

Table 1.3 Initial Team Plan for PDSA Cycles

Concept	PDSA Cycle #	Description of PDSA Cycle	Responsibility
A: Clinical Information System	A.1	Develop simple database in Access for diabetic patients. Download list of patients based on system codes for diabetics. Begin completing records during initial chart review.	Jones
	A.2	Develop method to put laboratory and visit data directly into the database.	Jones
	A.3	Test visit sheet printed from database with two physicians on the team.	Jones
B: Self-Management	B.1	Dr. Smith trial self-management goal setting process with five patients during next week.	Smith
	B.2	Test incorporating the self-management process into the diabetic visit flow sheet.	Smith
	B.3	Distribute information to diabetic patients on self-management.	Marshall
	B.4	Develop 2-hour session to educate staff and prepare for broader rollout of collaborative goal setting.	Marshall
	B.5	Schedule a documented encounter at least annually to promote patient identification of their appropriate self-management opportunities.	Rogers
C: Decision Support	C.1	Develop electronic prompts to communicate evidenced-based standards based on ADA guidelines.	Allen
	C.2	Recently established monthly QA review as part of the faculty meeting.	Allen
D: Delivery System Design	D.1	Test with two patients a letter to inform diabetics of the redesign of the diabetic care system. Requested them to schedule an appointment if they have not visited in the last six months.	Rogers
	D.2	Established a protocol for routine HbA1c measurements.	James
	D.3	Test a system for blood pressure documentation and tracking with protocols for identification and drug management.	James
	D.4	Develop an intervention program that advocates regular foot exams for all diabetics and protective foot care behaviors for diabetics with high-risk feet.	James

Exhibit 1.1 shows example of the documentation for one of the first PDSA Cycles completed. The team met over lunch every Friday during the next two months to work on the plan and study of the PDSA Cycles.

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**Study:** Three of the five patients left the visit with an agreed goal to be accomplished during the next month. Four of the five patients were appreciative of the opportunity and one patient was delighted with his involvement in setting a goal. Dr. Smith has some other ideas to modify the interviewing tool and for better incorporating the methods into the visit by modifying the visit flow sheet.

**Act:** Dr. Smith will continue to use the revised interviewing tool with all diabetic patients. Dr. James will try with one patient next week.

The team had an offsite meeting two months later to review progress on the project and make additional plans. They reviewed their aim and the run charts (Figure 1.8) of their two global measures related to the aim. They reviewed their progress on each of the components of the care model. For the next three months, they decided to concentrate on delivery system design and patient self-management. Table 1.4 shows some of the PDSA Cycles planned for continued testing and implementation of the changes.

**Table 1.4 Some Additional Plans for PDSA Cycles**

Concept	PDSA Cycle #	Description of PDSA Cycle	Responsibility
A: Clinical Information System	A.5	Test use of registry for follow-up phone calls by office staff, office initiated scheduling of visits with diabetics needing routine screening, and a reminder system for office-initiated patient notification of annual foot exams.	Jones
B: Self-Management	B.11	Update patient education material for use in clinic. Monitor patient satisfaction with education material and improved where appropriate.	Smith
	B.12	Worked with HMOs to make it possible for all patients to receive education regardless of health plan coverage.	Marshall
	B.13	Develop the concept of a clinical educator to lead self-management with providers, staff, and patients for all chronic diseases.	Marshall
C: Decision Support	C.8	Develop a set of decision support information (ASA, general guidelines to specialists, diabetes medication information and dietary recommendations) and made available in every examination room.	Allen
	C.9	Begin offering smoking cessation courses and document patient response to the offer.	Allen
	C.10	Test an annual meeting for the entire care team to assess their working relationships and make the appropriate improvements to maximize cooperation and the application of the best clinical expertise.	Allen
D: Delivery System Design	D.7	Develop prewritten prescriptions for glucometers and medical shoes to aid in the wording requirements for Medicare reimbursement.	James

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