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MacColl Center for Health Care Innovation

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.

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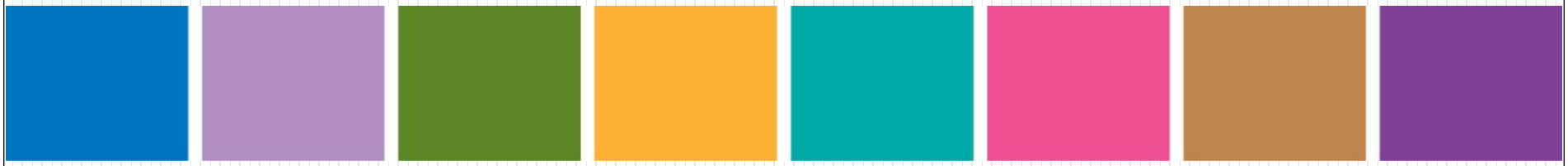

8 Change Concepts for Practice Transformation

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

Level of activation **(age 45 or older, 2.9 chronic conditions)** **diabetes, HTN, lung, cholesterol, arthritis, heart**	**Percent (cumulative)**
May be overwhelmed and unprepared to play an active role in their own health	12
May lack knowledge and confidence about self management	29 (41)
Taking action but may lack confidence and skill to support self management	37 (78)
Mastered self management but may not maintain behaviors at times of stress	22

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

Am J Public Health. 2003;93:635–64; Ann Fam Med 2005;3:209-214.

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

= 24 hours / day

Cut panel size to 1250

= 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

Relationship Communication and Efficiency

Mauksch et al. July 14 2008. Arch of Intern Med

Ongoing influence

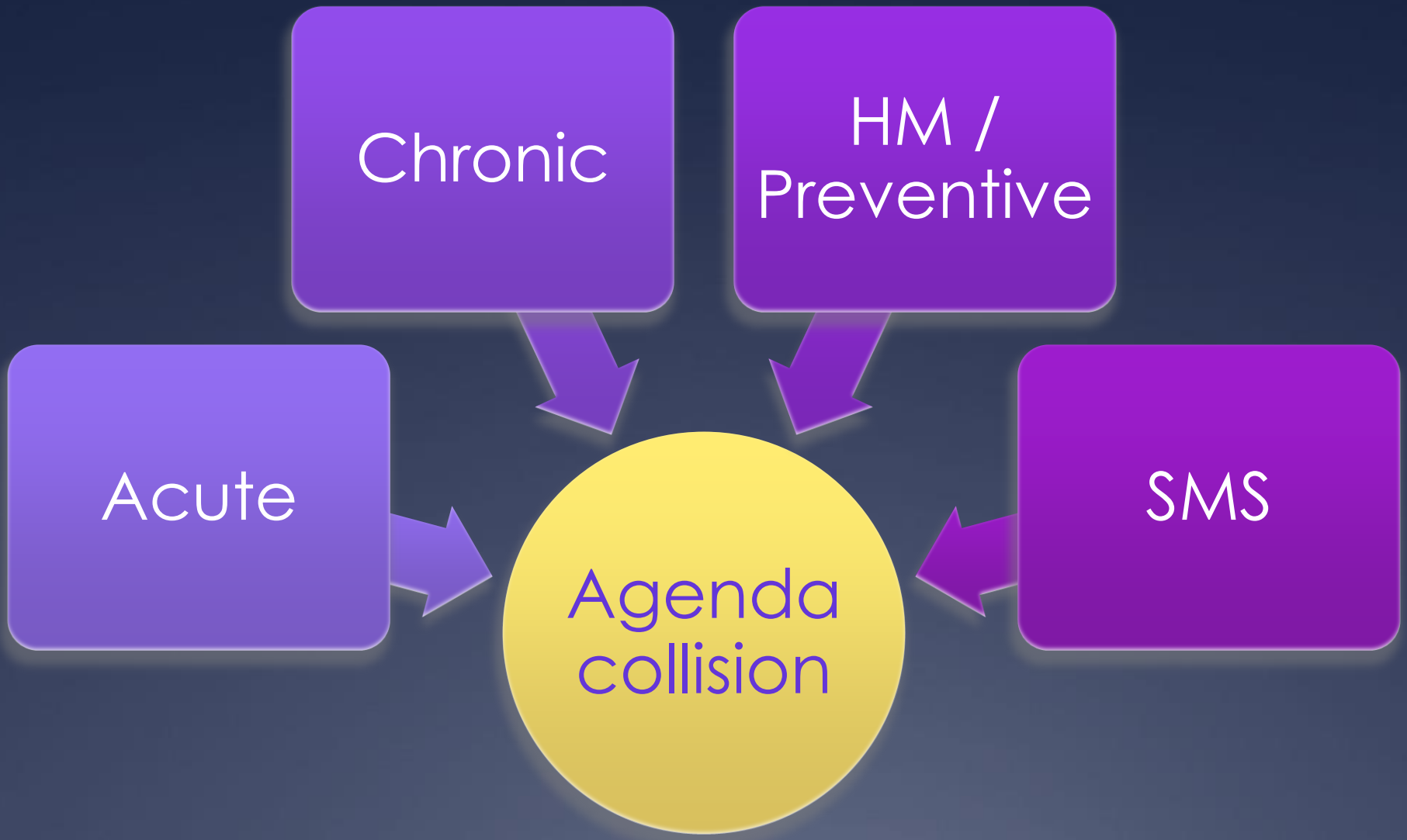
- Rapport and Relationship
- Mindfulness
- Topic Tracking
- Empathic response to cues

Sequential

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

SMS: problem solving

Visit Organization



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:	Acknowledge, Empathize Share reasoning

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

	Provider Determined	Patient Determined
Goal	Disease	Can be from a larger domain
Pros	Helps with disease management	Builds patient investment
Cons	Greater resistance (contemplation)	Requires more patience, may not be disease focused at first

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

PCCP Chart review

Chunchu, Mauksch, et al. Fam, Syst, Health, 2012, September

	PCCP 51 yrs; 60%F	Controls 55 yrs; 40% F
Goal documented	96 %	43 %
Ongoing activity	89	34
Specific activity	78	41
How often	68	07
When	68	07
Barriers	75	01
Confidence	71	00
What can help with confidence	53	00

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

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When?

Barriers?

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What can help increase confidence?

Work Flow Options

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

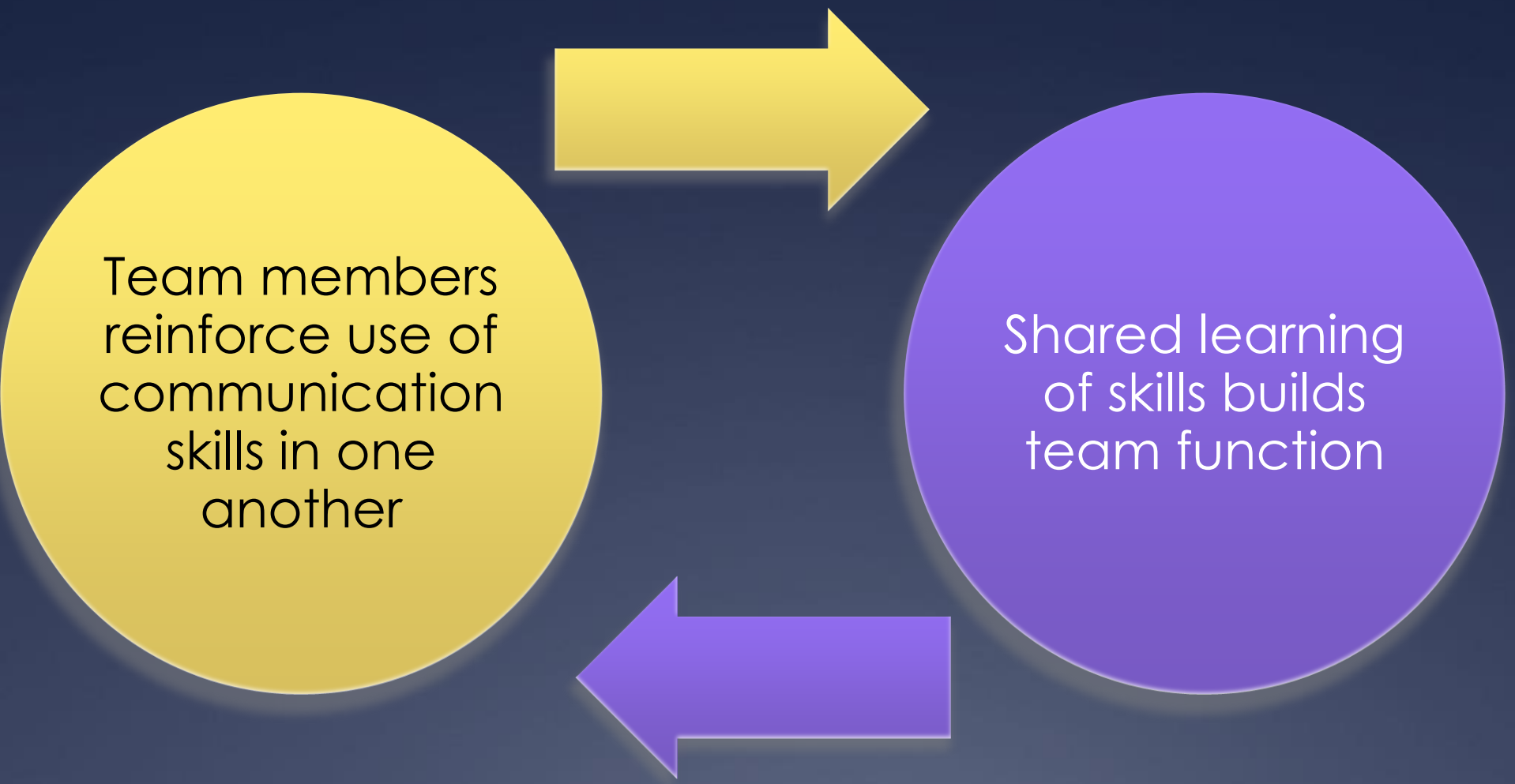
Physicians need extra training for complex patients and close relationship with care manager functionality

TEAM TRAINING

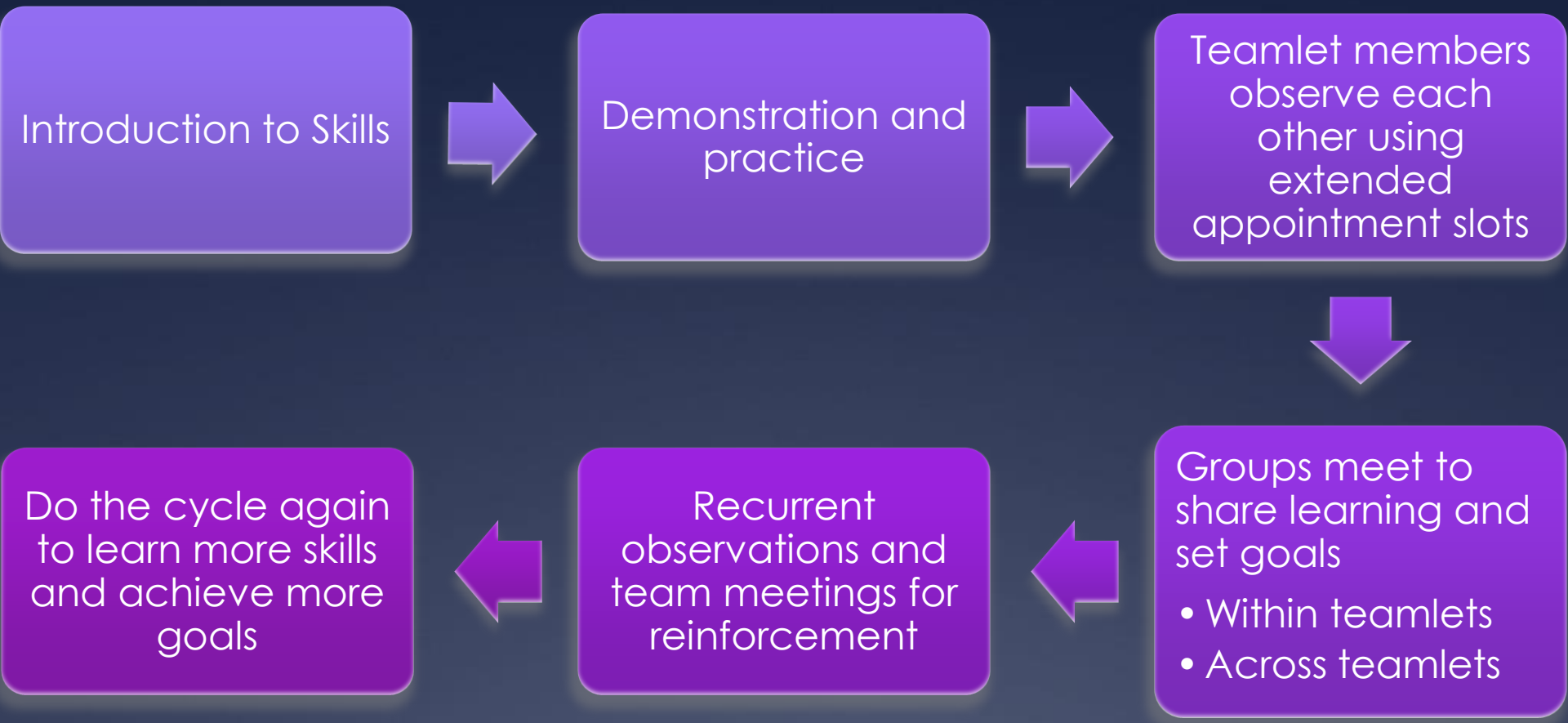
SKILL LEARNING TO IMPROVE PATIENT CARE AND TEAM WORK

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

TEAM COMMUNICATION TRAINING



Training Model



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http://www.safetynetmedicalhome.org/sites/default/files/Medical-Home-Digest-April-2011.pdf.

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 patent 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

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

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

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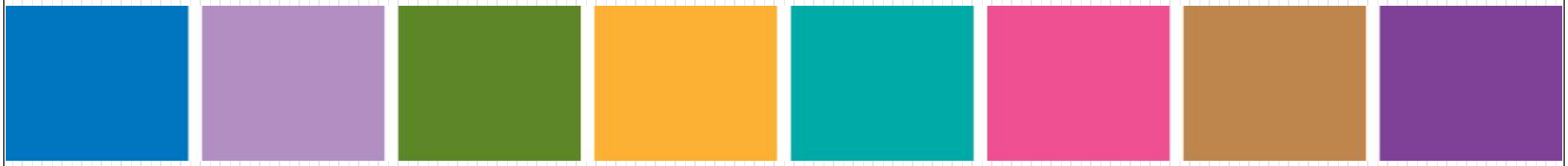
Q & A



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