**Analysis plan in Patient Support Groups (PSG):**

***To understand Patient’s improvement on self-management care (behavioral risk factors) -***

The base line data of self-management taken from elements of self-management care through self-assessment form during SALT visits to patient will be cross checked against self-assessment exercises happening after action plan development of patients’ respective groups. In each self-assessment exercise meeting patients will assess themselves periodically upon following self-management parameters through self-management assessment form.

1. Treatment adherence, instead of saying defaulter
2. Food regulation
3. Physical activity
4. Prevent injuries and care of any previous injuries for diabetes
5. Regular testing
6. Complication prevention and managements
7. Tobacco cessation
8. Alcohol cessation

Further the data could be cross checked and analyzed comparing the change in percentage of adherence for each parameter for all the patients who responded. We could also try to corroborate the treatment outcome of patients by corelating the clinical parameters recorded in the patient pass book to see the possible effect of PSG.

***To understand improvement in other members of group -***

Other members of PSG will also assess themselves on the action plan they would make to reach their respective dreams in order to make an enabling environment for our patients for better self-management care. The group will mark themselves on where they were and where they are now in order to achieve their dream of creating an enabling environment for our patient through a self-assessment tool built based on their dream. Further the groups will assess themselves periodically on the action plan developed to achieve their dream. The improvement across the groups could be reported on the 5-point rating scale.

**Table 1: Self-assessment tool for Hypertension and Diabetes Patients**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Item** | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| 1. I take my medication regularly | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I take food as per doctor’s advice/as required to take in my condition | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I do 30 minutes of physical exercise | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-19 days in a month | 20 days and more in a month |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I go to doctor for regular check up   *This indicator should be evaluated considering the First assessment and final assessment of the project* | Has gone only once to doctor, namely for registration | Visited twice or thrice the doctor or facility for the scheduled follow up in the last 1 year | Visited four or five times the doctor or facility for the scheduled follow up in the last 1 year | Visited six or seven times the doctor or facility for the scheduled follow up in the last one-year period | Visited eight or more times to the doctor or facility for the scheduled follow up in the 1-year period |
| *(If one year has not been completed since the patient enrolled in the program, ask till the time of recording this information how many times has he/she visited to the doctor and record the number in appropriate category)* |  |  |  |  |  |
| 1. I manage my current complication *(this should be asked only if respondent has any complication)* | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I make efforts to avoid any complication | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I take alcohol | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category))* |  |  |  |  |  |
| 1. I smoke/ or take tobacco in any form | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |
| 1. I prevent injuries and take care of my previous injuries (only for diabetics) | 0 days in a month | 1-4 days in a month | 5-10 days in a month | 11-29 days in a month (considering 30 days in a month) | 30 days in a month as per advice (considering 30 days in a month) |
| *(Ask how many times and record the number told by respondent in appropriate category)* |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Output Indicators** | **The First Assessment would give the answer to: Where we Are? while the subsequent would answer: Where we Reached?** | | | | | | | | | |
| **Sn.** | ***Source of information :*** *Periodic Report of Self-assessment tool of patients in group meetings (on elements of Self-management care)* |  | | | | | | | | | |
|  |  | **Never** | | **Rarely** | | **Sometimes** | | **Often** | | **Always** | |
|  | Status/improvement of patients on Self-management care | **N\*** | **%\*** | **N\*** | **%\*** | **N\*** | **%\*** | **N\*** | **%\*** | **N\*** | **%\*** |
| 1 | **Treatment adherence** - Patients Taking medication regularly |  |  |  |  |  |  |  |  |  |  |
| 2 | **Food regulation** – Patients taking food as per the doctor’s advice/ as required to take in my condition |  |  |  |  |  |  |  |  |  |  |
| 3 | **Physical activity** – Patients doing 30 minutes of physical exercise 5 days a week |  |  |  |  |  |  |  |  |  |  |
| 4 | **Patients preventing injuries and care of any previous injuries** for diabetes |  |  |  |  |  |  |  |  |  |  |
| 5 | **Regular or Defaulter** – Patients going for scheduled follow up check-ups and testing |  |  |  |  |  |  |  |  |  |  |
| 6 | **Complication prevention**– Patients preventing any complication |  |  |  |  |  |  |  |  |  |  |
| 7 | **Complication managements** – Patients managing current complication |  |  |  |  |  |  |  |  |  |  |
| 8 | **Patients taking Alcohol** |  |  |  |  |  |  |  |  |  |  |
| 9 | **Patients smoking or taking tobacco in any form** |  |  |  |  |  |  |  |  |  |  |

**N\* - Response of Number of patients among total available patients during assessment or meetings**

**%\* - Response of Number of patients among total available patients during assessment or meetings/ total available patients during assessment or meetings\* 100**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sn.** | **Output Indicators** | **Source** | **Data** |
| **1** | **Number of groups (response is mainly from group members other than patients) marked themselves improved to make an enabling environment for patients to better manage hypertension and diabetes** | *Periodic Self-assessment data of PSG members* (other than patients) |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sn** | **Outcome Indicators** | **First year Assessment** | | **Second year Assessment** | |
|  | ***Source of information:*** *– Data of PSG patients could be culled out from Ward After Event Reflections and Action Plans* |  | |  | |
|  |  | **N\*\*** | **%\*\*** | **N\*\*** | **%\*\*** |
| **1** | **Patients having test values under control who are enrolled under PSGs** |  |  |  |  |

**N\*\* - Total Number of patients Under PSG having controlled values for their last recordings.**

**%\*\* - Total Number of patients Under PSG having controlled values for their last recordings/Total available patients during assessment or meetings\* 100**