

Why the Patient is Truly at the Center of IIMH?

- **Axiomatic** (and the core of all Models such as CCM, etc.)
- Patient-based learning motivates us to improve the value of the health care “product”
- **Practical:**
 - Patient self-interest is a source of inexpensive, useful data* for:
 - Tailoring information to their needs
 - Decreasing fragmentation of information
 - Segmenting information for reliable, efficient care
 - Evaluating care processes and outcomes
 - Necessary to Leverage Patient Self-Care

* and we can supply the HYH tools to make this possible



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) (One Hour)	Variation in Practice Patterns of Care	Use Care Planning, Evidence and Sensible Referrals to Reduce Variation	Specialty Use Survey; Care Planning; Confidence Toolkit
4:2 Review of Progress and Medical Home Criteria (One Hour)	The Changes and Concepts that Seem Easiest and Most Difficult and How to Continue to Share Experiences with Peers	Define Areas in Which the Practice Still Needs to Make Progress to Become an Ideal Medical Home; Opportunities for Revenue	Progress Report

**CURRICULUM
ELEMENT**

**PHYSICIAN WILL
UNDERSTAND...**

PHYSICIAN WILL BE ABLE TO...

LINK

**Preceptor Option (Two
Hours)**

Tools Available for
Preceptors

Describe Concepts and Implement
New Tools for Students and
Residents

[EGEMS](#); [MedU](#)

The Ten “Bare Bones” Slides for IMH

- Based on work from IHI, IMP, and other sources
- Feedback from Faculty and Practices Participating in IHI and IMP

From the:

The Institute
for the
ideal medical
HOME



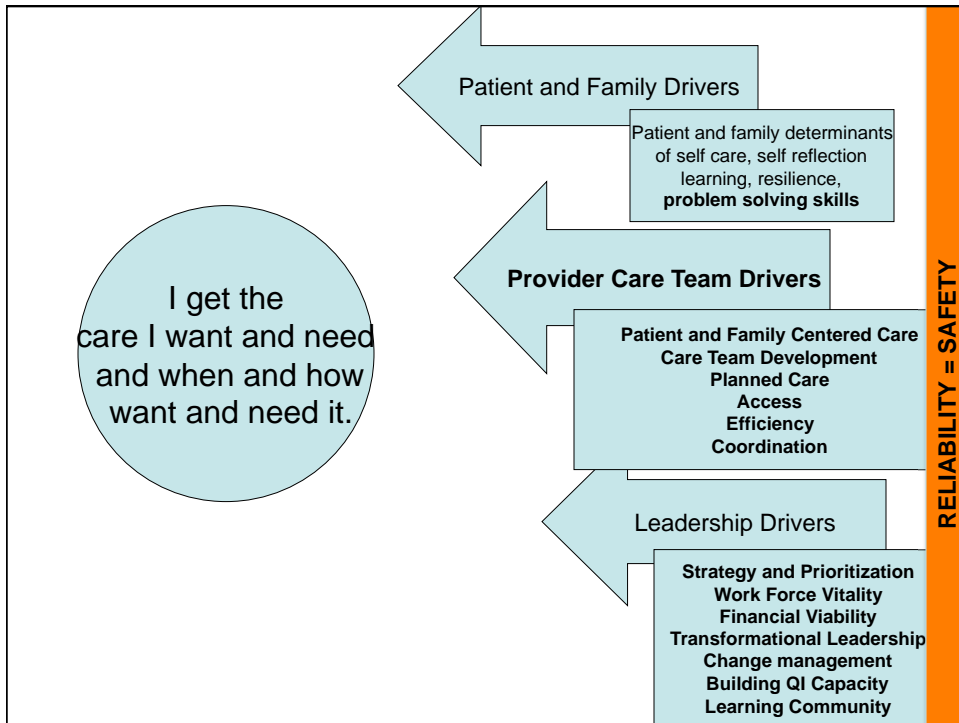
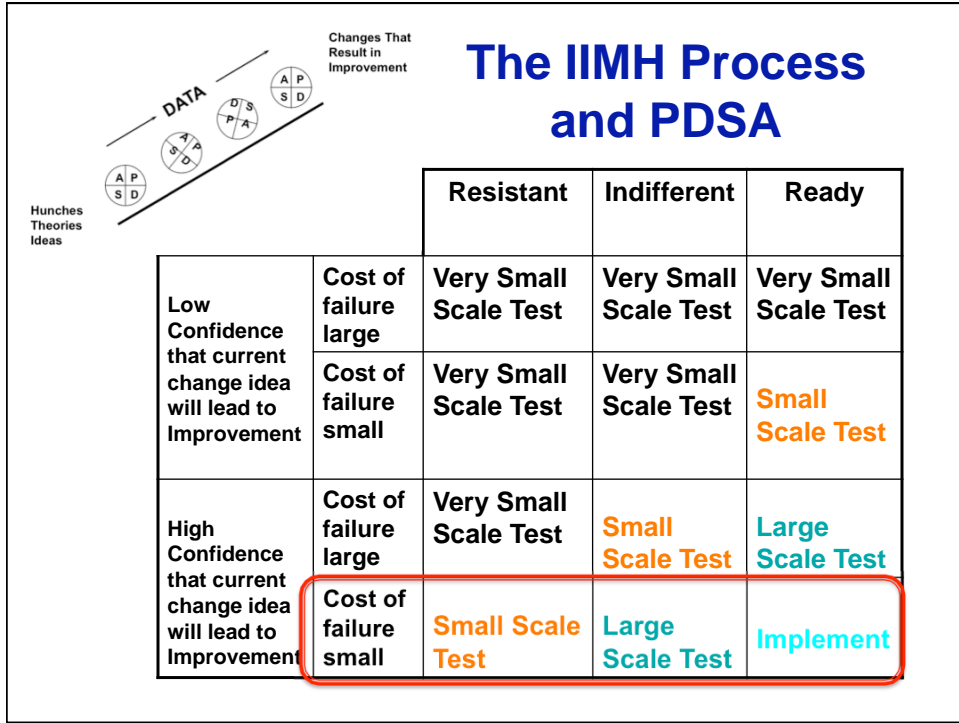
A Challenge
An Opportunity
A Solution



Why the Patient is Truly at the Center of IIMH?

- **Axiomatic** (and the core of all Models such as CCM, etc.)
- Patient-based learning motivates us to improve the value of the health care “product”
- **Practical:**
 - Patient self-interest is a source of inexpensive, useful data* for:
 - Tailoring information to their needs
 - Decreasing fragmentation of information
 - Segmenting information for reliable, efficient care
 - Evaluating care processes and outcomes
 - Necessary to Leverage Patient Self-Care

* and we can supply the HYH tools to make this possible



Behavioral change: What Works

- Good information (but information alone does not work)
- Motivation is a key determinant
 - (Is the agenda important to the patient?)
- Self efficacy (confidence) is a reliable predictor of behavior change
 - Skills mastery
 - action planning
 - problem solving
- Psychosocial context helps or impedes

Sample Tools for Assessment, Segmentation Self Management

CARE Vital Sign

What is it?

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

Patient Self Assessment

Name _____ Today's Date _____

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

2. Pain Score _____ (See reverse side)

3. Feeling Better _____ (See reverse side)

4. Health Knowledge 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!

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

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

High Leverage Changes for Access Improvement

- **Decrease appointment types**
- **Reduce demand for visits**
- **Optimize the Care Team**
- **Reduce backlog**
- **Balance demand and supply daily**
- **Develop contingency plans**

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

Reliability Strategies

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

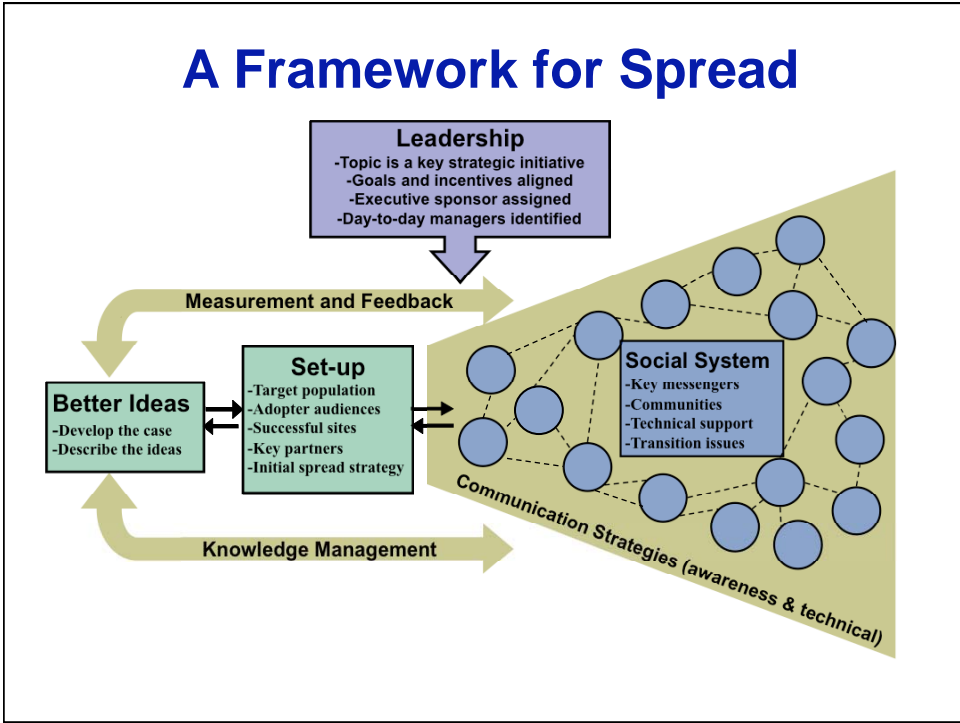
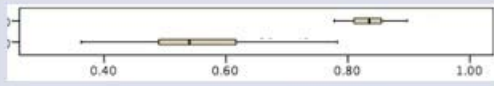
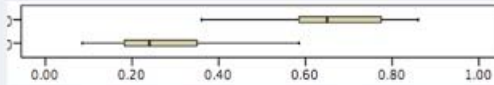
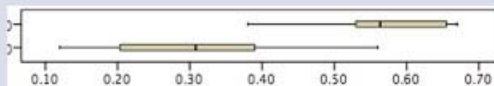
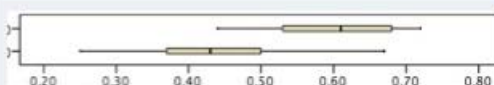
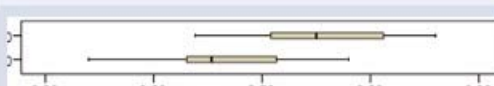



Table. Agreement between patient response domains and percentage of patients strongly agreeing with “I receive exactly the care I want and need exactly when and how I want and need it” as overall measure of patient-centered care.

Six Domains that Can Be Considered Attributes of a Patient-Centered Medical Home	Measure of Agreement (Kappa)¶	For Each of the Six Domains the Distribution of High and Low Tertile of Practices on the Overall Measure of a Patient-Centered Medical Home*
Medical Home Composite (Easy Access, Efficiency, Personal Continuity, and Coordinated Care).	Substantial 0.68¶	
Style of Physician and Staff is Courteous and Helpful	Substantial 0.66¶	
Communication Composite (Knows History, Explains Well, Educates Well for Disease and Decision-making)	Moderate 0.55¶	
Patient Confidence with Self-Management of Health Problems	Fair 0.38¶	
Preventive and Bio-clinical Performance Measures	Fair 0.33¶	
Activities to Maintain Health and Wellness (Exercise, Healthy Eating, Not Smoking or Excess Drink)	None -0.03	

¶ indicates statistical significance of agreement is $p < 0.01$. The verbal description of the strength of agreement is from Landis (6).

* Practices in high and low tertiles where the box-plot shows the median, the 25–75% inter-quartile range, and the total range.

Appendix 2

We use Cohen's Kappa Coefficient to assess the agreement of the six domains for the 51 practices ranked by tertile.

	Medical Home Composite	Interaction Style	Communication Composite	Patient Confidence	Prevent and Bio-clinical Performance	Wellness Activities	Hospital or ED Use In Past Year
Medical Home Composite	-	-	-	-	-	-	
Interaction Style	0.63¶	-	-	-	-	-	
Communication Composite	0.58¶	0.60¶	-	-	-	-	
Patient Confidence	0.18	0.14	0.35¶	-	-	-	
Preventive and Bio-clinical Performance	0.17	0.13	0.25	0.40¶	-	-	
Wellness Activities	-0.03	0.23	0.25	0.35¶	0.20	-	
Hospital or ED Use in Past Year	0.15	0.11	0.25	0.32¶	0.11	0.06	-

¶ Statistical Significance of Kappa= <0.01