doing/talking about _____

_____(name) doing/talking about _____

- **Practice Relaxing.**
  For many people, the change that comes with depression- no longer keeping up with our usual activities and responsibilities, feeling increasingly sad and hopeless- leads to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, or a warm bath, or just a quiet, comfortable, peaceful place and saying comforting things to yourself (like "It's OK").
  My Plan

  I will practice physical relaxation at least _____ times, for at least _____ minutes (make it easy, reasonable) each time during the next week.

- **Simple Goals and Small Steps.**
  It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down into small steps. Give yourself credit for each step you accomplish.

  The problem is _____

  _____

  My goal is _____

  _____

  Step 1: _____
  Step 2: _____
  Step 3: _____
  Date to complete by: _____

- **How likely are you to follow through with these activities prior to your next visit?**

  Not likely 1 2 3 4 5 6 7 8 9 10 Very likely

Things To Know About Your Antidepressant Medication

- Your antidepressant medication is **NOT ADDICTIVE OR HABIT FORMING**. They are NOT uppers or downers. It is safe for you to take according to your provider's orders. If you are using alcohol or other drugs, please discuss this with your provider.

- Target symptoms for antidepressant medication are sleep, appetite, concentration, mood and energy.

- It takes time for your medication to work. Most people begin to feel better in 4 – 6 weeks. Don't give up if you don't feel better right away.

Important things for you to do:

- ✓ Keep all your appointments
- ✓ Take the medicine exactly as your provider prescribes- even if you feel better.
- ✓ If you forget a dose DO NOT DOUBLE DOSE-take your next dose at the regular time

---

Since 1985, Baltimore Medical System (BMS) has been providing quality primary health care to patients of all ages. BMS, a federally qualified health center with six sites in Baltimore City and County, offers the full range of ambulatory care services: pediatrics, internal medicine, family practice, ob/gyn, and geriatrics.

Belair Road Family Health Center
410-558-4800

Highlandtown Community Health Center
410-558-4900

Matilda Koval Medical Center
410-558-4747

BMS at Falls Road
410-558-4848

Middlesex Health Center
410-687-1000

BMS at Annapolis Road
410-789-8399

Example: Goal-setting examples

EXAMPLES OF GOAL SETTING SELF MANAGEMENT TOOLS

SELF-CARE ACTION PLAN

Name _____ SM Goal Set Date: _____
Last Review Date _____ This Review Date: _____

EXERCISE

SOCIALIZE

VOLUNTEER

RELAXATION

MEDITATION/PRAYER

HOBBIES

COUNSELING

SIMPLE STEPS:

Short Term Goal _____ **Long Term Goal**
Step 1 _____
Step 2 _____
Step 3 _____

NEXT VISIT: _____
(6 to 8 weeks)
_____

How likely are you to follow your goals till your next appointment?
0 1 2 3 4 5 6 7 8 9 10

RULES OF THUMB!
Do not stop taking your medication without consulting your doctor
It may take 4-6 weeks for your medication to take effect
If you forget a dose do not double the dose

AHS Family Health Center, US

Depression Self-Care Action Plan

Name of Patient: _____
Clinician initiating plan: _____
Date: _____

Here are some ideas to help you take some steps toward managing your depression:

- **Stay Physically Active**
  Make sure you make time to address your basic physical needs, for example, get out and walk a little or engage in some other way of moving around.

- **Make Time For Pleasurable Activities**
  Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some activity each day that gives you pleasure. For example, doing a hobby, listening to music, watching a video, going outside, looking at pictures of loved ones, playing with a pet.

- **Practice Relaxing**
  Physical relaxation can lead to mental relaxation, can help with anxiety, and can increase positive mood. Try deep breathing; meditation; a warm bath; or just go to or think about a quiet, peaceful place. Practice saying comforting things to yourself (like "It's OK").

- **Simple Goals and Small Steps.**
  It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down into small steps. Give yourself credit for each step you accomplish.

During the next _____week(s), I will practice the following self management goal(s):

_____

_____

_____

Where: _____

When: _____

How often: _____

How Likely Are You to Follow Through With These Activities Prior To Your Next Visit?
Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

Plan reviewed in follow up by (write name and date):

Social Work: _____ Medical Provider: _____ Nurse: _____

My Personal Goals

I _____ have agreed that to improve my health I will:

☐ Work on something important to me:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ **Date**_____
Modification: _____
_____
_____

☐ Improve my food choices:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ **Date**_____
Modification: _____
_____
_____

☐ Get more active (walk, exercise):

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____
Date_____
Modification: _____
_____

☐ Reduce my stress:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ **Date**_____
Modification: _____
_____

☐ Take care of my health needs (Take my medications and keep my Appointments):

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ **Date**_____
Modification: _____
_____

☐ Cut down on smoking, alcohol or drugs:

What: _____
When: _____
How much: _____
How Often: _____
Confidence Level_____ **Date**_____
Modification: _____
_____
_____

Signature/Date_____

Health Care Worker
Signature/Date_____

Date	Goal	Complete	Modify	Cancel	Initial

Self–Care Action Plan

Setting goals and taking steps to reach them

Name: _____ **Date:** _____

Choose something you want to do, not something you think you should do.
Set a goal you think you can meet.
Think about the small steps you can take to help you reach your goal.

My goal is
_____
I will make the following small change as I work toward my goal:
_____
_____
_____

The things that could make it difficult to reach my goal are:

My plan for overcoming these difficulties includes:

Support/resources I will need to achieve my goal include:
(For example: Is there a friend, family member, counselor or clergy member who might help you track success in meeting your goal?)

How important is it that I reach this goal? _____
(0 = not at all important; 10 = extremely important)

How confident am I that I can achieve this goal? _____
(0 = not at all confident; 10 = totally confident)

Some types of activities to consider as you choose your goals:
Exercise
Socialize
Eat Well
Relax

Maine Health, US

Patients use pack of cards to set their agenda: a new approach to diabetes management

Agenda setting – Goal setting – Follow up

The Health Foundation's Co-creating Health Initiative

Introduction

The traditional style patient-clinician consultation being used across the diabetes service in Bolton lacked the psychological and self management elements to allow health professionals to help and support their patients. In a bid to rectify the problems a simple deck of playing cards with 'real world' descriptions of issues faced by people with diabetes has been introduced across a number of GP practices in the area. The aim is to change the nature of the contact between health professional and patient, helping the person with diabetes to take control and set the agenda for a consultation by picking out the relevant card, or cards, to highlight the issues of most concern to them at the time of the appointment. It is hoped the associated improvement in communication and dialogue will help motivate patients sufficiently to change their lifestyles and behaviours, thus reducing the burden of disease at both a personal and NHS level.

Description of the tool

• What is the tool?

A set of Agenda Cards, similar in size and look to a standard deck of playing cards, has been developed as a simple but effective way for patients to articulate a problem. On each card is a clearly defined description of an experience, feeling or need, these descriptions divided into six agenda areas.

- Relationships – "I feel like I'm a burden"
- Health – "I find exercise boring"
- Progress – "I have good intentions but they don't last"
- Food – "I've got a sweet tooth"
- Medication and treatment – "My blood test results are confusing"
- Emotions and feelings – "I'm scared of having diabetes"

Each pack consists of 40 cards with a further six blank cards included so patients can, quite literally, write their own healthcare agenda

The first card on opening the pack gives patients concise instructions on how to use them. The cards are only in English at the moment – rather than translate them into several different languages the idea of using cards with icons rather than words to cater for people from BME communities has been mooted.

• How does it work?

In Bolton there have been no set rules on how to use the cards – it has been left up to each individual to introduce them in their way, but in the main the aim has been to use them to open up dialogue. So rather that just using the standard pro forma questionnaire to steer the consultation which leads to a very formulaic experience that is neither personal nor unique, patients are asked to pick three cards before the appointment begins to identify the things they feel they really want to talk about at that time. The aim then is for the health professional to help patients find ways to overcome the barriers that currently stop them changing their behaviour and support them during the change process by checking back to see if they have reached their previous goals. Over time, patients can choose different cards as issues are ticked off and solutions found.

The cards are backed up by a website http://www.bolton.nhs.uk/BoND/card_front.aspx?card_type=1 which serves different functions. During a consultation a clinician can pull the website up and talk through some of the information which relates to the topic areas the patient has asked to talk about. There are links, for example, to the PCT's Stop Smoking Service. The second function is as an adaptive knowledge database so clinicians can see how colleagues have dealt effectively with a particular issue raised by a patient.

• Who is involved

The cards can be used alone, with a friend or relative the patient trusts, or with a health professional.

• Systems requirements

Definitive answers will not be available until a two-year clinical study is fully evaluated. However, issues that likely need consideration include:

- Identifying at what point in the clinical pathway, from both a patient's and a health professional's point of view, the cards are a useful tool.
- Who introduces the cards to the patient – doctors, nurses or other members of the diabetes care team?
- Are the cards to be used at every patient review or just as a one off?
- Will patients have them all the time but only use them when they want to?
- How can the cards be used outside of the clinical encounter – possibly for partners and other family members?

Although the cards have yet to be systematically implemented across the entire PCT, a two year clinical study involving 15 GP practices and 250 patients is currently being carried out to determine how the cards can work best in a clinical context, for example how and when they are handed out and how often there needs to be a consultation. Due to report in November 2009, the trial will look specifically at how a change in attitudes and support can help people with diabetes. An assessment will also be made as to whether the cards could be used for other long term conditions.

Findings from an original, small scale pilot showed the cards can shorten consultation times as they help patients get straight to the point. They were also found to be particularly useful for those patients with complex problems who can struggle to identify which of the whole range of health issues they are facing is the main concern at that time.

Case study examples

Example One
A young man in his 20s, in very poor health with a range of complex problems and health issues. Finding it hard to deal with the magnitude of all his poor health. Unsure what problem to tackle first. Invited to try the cards to help identify the main issues. Nurse left him alone with the cards for ten minutes, coming back to find he had laid them all out on the examination couch in order to pick the three that were most relevant.

"He had really studied them all and selected the three that were really shouting out to him at that point. One was about eye problems, one about not feeling he was dealing with his diabetes and the third about the impact on his family. The cards gave us a lead into a more detailed discussion and his feedback was that it was extremely useful to set the agenda. As a mental health worker he could appreciate from a professional point of view that they would be helpful in other settings."

Example Two
Man is his early 50s. Recently recovering from a life threatening tumour and spell in intensive care. Struggling to contend with all the threats to his longevity, of which diabetes was just one. Needed reassurance and advice about all the different medication he was on. There were so many issues, knowing where to start was a problem. Left alone with the cards to help him pick something that he really wanted to deal with first.

"He came to the centre with his wife. I explained the cards and that he was to pick out the three things that meant a lot to him. When I came back into the room just one card was put out – the one about impotence. They said that's the one thing they wanted help with. It was very stark. I could have gone off in all sorts of directions if it wasn't for the cards. They gave him the all important opportunity to talk about this, something he would have found hard to discuss otherwise."

Further reading

- For more detail on the original pilot project see the Design Council case study at: http://www.design-council.org.uk/en/Case-Studies/All-Case-Studies/RED---Diabetes-/

- Online version of the cards can be viewed on the Agenda Cards Portal: http://www.bolton.nhs.uk/BoND/card_front.aspx?card_type=1

Contact for further information
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Example: Bellin Health - Patient generated goal

bellinhealth

1/9/06 Revised 3/23/07

PATIENT GENERATED GOAL

Date: _____

I, _____, will do my part to achieve the following goal(s):

My Goal is:

_____

_____

How Important is it to Me? *(On a scale of 1-10. If less than 6 start over)*: _____

Describe What, How, Where, When, How Often, and Family/Friend Support:

_____

_____

Start Date: _____

Possible Barriers *(What might get in the way?)*: _____

_____

_____

Plan to Overcome Barriers *(What could you do to handle the barriers?)*: _____

_____

_____

How confident are you that you will succeed with this plan? *(On a scale of 1-10. If less than 6 start over)*: ____

Patient Signature: _____ Staff Signature: _____

When would you like us to call? 1 Week 2 Weeks 3 Weeks 4 Weeks

Call back week of: _____

Best Way to Contact Me: Home: _____ Cell: _____ Work: _____

Okay to Leave Message? Yes No Yes No Yes No

Follow-up:

_____

_____

_____

_____

_____

_____

_____

_____

10-8532.d

Follow Up:

Example: Bellin Health - Follow up

bellinhealth
FAMILY MEDICAL CENTER
3/28/06
Revised 6/5/06

(Patient Sticker)

PLEASE GIVE TO SCHEDULER BEFORE LEAVING

Planned Care: 10 / 15 / 20 / 30 Fasting Lab: _____ Well Check/Physical: _____ Interpreter Needed: Yes / No

If less than 2 months, patient should make appointment, pending appointment are for greater than 2 months.

1. ***Follow-up visit with provider (pending appointment)***

   For: _____

   _____ Lab Only _____ Lab Followed by OV _____ OV Only

   1 week 1 month 3 months 6 months 1 year Other: _____

2. ***Follow-up for labs (pending appointment)***

____ ALT	____ CMP	____ HGB	____ LFT	____ PSA	____ URINE CULTURE
____ BMP	____ CREAT	____ HGBA1C	____ LIPID PANEL	____ PT/INR	____ OTHER
____ BUN	____ FT4	____ K+	____ MICRO ALB	____ TSH	_____
____ CBC	____ GLU	____ LEAD	____ PAP	____ UA	_____

Write number of diagnosis below next to follow-up lab

1. Anemia (unspecified) 285.9	8. Fatigue/Malaises 780.79	15. Hyperlipidemia (unspecified) 272.4
2. Anemia Screen V78.1	9. Hypertension 401.1	16. Pure Hypercholesterolemia 272.0
3. CAD 414.00	10. Hypokalemia 276.8	17. Pure Hypertriglyceridemia 272.1
4. Congestive Heart Failure 428.0	11. Hypothyroid 244.9	18. Yearly PSA Screen V76.44
5. Diabetes Type 1 250.01	12. Lead Screen V82.5	19. _____
6. Diabetes Type 2 250.00	13. Long-Term Anticoag V58.61	20. _____
7. Elevated Liver Enzymes 794.8	14. Long-Term Med V58.69	21. _____

3. ***Follow-up for x-ray/diagnostic tests (pending appointment)***

_____ X-Ray Only	_____ X-Ray With OV	DX: _____
_____ FX F/U (same x-ray as previous one)	_____ Bone Density	_____ Mammography
_____ Chest – PA/LAT (W)	_____ Colonoscopy	_____ Spirometry
_____ Other _____	_____ EKG	_____ Eye Exam

4. ***Follow-up phone call by nurse/provider***

   For: _____ Phone: _____

   Please circle one: 1 week 2 weeks 1 month Other: _____

5. ***Follow-up visit with nurse***

   For: _____

   Please circle one: 1 week 1 month 3 months Other: _____

Provider Signature: _____ Date: _____

27-3049.d

Patient Needs Form

Example: Bellin Health - Planned care visits - family medical centers

Planned Care Visits

What a planned care visit is:

A planned care visit is an appointment with your physician to check your chronic condition. A chronic condition is any health problem that lasts for a long time, such as high blood pressure, diabetes, or arthritis.

What you can do to prepare for your planned care visit:

- Bring all your medicines in their original bottles to your visit.
- Have lab tests done before your visit.
- Ask a family member or friend to come with you to your visit. The person can give you support and help you attain your personal goals.

What your care team does at your planned care visit:

- Talks with you about your health and your lab results.
- Makes sure you have all your prescriptions and enough refills until your next visit.
- Discusses when your next planned care visit will be and orders any lab tests.
- Helps you set your personal goals and establish an action plan to attain them.
- Answers any questions.

What happens in between visits:

- After you set your goals, a member of your care team contacts you by phone to talk about your progress.
- If you need assistance with your goals, an appointment can be set up with a nurse to help you achieve your goals.

Goals For Better Health

It is important to set personal goals to help you manage your health condition. Each time you attain a goal, you improve your health and make your daily life easier.

The key to successful goal setting is to make them **your** goals. Your care team is there to help you achieve them!

Before you come to your next planned care visit, ask yourself these questions:

1. What is one new thing I can do to improve my life?

2. What steps will I take to reach this goal?

3. When will I start?

Follow Up:
