

**IMPLEMENTATION MANUAL FOR COLLABORATIVE PROJECTS
TO IMPROVE THE QUALITY OF CARE FOR
PEOPLE WITH CHRONIC DISEASES**



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*

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Introduction

In Latin America, an estimated 13.3 million people had diabetes in the year 2000, a figure that is projected to increase by 2030 to 32.9 million, or double the number of cases. The estimates indicate that the diabetes epidemic will persist, even if the prevalence of obesity remains at current levels until 2030. The doubling of case numbers will occur as a simple consequence of population aging and urbanization.¹ However, given the increase observed in the prevalence of obesity in many countries around the world and its importance as a risk factor for diabetes, the number of diabetes cases in 2030 could be much higher.

The increase in the prevalence of diabetes in the United States has been explained by a similar increase in the proportion of obese people, rather than an absolute increase in the risk of developing diabetes.² According to the [CAMDI](#) survey of people aged 20 and over in Central America, the prevalence was higher in Belize (12.4%), Nicaragua (9.01%), and Guatemala (8.23); intermediate in Costa Rica (7.9%) and El Salvador (7.4%); and lower in Honduras (6.1%).

Diabetes is often diagnosed late. Various research projects indicate that 50% of all patients with type 2 diabetes present with some type of cardiovascular complication at the time of their diagnosis. The most significant complications (micro- or macrovascular) are retinopathy, with percentages ranging from 10% to 30%; neuropathy, 8% to 33%; and impotence, 35% to 66%, with hypertension ranging from 32% to 65%. Diabetes is the most common cause of polyneuropathy, and roughly 50% of people with diabetes mellitus experience neuropathic alterations in the 25 years following diagnosis. Diabetes is responsible for about 90% of all nontraumatic amputations and the leading cause of terminal renal insufficiency.

The QUALIDIAB study conducted in clinics in the capital cities of Central America showed that people with diabetes treated in these centers did not achieve adequate glycemic control.

¹ Wild S, Roglic G, Green A, Sicree R, King H. Global prevalence of diabetes. Estimates for the year 2000 and projections for 2030. *Diabetes Care* 2004;27(5):1047-1053

² Gregg EW, Cadwell BL, Cheng YJ, Cowie CC, Williams DE, Geiss L, et al. Trends in the prevalence and ratio of diagnosed to undiagnosed diabetes according to obesity levels in the US. *Diabetes Care* 2004;27:2806-2812.

The proportion of patients with good glycemic control varied, with higher percentages in Nicaragua and Costa Rica and lower percentages in Guatemala and Honduras. Numerous incomplete clinical files were found, which made it impossible to adequately assess patient care. Preventive practices, such as nutrition education and physical activity, were deficient. Improving treatment for diabetes and other chronic diseases should be a priority in medical practice in Central America, since some 6% to 9% of all adults suffer from this disease and projections point to a sharp increase in the near future.

One strategy for improving the quality of care for people with diabetes is to develop and implement a collaborative project for countries or health services interested in launching projects for continuous improvement of the quality of care, based on the *Breakthrough Series* ([BTS](#)) model proposed by Boston’s Institute for Healthcare Improvement—a model that has proven effective in hundreds of initiatives in the United States, Canada, and many other countries around the world.

The objective of the Collaborative Project is ongoing improvement of the quality of care for people with chronic diseases through a joint effort by professionals and health managers to ensure excellent practices in health units or services. For approximately one year, managers, health professionals, and people with chronic diseases should come together in Learning Sessions (three in all) to participate in training, planning, and evaluation activities. During these Learning Sessions, the participants from the health units/services will work on evaluating their services and prepare an intervention plan based on the proposed change package, stating the activities programmed for the action periods. The commitment of each team to producing these plans is important for improving outcomes.

The methodology has already been used in several of countries and has permitted lasting change once it leads to a change in mentality and a joint effort by each and every health team, with the commitment of each professional.

PAHO’s experience in the implementation of this type of project in Mexico was positive. Through this manual, it now hopes to arouse enthusiasm in other countries with similar projects.

About This Manual

The **purpose** of this manual is to provide users with information from references on collaborative projects. The manual is also designed to help ensure successful initial preparations for the year of work on this project, whose aim is to improve the quality of life of people with chronic diseases.

The first part, ***Theoretical Framework for Collaborative Projects***, contains an overview on the Collaborative and its theoretical framework, with a proposed timeline for the most important events and activities.

The section ***Activities in the Preparatory Stage of the Collaborative*** gives a step-by-step description of the development of the project and organization of the participants, along with tools to establish the baseline that will be used to measure the impact of the project.

The section ***Operational Stage of the Collaborative*** details step by step the main activities of the Learning Sessions and Action Periods.

Finally, the ***Annexes*** contain the VICEN assessment and ACIC instruments, sample indicators, agendas, and model change packages.

Background

A collaborative project takes a systematic approach to improving the quality of health care. During this process, organizations and providers (the team) test and measure their innovative practices and share their experiences with other teams in an effort to accelerate learning and promote the adoption of best practices.

History of Collaboratives

The Institute for Healthcare Improvement (IHI) founded in Boston, U.S.A. in 1991, has sought to develop more effective health care strategies. Since 1995, when it launched its first collaborative project, IHI has been committed to developing systems for detecting persistent problems in health care and better organizing resources to actively combat them, so that health workers are proud of their work and the people they serve are fully confident about the care they are receiving. Over 700 teams from 450 health organizations in the United States and Canada alone have already participated in collaborative projects. IHI has now conducted more than 26 Collaborative Projects and trained other organizations to facilitate Collaboratives, using the Breakthrough Series (BTS) model.

PAHO’s Experience with the VIDA Project

In 2000, the data from the Mexican Secretariat of Health’s system for monitoring the quality of medical care showed that 66% of people with diabetes had poor metabolic control. In order to evaluate the use of a more integrated approach to chronic disease management, the Ministry of Health, in collaboration with the Pan American Health Organization/Regional Office of the World Health Organization for the Americas (PAHO/WHO), launched a collaborative pilot project, the VIDA Project, in the State of Veracruz. The pilot project lasted 13 months and covered 10 randomly selected health centers. Forty-three teams took part in the activities, and 317 patients (196 cases and 111 controls) were monitored. At the end of the project, an improvement in glycosylated hemoglobin levels and foot care was

observed, together with the inclusion of nutrition support, psychological assessment, and eye and dental check-ups for cases.

Our Proposal for Collaborative Projects

Based on Mexico’s successful experience, we recommend that other countries in the Region undertake similar projects (consistent with the local situation), getting government organizations, health services and health teams, the community, and NGOs involved to work together, test changes in their daily practice, and learn as a group to improve the quality of health care for people with diabetes.

Theoretical Framework for Collaborative Projects.

Chronic Care Model

Collaborative projects are a strategy to promote better care for people with chronic diseases, fostering changes in the basic components of the care or service delivery model. The reference model is the *Chronic Care Model* developed by Ed Wagner, MD, MPH, Director of MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, et al. with support from the Robert Wood Johnson Foundation.

The Wagner model (see Fig.1) identifies the following elements, considering them essential for promoting high-quality care for people with chronic diseases:

1. *Community.* By mobilizing resources through the community, patients can be motivated to participate in programs based on community needs. Forging partnerships with community organizations can also contribute to the development of interventions that in some cases complement or meet the needs of the health services. Another important factor is that the community can advocate for policies to improve patient care.
2. *Health system.* In order to create an organizational culture and mechanisms that promote high-quality care in health facilities, there must be visible support from the highest levels of the health system and service administrators. These people must encourage improvement strategies geared to a complete, integral change in the services through the systematic and transparent handling of problems or errors in the quality of care, so that they can be rectified. Similarly, incentives should be offered for improving care and agreements reached that facilitate coordinated efforts in the services and the organization, as well as intra- and intersectoral work.
3. *Support for self-management and self-monitoring.* This component centers on the importance of ensuring that patients understand their role in controlling his disease and

their responsibility for staying in good condition. Thus, for patients to play their role, health care providers must constantly provide basic information about their disease, promoting and guiding the development of self-monitoring skills and encouraging the involvement of

Chronic Care Model

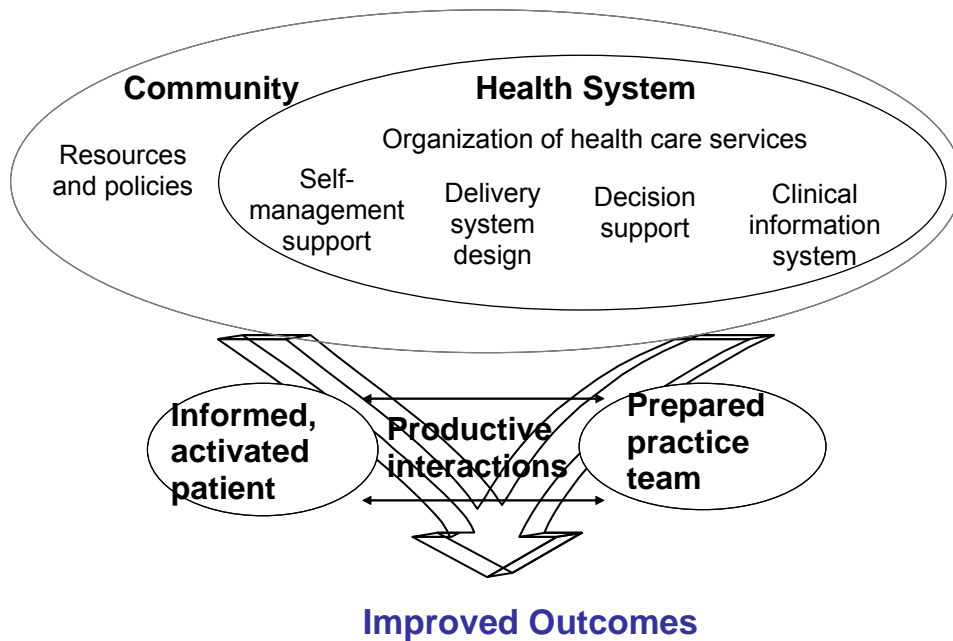


FIGURE 1

[Translator's note: I used the wording from the chart in Wagner, EH. Chronic Disease Management: What will it take to improve care for chronic illness?]

all members of health team, family, friends, and the community, so that patients feel that they are supported in this self-monitoring and self-management process. The goal is to make effective use of self-monitoring strategies that include goal setting, measurement, planning, problem solving, and monitoring of the activities of people who are self-managing their disease.

4. *Delivery system design.* Improving the health of people with chronic diseases requires shifting from a system that is eminently reactive (that responds mainly when a person is ill) to one that is proactive and designed to keep the person as healthy as possible. This requires clear roles and responsibilities for the members of the health team to guarantee delivery of the services that the person needs. Moreover, team members should have an information system at their disposal that enables them to know what is going on with the patient, update information on the patient's status, and monitor the use of standard procedures. Visits to patients are programmed according to their needs and self-management goals. Meetings in which patients share information with people in similar situations and members of health team are encouraged. Administrative personnel are trained to understand the needs of patients and the team that directly treats them. Services are provided in a way that ensures that patients understand the procedures and that the procedures are adapted to their culture.

5. *Decision support.* Treatment decisions must be based on explicit, tested guidelines that are supported by at least one clinical trial. Service providers must integrate the use of protocols and evidence-based guidelines in their daily practice and share information about them with the patients to encourage their involvement in monitoring and managing their disease. Appropriate educational methods should be used with both the professionals who provide the services and patients. An essential part of this process is the involvement of specialists, especially in first level services.

6. *Clinical information system* Effective care for chronic diseases is impossible without an information system that guarantees immediate access to key records on individual patients, as well as to the population or patient group to whom the facility offers services. The system is used by the members of the team to send reminders to patients and other eligible users of the services in order to direct the course of the treatment, anticipate problems, confirm changes, coordinate the action taken to benefit the patient, and monitor the performance of the health facility and the team that provides the care.

ACIC (Assessment of Chronic Illness Care).

Health organizations need practical measurement tools to guide efforts to improve patient care. The ACIC, designed by the Indian Health Service to evaluate health services, is a tool that helps health organizations measure and assess their performance, based on the six key elements of Wagner’s Chronic Disease Model [Translator’s note: Error in Spanish: Warner instead of Wagner].

The assessment enables organizations to identify areas for improving chronic illness care before launching collaboratives or projects to improve care; it also permits periodic assessment of the changes made during the improvement process.

The table below better explains measurement of the components of Wagner’s Chronic Care Model through ACIC:

Care Model	Subcomponents of ACIC.
<i>Organization of the health system.</i>	<ul style="list-style-type: none"> • General leadership of the organization in chronic illness care • Goals of the organization in chronic illness care • Strategies for Improving chronic illness care • Incentives for and regulations governing chronic illness care • Influential leaders • Benefits
<i>Self-management and self-monitoring support</i>	<ul style="list-style-type: none"> • Assessment and documentation of needs and self-management activities • Educational programs to support self-management • Support for patients and family members • Interventions for effective behavioral change and mutual support
<i>Community</i>	<ul style="list-style-type: none"> • Patient linkage with community resources • Cooperation agreements with community organizations • Regional and/or local health plans
<i>Delivery system design</i>	<ul style="list-style-type: none"> • Operations of the service delivery team • Leadership of the service delivery team • Multiple monitoring visits • Follow-up appointments • Programmed monitoring visits • Continuity of care
<i>Decision support</i>	<ul style="list-style-type: none"> • Evidence-based medical guidelines/standards • Specialist Involvement in improving first-level care • Education for the service delivery team • Information for patients about medical guidelines/standards
<i>Clinical information system</i>	<ul style="list-style-type: none"> • Records (lists of people with diabetes) • Reminders for the health team • Performance feedback • Relevant information on subgroups of patients requiring special services • Treatment plans

Improvement Process

The Model for Improvement, developed by Associates in Process Improvement, is a powerful tool for accelerating the improvement process. It is not meant to replace other models that the organizations have developed and are using. Health organizations have used the model very successfully in several countries. It has two parts (Figure 2):

a) Three basic questions:

- *What are we trying to accomplish?*
The improvement process requires setting aims that are measurable and time-specific.
- *How will we know that a change is an improvement?*
Teams should use quantitative measures to determine if a specific change leads to an improvement. They should measure both the process itself and the end result, seeking a balance between the two.
- *What changes can we make that will result in an improvement?*
Changes that will very likely lead to an improvement should be selected

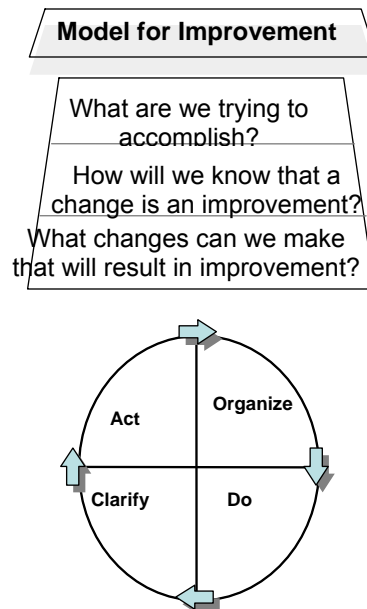


FIGURE 2

b) ODCA (Organize, Do, Clarify, Act) quality cycles (originally the Plan, Do, Study, Act cycle) are tools for testing and implementing changes in the workplace and guide the testing of a change to determine whether it leads to an improvement. Their use involves the following steps:

<p>Step 1: Organize (Plan) Organizing the test or observation includes planning for information gathering.</p>	<ul style="list-style-type: none"> • State the objective of the test or observation • Forecast the results that it will yield • Plan the execution of the test.
<p>Step 2: Do Carry out the organization and planning in the previous step.</p>	<ul style="list-style-type: none"> • Conduct the test or make the observation • Document unexpected problems and results • Begin the data analysis
<p>Step 3: Clarify (Study) The point where the information obtained is analyzed and the results studied.</p>	<ul style="list-style-type: none"> • Complete the data analysis • Compare the data to the forecasts • Summarize and consider what has been learned
<p>Step 4: Act Based on what has been learned in the previous step, adjust the change to perfect it.</p>	<ul style="list-style-type: none"> • Determine what changes should be made • Draw up a plan for the next test.

Testing changes that will result in an improvement is an interactive process. The end of each ODCA cycle marks the beginning of a new one. This is where the teams that carry out the intervention learn, responding to these questions: What worked and what didn't? What should be kept, changed, or dropped?. The resulting knowledge will be used to plan the next test. Thus, the quality process continues, improving the testing until the change is perfected and ready for wider implementation (Figure 3).

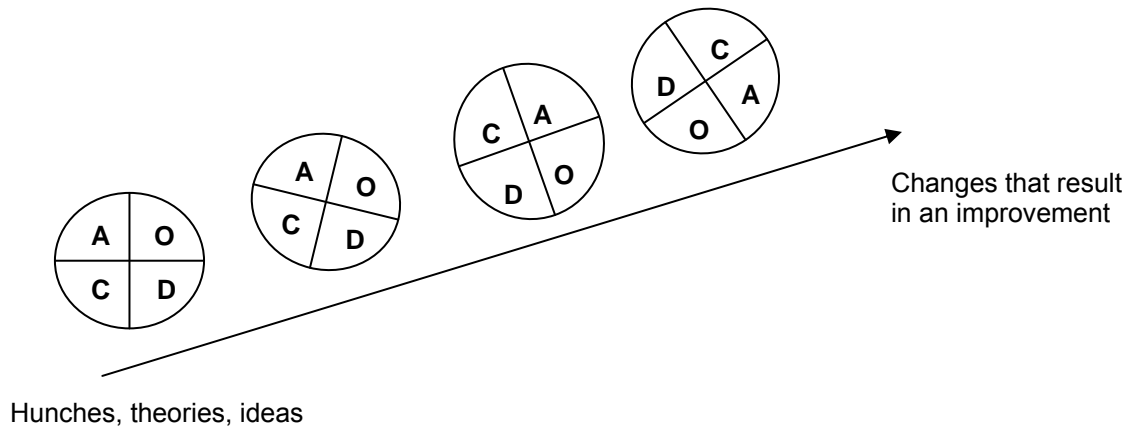


Figure 3

Teams simultaneously test many changes designed to meet the same goal. The use of several related ODCA cycles enables them to test more than one change at a time (Figure 4).

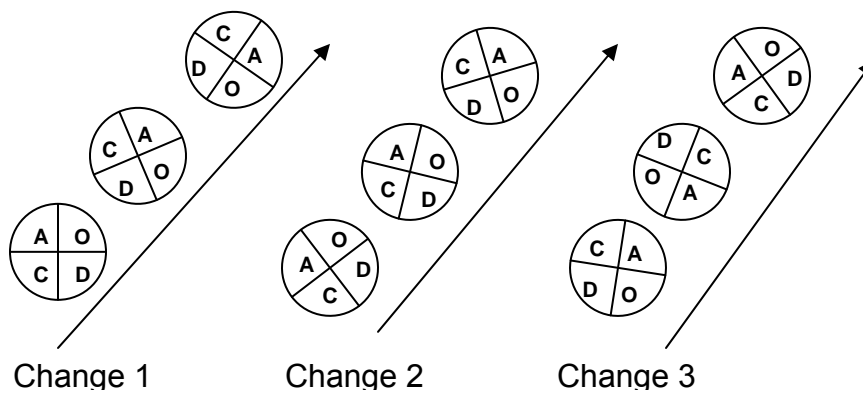


Figure 4

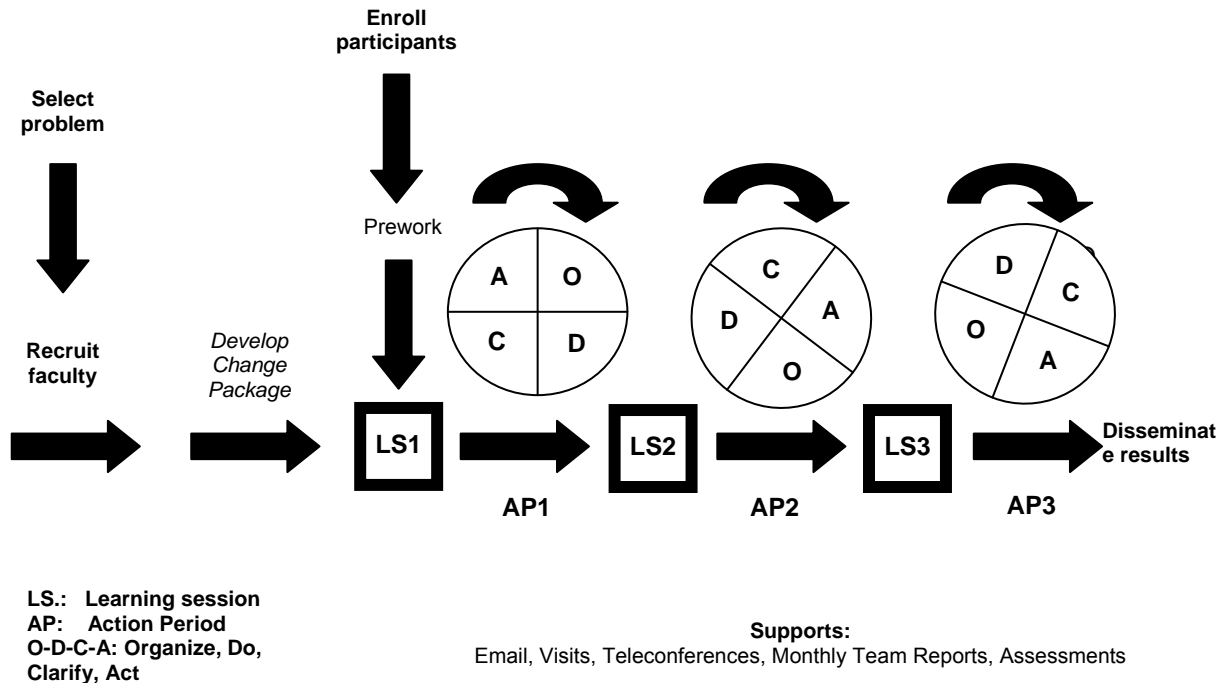
Breakthrough Series

A Collaborative is implemented by means of the Breakthrough Series model, comprised of the activities that should be followed to lay the foundation for the project teams to share experiences, receive expert advice, and learn from each other in the areas identified to improve care for people with chronic diseases.

The key elements in the Breakthrough Series (Figure 5) are:

1. Topic Selection. Identification of a particular area of patient care that it is ripe for improvement.
2. Faculty Recruitment. Identification of at least five experts in the disciplines relevant to the area to be improved who have demonstrated their knowledge through good performance and relevant contributions in their specialty. One of these experts should chair the Collaborative. All the experts should be involved in the creation of the Collaborative, contributing to the selection of the aims that will be pursued, along with the measurement strategies, and based on the evidence, providing a list of activities that have produced changes.
3. Enrollment of Participants. It is expected that key people in the services will launch the improvement process. The most experienced staff will guide, support, and motivate the rest of the teams to responsibly lend sustainability to the effective changes that the teams have shown.

Figure 4: Breakthrough Series of



4. Learning Sessions. These are meetings for sharing ideas. Three are usually held, bringing the people who are implementing the changes for improvement together with the team that is guiding the Collaborative. During *Learning Session 1*, the team of experts presents the vision of ideal care in the area in question and the specific changes that will be made; this is the *Change Package*, which, when implemented locally, will significantly improve the health service's performance. During *Learning Sessions 2 and 3*, team members learn more from one another, reporting on progress, problems, and lessons learned during their meetings, workshops, poster presentations, and informal dialogue and exchange.
5. Action periods These occur between Learning Sessions. Teams will work in their units or health services, testing and carrying out the changes proposed during the learning session and implementing the ODCA quality cycles. Teams will present their results in monthly reports and at the next learning session through posters. E-mail or a website can be also be used to communicate and share ideas.
6. Implementation of the Model for Improvement. Implementation of the ODCA quality cycles described above makes it possible to identify four elements that are key to the success of the process: specific and measurable aims, changes that are tracked over time, the key changes desired, and the ODCA quality cycles.
7. Dissemination of results. Once the Collaborative Project is over, the work is documented and the teams present their results and lessons learned to people and organizations that did not participate in the process through national and international conferences, congresses, publications, and meetings.

Project Timeline

Sequence of events for the Collaborative Project:

EVENTS	MONTH															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<u>Preparatory activities</u>																
• Preparation of the project document																
• Meeting with national authorities and managers																

COLLABORATIVE PROJECT
"Improving Care to Change Lives"

EVENTS	MONTH																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
• Panel of experts		█															
• Formation of teams		█															
• Memorandum of Understanding		█															
• Scheduling of meetings		█															
• Development of the contact list		█															
• Implementation of ACIC			█														
• Preparations for Learning Session 1			█														
• Work proposal of health centers			█														
• Definition of pilot population			█														
• Selection of indicators			█														
• Preparation of posters on experiences			█														
• Coordination with local NGOs			█														
<u>Learning Session 1 (LS1)</u>				█													
<u>Action Period 1 (AP1)</u>					█	█	█										
• Implementation of VICEN panamericano					█												
• Taking of A1c					█												
• First round of ODCA cycles					█												
• Second round of ODCA cycles						█											
• Third round of ODCA cycles							█										
• Preparation of poster on experiences							█										
• Preparations for Learning Session 2							█										
<u>Learning Session 2 (LS2)</u>								█									
<u>Action Period 2 (AP2)</u>									█	█	█						
• First round of ODCA cycles									█								
• Second round of ODCA cycles										█							
• Third round of ODCA cycles											█						
• Preparation of poster on experiences											█						
• Preparations for Learning Session 3											█						
<u>Learning Session 3 (LS3)</u>												█					
<u>Period of Action 3 (AP3)</u>													█	█	█		
• First round of ODCA cycles													█				
• Second round of ODCA cycles														█			

COLLABORATIVE PROJECT
"Improving Care to Change Lives"

EVENTS	MONTH																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
• Third round of ODCA cycles																	
• Implementation of VICEN panamericano																	
• Taking of A1c																	
• Preparation of poster on experiences																	
• Preparations for final event																	
Final Event																	

Activities in the Preparatory Stage of the Collaborative

In the pages below we will review the information on how to complete each preliminary activity. At the end, we have a sheet that each team can fill out to track their work.

1. Project Document and/or Declaration of Principles

Each country or organization that wishes to undertake a collaborative project should name a planning group to prepare a project document that reviews the situation of the chronic disease that the country is interested in addressing and that uses national indicators to justify the project. The document should also spell out the project's mission, the scientific evidence supporting the selected lines of work, the Change Package, the methods that teams should employ to carry out the mission, the expectations that participating teams should have about project leaders and those that leaders should have about the team, and the model Patient Record to be used in monitoring patient progress (See Annex ##)

The Annexes contain sample declarations of principles and a list of tasks that the Local Planning Group can use as models. Some countries or organizations may prefer to develop their own Declaration of Principles, which would be a statement of commitment indicating the problem, mission, goals, methodology, and expectations of the project..

2. Meeting with National Authorities and Managers

In order to launch the project, it will be necessary to meet with the health authorities of the country in which the Collaborative will be implemented. During the meeting, the Collaborative's Planning Group will describe the purpose, goals, and expected results of the project, and a list of all health units in the region designated as the demonstration area will be drawn up. This list is necessary for selecting the health units (cases/controls) that will participate in the project. The purpose of this meeting is to obtain authorization for the Collaborative from the national health authorities and identify the experts that will make up

the National Leadership Team and Local Coordinating Group. The expected end result is comments on the initial proposal for the Collaborative and the adaptation of the Change Package and monitoring and assessment strategies to the national situation.

3. Creating the Panel of Experts

The creation of an panel of experts, in which the country's or city's diabetes experts participate, is also key to project success. The expert group should study the proposed Change Package and adapt it to the country's situation. It should also review the indicators proposed for the collaborative project. Experts from the Regional Coordinating Group will also participate in this panel.

4. Forming Teams

An appropriate and effective team is key to the success of improvement efforts. Three teams are recommended: national leadership, regional leadership, and local leadership.

[Translator's note: The names of two of the teams below are not the same as those listed here].

The **National Leadership Team** should be made up of national public health authorities, especially those responsible for chronic diseases and/or improvements in the quality of health care, and they should be knowledgeable, interested, and enthusiastic about continuous improvement processes. It is recommended that teams include: The coordinator of the chronic disease program and/or the coordinator for health care quality improvement, the national epidemiology coordinator, a representative of the societies for chronic diseases, NGOs working for the control of chronic diseases, universities (through representatives of their medical school or master's programs in public health or epidemiology), and patient advocacy groups.

The **International Advisory Team** will be made up of representatives of the Chronic Diseases Group of the Pan American Health Organization (PAHO), whose Headquarters is in Washington, D.C.

The **National Advisory Team** will be made up of the chronic disease and/or health promotion focal points in the PAHO Representative Office .

Like the National Leadership Team, the **Regional Coordinating Group** should have an appropriate and effective team. Achieving the project’s proposed results will require the teams from the units to have in people in the regional coordinating office to instruct and support them. All team members should be knowledgeable, interested, and enthusiastic about the continuous quality improvement system and its processes. Efforts will be made to ensure that the group includes professionals of recognized technical and scientific prestige in the area addressed. The participation of the following individuals is recommended: the regional director of the health system, the regional epidemiology coordinator, representatives of relevant scientific societies, patient advocacy groups, and NGOs with related programs in the Region.

The Regional Coordinating Group will name a **Monitoring and Evaluation Team**, which will support local monitoring of the Collaborative.

The **Health Unit Teams** will elect team members on the basis of their knowledge, interest, and enthusiasm about the system and processes that they will work to improve. In order to implement the project, health units will need to name the people in charge of the team’s four leadership functions: **unit leader, unit systems leader, clinical leader, and change leader**. The unit leader should plan to attend at least the Learning Sessions 1 and 3, as well as the final event. The project [TN: systems?], clinical, and change leaders should plan to attend the three Learning Sessions and the final event. More than one person may be responsible for the same function. Likewise, a single person may be responsible for more than one function. In any case, filling all the positions is essential to the success of the team.

When selecting leaders, consider the following recommendations:

The ideal unit leader:

- Should have the final authority in allocating the time and resources necessary for the team to perform its work
- Should have administrative authority in all areas affected by the changes to be tested, and
- Should be willing to exercise leadership to achieve successful changes through the unit.

The unit leader is usually one of the directors of the unit. He should be encouraged to participate in all the Learning Sessions and the final event.

The ideal systems leader:

- Should have direct authority to assign the necessary time and resources for the team to perform its work
- Should have direct authority over the systems affected by the changes that the team is going to test, and
- Should exercise leadership to achieve successful changes through his department or service.

An example of a system leader would be the medical director or clinic director. The system leader should participate in all the Learning Sessions and the final event.

Comment: In small units, the unit and systems leaders may be the same person. Furthermore, the clinical leader (see below) may be the systems leader or unit leader or both.

The ideal clinical leader:

- Is a professional who is an opinion-maker and is respected by his peers
- Is thoroughly knowledgeable about diabetes and understands the health care process
- Has good working relationships with his colleagues and the change leader, and

- Is interested in improving the system.

It is essential to have a clinical leader—usually a physician but in some cases a nurse or another health professional—on the team. The clinical leader should participate in all Learning Sessions and the final event.

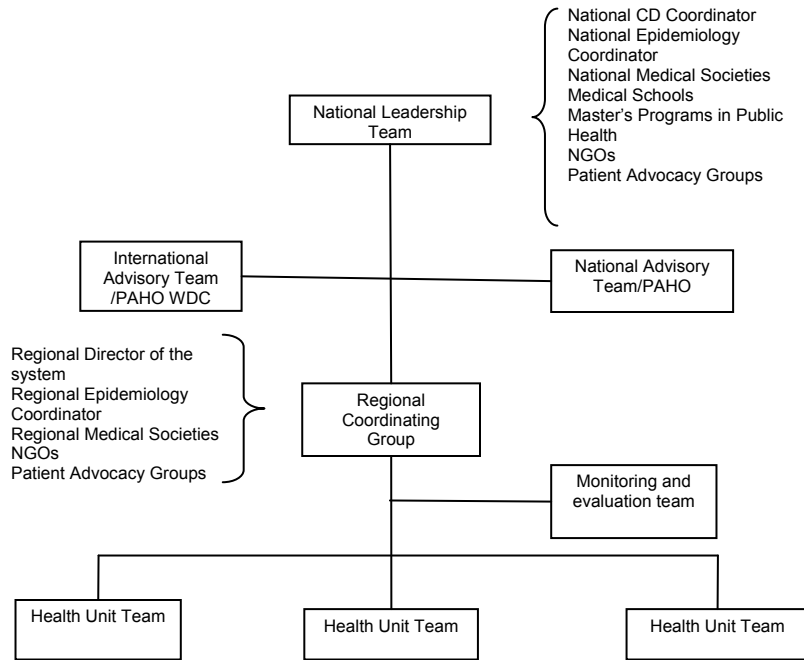
The ideal quality improvement leader [TN: change leader? See next paragraph and also pg. 22 .]:

- Runs the project, ensuring that the change cycles are tested, implemented, and documented
- Coordinates communication between the team and the Project Planning Group
- Reviews and oversees data collection, and
- Works effectively with the clinical leader.

The change leader is a quality manager, nurse, or diabetes educator. He should understand how the changes will affect the system and have time to keep the project on track. The change leader should participate in all Learning Sessions and the final event.

In addition to the four key members listed thus far, the teams will include **other members from the unit**, who will take part in testing and implementing the changes. They will also be invited to participate in the Learning Sessions and final event. Teams should have five to eight members in all.

The following organizational structure is proposed for implementing the Collaborative:



A National Project Director and a Local Coordinator should be named, who will be in charge of executing the Collaborative. It is recommended that the Director be a representative of the National Leadership Team and that the Regional Coordinating Group name the Project Coordinator, who will be a member of the health unit's team.

5.Preparing and Completing the Memorandum of Understanding

The draft Memorandum of Understanding (MOU) should be prepared by the Project Planning Group. The document should state the responsibilities that the team assumes by agreeing to participate in the project (see Annex # model MOU).

The MOU will be signed by the person in the organization or service who has the authority to sign contracts.

The Local Coordinating Group should report the names, so that individual MOUs can be prepared for every service and are signed and returned to the Planning Group and kept in the project files.

6. Scheduling Meetings and Teleconferences

a) Local Coordinating Group, National Leadership Team, and Planning Group

The Planning Group should periodically suggest teleconferences to keep up-to-date on what is happening with the project: progress, barriers encountered, and the execution of activities. The National Leadership Team and/or the Local Coordinating Group can participate in these conferences, as appropriate. At the end of each teleconference, it is always important to prepare a record of the agreements and commitments made by each participant.

b) Health Unit Team and Local Coordinating Group

Each team should schedule a meeting with the Local Planning Team before Learning Session 1. A member of the Local Planning Team will assist the teams with the preparations and answer any questions that the teams may have about participating in the Project. The teams should have begun the preliminary activities prior to the meeting.

7. Creating an E-mail List

E-mail is a fast and easy method of communication for the groups and teams. All members of the Project Planning Group, the National Leadership Team, and the Local Coordinating Group should have a project e-mail address for sending and receiving messages. It is also suggested that at least one member of the health unit teams have an e-mail address, so that he can be on the list for the collaborative project and facilitate communication for the rest of the health unit team. All participants will be encouraged to obtain an e-mail address so that they can be on the project list and receive information and tools, ask questions and receive responses, and participate in Web discussions.

8. Administering ACIC in Health Units (Baseline)

The *Annexes* to this Manual contain the instrument to be used in each health unit: "**Assessment of Diabetes Care (Modification of ACIC Version 3)**", which consists of a qualitative and quantitative assessment of the quality of care provided to people with diabetes. This assessment will be done at the start of the project—to determine the baseline -

and at the end to evaluate health professionals’ views about their system’s or organization’s chronic care model. A person from the Planning Group should visit each health unit to administer the questionnaire to the professional staff.

9. Preparing Learning Session 1

The Learning Sessions will require a location that can comfortably accommodate all the health unit teams, the Local Coordinating Group, the National Leadership Team, and the Planning Group. Transportation and a strategy to cover the needs of the group should be provided, so that all group members can participate. The participants will register at the beginning of each session, at which time they will receive personal and team materials. Annex # of this manual contains model agendas for the Learning Sessions and the discussion. Each service should be responsible for the food and lodging of the health teams and patients (if any). Coffee and lunch will be served during the session.

Health unit teams should be organized in a way that facilitates their participation in the event while guaranteeing that services in the health unit will not be interrupted. The unit leader should decide who will participate in the sessions, based on the interests and work of the unit.

10. Developing the Work Proposal in the Health Unit

The health unit’s work proposal should be a consistent, objective document that describes what the team hopes to accomplish during the Collaborative Project; the plan will serve as a script for the team for the duration of the project and will help achieve specific improvement efforts.

The work proposal guarantees that the team will be guided by the strategic objectives of the entire health system, but in a manner consistent with the local situation. It should involve the unit leader in the implementation of this activity to guarantee his support for the work.

When drafting the plan, make sure that:

- ☑ **The health unit leader is involved:** The leader should align the proposal with health system objectives and provide staff support and the resources of the information system, as well as financial resources and resources for the relocation of the health teams;

- ☑ **The Plan is based on the data or needs of the organization;**

- ☑ **The Work proposal is clear and contains numerical objectives:** Teams make more progress when they know where they want to get to. In addition to having specific objectives, try to select more appropriate indicators for determining whether you are moving in the right direction. Concrete numerical objectives will enable teams to visualize their goals and help create the desire for change. For example, the goal "to improve the percentage of patients with self-care education by 50%" will be more effective than one that says "to improve self-care practices."

Learning Session 1 should allow time for teams to develop their work proposals.

Sample Diabetes Goals:

Health teams will redesign their care practices to implement the Diabetes Care Model (Wagner Model). Thus, 60% of the patients being followed for diabetes will have an HbA1c level of less than 8.0%; over 70% will have blood pressure below 140/90mm Hg; 70% will have LDL cholesterol of less than 130 mg/dl; 80% will have diabetes education and self-care practices documented in their medical records; and 80% of smokers will have received counseling/psychological support to quit smoking.

11. Defining the Pilot Population

During the collaborative project, teams will test and implement changes in care in a pilot population, which may be some or all the patients of the health unit, indicating the inclusion or exclusion criteria in the Work Proposal.

Normally, bearing in mind the project experience in Mexico, it is preferable to have case units --where all the patients with diabetes in the unit participate in the pilot project, once they voluntarily agree to participate (this should be documented with an informed consent form for every patient)-- and control units --where there is no intervention other than the baseline and end-of-project assessments. Patients in the control units receive the customary care.

Sample inclusion criteria in the pilot project:

Diabetic patients aged 18-75 who, during data gathering at the start of the project, are diagnosed with type 1 or 2 diabetes and have had at least one medical appointment during the past year.

12. Administering the Questionnaires and Making Entries in the VICEN Panamericano Database

Administering the Questionnaires

In order to determine whether changes have taken place in the pilot population, information must be obtained from medical records and the patient interview forms from the Pan American Sentinel Surveillance System for the Management of Chronic Noncommunicable Diseases (VICEN panamericano), which should be distributed to all health units in sufficient quantity for the pilot population. A member of the health team, preferably the system leader and a member of Local Coordinating Group, should be responsible for data gathering. For information or concerns about the questionnaires, consult the National Leadership Team or the Project Planning Group. Annex 3 contains the explanatory material for the questionnaire.

Making Entries in the VICEN Panamericano Database

The VICEN Panamericano Database will be installed on the computers where the Local Coordinating Groups work. To feed the VICEN Panamericano Database, health unit teams should send the completed questionnaires to their respective Local Coordinating Group, so

that, once the questionnaires have been centralized in the Coordinating Group, the information can be entered in the database.

For information, concerns, or problems with data entry, groups should contact the National Leadership Team or the Project Planning Group.

13. Selecting the Indicators

Selecting indicators for the project will enable the team to monitor project performance and evaluate the changes tested. Indicator monitoring is not an end in itself, but should promote or accelerate the process of change rather than delay it.

Each team should test and implement changes and monitor the progress made; sometimes, this may require additional or optional measures or indicators, which should be selected by each team. It is recommended that 5 to 7 indicators be selected in all. They should be related to areas that have been identified as weak in the ACIC and correspond to the area identified in the Wagner Chronic Care Model. Annex 4 contains sample indicators.

14. Preparing your Poster on Experiences

Health unit teams should prepare posters reflecting their experiences in caring for patients with diabetes for display at each Learning Session. The posters will provide participants with a way of sharing experiencing and information. Time will be allotted during the sessions to view the posters, where one person from the respective center should remain to explain its content. The poster stands should be a maximum of 1 x 2 m. The name of the health center and/or group should be at the top for easy identification. The text should be large enough to read at a distance. Drawings, illustrations, photos, and tables should also be large enough. Handwritten material is unacceptable.

VIDA COLLABORATIVE PROJECT - Learning Session 1 HEALTH CENTER AND/OR GROUP	
Introduction, Objectives	Care activities. Values of the known Indicators. Text/Figures/Tables/Photos
Material and methods (not of patients; not of groups. Description of the methodology)	Conclusions, (Strengths and Weaknesses)

15. Collaborating with Local NGOs (optional)

Many health units can or will be able to work with NGOs or local groups (churches, neighborhood associations, professional societies, etc.) to support activities in units that have patients with chronic diseases. This collaboration should be encouraged by the Collaborative, since it contributes with the team to better patient care.

Operational Stage of the Collaborative

Learning Session 1

Learning Session 1 is the formal opportunity for the members of the team that will implement the Collaborative to have contact with the project. Alternating instructional presentations with periods of supervised work provides didactic information and clinical scenarios that will help team members learn and apply the Chronic Care Model.

By the end of the session, teams are expected to draft their improvement plan for implementation in their services. To accomplish this, they are introduced to the Collaborative Project's methodology and the style that cooperation among team members implies, ODCA cycles, and the monitoring of activities. At the end of Learning Session 1, participants should be fully motivated to transform the care model.

The objectives of Learning Session 1 are:

1. To improve knowledge about the Chronic Care Model, with special emphasis on the following areas: clinical information systems, basis for decision-making, design of the health service delivery system, and self-monitoring.
2. To describe the specific changes in the clinical information system, the basis for decision-making, the design of the health service system, and self-monitoring that have already been tested in other experiences.
3. To discuss the Model for Improvement, including the tests of change and the need for ODCA cycles for each of them.
4. To help teams implement the Model for Improvement and the ODCA cycles, especially the first step (organization and planning) for each of the changes to be tested.
5. To describe the reporting methodology of the Collaborative, the forms that will be used, and the participants' expectations regarding this system.

In the Annexes you will find a list of tasks to guide you in planning Learning Session 1, in addition to other tools for planning the Change Package.

Action Period 1

Action Period 1 is the stage in which the teams will test the changes, share information with each other and the rest of the staff at the health center, and have the opportunity to contact the experts to clear up any questions.

The leader of the Collaborative will begin drafting his report, which will be shared with the members of the local, regional, and national teams. The report will include the goal, measurement indicators, summaries of the ODCA cycles implemented, monitoring sheets for the indicators measured, and the self-measurement of achievements to date.

Learning Session 2

This session is designed to broaden the teams’ knowledge in the components of the Chronic Care Model, especially clinical information systems, service delivery design, evidence-based decision-making, and self-monitoring. The goal is to identify further activities that could be tested and to apply each component to facility’s situation. Teams learn to use the testing cycles to accelerate improvement. The measurement and reporting system is adjusted to strengthen the process. The teams draw up a plan to test new changes, attempting to incorporate additional elements of the Chronic Care Model.

The objectives of Learning Session 2 are:

1. To promote self-measurement of the implementation of Chronic Care Model
2. To describe specific changes in the clinical information system, the basis for decision-making, the redesign of the health service delivery system, and the support for self-monitoring that have proven successful and been implemented in the services.

3. To introduce the community component of the model
4. To include group presentations and collaboration in separate sessions
5. To describe ways to accelerate testing of the changes and improvements
6. To introduce the concept of information dissemination
7. To assist the team in drawing up plans for additional tests in the different components of the model
8. To strengthen the reporting methodology and solve particular problems with each team

Action Period 2

During Action Period 2, the teams continue perfecting their improvement plans. As in Action Period 1, they stay in contact with each other and consult the experts and leaders of the Collaborative.

Learning Session 3

The objectives of Learning Session 3 are:

1. To promote self-measurement of the implementation of Chronic Care Model
2. To make presentations on measurements of the improvements and the specific tests that contributed to the improvement
3. To identify presentations that provide a description of well-developed tests for the components of the model
4. To introduce the “organization of health care services” component of the model
5. To include as much collaboration as possible in the team presentations during the plenary session
6. To describe strategies for support and the dissemination of improvement activities
7. To assist to teams in developing plans for testing and implementing the components of the Chronic Care Model

Action Period 3

During Action Period 3, teams focus on instituting improvements in the health system, making a monthly effort to improve services. They continue gauging their success and can develop a tool for measuring the spread of the innovations throughout the health system. They will remain in contact with the experts and leaders of the Collaborative Project; however, the teams will have a more important role during this period.

Final Event

In the final event, the successful cases of the Collaborative are demonstrated. The achievements of all the teams are celebrated. The event is an opportunity to promote the Chronic Care Model. During the preparations for the event, the teams with the best performance are asked to present the work completed to date. Some are requested to describe the activities in only one component of the model, while others are requested to document the activities for all the components. Some teams will also take advantage of the event to publicize their results in the media.

ANNEXES

ANNEX 1 List of Tasks for Preliminary Activities

In preparation for Learning Session 1, each group should complete a series of tasks:

1- The **Planning Group** and the **National Leadership Team** should complete the tasks below:

- Prepare the Project Document and Declaration of Principles
- Select the participating health units–cases/controls
- Meet with local authorities and managers
- Prepare the Memorandums of Understanding for signature by the authorities
- Prepare the panel of experts to discuss the proposed Change Package
- Select the Local Coordinating Team
- Prepare the *Qualidiab* questionnaires for establishing the baseline
- Define the pilot population
- Administer the ACIC to the professionals in the participating health units (baseline)
- Create an e-mail list for the different groups and project teams (Planning Group, National Leadership Team, Local Coordinating Team, teams from the participating units)
- Develop the structure for Learning Session 1

2–The **Local Coordinating Group** should complete the tasks below:

- Read this Manual and all the documentation on the project
- Inform the selected units or services so that they can inform the Planning Group about project activities [Translator's note: This is a guess. Phrase doesn't make sense in Spanish]
- Support the organization of the meeting and participate in it with local authorities and managers
- Name the people in charge and provide orientation on administering the Qualidiab questionnaires
- Ensure that the local authorities and/or managers sign the Memorandums of Understanding
- Participate in the teleconferences and e-mail lists

3–Teams from the Participating Health Units should complete the tasks below:

- Read this Manual and other documents on the VIDA Collaborative Project
- Create the team in the health unit
- Sign the Memorandum of Understanding with PAHO and the Ministry of Health
- Participate in the e-mail lists
- Arrange for or request the necessary support for participating in Learning Session 1 (travel, per diem, etc)
- Define their pilot population
- Provide support for administering the questionnaires in their area
- Participate in the ACIC
- Prepare a poster on your experiences for LS1
- Select organizations (friendly ones) to participate in the project

ANNEX 2 Fact Sheet for Preliminary Activities

The purpose of this document is to facilitate the preliminary activities and assist in the planning of activities. During the meetings and teleconferences, it will help clear up any issues or problems that the teams encounter in carrying out their activities with the Local Coordinating Group (LCG). It is not necessary to return this sheet to the LCG.

1. General Information

Name of the Unit _____

2. Team Members

Unit leader _____

System leader _____

Clinical leader _____

Change leader _____

Other team members _____

3. Memorandum of Understanding Signed: () Yes () No

4. Project Documents Reviewed: () Yes () No

5. Choice/Selection of cases - Pilot Population: () Yes () No

6. Establishment of the Baseline: () Yes () No

7. Administration of the ACIC: () Yes () No

8. Potential Issues in connection with the Records:

9. List of Indicators for the Team:

Mandatory Indicators

- _ Fasting Glucose < 130
- _ HbA1c < 8.0%
- _ BP < 140/90 mm Hg
- _ LDL < 130 mg/dl
- _ Participation in patient support groups
- _ Foot examination at every consultation
- _ Counseling for smoking cessation

Optional Indicators

ANNEX 3. Strategies for Evaluating Results

1-Administration of the *VICEN panamericano* questionnaire

The *VICEN panamericano* questionnaire is an instrument that will facilitate the evaluation of the Project. The questionnaire contains three modules: Personal Data, Review of Files, and Economic Module (interview). It also has a Question-by-Question guide, which is included in this Annex.

Information will be obtained from patients aged 18 to 75 with type 1 or type 2 diabetes who have been seen at the health center for at least 1 year and have had at least one consultation with their physician during the past year.

In order to enroll the patient, he/she must first complete an **informed consent** form to participate in the project.

Study the proportion of patients who receive:

- Diabetes education
- An eye exam
- A foot exam
- Glucose monitoring or self-monitoring
- Annual lipid profile
- Blood pressure test

Study the proportion of patients with:

- Poor metabolic control
- Unsatisfactory lipid profile
- Overweight
- Hypertension
- Micro- and macroangiopathic complications

Study therapeutic practices followed with diabetic patients, such as nutrition counseling, physical activity, and drug therapy for controlling diabetes and its complications or associated risk factors, and their relation to metabolic control. Below are the indicators initially selected for the VIDA project in Mexico. In addition, Annex 4 contains a table with sample indicators and how to calculate them.

ANNEX 4 Sample Indicators for measuring Improvements in the Quality of Diabetes Care in Mexico

Indicator	Definition	Information source	Baseline	Goal
Glycemic control	< 126 mg of glucose	SISPA	34%	40%
Glycosylated hemoglobin	< 8%	Results of the lab test – VIDA		
Blood pressure	< 140/90 Hg mm	SISPA	40%	50%
Record of foot examination	Examination of skin, nails, temperature, pulses, and osteotendinous reflexes in the feet of diabetic patients.	CLINICAL FILE	0%	50%
Nondrug therapy record	Record of diet and physical activity.	CLINICAL FILE	40%	80%
Drug therapy record	Record of the drugs that this diabetic patient is taking.	CLINICAL FILE	90%	100%
Education of the diabetic patient	Awareness of information for controlling the disease	Questionnaire	Define	Define
Availability of drugs	Drug available for the diabetic patient in treatment	CLINICAL FILE	State Information	90%
Degree to which appointments are kept	Attendance	Attendance and DM Control Card	- Investigate - Sample	50% of what they have [TN: appointments made?]

2- Qualitative/Quantitative Assessment of Health Technologies **Assessment of Chronic Illness Care (ACIC), Version 3–Adapted to Spanish**

Explanation for completing the questionnaire:

This questionnaire should be filled out by a team of health workers that includes representatives of at least three health services—e.g., laboratory technician, dietitian, social worker, psychologist, doctor, or nurse. Each area has several components. Each component should be read and analyzed by the team so that a consensus is reached on a response. Each component has four levels: Level A represents the ideal level of care. Level D is the level at which the resources for diabetes care are nonexistent or extremely limited. Each level has a range of 0 to 11. The questionnaire should be marked to reflect the consensus of the group. It should be recalled that only one value per component should be marked in the level selected.

Area 1. Health System Organization. Diabetes management can be more effective if the health system is organized to ensure better monitoring of chronic diseases and their complications.

Components	Level D	Level C	Level B	Level A
<p>Organization and leadership for diabetes care</p> <p style="text-align: right;">Score</p>	<p>... nonexistent or there is little interest.</p> <p>0 1 2</p>	<p>... reflected in the health system's vision and the organization's plans, but resources are not available.</p> <p>3 4 5</p>	<p>... reflected at high administrative levels, and funding and human resources are allocated to the initiative.</p> <p>6 7 8</p>	<p>... part of the long-term strategy, they receive the necessary resources, and specific human resources are in charge of the initiative.</p> <p>9 10 11</p>
<p>Organizational goals for diabetes care</p> <p style="text-align: right;">Score</p>	<p>... nonexistent or limited.</p> <p>0 1 2</p>	<p>... exist but are not regularly reviewed.</p> <p>3 4 5</p>	<p>... exist and are regularly reviewed.</p> <p>6 7 8</p>	<p>... are quantifiable, systematically reviewed, and integrated into improvement plans.</p> <p>9 10 11</p>
<p>Improvement strategies for diabetes care</p> <p style="text-align: right;">Score</p>	<p>... are informal, disorganized, and lack permanent support.</p> <p>0 1 2</p>	<p>... use informal approaches to solve the problems that arise.</p> <p>3 4 5</p>	<p>... use improvement strategies to solve unanticipated problems.</p> <p>6 7 8</p>	<p>... include prevalidated strategies that are actively used to meet institutional targets.</p> <p>9 10 11</p>
<p>Incentives that include recognition for health workers and regulations for diabetes care</p> <p style="text-align: right;">Score</p>	<p>... are not used to influence clinical improvement targets.</p> <p>0 1 2</p>	<p>... are used to influence the use and cost of diabetes care.</p> <p>3 4 5</p>	<p>... are used to support patient goals.</p> <p>6 7 8</p>	<p>... are used to motivate and empower health workers so that they support the goals of diabetes care.</p> <p>9 10 11</p>
<p>Influential leaders with decision-making power in the health sector and other ministries</p> <p style="text-align: right;">Score</p>	<p>... do not promote diabetes care.</p> <p>0 1 2</p>	<p>... do not give priority to diabetes care.</p> <p>3 4 5</p>	<p>... promote efforts to improve diabetes care.</p> <p>6 7 8</p>	<p>... openly participate in the efforts to improve diabetes care.</p> <p>9 10 11</p>

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Benefits of educating patients for self-care of diabetes	... no promotion of patient self-care and changes in the health system.		... patient self-care and changes in the health system are neither promoted nor NOT promoted.			... patient self-care and changes in the health system are promoted.			... specific resources are allocated for the promotion of diabetes care.		
	Score	0 1 2	3 4 5	6 7 8	9 10 11						

Total score for health system organization: ____ Average score (score for health system organization/6) ____

Area 2: Community Cooperation: Cooperation between the health system, community agencies (or service providers), and community resources that play an important role in diabetes management.

Components	Level D	Level C	Level B	Level A
Availability of community resources for people with diabetes	... none, or they are not systematically organized.	... limited to a list of community resources on an accessible form.	... accomplished through an individual who is responsible for ensuring that health teams and people with diabetes use community resources to the fullest possible extent	... accomplished through active coordination between the health system, community service agencies, and people with diabetes.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Cooperation/coordination with community agencies such as the Diabetes Association, pharmaceutical houses, faith-based organizations, etc.	... nonexistent.	... still under consideration but has not been implemented.	... done to develop programs and support policies.	... actively sought to develop programs and support policies for the entire system.
Score	0 1 2	3 4 5	6 7 8	9 10 11

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Regional and/or Local Health Plans	... no coordination of clinical guidelines/ standards nor of health plans, measures, or resources for diabetes care in medical practice.	... consider to some degree the coordination of clinical guidelines/standards, standardized measures, or resources for care in medical practice, but the plans have not yet been executed.	... coordinate the use of medical guidelines/ standards, measures, or resources for care in medical practice for one or two chronic diseases concomitant with diabetes.	... coordinate the use of medical guidelines/standards, standardized measures, or resources in medical practice for the majority of chronic diseases.							
	0	1	2	3	4	5	6	7	8	9	10

Total score for community cooperation___ Average score (total score for community cooperation/3) _____

Level of practice: Several components seen in the practice of each health care provider have been shown to improve care for DM.

Area 3: Self-care of diabetes: Effective programs to support self-care among diabetics and their families, enabling them to adapt and accept the challenges of living with and managing diabetes and reducing its symptoms and complications

Components	Level D	Level C	Level B	Level A								
Evaluation and documentation of needs and activities for <u>self-care</u> of diabetes	... none	... expected.	...done in a standardized manner	... regularly evaluated and documented in a standardized manner, based on a treatment plan available to the health team and people with diabetes.								
Score	0	1	2	3	4	5	6	7	8	9	10	11

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<p>Support for diabetes self-care</p> <p align="right">Score</p>	<p>... limited to the distribution of information (pamphlets, brochures)</p> <p align="center">0 1 2</p>	<p>... available through referral to classes on self-care or counselors specializing in diabetes.</p> <p align="center">3 4 5</p>	<p>... provided by trained clinical educators appointed to support self-care and coordinated with the clinics that see these patients.</p> <p align="center">6 7 8</p>	<p>... offered by clinical educators trained to support patients with chronic diseases and to teach them problem-solving techniques.</p> <p align="center">9 10 11</p>
<p>Alleviation of the concerns of patients and their families</p> <p align="right">Score</p>	<p>... not systematic.</p> <p align="center">0 1 2</p>	<p>... provided for patients and family members through medical referrals.</p> <p align="center">3 4 5</p>	<p>... promoted through support groups or individual support and programs for educators.</p> <p align="center">6 7 8</p>	<p>... is an integral part of diabetes care that includes systematic routine evaluation, including support groups, individual support, and/or counseling programs.</p> <p align="center">9 10 11</p>
<p>Behavioral change and group support</p> <p align="right">Score</p>	<p>... none or unavailable.</p> <p align="center">0 1 2</p>	<p>... limited to the distribution of pamphlets, folders, brochures, and other types of written material</p> <p align="center">3 4 5</p>	<p>... available only through referrals to specialized centers.</p> <p align="center">6 7 8</p>	<p>... available and are an integral part of diabetes care.</p> <p align="center">9 10 11</p>

Total score for support for self-care of diabetes ___ Average score: (score for support for self-care/4) _____

Area 4: Standards of care of diabetes. Effective diabetes management ensures that the health team has access to evidence-based medical information for the care and support of people with diabetes. This includes medical evidence and clinical guidelines or protocols, consultations with specialists, education for the available health team, and information for the health team on effective treatments.

Components	Level D	Level C	Level B	Level A
Diabetes guidelines/standards based on medical evidence	... none or unavailable.	... exist but are not part of diabetes care.	... exist and are supported by education offered through teams of health workers.	... exist, support the health team, and are part of the care for people with diabetes through reminders and other methods to encourage changes in behavior.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Participation of <u>specialists</u> in the health system to improve <u>primary care</u> for diabetes	... offered primarily through traditional referrals.	... provided through specialists to improve the overall ability to implement the guidelines/standards for diabetes management.	... includes influential specialists, as well as others designated to provide training for the primary health care team.	... includes influential specialists and others designated to improve primary diabetes care.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Education for the <u>health team</u> on diabetes care	... sporadic..	... systematically provided through traditional methods.	... provided using optimal methods (e.g., accredited or certified courses).	... includes training for the entire health care team and includes the management of diabetic populations and support for self-care.
Score	0 1 2	3 4 5	6 7 8	9 10 11

COLLABORATIVE PROJECT

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Information on medical guidelines/ standards for people with diabetes	...no information is provided.		... provided on request or through publications.			... provided through specific educational materials for every clinical guideline /standard			... includes specific materials developed for patients that describe their role in adhering to and complying with guidelines/standards.			
Score	0	1	2	3	4	5	6	7	8	9	10	11

Total score for the design of the diabetes health care system: ___Average score (score for the design of the system /4) _____

Area 5: Technical support: The evidence suggests that effective management of DM care requires more than simply adding interventions to the current system, which is based on the care of acute illness. It could require changes in organizational practices that impact the delivery of care

Components	Level D	Level C	Level B	Level A								
Operations of the health team	... not addressed.	... addressed, assuming that individuals are available who have training in the key elements of diabetes care.	... guaranteed through periodic meetings of the team to discuss standards, functions, and problems in the management of DM care	... team meets regularly and members have clearly defined functions, including education, self-care, preventive monitoring, and coordination with other resources.								
Score	0	1	2	3	4	5	6	7	8	9	10	11
Leadership of the health team	... not recognized locally or by the system.	... recognized by the organization, which assigns it a specific place in the organizational chart.	... guaranteed by appointing a team leader, but his/her role in DM care is not defined	... a team leader is appointed who ensures that functions and responsibilities in DM care are clearly defined.								
Score	0	1	2	3	4	5	6	7	8	9	10	11

COLLABORATIVE PROJECT

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Appointment System	... can be used to schedule visits for preventive care or acute decompensations	... guarantees timely care for people with diabetes.	...is flexible and can include innovations such as personalized visits without a definite time frame or group visits.	... includes the organization of care, which enables patients to see several health care providers during a single visit.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Follow-up appointments	... scheduled by the patients or providers on a case-by-case basis.	... scheduled by the practice, adhering to guidelines/standards.	... guaranteed by the health team through patient monitoring	... based on patient needs; the intensity and methodology vary (telephone, personal,), and the use of guidelines/standards is guaranteed.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Floating visits or spontaneous visits by the patient	... none	... occasionally, permitted for complicated cases.	... are options for interested patients.	... permitted for all patients and include periodic check-ups, preventive interventions, and support for self-care
Score	0 1 2	3 4 5	6 7 8	9 10 11
Continuity in diabetes care	... is not a priority.	... depends on primary communication <u>in writing</u> among health care providers, specialists, and case managers.	... is a priority for health care providers, specialists and other providers but is not systematic.	... is a priority, and interventions for DM include active coordination among primary care, specialists, and other relevant groups.
Score	0 1 2	3 4 5	6 7 8	9 10 11

Total score for technical support in care: _____ Average score (score for technical support in care: /6) _____

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“Improving Care to Change Lives”

Area 6: Diabetes information system: One very important issue in diabetes care and programs is having timely and useful information on patients and patient populations with diabetes.

Components	Level D	Level C	Level B	Level A
Records (lists of people with diabetes)	... none	... include names, the diagnosis, and information on a contact person, either in <u>hard copy</u> or on the <u>computer</u>	... permit the classification of patients by clinical priorities.	... are linked to medical guidelines/standards, and issue reminders and alerts about the necessary services.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Reminders for the health team (e.g., reminders about an appointment with a nephrologist, the laboratory, an ophthalmologist, etc.)	... none.	... include general notices about diabetes care but do not describe the services needed at the time of the visit.	... necessary for groups of patients with diabetes through periodic notices.	... include specific information for the team about observing clinical guidelines/standards with respect to medical information.
Score	0 1 2	3 4 5	6 7 8	9 10 11
Feedback	...none or not specifically for the team of health workers.	... is provided infrequently and communicated in an impersonal manner.	... occurs at sufficiently frequent intervals to monitor its quality and is geared specifically to the health team that provides care for patients with diabetes.	... is timely, geared specifically to the health team, and is communicated systematically and in person by a leader to improve team performance.
Score	0 1 2	3 4 5	6 7 8	9 10 11

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Information about patient subgroups requiring special services <p align="right">Score</p>	... none. 0 1 2	... can be obtained only through special efforts or additional programming. 3 4 5	... can be obtained on request, but has not been systematically provided. 6 7 8	... is systematically provided to the team to help it provide the programmed assistance. 9 10 11
Treatment protocols and plans <p align="right">Score</p>	... are not expected to exist. 0 1 2	... are achieved through a standard approach. 3 4 5	... are established in a coordinated manner and include self-care as well as clinical goals. 6 7 8	... are established in a coordinated manner and include self-care and clinical care. Follow-up is provided that guides/regulates care. 9 10 11

Total score for information systems: ____ Average score (score for information systems /5) ____

Assessment of Diabetes Care (Modification of the ACIC, Version 3)

Summary of Scores (Takes the average scores of each of the previous sections)

Total Organization of Health System _____
Total Community Cooperation _____
Total Diabetes Self-care _____
Total Standards for Diabetes Care _____
Total Technical Support _____
Total Clinical Information System _____
Total Score of the Program in the Service/Unit (Sum of all scores) _____
Average Score of the Service/Unit (Previous Total /6) _____

ANNEX 5. Model Change Package

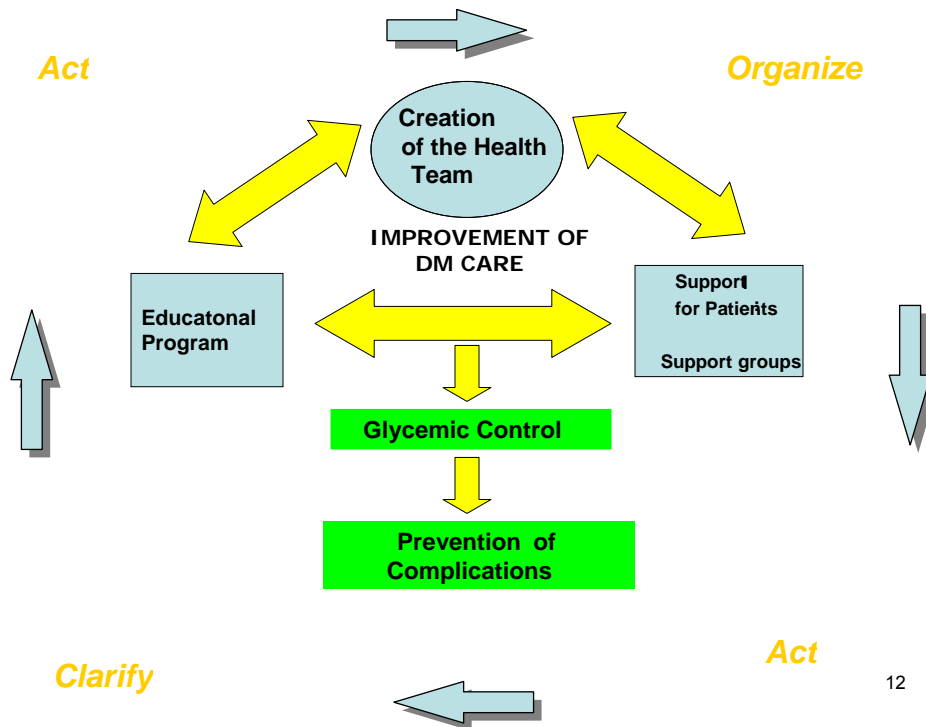
General Principles:

General Objective

- Improve the quality of life for people with diabetes by improving the quality of care.

Specific Objectives:

- Train health professionals in the prevention, detection, and control of diabetes and its complications
- Train all the patients in self-care and glycemic control
- Insofar as possible, achieve blood glucose control in all patients (fasting capillary glucose ≤ 126 mg/dl, HbA1c consistent with laboratory's normal range) to prevent or delay chronic complications.
- Provide emotional support for all patients and their families



Strategies

- Organize training for health care teams in the diagnosis and management of diabetes and its complications (feet, eyes, kidneys, cardiovascular)
- Train diabetes patient education coordinators at every health center
- Identify patients at greatest risk for chronic complications (weight, blood glucose, failure to take medication) to provide ongoing personalized care
- Follow with the regulations governing referral and counter-referral. Consult specialists in hard-to-manage cases
- Use Diagnostic and Treatment Guides based on international protocols or national standards
- Identify community resources for patient support
- Have all patients with DM in treatment join a support group
- Monitor the indicators of the QUALIDIAB system at the beginning and end of the project

Activities of the Change Package

a) PREVENTION OF COMPLICATIONS

- Negotiate therapy goals with the patient at each consultation (T)
- Ensure monthly check-ups for the patient
- Take blood pressure twice a month and suggest that patients, insofar as possible, monitor themselves at least once a week in the support group [Translator's note: The Spanish is ambiguous; it's not clear whether the suggestion should be made in the support group or the patients should self-monitor when they attend the support group]
- Order urinalyses (creatinine/proteinuria) and a lipid profile once a year
- Examine the feet during each consultation
- Refer patient to the second level for an eye examination with dilation once a year
- Observe and note lifestyle changes at each consultation (diet and physical activity) and invite and encourage patient to comply with the treatment

b) CREATION OF THE HEALTH CARE TEAM

- Hold monthly meetings of the basic groups in the health center to discuss patient care strategies
- Ensure that one or two patients are present at the meetings
- Name a secretary to note any agreements or commitments at the meetings
- Train the health care team
- Provide for consultations with specialists in hard-to-manage cases.

c) GLYCEMIC CONTROL

- From the time of the first consultation, negotiate with the patient and set treatment goals.
- At each consultation, review control goals with the patient, determine whether they were met, and note the causes and new strategies adopted to meet them.

d) CLINICAL PROTOCOLS - PATIENT CARE

- Prescribe accessible drugs (basic drug list) to patients
- Examine feet, kidneys, cardiovascular system, eyes, etc at every consultation
- Provide referral and counter-referral for patients who do not meet treatment objectives. (T)

e) SUPPORT FOR PATIENTS

- Encourage all patients and their families to participate in support groups
- Have professionals or interns from the areas of nutrition, physical education, psychology, podiatry, social work, and health promotion attend the meetings of the support group (T)
- Provide psychological support for patients and their families
- Hand out educational material to the patients
- Hold group consultations using the support groups. (M)

f) SURVEILLANCE AND INFORMATION HANDLING

- Ensure that entries in the clinical files clear and complete
- Document all activities of both the professional and support groups
- Support supervision and evaluate its results

ANNEX 6. Members of the Planning Group and National Leadership Team

PLANNING GROUP

NAME	FUNCTION	TELEPHONE and E-MAIL
Alberto Barceló	Principal Investigator	
Enrique Flores	Coordinator	
Elisabeth Cafiero	Project Officer	
Oscar Dias Dias	Endocrinologist	
Carlos Gurrola	Podiatrist	
Pablo Ashner		

NATIONAL LEADERSHIP TEAM

To be completed with the information on each country team

ANNEX 7. Proposed Agenda for Meeting with Local Authorities

AGENDA

- 08:30-08:45 Presentation of national and local authorities and the international team
- 08:45-09:15 Presentation of the project proposal and its methodology and objectives
- 09:15-10:00 Plan of Action, situation of health centers and priorities
- 10:00-10:30 Coffee break
- 10:30-11:00 Selection of medical intervention and control units from the units selected
- 11:00-11:30 Proposed participants in the Local Coordinating Group (names and addresses)
- 11:30-12:00 Structure of the Local Coordinating Group I (names, functions, and responsibilities)

ANNEX 8. Proposed Agenda for the Panel of Experts

Participants

Expected results

Creation of the Planning Group

Preparation of the Declaration of Principles

Construction of the Change Package (concepts and ideas)

Construction of the Assessment System

TENTATIVE AGENDA

09:00-09:20 Welcome and Introduction.

09:20-09:30 Presentation of the participants

09:30-10:00 Project on the quality of care for diabetes mellitus in the country

10:00-10:30 Project *Quality of Diabetes Care*, technical aspects. clinical information system.
Dr. Alberto Barceló, PAHO, Washington, D.C.

10:30-11:00 Discussion, questions, and answers

11:00-11:35 Strategies for improving the quality of care

11:35-12:05 Proposed Indicators for the project *Quality of Diabetes Care*.

12:05-13:05 Discussion

13:05-14:30 Luncheon

14:30-15:30 Continuation of the discussion

15:30-17:30 Summary and drafting of the Change Package.

ANNEX 9. Suggested Project Indicators

Indicator	Statistical calculation	Typical value	Proposed Goal
Glycosylated hemoglobin	Numerator: # of patients with recent HbA1c < 8.0% Denominator: # of patients in the pilot population	58%	75%
Blood pressure	Numerator: # of patients with recent blood pressure < 140/90 mm Hg Denominator: # of patients in the pilot population	64%	75%
LDL	Numerator: # of patients with recent LDL < 130 mg/dl Denominator: # of patients in the pilot population	70%	85%
Self-monitoring	Numerator: # of patients with self-monitoring objectives entered in the clinical file Denominator: # of patients in the pilot population	< 20%	> 70%
Smoking cessation program	Numerator: # of patients who attended the smoking cessation program during the project Denominator: # of patients in the pilot population who smoke	< 50%	> 90%
Use of ACE inhibitors	Numerator: # of patients with a prescription for ACE inhibitors Denominator: # of patients in the pilot population aged 55 or older	n/a	n/a
Blood pressure < 130/80mm Hg	Numerator: # of patients with recent blood pressure < 130/80 mm Hg Denominator: # of patients in the pilot population	n/a	n/a
Average HbA1c	Average value (using most recent value) for patients in the pilot population with at least one HbA1c reading in the past year	> 9.0	< 8.0
LDL < 100 mg/dl	Numerator: # of patients with most recent (within the past year) LDL < 100 mg/dl Denominator: # of patients in the pilot population	38%	50%
Use of aspirin, 100mg daily	Numerator: # of patients with prescription for daily aspirin 100mg Denominator: # of patients in the pilot population aged 30 and over	< 50%	> 80%
Examination of the fundus of the eye	Numerator: # of patients with documented results of fundus examination Denominator: # of patients in the pilot population	< 30%	> 70%
Examination of the feet	Numerator: # of patients with documented examination of the feet Denominator: # of patients in the pilot population	< 30%	> 90%
Microalbuminuria test	Numerator: # of patients with documented order for a microalbuminuria test Denominator: # of patients in the pilot population with normal creatinine and no neuropathy	42%%	> 50
Dental Examination	Numerator: # of patients with documented dental examination Denominator: # of patients in the pilot population	n/a	n/a
Psychological assessment	Numerator: # of patients with documented examination by a psychologist for the detection of depression Denominator: # of patients in the pilot population	n/a	n/a

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"Improving Care to Change Lives"

Indicator	Statistical calculation	Typical value	Goal proposal
Access	Average waiting period for an appointment [NOTE: Spanish has a typo here. "sita" should be "cita"]	n/a	n/a
Days of hospitalization	Total days of hospitalization per 100 patients in the pilot population	n/a	n/a
Patient or professional satisfaction with the care	Average index of satisfaction or percentage of high satisfaction in the interview or survey	n/a	n/a
Pharmaceutical costs	Average annual cost of drugs per patient in the pilot population	n/a	n/a
Primary care appointments	Average annual appointments per patient in the pilot population	n/a	n/a
Appointments with specialists	Average annual appointments per patient in the pilot population	n/a	n/a
Total medical cost per patient	Average annual cost of medical care per patient in the pilot population	n/a	n/a
Average sedentary lifestyle rate	Numerator: # of patients who do not engage in physical activity Denominator: # of patients in the pilot population	n/a	n/a
Participation in patient support groups	Numerator: # of patients who participate in patient support groups, documented Denominator: # of patients in the pilot population	n/a	n/a

ANNEX 10. Proposed Agenda for the Learning Sessions

Agenda. Learning Session 1 [LS1]

Participants: Define

Explanation:

Selected health units participated In Learning Session I (SA1). The health teams (physician, nurse, health promoter, and patient) of the centers selected for intervention should bring posters that reflect the diabetes care situation in their units.

The LS1 will consist of presentations by national and international experts that will address the different components of the Chronic Care Model, as well as working groups that will discuss the methodology of the intervention and the preparation of a plan of action.

TENTATIVE AGENDA

DAY ONE

- 09:00-09:20 Welcome and Introduction [General information about LS1].
- 09:20-10:00 Presentation on the Mission, Objectives, and Methodology of the VIDA project.
- 10:00-10:20 Presentation of the groups
- 10:20-11:00 Improving Diabetes Care: the *Change Package*. Dr. Alberto Barceló, PAHO-Washington, D.C.
- 11:00-12:00 Role of Education and Self-care in Diabetes Control.
- 12:30-13:00 Break to view posters
- 13:00-14:30 Discussion groups (by professional area):
 - **Clinical guidelines: Physicians**
 - **Education: Nurses**
 - **Self-care: Other professionals (Diabetic foot and Nutrition)**
 - **Support groups: Patients**
- 14:30-15:00 Presentation of Group Results.
- 15:00-15:30 Personal experiences: Living with Diabetes. TBD
- 15:30 Luncheon

DAY TWO

- 09:00-09:30 Diabetes situation in the country
- 09:30-10:30 Discussion groups: Diabetes Care Situation in the Intervention Localities
➤ By health care team: Diagnosis.
- 10:30-11:30 Discussion group: Identification of Community Resources.
➤ By health care team: Diagnosis.
- 11:30-12:00 Strategies for Improving Diabetes Care: Application of the National Standard
- 12:00-12:30 Break to view posters
- 12:30-14:00 Discussion groups: Establishing Improvement Plans
➤ By health care teams
- 14:00-14:40 Presentation of the Teams' Work
- 14:40-15:30 Closure: Commitments on Interventions for Improving Diabetes Care
- 15:30 - Luncheon

ANNEX 11. Agenda. Learning Session 2 [LS2]

DAY ONE

- 09:00-09:20 Welcome and general information on LS2.
- 09:20-09:50 Progress Report on the VIDA project. Dr. Alberto Barceló, PAHO-Washington, D.C.
- 09:50-10:10 Presentation on successful experiences (2 health centers).
- 10:10-10:30 Improving Diabetes Care: *VIDA Project Indicators and Change Packages*.
- 10:30-11:30 Course: Integrated Management of Diabetes Prevention and Control.
- 11:30-11:50 Break to view posters
- 11:50-13:00 Continuation of the course
- 13:00-14:00 Discussion Group 1 (by professional area):
- **Clinical Cases: Physicians**
 - **BP, BMI, Glucose Measurements: Nurses**
 - **Diet: Other professionals and patients**
- 14:00-15:00 Continuation of course
- 15:00-15:30 Referral and Counter-referral systems: Current situation and proposals for streamlining them.
- 15:30 Luncheon - Dynamic for the close of the day

DAY TWO

09:00-10:30 Results of the ACIC.

10:30-11:20 Discussion Group 3 (by health care team) [NOTE: There is no Discussion Group 2 here]
Dynamic: Changing Roles

11:20-11:50 Course: Diabetic Foot. Mr. Carlos Burrola, Podiatrist, Ministry of Health. Mexico, DF

11:50-12:10 Break to view posters

12:10-13:00 Continuation of course

13:00-13:50 Discussion Group 4 (by health care team)
Assessment of Action Period 1

13:50-14:00 What should take place in the next three months?

14:00-/15:00 Discussion Group 5 (by health care team)
➤ **Planning of Action Period 2**

15:00-15:30 Closure: Commitments for Improving Diabetes Care: Action Period 2.

15:30 Luncheon

ANNEX 12. Agenda. Learning Session 3 [LS3]

DAY ONE

09:00-09:20 Welcome and General Information on LS3.

09:20-09:30 Progress Report on the VIDA project. Dr. Alberto Barceló, PAHO-Wash/DC

09:30-10:20 Presentation on successful experiences (5 health centers).

10:20-11:40 Presentation: Tackling Obesity

11:40-12:10 Break to view posters

12:10-13:00 Dramatization (by the patients): Diabetic!! So what?

13:00-13:45 Discussion Group 1 (by specialty):
Problems achieving metabolic control in people with diabetes.

13:45-14:00 Presentation of group results

14:00-15:00 Discussion Group 2 (by Health Center)
Proposals for improving metabolic control in people with diabetes.

15:00-15:15 Presentation of group results

15:30 Luncheon

DAY TWO

08:45-09:40 Course: Acute Complications–

09:40-10:20 *Improving the Quality of Care: Quality Management Cycles.*

10:20 11:00 Discussion Group 3 (by health care team)

➤ ***Assessment of Action Period 2***

11:00-12:00 Support Group–*Successful Experience of a Community- and Patient-supported Initiative.*

12:00-12:30 Break to view posters

12:30-14:00 Course: Diabetic foot–Mr. Carlos Gurrola Togasi, Podiatrist

14:00-14:10 What should take place in the next three months?

14:10-15:00 Discussion Group 5

➤ ***Planning for Action Period 3***

15:00-15:30 Closure: Commitments for Improving Diabetes Care: Action Period 3.

15:30 Luncheon

ANNEX 13, FACILITATOR GUIDE: *Assessing the Action Period*

Each Group = Health Teams

Time: 40 min.

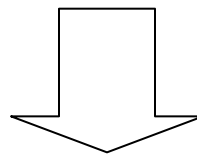
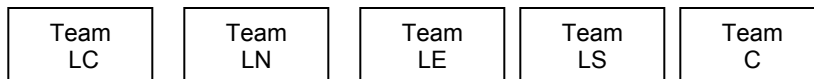
For Each Group:

Materials: Monthly Reports (Sept.-Dec.) for each team (reports of each team)

Change Package (copy for each participant)

2 Stands for flip charts/markers [Flip Chart 1 and Flip Chart 2]

Clock [Translator's note: There's not enough information to determine what the abbreviations in the figure below stand for]



Teams determine what changes they have made for the first component of the Change Package (5 min.).

Annotator writes changes on flip chart 1 (3 min.)

Component I

Discussion (5 min.) *Why isn't anyone working on some of the concepts of change?* When only one team has worked on the change, ask it to share its experiences.

Don't exceed the time limit. If are many the innovative ideas, problems, and aspects that the team wishes to discuss, then...

Ideas for change	Teams					
	1	2	3	4	5	6
.....						
.....						
.....						
.....						
.....						
Etc.						

...summarize the issues, barriers, and innovative ideas in Flip Chart 2, indicating the name of the component in the upper part. Begin a new page for each component. These will be discussed in Group Work sessions B and C

Repeat the process for each component. A similar matrix is prepared for each of the seven components (15 min./component) There should be 10 minutes at the end of the session for discussions or to make up lost time.

At the end of the session, there should be:

7 flip charts with the full matrix—to be summarized

7 flip charts with the issues, barriers, ideas to be discussed in the main session

ANNEX 14/ Commitment Sheet for the Action Period

COMMITMENTS MADE IN LS ____

HEALTH CENTER _____ Date _____

STRATEGY _____

COMMITMENT	GOAL	RESPONSIBLE PARTY

NAME AND SIGNATURE:

ANNEX 15. Model Monthly Report of Unit Leader

COMMITMENT/GOAL	ACTIVITIES	RESULTS

Comments can be made on a separate sheet or on the back of this form

NAME AND SIGNATURE: _____

Date: _____

ANNEX 16. Scale for Evaluating Collaborative Projects that Use the Chronic Care Model–CCM (Wagner)

Evaluation/Description	Definition
1.0 <i>Creating the team</i>	The team was organized; the target population was identified; the goals were defined; and work was begun on the baseline.
1.5 The plan for the project was initiated	The team is meeting, discussions are under way. Plans for the project have been drawn up.
2.0 Activities, but no changes	Team actively participating in development, research, and discussion, but changes not tested
2.5 Changes tested, but no improvement	Components of the model were tested but there has been no measurable improvement. Data on key measures are reported. The Wagner model was understood
3.0 Modest improvement	Initial testing of the cycles was completed and implementation of many components already under way. There is evidence of moderate improvement in process measures.
3.5 Improvement	Some improvements in outcome measures, process measures steadily improving. ODCA cycles tested for all components, changes implemented in many components of the model.
4.0 Significant improvement	Most components of the model implemented for the target population. There is evidence of sustainable improvement in outcome measures, around 50% of goals met. Plans are under way for expanding the improvements.
4.5 Sustainable improvement	Sustainable improvement in the majority of outcome measures, 75% of goals met, expansion to a wider population has begun
5.0 Excellent sustainable results	All components of the model were implemented, all goals were met, outcome measures were compiled for reference by the national level and expansion to other areas in progress.

ANNEX 17. Model Agenda for the Course/Workshop on Diabetes Education

Day One	Day Two
8:30 to 8:45 Registration	8:30 to 8:45 Group work All participants
8:45 to 9:00 Opening Session Chief of the Health District	8:45 to 9:00 Presentation on the Education Program for People with Type 2 Diabetes (PEDNID) Dr. Rosa Aurora Jiménez
9:00 to 9:15 Presentation of participants All participants	9:00 to 09:30 Unit 1 of PEDNID - General Information on DM All participants
9:15 to 10:45 Group work All participants	09:30 to 10:00 Unit 2 of PEDNID- Self-monitoring All participants
9:45 to 10:00 Presentation on program and course objectives. Dr. Rosa Aurora Jiménez	10:00 to 10:30 Unit 3 of PEDNID- Diet - 100-calorie portions All participants Dr. Rosa Aurora Jiménez
10:00 to 10:45 Overview of Support Groups Dr. Rosa Aurora Jiménez	10:30 to 11:00 Workshop 1 – Unit 3 of PEDNID- Diet All participants
10:45 to 11:00 Break	11:00 to 11:15 Break
11:00 to 11:45 Workshop on Support Groups All participants Organization and operation of support groups Dr. Rosa Aurora Jiménez	11:15 to 11:45 Workshop 2 – Unit 3 of PEDNID- Diet All participants
11:45 to 12:00 Results of support group assessment Dr. Rosa Aurora Jiménez	11:45 to 12:15 Unit 4 Difficult days All participants
12:00 to 1:00 Communication exercise All participants	12:15 to 1:00 Instruments used in assessomg PEDNID All participants Dr. Rosa Aurora Jiménez
1:00 to 2:20 Tool for communication on diet Dr. Rosa Aurora Jiménez	1:00 to 1:45 Exercise ¿ Why should we prevent complications? All participants Dr. Rosa Aurora Jiménez
2:20 to 2:30 Closing session for the day All participants	1:45 to 2:00 Commitments. All participants
	2:00 to 2:15 Close of the course. All participants
	2:15 to 2:30 Closure