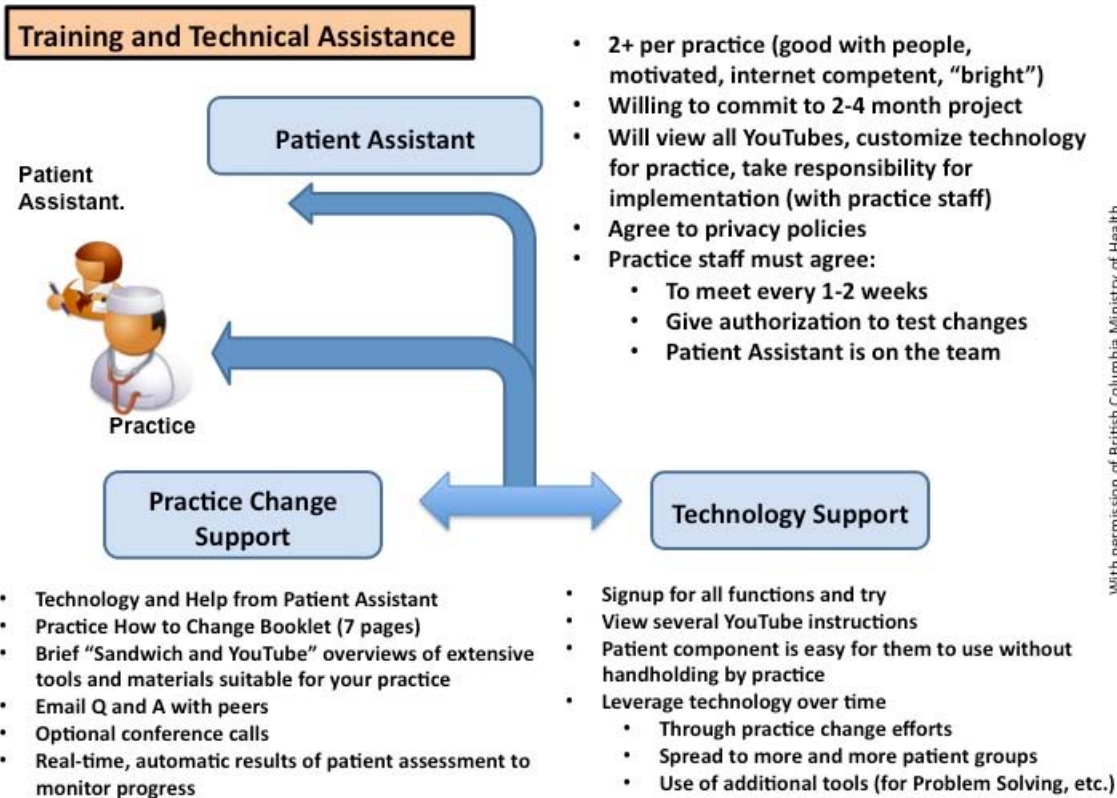
PATIENT AS ADVISOR/COACH
FOR PRACTICE IMPROVEMENT

The patient advisor idea builds on these facts:

- almost all physicians who have been in practice a while know of patients who have very high skills in areas such as technology, dealing with others, dealing with challenging health or social conditions, teaching, etc.
- "aging boomers" are entering retirement or partial retirement. Many have both interest and time to offer help to the community or other patients.
- when a physician is asked to create a time-limited, physician-patient partnership to implement the very brief Ideal Medical Home curriculum it changes faster.
- once this partnership implements the interaction technology the patient and physician may uncover new areas in which other patients can be involved.
- an overworked office staff and physician can continue to make progress because the patient advisor can help support changes.

In short, a positive feedback cycle is created into which patient experiences and skills can enhance and/or supplement skills of the office without requiring more staff time.



Notes from the first cohort of patient advisor/coaches from British Columbia.

The comments were:

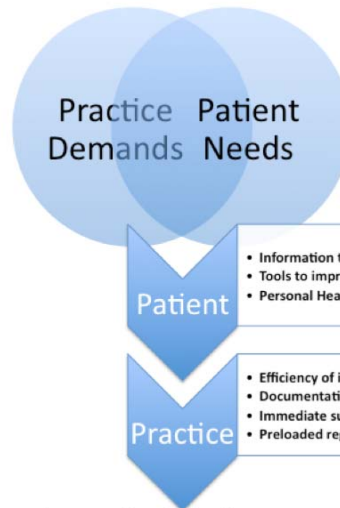
" 1) Advisor/coach able to assess how well the HYH survey questions reflect practice population concerns
2) Ability to customize the questionnaire could be leveraged to ensure questions are relevant to practice population and for the community
3) Patient advisor/coach could assist with design of open-ended questions
4) Patient advisor/coach felt the work along side the practice helped them to understand practice challenges
5) Advisor/coach felt the work along side their physician helped them to build a stronger and improved relationship with their physician and Medical Office Assistant
6) Advisor/coach able to consider some of the challenges to patients in completing HYH and suggest ways to reach out to patients to assist in attracting them to complete HYH (email, letters, bulletin board notices, calls...)
7) Advisor/coach could assist with data review - some able to navigate excel and work with graphs etc"

User Guide #1

To Get Started you must read this.

1. Set aside 10 minute blocks (over lunch) to familiarize yourself with “curriculum” resources by watching the YouTubes.
2. Review relevant articles described on page 2.
3. Key Homework: HowsYourhealth. Consider Staff Survey, CARE Vital, Your Efficiency

Patients as Partners



With interactive technology patients do the “work” to meet their needs and reduce practice demands

- Information tailored to need
- Tools to improve self care
- Personal Health Record and SAFE

- Efficiency of informed patient
- Documentation for quality and billing
- Immediate summary data for practice improvement
- Preloaded registry for population management

Improve Population Awareness, Patient Confidence and Desirable Consequences

HowsYourHealth

This technology enables patients and health professionals to maximize patient communication and confidence and practice quality.

Effective Design

Segmenting care based on behaviorally proved methods makes practice efficient , effective and enjoyable. Aim for high reliability in all care.

Resources and “Curriculum”

Many practices have distilled the best slides, stories, and methods. Here they are, all packaged for your use. Watch the You Tubes for an overview.

HowsYourHealth: Move Your Practice and Patients to the Web

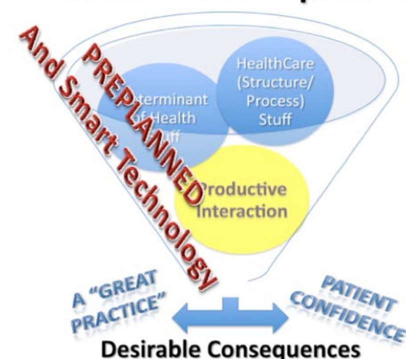
Practices gain efficiencies today even if many of your patients are not yet using the web

The first step after registering at www.idealmedicalhome.org is to review the use of www.howsyourhealth.org and customize it using your user name and password. Decide if you wish your patients to email their results to you…if yes, set up a private email address.

Ask patients to complete HowsYourHealth every year or two before an office visit and bring or email their information to the practice.

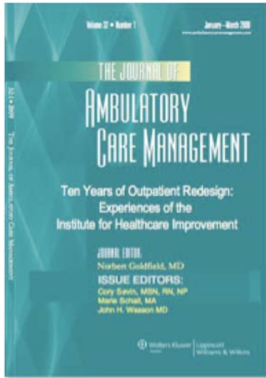
You will discover that most patients report important issues of which you have not been aware. You will also learn that HowsYourHealth provides easy-to-use tools to help you and your patients deal with issues such as the need for behavioral change/ improved confidence (use Problem Solving), fragmented care and miscommunication (use the Personal Health Record), or poor understanding (reinforce the information already tailored to the patient’s needs).

Smart Technology is Critical for Desirable Consequences



You can use the registry in HowsYourHealth to identify and plan management for groups of patients: those with low or high confidence, pain, emotional problems, etc.

HowsYourHealth is just a set of tools. You must learn how to use them to design and build an efficient, effective practice. The next page focuses on that topic.



Article	Theme	"Take-home"
"Making high-quality, patient-centered care a reality"	For practices large and small, much has been learned through the experiences of Institute for Healthcare Improvement and others	Five lessons for office practice improvement
"Making patient-centered care reliable"	Reliability principles underlay all high-quality activities of patient care	The 3-tiered process for building reliability
"Activation of patients for successful self-management"	Collaborative care and improved patient outcomes depend on patient self-management	Tools and methods for patient activation. Practice changes to incorporate patient activation
"Optimizing the care team"	For many practices, a care team is needed to provide the best possible care. The challenge is to make the team processes reliable and patient-centered	Attributes of highly functional care teams and how to implement and measure these attributes in practice
"Accessing patient-centered care using the advanced access model"	Advanced access is of high value to patients and improves office efficiency	Six high leverage changes for advanced access. Case examples show systemwide improvement
"Balanced measures for patient-centered care"	Balanced measurement is feasible in busy office practices and critical for improvement	Patient-reported measures that are actionable offer many benefits at little cost. Brief baseline measures for patients. Brief baseline measures for office staff
"CARE vital signs"	For visual learners or time-constrained practitioners, "CARE vital" signs offers an easy way to plan patient-centered care for every patient	Adolescent, adult, and geriatric examples that illustrate C = Check for what matters A = Action as planned R = Reinforcement for impact E = Engineer for many

http://journals.lww.com/ambulatorycaremanagement/toc/2009/01000

Effective Practice Design

Primary care practices are generally so busy that the concept of change is painful to contemplate and difficult to accomplish. Fortunately, other practices have found that a few approaches are really "high leverage." This User Guide emphasizes the best.

For specific discussion review the content of the Journal of Ambulatory Care Management

The articles listed above are based on a decade of experience in designing effective primary care practices. Most of the concepts in the stories and articles are self-evident though some – such as "reliability"- take some getting used to.

• Making high quality patient centered care a reality gives five basic lessons for practice improvement.

• KEY ARTICLE: Making patient centered care reliable describes a 3-tiered process for building reliability. This enables practices to make the most durable and effective choices for change.

• Activation of patients for self-management provides many tools and examples.

• Optimizing the care team describes the attributes of highly functional teams. (Combine the concepts to the results you have gotten from the Staff Survey)

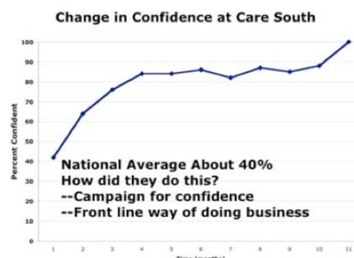
• Accessing patient centered care provides the necessary tips and techniques for providing advanced access.

• Balanced measures describes the use of the measures recommended as part of Patients as Partners, BC

• KEY ARTICLE: Finally, CARE Vital Signs is down-to-earth method for making a difference for patients now and seeing how your practice might make care much more effective. When the insights from CARE Vital Signs are combined with the efficiency and comprehensiveness of HowsYourHealth, a practice can make dramatic progress in a very short time.

Take time to familiarize yourself with the articles by using the address shown above or going to your practice page on www.idealmedicalhome.org and choosing the link for "journal review" under the "curriculum".

Generic CARE Principles



Wasson JH, Baker NJ. Balanced Measures for Patient-Centered Care. Jamb Care Mngmnt. 2009;32: 44-51.

1. Segmentation of patients into meaningful categories for which specific actions are routinely prescribed. (Low, Medium, High Need, for example)
2. Problem-Solving and Action Planning as techniques to identify key issues of concern and simple, feasible strategies to begin addressing these issues.
3. Brief, Repetitive Intervention rather than overwhelming, one-time exhortation.
4. Confidence-Building so that patients become comfortable and adept at self-management.

Despite its low educated patient population, Care South Carolina has been able to use the a few effective redesign principles to attain great results. The principles are listed to the left .

The Curriculum is Designed for Distance Learning and Busy Learners

- Brief "U-Tubes" for overview of each session
- One-click downloads of PDFs
- Easy-to-use conference calls from anywhere
- E-mail list-serve to communicate with peers
- "Plug and Play" technology to maximize efficiency, effectiveness, patient-centeredness of practice and support of patients

The Institute for the ideal medical HOME

A Challenge An Opportunity A Solution

Curriculum

CURRICULUM ELEMENT	PHYSICIAN WILL UNDERSTAND...	PHYSICIAN WILL BE ABLE TO...	LINK
Prework (One Hour)	How to Find Breathing Room;Office Function and Patient Experience Compared to Peers	Assess Patient-centeredness and Workforce Function in the Practice; Keep Track of Progress	Prework
1:1 Patient At the Center (One Hour)	How Patient-Centered Care Enhances Practice Efficiency and Effectiveness	Use Baseline Data to Identify Opportunities to Improve Patient-Centered Care	Comparisons and IMH Criteria
1:2 Ten Slides to Transform Practice (One Hour)	Previous Successful Methods for Practice Transformation and CARE Vital Signs	Use CARE Vital Signs, Problem Solving and PDSA to Improve Care	CVS and Problem-Solving Toolkit
2:1 Reliability and Patient-Centeredness (One Hour)	Their Practice Experiences Using CARE Vital as a Tool for Reliability	Identify Methods to Make the Practice More Reliable	Self-Management Support and Decision-Making Toolkits
2:2 Efficiency and Access (One Hour)	Practice Experiences with Efficiency and Access	Describe and Implement Methods to Improve Access and Efficiency in the Practice	The Access, Efficiency Toolkit
3:1 Team Building and Adding Value (1) (One Hour)	How the Practice Can Use Insights from Activities to Date to Improve Care	Conveniently Fit Elements of the Chronic Care Model into a Workable Plan of Care for the Patient and Practice	
3:2 Technology (One Hour)	How to Take Advantage of Inexpensive Technologies	Determine How to Choose and Use Technologies	Technology Update
4:1 Planning Care to Improve Equity, Safety and Value (2) [illegible]	Variation in Practice Patterns of Care	Use Care Planning, Evidence and Sensible Referrals to Reduce Variation	Specialty Use Survey; Care [illegible]
4:2 Review of Progress and Medical [illegible]	The Changes and Concepts that Seem [illegible] Continue to Share Experiences with [illegible]	Define Areas in Which the Practice Still Needs to Make Progress [illegible]	Progress Report

Brief You Tubes (over lunch) enable practices to scan for ideas and tools contained the Curriculum.

In our experience, adult learners in practices have no desire to learn new languages. Unfortunately, the language of practice design contains a lot of jargon.

As an example consider the slide at the right. In summarizes the key concepts for improving office efficiency. The advantage of the slide is that it is concise and covers all the key points. But a busy clinician will want to know what the terms mean.

The curriculum is the reference that "backs up" the slide. It makes available materials from many sources that have been found necessary or very useful by previous adult learners from busy office practices. The curriculum translates the jargon.

Each practice must find the redesign methods and tools most suitable for its patients and setting. However, the "main road" to the best care possible will require most practices to:

- Use new technologies such as the family of HowsYourHealth tools
- Segment care based on behaviorally proved methods
- Aim for high reliability in any change
- Whenever possible, share insights with peers (with list serves or conference calls) and steal from them too!!!

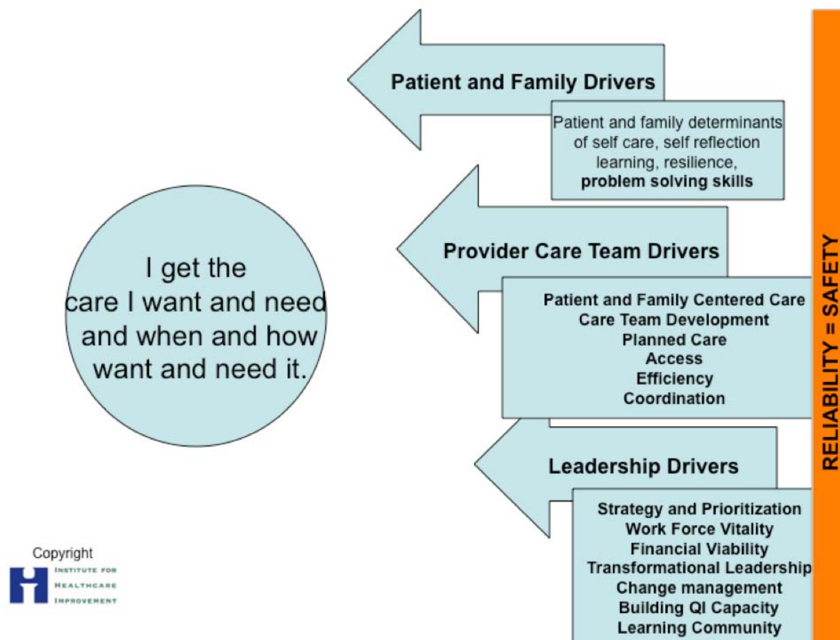
Key Concepts for Improving Efficiency

Baseline surveys, walk through, "know your processes" and cycle time diagnostics

- Use continuous flow: streamline key processes – e.g. prescription refills
- Optimize rooms & equipment: co-locate equipment
- Manage your bottlenecks: detailed cycle time analysis
- Standardize work, rooms, equipment, procedures
- Anticipate patient needs at appt: huddle agenda
- Optimize the care team: interruption analysis
- Synchronize pt, provider, info: Start AM & PM appts on time, HowsYourHealth tools

Copyright INSTITUTE FOR HEALTHCARE IMPROVEMENT

If you are on calls please have this material in hand so that you and your colleagues are speaking the same language and working from the same blueprint for change.

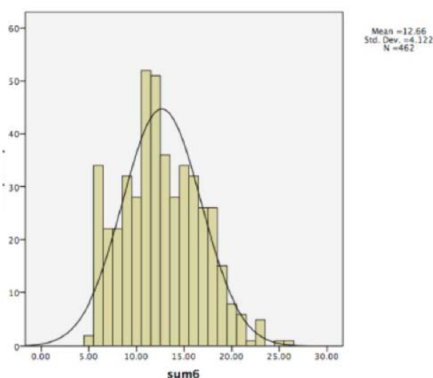


This driver diagram reminds us of all the ways a practice can give patients exactly the care they want and need. We emphasize Efficiency (previous page) and teamness (with a touch of review of other "drivers") because these approaches seem the best way for most practices to begin. It also fits nicely with THE CHRONIC CARE MODEL.

Optimizing the Care Team

- Define aims and goals; review performance regularly
- Define panel and assure continuity
- Assess and continuously improve processes
- Define and optimize tasks and roles
  - Training and cross training
  - Staff work to highest level of training.
- Establish regular and just-in-time communication processes
  - Meetings, huddles
  - Norms of mutual respect, value, sharing, positive attitude
  - Conflict resolution

Efficiency and "teamness" are "common sense" concepts. The devil is in the doing. We will share how some practices are attaining high efficacy and teamness.



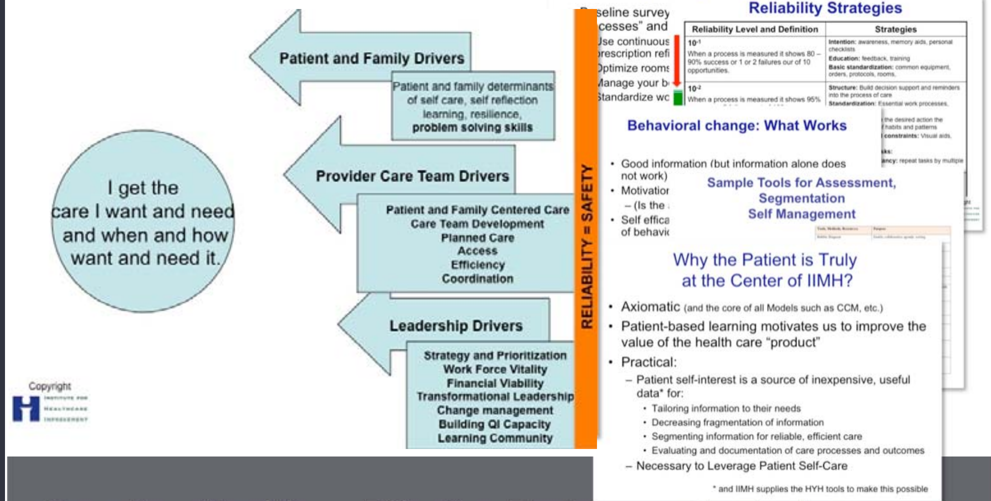
The baseline staff survey (sample of results on left) is a good way to see how well a team is functioning. Patients can tell the difference too.

User Guide #2

1. Use data from HowsYourHealth to target needed changes.
2. Use curriculum resources and ideas from staff and colleagues to support PDSA of these changes.
3. Add more custom options or tools from HowsYourHealth to automate useful changes.

Patients as Partners

These Pieces Should Seem Familiar



HowsYourHealth

This technology enables patients and health professionals to maximize patient communication and confidence and practice quality.

Effective Design

Segmenting care based on behaviorally proved methods makes practice efficient , effective and enjoyable. Aim for high reliability in all care.

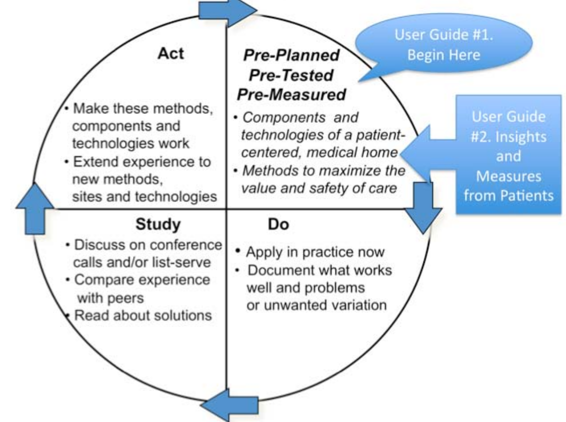
Curriculum

Many practices have distilled the best slides, stories, and methods. Here they are, all packaged for your use.

Choosing from a Collage of Practice Design Principles

By now practices understand the fundamentals of Collaborative Learning, HowsYourHealth, Effective Design, and the Curriculum

Begin with HowsYourHealth and Curriculum and then Use Insights From Patients to Continuously Improve



The IIMH is designed for adult learners who already know how to select information, methods and tools that may be best for their practice.

After viewing the You Tubes the pieces of the "practice design collage" (shown above) should be familiar. By now, practice should be understand how to use: 6 item staff survey, CARE Vital Signs, HowsyourHealth Registry, Campaign for Confidence, Referral Management forms, and Know Your Processes.

How does a practice put the design principles into practice?

The content of User Guide #1 gets practices started with pre-planned, pre-tested, and pre-measured approaches This User Guide #2 emphasizes the need to take advantage ongoing insights and measures from patients to continuously improve care.

After 30 HowsYourHealth responses your practice will have a pretty good idea about how it is doing in broad areas such as access, efficiency, continuity, coordination of care with specialists.

As the numbers of HowsYourHealth users increase the practice will be able to examine more focused issues such as the delivery of preventive services to older women of the care of chronic diseases.

A Key Principle to Understand and Test Explicitly Manage (Resource Plan) Care

CARESOUTH CAROLINA
HELP US BETTER MEET YOUR NEEDS

Please help us better meet your needs by answering these questions as honestly and completely as you can. All replies are confidential and will be reviewed only by your primary care team. Our aim is to work with you and develop a plan of care that meets your needs and will improve your health.

1. In the past four weeks, how much bodily pain have you had?
   __ No Pain ___ Very Mild Pain ___ Moderate Pain
   __Severe Pain
2. In the past four week, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted or "blue?"
   __ Not at all ___ Slightly ___ Moderately ___ Quite a bit
   ___ Extremely
3. In the past four weeks, was someone available to help you if you needed and wanted help? For example, if you felt nervous, lonely, needed help with chores, got sick and had to stay in bed, needed someone to talk to, needed help just taking care of yourself?
   ____ Yes, as much as I wanted ___ Yes, quite a bit
   ____ Yes, some ____ Yes, a little ____ No, not at all
4. Do you have enough money to buy the essentials (such as food, clothing, housing?)
   _____ Yes, always ____ Sometimes _____ No
5. Does not having enough money prevent you from going to the doctor or getting medicines?
   _____ Yes, Always ____ Sometimes ____ No
6. How confident are you that you can manage or control most of your health problems?
   ____ Very confident ____ Somewhat confident
   ____Not confident _____ I have no health problems

Name__________________________ Date__________

CARE Vital Signs

Development of a Shared Care Plan
And
Determination of Resource Allocations Based on the Plan

The Shared Care Plan is to be a plan, collaboratively evolved between the patient and the primary care team, that will be used to determine a plan of care based on the patient's needs.

The Shared Care Plan will begin with an assessment. This assessment will have two aspects: clinical and patient centered. The Clinical Assessment will encompass those evidence based processes and procedures according to the patient's age, sex, and medical condition(s). This assessment will be a report generated by the PECS registry which will delineate all issues and needs related to chronic conditions and prevention.

The Patient Centered Assessment will be a questionnaire administered to the patient, determining their needs as related to pain management, socio-economic, psychosocial and confidence.

Once these Assessments have been completed, a Plan of Care will be collaboratively developed with the patient. The Plan of Care will determine resources to be allocated. The resources to be considered:

- Provider
- Nursing
- Care Manager
- Outreach Worker
- Behavioral Health Counselor
- Referral including Alcohol and Drug, specialty medical, dental, etc.

Level 1 (Low Needs):

- Provider: 1 – 2 visits annually

Planning

- Nursi… , prevention screen…
- Care Manager: 1 – 2 contacts annually for self management goal setting
- Outreach Worker: 0 visits
- Behavioral Health Counselor: 0 visits
- Referral including Alcohol and Drug, specialty medical, dental, etc

Level 2 (Moderate Needs)

- Provider 3-4 visits annually (waive CSC co-pay for all visits except 2 when warranted)
- Nursing: 3-4 visits annually for group
- Care Manager: 3-4 visits contacts for follow up and SMS with additional focus on education
- Outreach Worker: 1-2 contacts for follow-up, additional support
- Behavioral Health Counselor: 1-2 visits annually
- Referral including Alcohol and Drug, specialty medical, dental, etc.

Level 3 (High Needs)

- Provider: 5-12 visits annually (waive CSC co-pay for all visits except 2 when warranted)
- Nurse: 5 -12 visits annually for education, group visits
- Care Manager: 5-12 contacts annually for SMG, education, group visits
- Outreach Worker: 3-6 contacts for follow up
- Referral

By Segment

For Effective Design

As patient report becomes central the practice finds that it is very effective and efficient to reliably design care for common, repetitive problems. Build in to the design some behaviorally smart principles and everyone wins. CARE Vital Signs illustrated how to understand this concept.

For specific discussion review the CARE Vital Sign article in the Journal of Ambulatory Care Management and You Tube #8

Practice improvement can seem too daunting even when the practice recognizes that current care patterns are counterproductive.

Despite this barrier many practices are regularly making desirable changes by leveraging the HowsYourHealth technology and applying the principles described in these two User Guides.

• segment patients into behaviorally sophisticated groups (such as patient confidence with self-management).

• plan the care for those segments… literally script out what should be done to minimize unwanted variation (see the example of the Care South "Thermometer").

• Recognize that small repetitive interventions are more "doable" and effective than the typical approach of overwhelming the patient and overloading the practice staff.

• PDSA and share with and learn from others

Key Questions in a PDSA

- What are the change/improvement options identified by patient report and other sources?
- What are the priorities among these?
- Processes to secure reliable (standard) implementation of a change for a priority? Who, when and how to run the test of change
- Process improved? How do we know? How to sustain?
- If failed, why?

CareSouth Carolina, SC
High Blood Pressure and Diabetes (sugar)
Patient Education Thermometers

Date: ____/____/____

Hello:______________

Today your blood pressure is:

Emergency
Danger
Not There Yet
Getting Closer

We Now Have "Cool Tools" To Support Confidence

But How Do We Fit Them Into EverydayWork?

Health concerns of older adults

Here are some things older adults have told us they think about. Maybe some of these things concern you. You may add your concerns in the empty bubbles. Would you like to talk today about the one that matters to you the most? Would you like to make a change in one of them?

Medications
Preventing falls
Staying independent
Memory
Healthy eating
Anger
Exercise
Managing pain
Managing stress

Activation of Patients for Successful Self Management JACM 32;1:14-21. 2009

This is how we keep track of your diabetes (just like blood pressure for hypertension). It is important that we get this number **under 6.0** if possible. It should be checked **every 3 months.** The closer to 6.0 your number is the less chance of **blindness, stroke, heart, or kidney problems, or damage to your nerves (causing chronic pain).** **Please ask how we can work together to help you to reach this goal.** ***Thanks for bringing all your medications to your doctor appointments***

Not Good
Need Some Work
Getting Close!
Very Good

#1: Everyone Has Problems

Problems are part of living. Some problems are more im… than others.

A problem may be how you manage schoolwork, work, … manage and control problems is stressful, bad for health…

Good Problem-Solving is useful now. Good Problem-So… problems arise. If you want more information about prob…

These next 10 screens will help you think about a proble… backwards and forwards at any time to change what you…

1 Next>>

© 2003-2008 FNX Corporation and Trustees of Dartmouth Co… All Rights Reserved.

HowsYourHealth

DecisionsInTheGrey.org

Health Decisions at Any Age Can Be Difficult

- ***Health Decisions For Older Adults Can Be Especially Challenging***
- ***This Website Helps Older Persons Make Difficult Decisions***

About Website

Dartmouth Centers for Health and Aging

Begin Here — To Better Understand a Test or Treatment Decision

At Any Time Use Tools and Special Check-Up Below

Check-up — If you are very sick or frail

DON'T REINVENT THE WHEEL!!!!

You can find in the IIMH Curriculum or on HowsYourHealth many tested methods and tools to use or adapt for your practice.

What is the "Pre-Work?"

Before the telephone coach calls you, please do the following:

1. Complete a health survey.

   Go to www.howsyourhealth.org.
   "Click" on "Begin HowsYourHealth"
   The practice code is: ________.

2. At the end of the survey, print out the Action Form and bring with you to your next appointment.
3. Review Action Form and identify any problem(s) you may have.
4. Go to www.howsyourhealth.org. and "Click" on "Begin Problem-Solving Planning Your Care." Complete this section. Remember to print out screen #10 "Your Problem-solving Worksheet." Have this available to talk with the coach.
5. Review #11 "Tips for Problem-solving Now."
6. Try visiting the Information Sharing Area.
7. Be prepared with dates and times to schedule your second and third call when the telephone coach calls you.

How convinced are you that this is the right work for you?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very convinced

How confident are you now that you can manage and control health problems or concerns?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very confident

PROBLEM-SOLVING WORKSHEET
-EXAMPLE-

1. **Problem**:

   Back pain from weak back muscles and being out of shape in general

2. **Achievable Goal**:

   Exercise 3 times a week for 30 minutes

3. **How convinced are you that this is the right work for you**:

   Not at all 0 1 2 3 4 5 6 7 8 (circled) 9 10 Very convinced

Solutions	Pro's	Con's
Walk with spouse after work, Mon, Wed, and Fri.	More time with spouse, spouse will remind me to walk	We may decide to sleep in instead on cold mornings
Buy a treadmill	Can exercise whenever I want	Expense
Go to the pool after work on the way home	Convenient, doesn't hurt my back	Have to remember to pack my gear, pool costs, time
Put bicycle on trainer for indoor use	Can exercise anytime, I like to bicycle outdoors	Bicycling hurts my back after a few minutes, boring indoors

Choice of solution:
Swim after work three days a week.

Steps to achieve solution:
1. Pay pool costs Monday.
2. Pack gear for the week on Sunday night.
3. ??

How confident are you that you can reach your goal?
Not at all 0 1 2 3 4 5 6 (7 circled) 8 9 10 Very confident

An Example of a patient "worksheet" for the "Campaign for Confidence." This has been successfully implemented by a high school student for a practice; what would it take in your practice?

Effective and reliable care must become part of the "routine". The Campaign for Confidence" is a good example. One practice's approach:

- The practice identifies patient confidence with self-management by using CARE Vital Signs* and/or by asking all patients to complete HowsYourHealth every two years.
- A member of the office staff lists those with low confidence from CARE Vital signs* or the HowsYourHealth registry every six months (Example on right).
- When those with low confidence visit the office the medical assistant follows a script using the "thermometer" as a visual aid.
- Patients use the problem-solving tool to prioritize their needs. For the highest need patients phone coaching by the medical assistant is offered.

** For practices unable to initiate HowsYourHealth the CARE Vital Sign approach (exemplified by Care South Carolina) is a useful way to begin.*

In Summary, practice improvement can be easily attained following a few simple principles that rely on making the patient a partner in care.