Using a Patient-Centered Care Plan and Teamwork to Support Self-Management

**Speakers:** Larry Mauksch, MEd, Senior lecturer and licensed mental health counselor, UW Department of Family Medicine; and Berdi Safford, MD, Family Care Network.

**Moderator:** Judith Schafer, MPH, The MacColl Center for Health Care Innovation
8 Change Concepts for Practice Transformation

1. Laying the Foundation
   - Engaged Leadership
   - Quality Improvement Strategy

2. Building Relationships
   - Empanelment
   - Continuous, Team-Based Relationships

3. Changing Care Delivery
   - Patient-Centered Interactions
   - Organized, Evidence-Based Care

4. Reducing Barriers to Care
   - Enhanced Access
   - Care Coordination
Tools for Your Team to Engage Patients in Collaborative Care Plans

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Objectives

At the end of session, participants will be able to:

1. Explain skills and team designs to engage patients in goal setting and action planning.
2. Describe EHR tools and design features to efficiently engage patients in self-management.
3. Apply a team-training model to use in their sites of practice.
Workshop Outline

Introduction and rationale

Time management

• Using the PCOF- agenda setting

A team approach to goal setting and action planning

• Video demonstration

Goal setting and action planning- practice

Team Training, EHR Design tips, and common pitfalls

Questions
## Stages of Activation

Hibbard et al Health Services Research 2007, 42(4) 1443-63

<table>
<thead>
<tr>
<th>Level of activation</th>
<th>Percent (cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May be overwhelmed and unprepared to play an active role in their own health</td>
<td>12</td>
</tr>
<tr>
<td>May lack knowledge and confidence about self management</td>
<td>29 (41)</td>
</tr>
<tr>
<td>Taking action but may lack confidence and skill to support self management</td>
<td>37 (78)</td>
</tr>
<tr>
<td>Mastered self management but may not maintain behaviors at times of stress</td>
<td>22</td>
</tr>
</tbody>
</table>

(level 45 or older, 2.9 chronic conditions: diabetes, HTN, lung, cholesterol, arthritis, heart)
Primary Care Realities

- Primary Care patients average 3-6 problems per visit
- Indigent primary care populations have a greater illness burden
- Half of adults have two or more chronic illnesses
- 75% of US health care dollars go to care for chronic illness
Time Demands in Primary Care

- 2500 patients
- Conservative time estimates
- Ten most common Chronic illnesses
- Preventive care Level A and B recommendations
- Well controlled 3.5 hrs/day
- Poorly controlled 10.5 hrs/day
- 7.4 Hours per day

Add the 60% of patients with acute problems, plus paperwork, phone calls and charting

Cut panel size to 1250

= 24 hours / day
= 12 hours / day
“Primary Care is a team sport.”

Bruce Bagley, MD, Medical Director of Quality, American Academy of Family Physicians
Teamwork for what?

To manage time

To support self management
Ongoing influence

Sequential

1. Upfront collaborative agenda setting
2. Hypothesis testing and understanding the patient perspective
3. Co-creating a plan

SMS: problem solving
Agenda Creation

Orient the patient:
“\( I \) know you are here to talk about \( \_ \_ \_ \). Before we get into \( \_ \_ \_ \) is there something else important to addresses today? Making a list will help us make the best use of time”.

If the list is greater than three items, the patient is screen positive for depression or anxiety

Ask, “what is most important”
• Listen (feel) for the most important concern
• Introduce self management if time allows and appropriate

Avoid premature diving by patient or yourself

When needed interrupt the patient or yourself:

<table>
<thead>
<tr>
<th>Acknowledge, Empathize</th>
<th>Share reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Upfront Collaborative Agenda Setting
Brock, Mauksch, et al. JGIM, Nov, 2011; Mauksch et al, Fam, Syst, Health, 2001

- Identifies patient’s priorities
- Organizes the visit
- Decreases chance that patients or providers will introduce “oh by the way” items
- Screens for mental disorders
- Facilitates shared decisions about time use between acute, chronic, health maintenance care, including self management support
- Does not lengthen the visit; protects time for planning
- Decreases clinician anxiety
Observation Form Purpose and Training

The value

- Structures vision
- Creates and standardizes vocabulary

Primarily for formative assessment and to strengthen the "observer self" (mindfulness)

Online training:
http://uwfamilymedicine.org/pcof
PCOF Use

Behavior in either of the columns to the right of thick vertical line is in the competent range

Observers mark accurately and avoid giving the benefit of the doubt

Feedback is best: When solicited, specific, rather than general, curious, not judgmental
Self-management Principles of PCMH

- Respect patient and family values
- Encourage patients to expand their role in caring for their health
- Communicate with patients in a culturally appropriate manner that the patient understands
- Provide support at every visit through goal setting and action planning
Self-management Support

“Education is not the filling of a pail, but the lighting of a fire.”

-- William Butler Yeats
Self-management Support

Remove guilt

No more “noncompliant” patients

• “if a patient does not do something you recommend, there is always a reason”
  --quote from a surgeon
Enjoy your Practice

Be a coach – this is the patient’s chronic condition

Dance not wrestle
Collaborative Goal-setting

- Offer a variety of choices
- Listen to what the patient wants
- Go with the patient’s choice
- Just ONE goal at a time 😊
## Behavior Change and Goal Setting

<table>
<thead>
<tr>
<th></th>
<th>Provider Determined</th>
<th>Patient Determined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Disease</td>
<td>Can be from a larger domain</td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td>Helps with disease management</td>
<td>Builds patient investment</td>
</tr>
<tr>
<td><strong>Cons</strong></td>
<td>Greater resistance (contemplation)</td>
<td>Requires more patience, may not be disease focused at first</td>
</tr>
</tbody>
</table>
Patient Centered Problem Solving

Meet the patient where s/he is and hone

Name the goal (wt loss)

Brainstorm activities (different ways)

Name an activity (exercise)

Focus the activity (biking)

How often?

When?

Barriers?

Confidence- 1 (low) to 10 (high)

What can help increase confidence?
Assist with Action Planning

Things I can do to help reach this goal:

a.

b.

c.

d.
Action Planning

My Ongoing Action Steps

- What I will do:
- How often?
- When?
- Potential barriers?
- How will I overcome these barriers?
Confidence Ruler

1 2 3 4 5 6 7 8 9 10

Not Confident Somewhat Confident Very Confident
Increase Confidence

What would it take to make your confidence a ____?

• (1 higher than their current rating)
Arrange follow-up

Would it be OK if Christine calls you next week to see how this is going?
Video 1
Video 2
<table>
<thead>
<tr>
<th></th>
<th>PCCP (51 yrs; 60% F)</th>
<th>Controls (55 yrs; 40% F)</th>
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</thead>
<tbody>
<tr>
<td>Goal documented</td>
<td>96%</td>
<td>43%</td>
</tr>
<tr>
<td>Ongoing activity</td>
<td>89</td>
<td>34</td>
</tr>
<tr>
<td>Specific activity</td>
<td>78</td>
<td>41</td>
</tr>
<tr>
<td>How often</td>
<td>68</td>
<td>07</td>
</tr>
<tr>
<td>When</td>
<td>68</td>
<td>07</td>
</tr>
<tr>
<td>Barriers</td>
<td>75</td>
<td>01</td>
</tr>
<tr>
<td>Confidence</td>
<td>71</td>
<td>00</td>
</tr>
<tr>
<td>What can help with confidence</td>
<td>53</td>
<td>00</td>
</tr>
</tbody>
</table>
Pick something to change in your life

One person counsels
One is the patient

Focus on a simple, real issue

Patient: Be ambitious
Counselor: restrain for success

Each person plays patient and clinician
Patient Centered Problem Solving

- Meet the patient where s/he is and hone
- Name the goal (wt loss)
- Brainstorm activities (different ways)
- Name an activity (exercise)
- Focus the activity (biking)
- How often?
- When?
- Barriers?
- Confidence- 1(low) to 10(high)
- What can help increase confidence?
Work Flow Options

MA establishes goal and plan

MA establishes goal, part of plan, PCP finishes

MA establishes goal, PCP completes plan

PCP establishes goal and completes plan

MA integrates progress check into agenda setting at subsequent visits or on the phone
For any patient who is working on self management

Weave it into the discussion

- Most patients with chronic illnesses
- Patients with whom you discuss health risk behaviors, eg, diet, alcohol, exercise
- Patients who need help with simple behavior changes, eg., remembering to take Rx
Team Design Reflections

Team expansion is needed for ambivalent or pre-contemplative patients

- Nurse
- Care manager
- Behavioral health
- Extra medical assistant with extra training

Physicians need extra training for complex patients and close relationship with care manager functionality
TEAM TRAINING

SKILL LEARNING TO IMPROVE PATIENT CARE AND TEAM WORK

Larry Mauksch, M.Ed University of Washington Department of Family Medicine
TEAM COMMUNICATION TRAINING

Team members reinforce use of communication skills in one another.

Shared learning of skills builds team function.
Training Model

Introduction to Skills

Demonstration and practice

Teamlet members observe each other using extended appointment slots

Do the cycle again to learn more skills and achieve more goals

Recurrent observations and team meetings for reinforcement

Groups meet to share learning and set goals
  • Within teamlets
  • Across teamlets


Patient Template: Teamlet training

8:30-8:40 discuss needs of first three patients

8:40-8:45 MA bring patient to exam room and explains teamlet training- at some point is joined by MD, ARNP or PA

8:45 -9:30

8:45 to 9:00 MA interview patient and MD observes

9:00 to 9:30 MD interviews patient and MA observes

9:30 to 9:40 debrief encounter

9:40 MA gets next patient and repeat cycle two more times
New applications of the EMR

Patient Engagement
(the patient – team member – screen triangle)
The patient and provider collaboratively problem solve

Team member training
Reminds the team member about core ingredients

Facilitates Team Communication to:
Organize care with action planning
Reinforce, refine and celebrate
Capture each team member’s contribution

Work into the existing workflow

Be able to generate a printable action plan for the patient

Be easily visible when first entering the chart
# Options for Collaborative Care Plan Integration into an Electronic Health Record

<table>
<thead>
<tr>
<th>Collaborative Care Plan Design within the Electronic Health Record</th>
<th>Accessible to patients</th>
<th>Accessible to team members</th>
<th>Prompts team communication</th>
<th>Organizes problem solving</th>
<th>Engages patients</th>
<th>Promotes efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smart / Quick text in progress note</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Smart / quick text in progress note and pasted in a freestanding section, eg. Social History</td>
<td></td>
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<td></td>
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<tr>
<td>Face page CCP form</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Front page CCP form and instruction / AVS that auto populate one another</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Front page CCP form that auto-populates the AVS and that is accessible to the patient via secure connection</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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EHR Design Modification Ideas

The PCCP should be easily visible when first entering the chart

Supports efficient workflow

- Minimal clicks to move through the chart
- Related sections auto populate one another
- Easy print function.

Easy way to revise the action plan to note progress, revise or create new goals

Part or all of PCCP available to patient via portal or via an APP
References


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Q & A
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Beth Israel Deaconess Medical Center
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Please take our survey by clicking on the following link:

http://www.surveymonkey.com/s/KSHNXSP