

1. What questions or concerns do you wish to discuss?  
(please state in the space provided)

---

2. Pain Score \_\_\_\_\_ (see attached)

3. Feeling Score \_\_\_\_\_ (see attached)

4. Social Support \_\_\_\_\_ (see attached)

5. Do you often have trouble eating well? (circle one)  
 Yes, often      Yes, sometimes      No, never

6. Do you often have trouble remembering or thinking clearly? (circle one)  
 Yes, often      Yes, sometimes      No, never

7. Do you often have trouble with dizziness or falls? (circle one)  
 Yes, often      Yes, sometimes      No, never

8. Are your pills making you ill? (circle one)  
 Yes      No      Maybe      Not Applicable

9. Are you confident in managing your health problems? (circle one)  
 Yes      No      Maybe      Not Applicable

10. How do you rate your health in general? \_\_\_\_\_ (see attached)

**PAIN**  
During the past 4 weeks:  
How much bodily pain have you generally had?

No pain	1
Very mild pain	2
Mild pain	3
Moderate pain	4
Severe pain	5

During the past 4 weeks:  
What answer is closest to help you if you need and would help? For example if you:  
—do very serious, daily, or blue  
—get sick and had to stop to bed  
—needed someone to talk to  
—needed help with daily chores  
—needed help just taking care of yourself?

No, not at all	1
Yes, quite a bit	2
Yes, some	3
Yes, a little	4
Yes, not at all	5

**FEELINGS**  
During the past 4 weeks:  
How much have you been bothered by emotional problems such as feeling nervous, depressed, irritable or downhearted and blue?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Very much	5

**OVERALL HEALTH**  
During the past 4 weeks:  
How would you rate your health in general?

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

Copyright by Trustees of Dartmouth College  
And FHC Corporation 1995-2000

## Patient Report of Problems “That Matter”



HOME | CURRENT ISSUE | PAST ISSUES | TOPIC COLLECTIONS | CME | SUBMIT | SUBSCRIBE | HELP

Vol. 249 No. 24, June 24, 1983  
ARTICLE

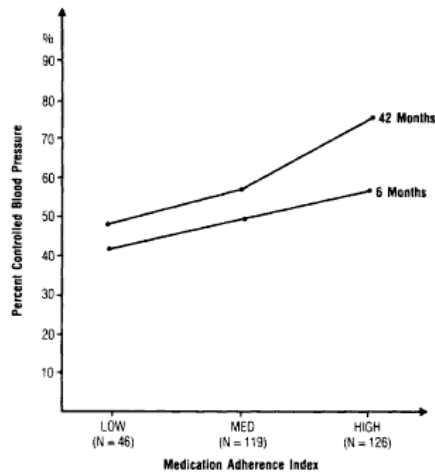
### Functional health status levels of primary care patients

E. Nelson, B. Conger, R. Douglass, D. Gephart, J. Kirk, R. Page, A. Clark, K. Johnson, K. Stone, J. Wasson and M. Zubkoff

A cross-sectional study was conducted on functional status of adults visiting primary care practices. Limitations in physical and mental function were assessed independently in 28 practices by patients (N = 1,227) and physicians (N = 47) using a simple global index of disability. Results indicated 12% of patients rated their physical limitations as major and 8% rated major emotional limitations during the past month. Comparable assessments by physicians were 5% and 4%, respectively. Differences between patients and physicians were statistically significant and are demonstrated to be clinically relevant. Patients' functional limitations were associated with increased utilization of ambulatory care, older age, lower level of education, unemployment, and a primary diagnosis of a chronic condition. We conclude that functional status can be routinely recorded in medical practice to help describe severity, predict utilization, and improve the physician-patient relationship.

THIS ARTICLE HAS BEEN CITED BY OTHER ARTICLES

# Patient Report “Compliance”



Concurrent and Predictive Validity of a Self-Reported Measure of Medication Adherence  
 Donald E. Morisky, Lawrence W. Green and David M. Levine  
 Medical Care, Vol. 24, No. 1 (Jan., 1986), pp. 67-74



## The CAGE Questionnaire: Validation of a New Alcoholism Screening Instrument

DEMIE MAYFIELD M.D.<sup>1</sup>, GAIL MCLEOD M.S.W., and PATRICIA HALL M.S.W.

<sup>1</sup> Chief, Psychiatry Service, Veterans Administration Hospital, Providence, R.I. 02908, and Professor of Psychiatry, Brown University Program in Medicine, Providence

The CAGE questionnaire, a new brief alcoholism screening test, was administered to all patients (N = 366; 39 percent alcoholic) admitted to psychiatric service over a one-year period. The authors indicate that the CAGE questionnaire is not a sensitive alcoholism detector if a positive response is the criterion; however, if a two- or three-item criterion is used, it becomes a viable rapid alcoholism screening technique for large groups.

## Other Patient Reports

### Can patients help with long-term total knee arthroplasty surveillance? Comparison of the American Knee Society Score self-report and surgeon assessment

T. J. Gioe<sup>1,2</sup>, D. Pomeroy<sup>3</sup>, K. Suthers<sup>4</sup> and J. A. Singh<sup>2,5,6</sup>

A number of studies that have compared patient vs physician reporting of function, or symptoms such as pain, have shown substantial differences between the two, typically with the physician reporting better scores than the patient [8–11]. The difference between patient and physician measurements for the scale in our study was 8 points with patients consistently scoring the patient as having less pain than the patient self reported. That patients tend to assign better (or lower) pain scores than physicians, has been previously reported following total knee arthroplasty as well [12].

### Rising importance of patient-reported outcomes

Pamela J Atherton<sup>a</sup> and Jeff A Sloan<sup>a</sup>

<sup>a</sup>Cancer Center Statistics, Mayo Clinic Cancer Center, College of Medicine, Mayo Clinic, Rochester, Minnesota, MN 55905, USA

Available online 30 October 2006.



## Agreement of Patient-Reported Measures with Data from the Medical Record

Patient-Reported Measure	Patient Response	Agreement with Medical Record Audit
Screening for Breast Cancer (Age 50+)	Done	<b>96%</b> (104/109)
	Not Done	68% (17/25)
Screening for Bowel Cancer (Age 50+ in 2 years**)	Done	<b>76%</b> (88/116)
	Not Done	80% (53/66)
Recent Blood Pressure (If Diagnosis of Hypertension, Diabetes, or Cardiovascular Disease)	150 or less	<b>94%</b> (162/173)
	More than 150	36% (10/28)
Recent Blood Sugar (if Diabetic)	140 or less	<b>75%</b> (47/63)
	More than 140	59% (23/29)
Total Cholesterol (If Age 50+ and Diagnosis of Hypertension, Diabetes, or Cardiovascular Disease)	200 or less	<b>86%</b> (42/49)
	More than 200	84% (16/19)



## Even Bio-clinical Measures and Newer Concepts Such as “Quality” and “Confidence”

### Influences of Quality of Care and Patient Self-Confidence on Diabetes Control

Overall Quality of Care	Patient-report that Blood Sugar is Always between 80-150*	
	Confident with Self-Management	Not Confident with Self-Management
<b>Strongly Agrees</b> “I receive exactly the care I want and need”	<b>39%</b> (37/95)	<b>24%</b> (15/62)
<b>Does Not Strongly Agree</b> “I receive exactly the care I want and need”	<b>24%</b> (15/62)	<b>9%</b> (25/297)

Of patients reporting “always in the range 80-150”,  
more than 90% can be expected to have a HgbA1c less than 8.



# Care South Example

Wasson JH, Anders GS, Moore LG, Ho L, Nelson EC, Godfrey MM, Batalden PB. Clinical Microsystems, Part 2. Learning from Micro Practices about Providing Patients the Care They Want and Need. Joint Commission Journal of Quality and Patient Safety 2008;34:445-452

Time Period	Range of Patient-Reported Measures of Collaborative Care		Range of Outcome Measures
	Information is Excellent	Confidence with Self-Management	Blood Pressure Controlled
Baseline: 2007 (January-June)	10-33%	40-60%	51-55%
Changing Phase 1: 2007 (July-December)	35-88%	40-80%	58-64%
Changing Phase 2: 2008 (January-April)	80-90%	80-90%	66-67%

- C**heck BP and education quality and confidence
- A** Medical Assistant Use BP Tool and Educates
- R**einforced at every visit
- E**The way they do business on every hypertensive



# Every Office Does Vital Signs


Why not make them focus on issues that:

- matter to patients
- are actionable
- are “high leverage” and behaviorally sophisticated
- place patients into categories for planning resources?



# CARE Vital Sign

## What is it?

- C = Check 
- A = Action (Activate)
- R = Reinforce
- E = Engineer

## Patient Self Assessment

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

1. What questions or concerns do you wish to discuss?  
(please state in the space provided)

\_\_\_\_\_

2. Pain Score \_\_\_\_\_ (see reverse side)

3. Feeling Score \_\_\_\_\_ (see reverse side)

4. Health Habits Score \_\_\_\_\_ (see reverse side)

5. Are you confident in managing your health problems? (circle one)

Yes No Maybe Not Applicable

6. Are your pills making you ill? (circle one)

Yes No Maybe Not Applicable

If it is left up to chance or "usual care," it will not happen!



## Accept the "C" --Plan for the "A R E"

Problems from Geriatric CARE Vital Signs	Initial Actions*
Not Confident	1. Review understanding of confidence. 2. Identify what things patients feels least confident about and why. 3. Begin "Campaign for Confidence."
Pain	1. Source and nature of pain. 2. Problem-solving Strategies. 3. Medication management.
Overall Health Fair or Poor	1. Reconfirm rating with patient. 2. Use for "Decision-Making in the Grey." 3. Use to trigger reminder for Advance Care Planning 4. For those who are in Fair or Poor Health have someone help them complete the special HowsYourHealth.org for the "very sick or frail."
Pills Perhaps Causing Illness	1. Which pills. 2. How are they "causing illness". 3. Impact on patient "compliance" with pill-taking. 4. Explore possible alternatives.
Lacking Social Support	1. Why the response. 2. What is needed. 3. What is lacking. 4. Problem-solving. 5. Possible Referral
Emotional Problems	1. Source and nature of emotional problem. 2. Problem-solving Strategies. 3. Medication management.
Problems Thinking	1. Why the response. 2. MMSE or MiniCog. 3. Review Options based on results.
Dizzy or Falling	1. Explore nature of problem. 2 Get-up-and-go. 3. Orthostatic blood-pressure. 4. Evaluate as needed with particular focus on medications.
Eating/Nutrition Problems	1. Explore nature of the problem. 2. Weight and BMI. 3. Evaluate as needed.

\*For more detail on these initial generic solutions, refer to *Activation of Patients for Successful Self-Management*. Several tools are available at [www.howsyourhealth.org](http://www.howsyourhealth.org)



## Health Behavior Change What Works

---

- **Understanding**
  - Information
  - Same pageness
- **Importance**
  - Motivation is a key determinant
- **Confidence (self efficacy)**
  - Finding success in small steps
    - action planning—setting goals
    - problem solving—anticipate roadblocks
    - Follow-up—ongoing support

**This requires a shift in paradigm from the traditional medical model**



## Tools and Methods for Patient Collaboration and Engagement

---

- Preparation for the visit (e.g. CAREVitals)
- Agenda building (e.g. CAREVitals, bubble diagram)
- Ask-Tell-Ask-Close the Loop
- Readiness for change assessment
- Goal setting, action planning
- Problem solving
- Follow-up



# Activation of Patients for Successful Self-Management

Tools, Methods, Resources	Purpose
Bubble Diagram	Enable collaborative agenda setting
Ask-Tell-Ask-Closing the Loop	Ensure patient understanding and recall
Readiness for Change Sample Dialogue	Enable collaborative agenda setting
Importance/Confidence Rulers	Support and initiate behavior change
Goal Setting/Action Planning Forms	Support and initiate behavior change
Problem Solving Form	Address patients' barriers to achieving success with behavior change
Follow-up Checklist	Design a process for patient follow-up
How's Your Health	Support and evaluate patient self-management
Communications Skills Reference	Remind providers of good communication techniques using a simple reference
Planned Visit Checklist	Design efficient self-management support visits using all staff
Ottawa Decision Aid Website	Provide patients with evidence-based decision support



### Patient Self Assessment

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

- What questions or concerns do you wish to discuss?  
*(Please state in the space provided)*
- Pain Score \_\_\_\_\_ *(see reverse side)*
- Feeling Score \_\_\_\_\_ *(see reverse side)*
- Health Habits Score \_\_\_\_\_ *(see reverse side)*
- Are you confident in managing your health problems? *(circle one)*  
Yes No Maybe Not Applicable
- Are your pills making you ill? *(circle one)*  
Yes No Maybe Not Applicable
- What does your weight and height tell you? *(see below)*

What is Your Weight? (in pounds)		
Your Height without Shoes	Pay Attention	Trouble
5 Feet	Over 228	Over 148
5 Feet 4 Inches	Over 146	Over 149
5 Feet 8 Inches	Over 164	Over 190
6 Feet	Over 184	Over 213
6 Feet 4 Inches	Over 205	Over 238

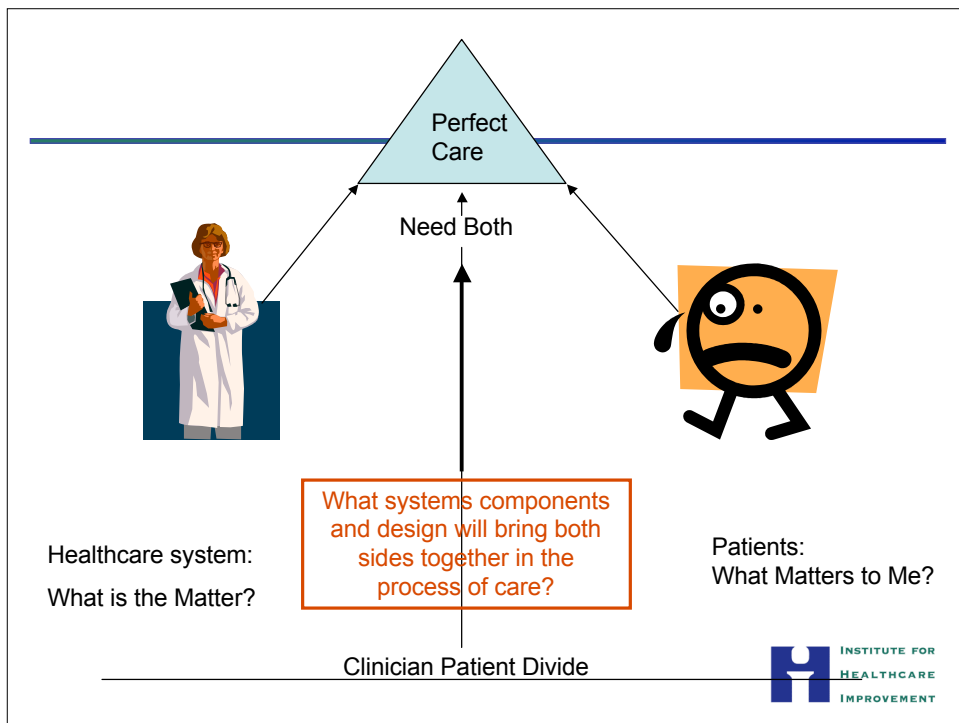
\_\_\_ Pay Attention \_\_\_ Trouble \_\_\_ Neither "Pay Attention or Trouble"

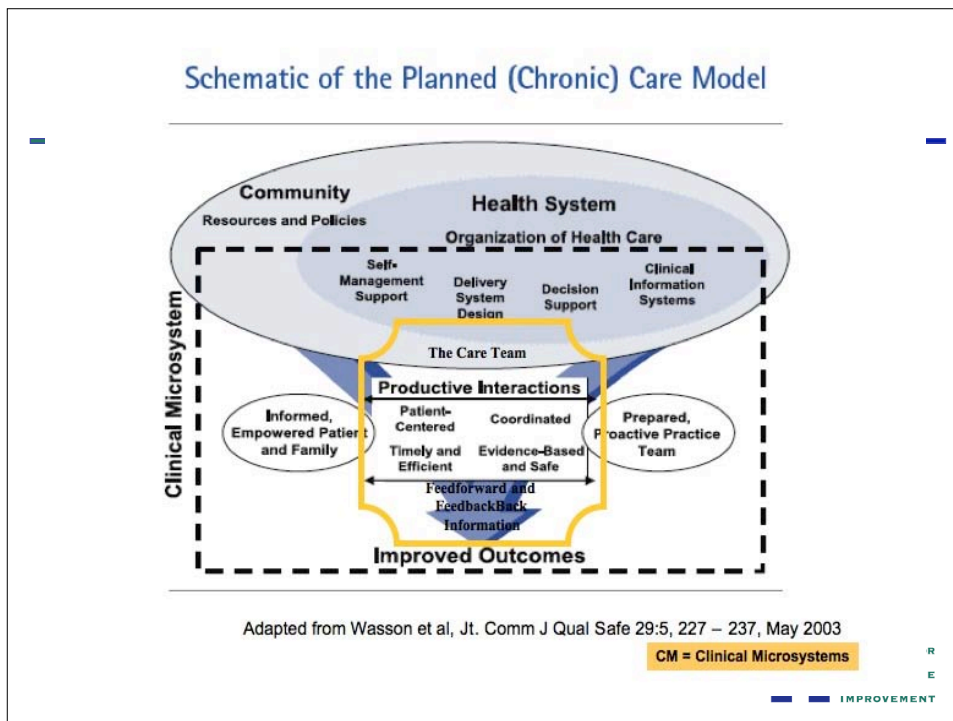
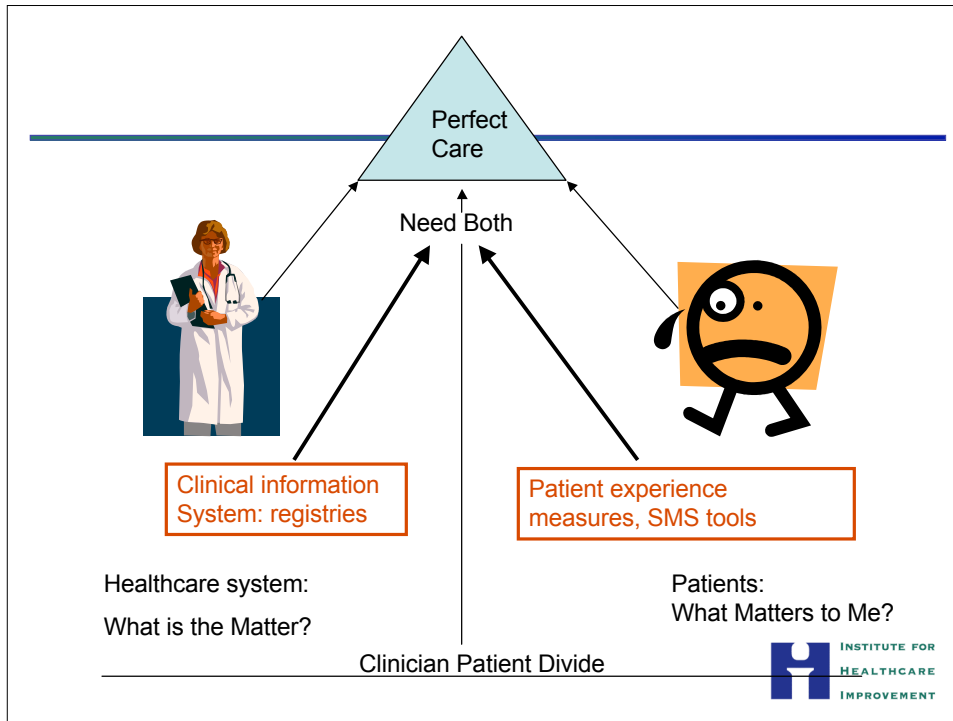
### Activation of Patients for Successful Self Management JACM 32;1:14-21. 2009

**CARE Vital Signs**  
JACM 32;1:55-69. 2009

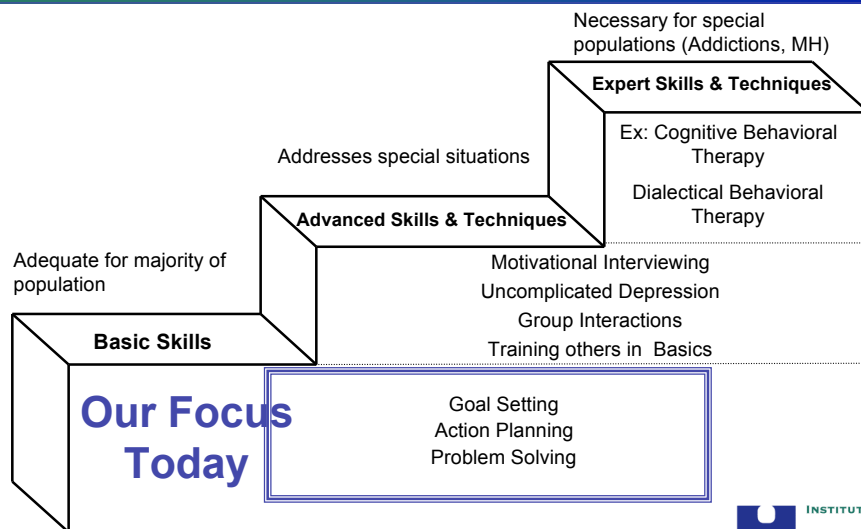
**Physician tip sheet for self-management support**  
How to support someone along the path to making a healthy behavior change

[www.ama-assn.org/go/aging](http://www.ama-assn.org/go/aging)





## Self-management Support Steps to Build Skills and Confidence



Source: Connie Davis, RNP



## Practice redesign

(multi physician practices and larger organizations)

- Train the entire team for effective communication
- Optimize roles and develop the care team
- Plan the visit
- Document self management activity
- Link to community resources
- Offer patient decision support
- Develop a range of self management support in order to be able to tailor to support need



# Reliability Strategies

Reliability Level and Definition	Strategies
<b>10<sup>-1</sup></b> When a process is measured it shows 80 – 90% success or 1 or 2 failures out of 10 opportunities.	<b>Intention:</b> awareness, memory aids, personal checklists <b>Education:</b> feedback, training <b>Basic standardization:</b> common equipment, orders, protocols, rooms
<b>10<sup>-2</sup></b> When a process is measured it shows 95% success or 5 failures out of 100 opportunities.	<b>Structure:</b> Build decision support and reminders into the process of care <b>Standardization:</b> Essential work processes, tasks, roles <b>Affordances:</b> Make the desired action the default; make use of habits and patterns <b>Differentiation and constraints:</b> Visual aids, blocking actions <b>Scheduling key tasks:</b> <b>Intentional redundancy:</b> repeat tasks by multiple staff/providers
<b>10<sup>-3</sup></b> When a process is measured it shows 99.5% success or 5 failures out of 1000 opportunities	<b>Monitor performance:</b> Review performance regularly and feedback into the system <b>Examine every failure:</b> Use every failure to redesign the process



# Design Strategy

- Prevent Initial Failure**

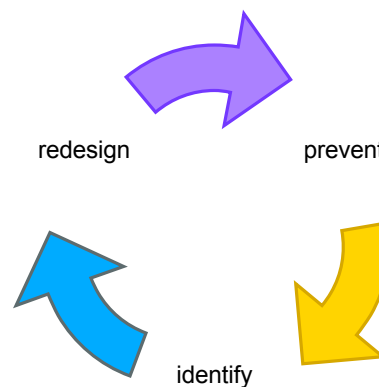
- Segmentation
- Using intent and standardization

- Identify failure and mitigate**

- Human factor changes
- Redundancy function

- Redesign from failure modes**

- Identify critical failures and then redesign



# When Should You

1. What questions or concerns do you wish to discuss?  
(please state in the space provided)

# Believe Your Patient?

2. Pain Score \_\_\_\_\_ (see attached)

3. Feeling Score \_\_\_\_\_ (see attached)

4. Social Support Score \_\_\_\_\_ (see attached)

5. Do you often have trouble eating well? (circle one)  
 Yes, often      Yes, sometimes      No, never

6. Do you often have trouble remembering things? (circle one)  
 Yes, often      Yes, sometimes      No, never

7. Do you often have trouble with dizziness or lightheadedness? (circle one)  
 Yes, often      Yes, sometimes      No, never

8. Are your pills making you ill? (circle one)  
 Yes      No      Maybe      Not Applicable

9. Are you confident in managing your health problems? (circle one)  
 Yes      No      Maybe      Not Applicable

10. How do you rate your health in general? \_\_\_\_\_ (see attached)

**Whenever You Ask:  
(And You Must Plan to Act,  
Reinforce  
and "Engineer")**

**FEELINGS**  
 How often do you feel nervous, jittery, or blue?  
 How often do you feel dizzy or lightheaded?  
 How often do you feel sick or nauseous?  
 How often do you feel tired or exhausted?  
 How often do you feel sad or depressed?  
 How often do you feel angry or frustrated?  
 How often do you feel anxious or worried?  
 How often do you feel stressed or overwhelmed?  
 How often do you feel lonely or isolated?  
 How often do you feel hopeless or despairing?  
 How often do you feel like giving up?  
 How often do you feel like you're not in control?  
 How often do you feel like you're not listening to your body?  
 How often do you feel like you're not taking care of yourself?  
 How often do you feel like you're not doing enough?  
 How often do you feel like you're not trying hard enough?  
 How often do you feel like you're not pushing yourself?  
 How often do you feel like you're not challenging yourself?  
 How often do you feel like you're not growing?  
 How often do you feel like you're not learning?  
 How often do you feel like you're not improving?  
 How often do you feel like you're not becoming a better person?  
 How often do you feel like you're not reaching your potential?  
 How often do you feel like you're not living your best life?  
 How often do you feel like you're not making the most of your time?  
 How often do you feel like you're not being the best you can be?  
 How often do you feel like you're not being a good role model?  
 How often do you feel like you're not being a good parent?  
 How often do you feel like you're not being a good friend?  
 How often do you feel like you're not being a good citizen?  
 How often do you feel like you're not being a good human being?

**OVERALL HEALTH**  
 During the past month, how would you rate your health in general?  
 Excellent  
 Very good  
 Good  
 Fair  
 Poor



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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hello: \_\_\_\_\_

Today your blood pressure is: \_\_\_\_/\_\_\_\_

(Please draw a line on thermometer to show patients where their blood pressure reading scores.)  
 It is important that we get the top number of your blood pressure to below **130**. **120 is perfect**

The closer we get your blood pressure to 120/70, the less chance you'll have of having a **heart attack, stroke, or kidney disease**. You can help by eating less salt (called sodium on food labels) and walking 30 minutes a day.

Your Last HbA1c was: \_\_\_\_\_

On: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Please draw a line on thermometer to show patients where their blood pressure reading scores.)

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**



Please have this form available for your Telephone Coach call.

**PROBLEM-SOLVING WORKSHEET**

1) Problem:

2) Achievable Goal

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

0 1 2 3 4 5 6 7 8 9 10  
 ☹️ 😐 😊

Totally Unconvinced      Unsure      Somewhat Convinced      Very Convinced      Extremely Convinced

4) Solutions:

a)	Pro's (+)	Con's (-)
b)	Pro's (+)	Con's (-)
c)	Pro's (+)	Con's (-)

5) Choice of solution:

5) Steps to achieve solution:

a)



b)

c)

Confidence Ruler: My confidence that I can reach my goal:


0 1 2 3 4 5 6 7 8 9 10  
 ☹️ 😐 😊

Not Confident      At All      Unsure      Somewhat Confident      Very Confident      Extremely Confident

## Patient-Reported Overall Care Quality and Measures for Practice Process and Communication

	Strongly Agree (N=1507)	Agree (N=2269)	Disagree (N=794)
<b>Patient-Reported Measures for:</b>			
<b>Practice Processes</b>			
Very Easy Overall Access- "Easy to get medical care when needed"	80	39	16
<i>Excellent Appointment Access (4)</i>	48	15	4
<b>General Communication</b>			
Excellent Information Received for Chronic Disease(s)	49	23	7
<i>Excellent Explanations and Knowledge of "My History" (2)</i>	65	30	6
<b>Specific Communication</b>			
Excellent Information for Bothersome Emotional Problems	49	23	7
<i>Emotional Health Screening and Discussion (2)</i>	47	31	31



## Differentiation of Practice Groups Based on Patient-Reported Measures

Patient-Reported Measures <sup>#</sup> for:	Ideal Medical Practices (N=16)*			Usual Care Practices (N=30)*		
	25 <sup>th</sup>	Median**	75 <sup>th</sup>	25 <sup>th</sup>	Median**	75 <sup>th</sup>
<b>Overall Quality</b>						
Strongly Agrees “I receive exactly the care I want and need”	61	<b>75</b>	78	45	<b>50</b>	63
<i>Best Doctor Possible (10 on 0-10 scale)</i>	51	<b>77</b>	100	43	<b>50</b>	61
<b>Practice Process</b>						
Very Easy Access- “Easy to get medical care when needed”	52	<b>69</b>	79	47	<b>50</b>	64
<i>Excellent Appointment Access</i>	55	<b>72</b>	91	41	<b>50</b>	61
<b>General Communication</b>						
Excellent Information Received for Chronic Disease(s)	53	<b>72</b>	81	37	<b>50</b>	61
<i>Excellent Explanations and Knowledge of “My History”</i>	46	<b>64</b>	81	32	<b>50</b>	64

