Division of TennCare

STATE OF TENNESSEE

PCMH WEBINAR:

Population Health Management
Brief Action Planning (BAP) /Goal-Setting

Presented by: Rick Walker, Coach Lead, PCMH CCE

5/23/18

Today's Agenda

12:00-1:00 pm

- Introduction to today's topic
- Brief Action Planning (BAP)
- Goal Setting for High-Risk patients
- Facilitated Discussion
  - Best Practices, Challenges and Novel Ideas

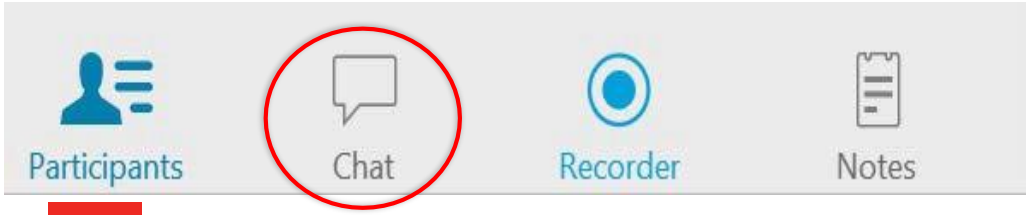
Introduction to Today's Webinar

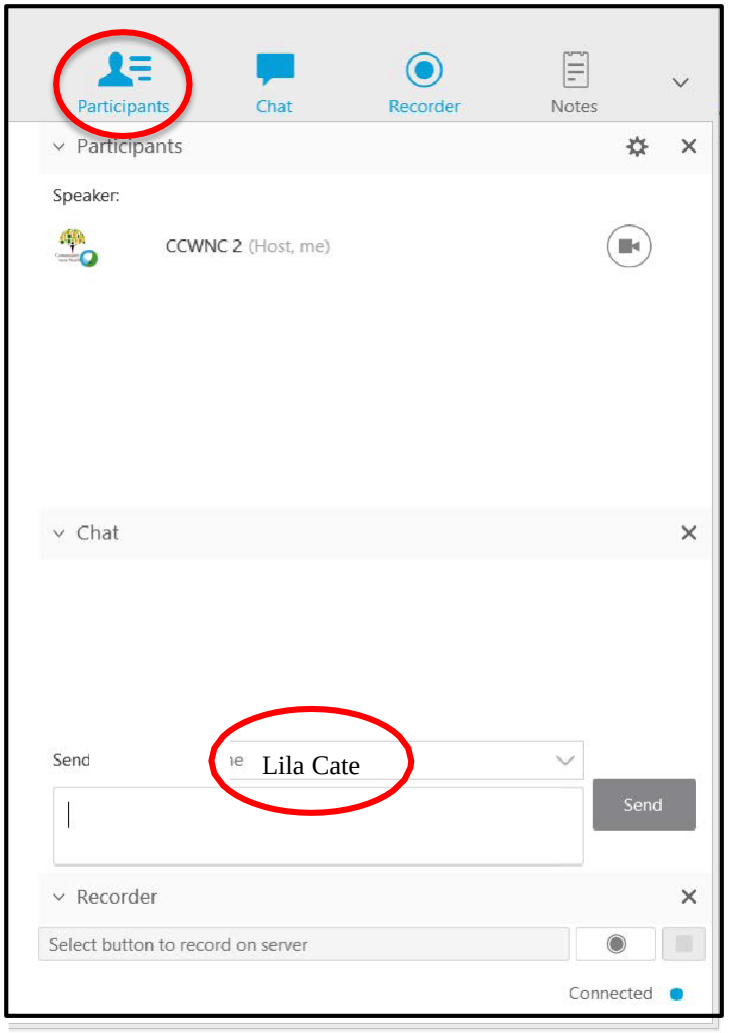
Use the Chat Box during the presentation:

- Send to the Host
  - BEST PRACTICES
  - CHALLENGES
  - NOVEL IDEAS
  - QUESTIONS

Example:

- "NOVEL IDEA – STRUCTURED COMMUNICATION: My practice meets at the end of the day, rather than in the morning"





Quick Review: PCMH 2017 Terminology

6 Concepts

TC: Team-Based Care and Practice Organization

KM: Knowing and Managing your Patients

AC: Patient-Centered Access and Continuity

CM: Care Management and Support

CC: Care Coordination and Care Transitions

QI: Performance Measurement and Quality Improvement

Today we will cover the following concept:

CM : Care Management and Support

Population Management: Brief Action Planning (BAP)

Relevant PCMH 2017 Criteria

Goal Setting for HIGH-RISK PATIENTS *(This requires a CHART AUDIT)*:

- **CM4 (Core):** Establishes a person-centered care plan for patients identified for care management.
- **CM5 (Core):** Provides written care plan to the patient/family/caregiver for patients identified for care management.
- **CM6 (1):** Documents patient preference and functional/lifestyle goals in individual care plans.
- **CM7 (1):** Identifies and discusses potential barriers to meeting goals in individual care plans.
- **CM8 (1):** Includes a self-management plan in individual care plans.
- **CM9 (1):** Care plan is integrated and accessible across settings of care.

Why Take Time to Talk About All This?

1. High Risk Patients are ***HARD***!
2. History (and the medical literature) has shown us we ***could do better***
3. We may need some ***new approaches***
4. BAP grew out of ***Motivational Interviewing***

Spirit of MI

- **C**ompassion
- **A**cceptance
- **P**artnership
- **E**vocation

Miller W, Rollnick S. Motivational Interviewing: Preparing People for Change, 3ed, 2013

Spirit of MI?

Compassion

Acceptance

Partnership

Evocation

CAPE

- Sign of Respect
- Protection – creating a space for them to work on change
- Not “tricks” or “techniques”

What We Know Doesn't Work

- Persuasion
- Telling
- Guilting
- Fearmongering
- Warning

We call this the "Righting Reflex"

A Big Assumption and Mistake?

- We actually ***BELIEVE*** that patients are ready to change.

- But What About **Ambivalence**?

Feeling Ambivalent? Well…
Yes – and – No

Ambivalence is *NORMAL*

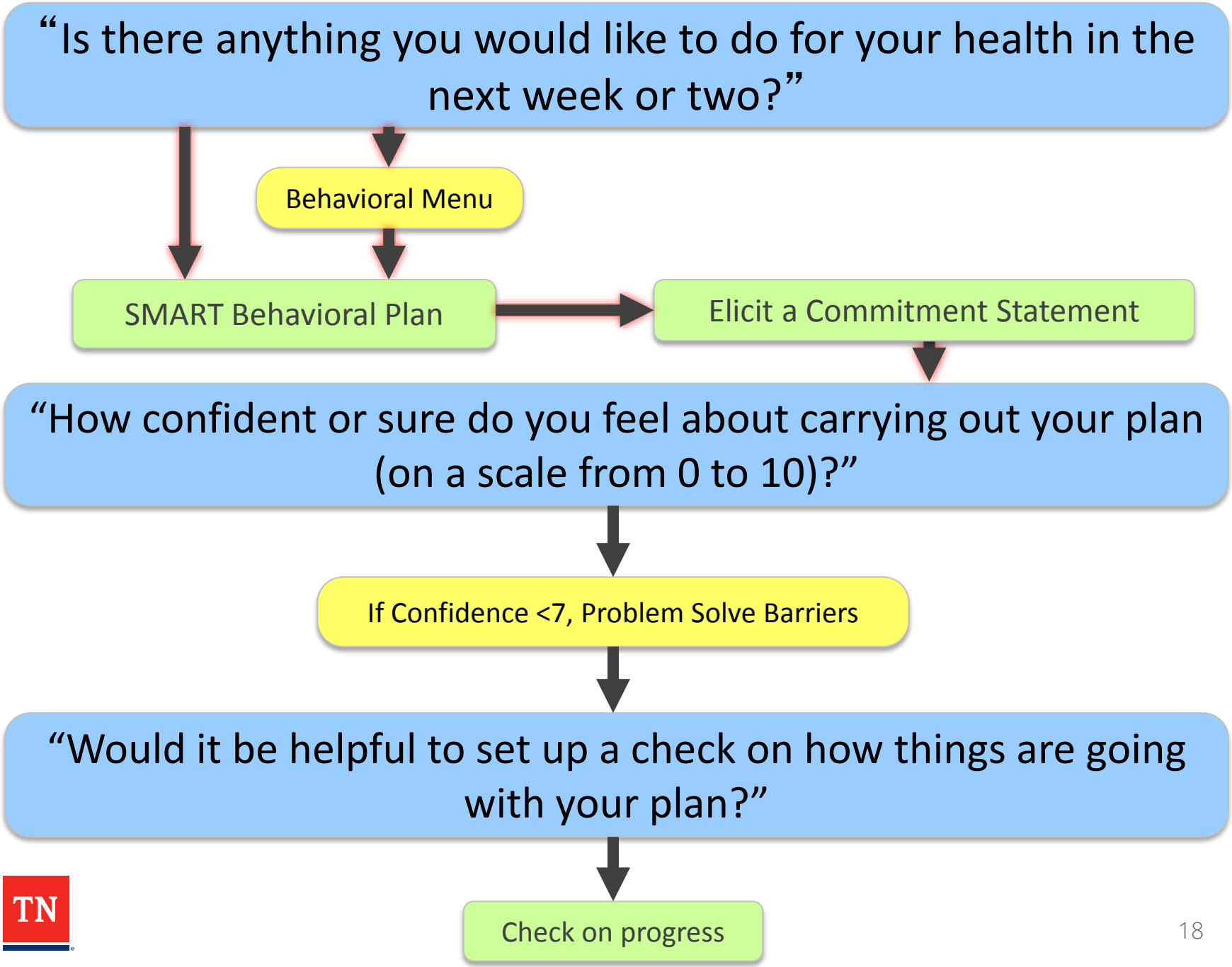
NO FIXIN'!!

Buy-In is the Key

"People are usually better persuaded by the reasons which they have themselves discovered than by those which have come to the minds of others."

~ Blaise Pascal

Brief Overview of BAP / Goal-Setting


"Is there anything you would like to do for your health in the next week or two?"
Behavioral Menu
SMART Behavioral Plan
Elicit a Commitment Statement
"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"
If Confidence <7, Problem Solve Barriers
"Would it be helpful to set up a check on how things are going with your plan?"
Check on progress

Question #1: Focusing

"Is there anything you would like to do for your health in the next week or two?"

Possible Responses to Question 1

1. Have an idea
2. Need some help with an idea (or not sure what you mean)
3. Not at this time
    a. Healthy
    b. Not interested

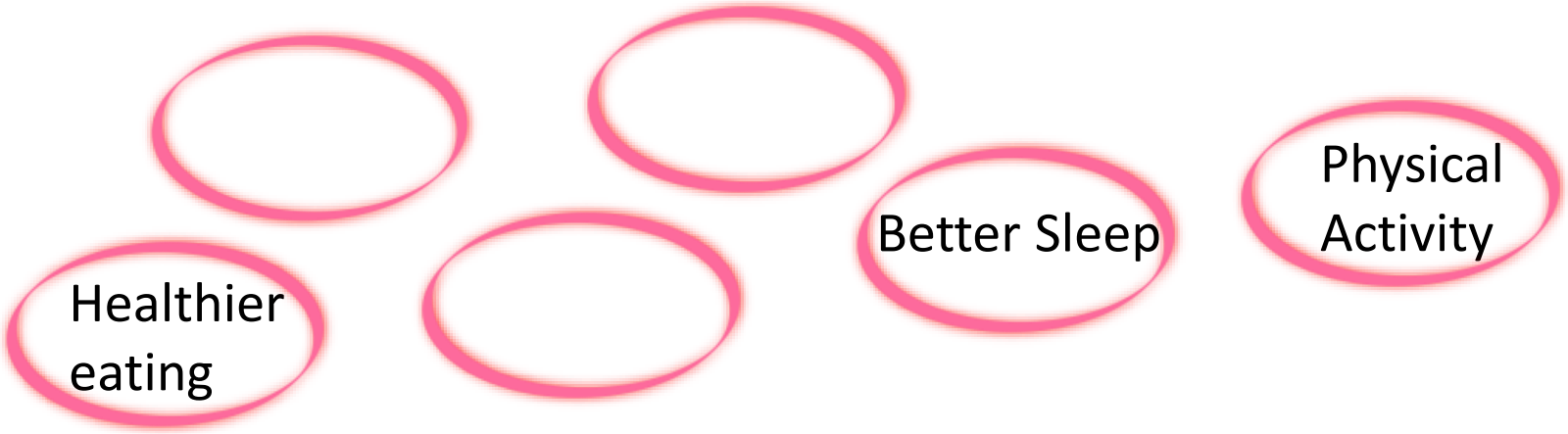
Skill #1

Behavioral Menu

Offer a behavioral menu when needed or requested

Behavioral Menu

1. “Is it okay if I share some ideas from other people who are working on something similar?”
2. If yes, share two or three varied ideas briefly all together in a list. Then say…
3. “Maybe one of these would be of interest to you or maybe you have thought of something else while we have been talking?”



Adapted from Stott et al, Family Practice 1995; Rollnick et al, 1999, 2010

Skill #2

SMART Behavioral Plan

Action Planning is “SMART”:
Specific, Measurable, Achievable, Relevant and Timed

With **permission**:

- What?
- When?
- Where?
- How often/long/much?
- Start date?

Based on the work of Locke (1968) and Locke & Latham (1990, 2002); Bodenheimer, 2009

Skill #3

Elicit a Commitment Statement

After the plan has been formulated, the clinician/coach elicits a final "commitment statement."

Strength of the commitment statement predicts success on action plan.

Aharonovich, 2008; Amrhein, 2003

Question #2: Confidence Scale

"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"

Skill #4

Problem Solving

Problem-solving is used for confidence levels less than 7.

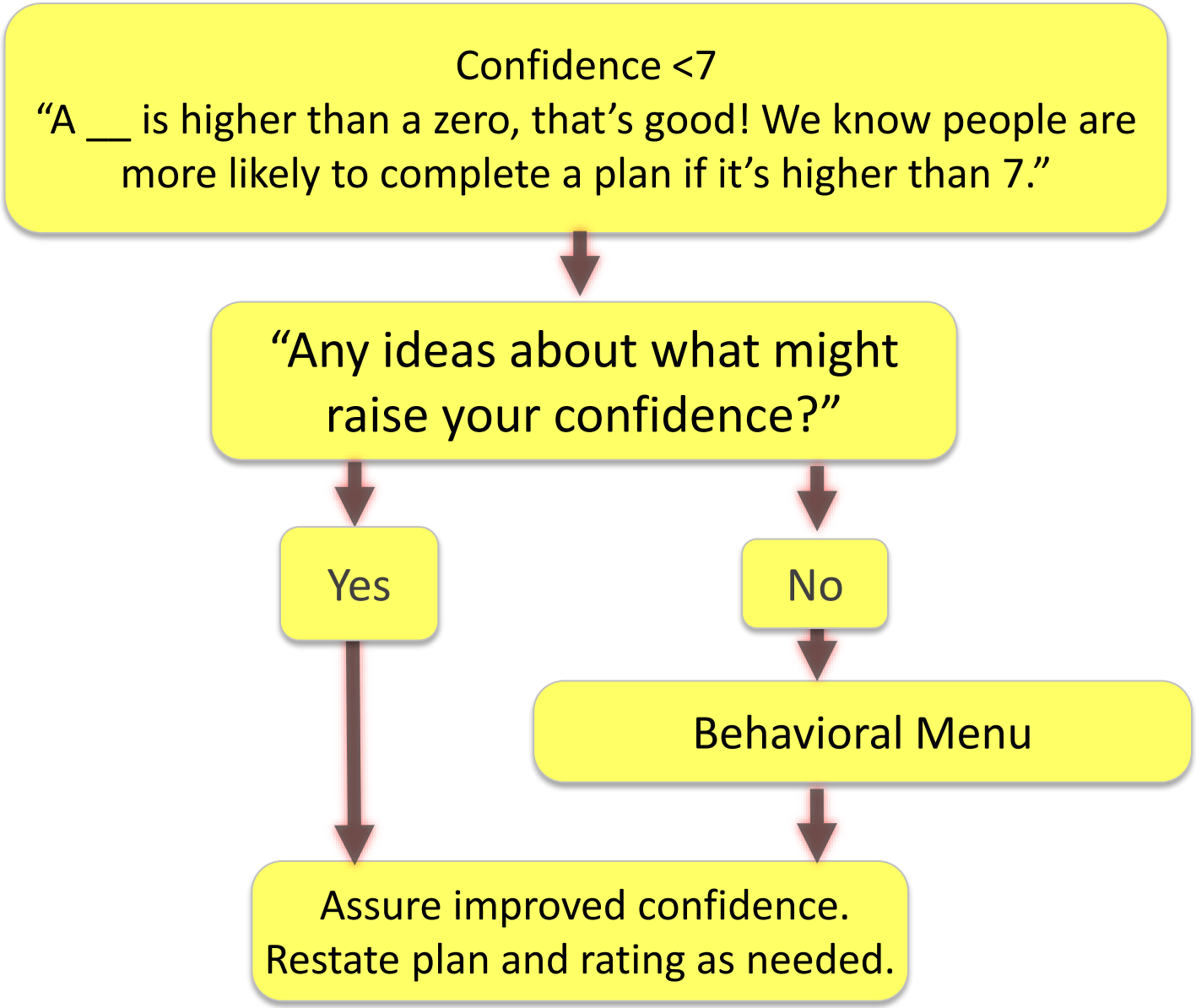
Bandura, 1983; Lorig et al, Med Care 2001; Bodenheimer review, CHCF 2005; Bodenheimer, Pt Ed Couns 2009.

Self-efficacy

People's beliefs about their capabilities to perform specific behaviors and their ability to exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave.

- Albert Bandura

Problem solving



Question #3 - Accountability

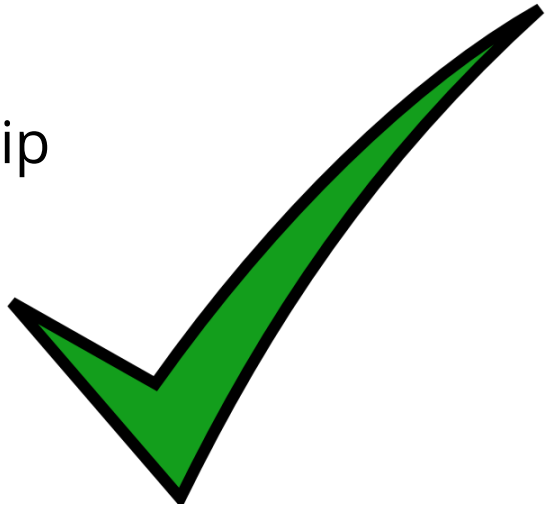
"Would it be helpful to set up a check on how things are going with your plan?"

Skill #5

Check on progress

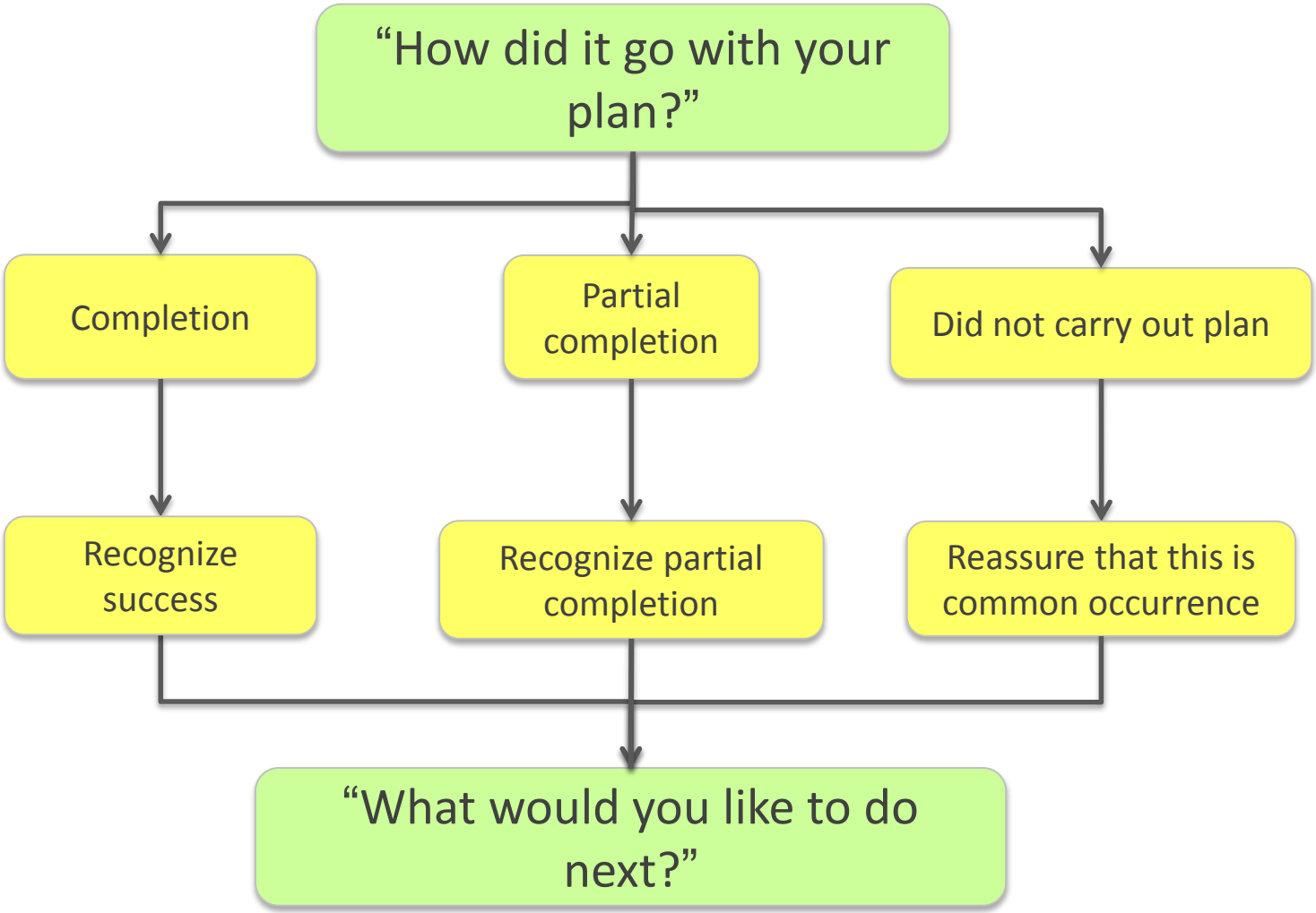
Checking on the plan builds confidence

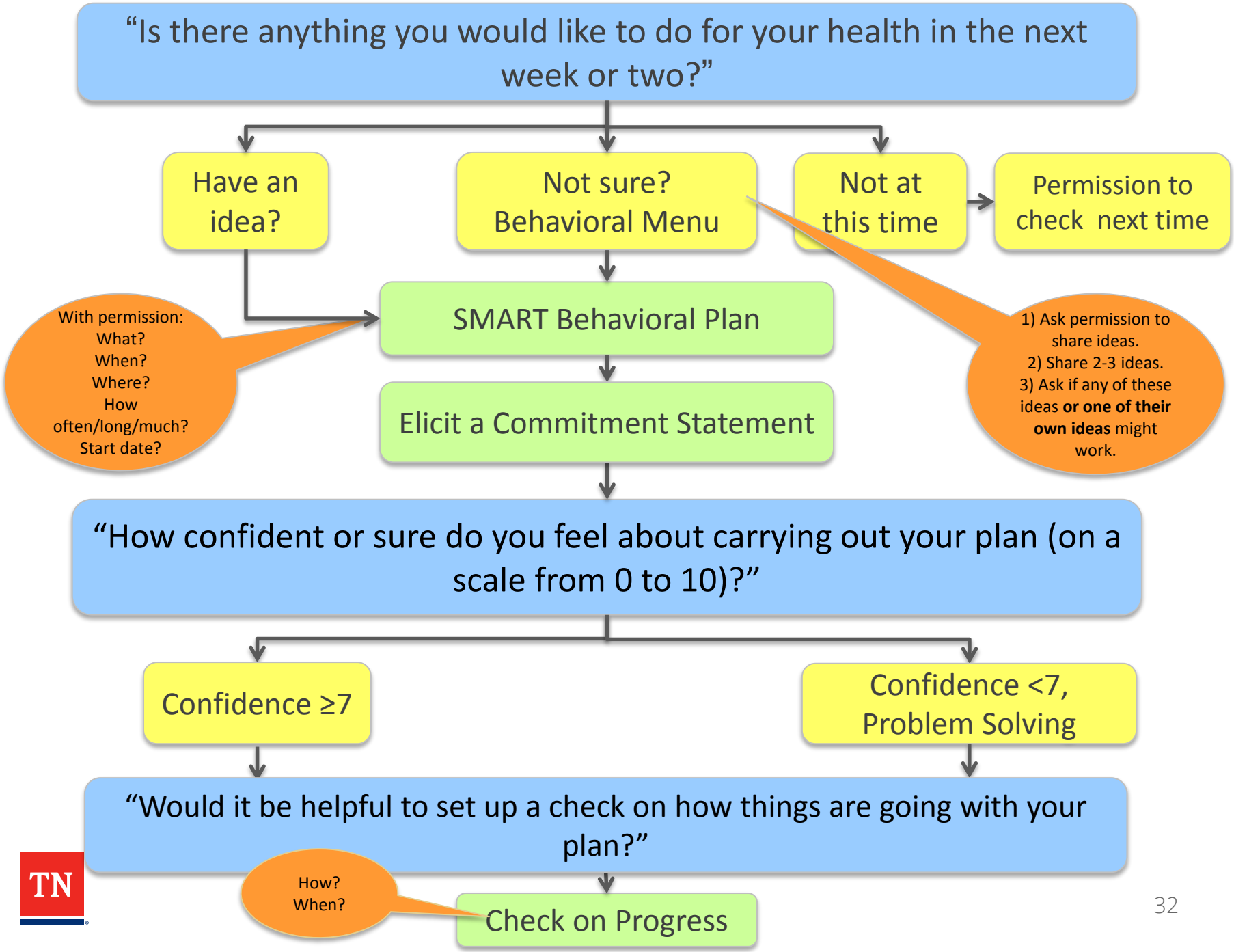
- Check often with new action plans and decrease frequency as behavior is more secure.
- When working with a clinician
- Regular contact over time is better than 1x intervention.
- Follow-up builds a trusting relationship



Resnicow, 2002; Artinian et al, Circulation, 2010

Checking On Plan with Clinician




"Is there anything you would like to do for your health in the next week or two?"
Have an idea?
Not sure? Behavioral Menu
Not at this time
Permission to check next time
With permission: What? When? Where? How often/long/much? Start date?
SMART Behavioral Plan
Elicit a Commitment Statement
1) Ask permission to share ideas. 2) Share 2-3 ideas. 3) Ask if any of these ideas or one of their own ideas might work.
"How confident or sure do you feel about carrying out your plan (on a scale from 0 to 10)?"
Confidence ≥7
Confidence <7, Problem Solving
"Would it be helpful to set up a check on how things are going with your plan?"
How? When?
Check on Progress

BAP Guide

- https://old.centrecmi.ca/wp-content/uploads/2016/08/BAP_guide_2016-08-08.pdf

The Brief Action Planning Guide
A Self-Management Support Tool for Chronic Conditions, Health, and Well-being
8 Aug 2016

Brief Action Planning is structured around 3 core questions, below. Depending on the response, other follow-up questions may be asked. If at any point in the interview, it looks like it may not be possible to create an action plan, offer to return to it in a future interaction. Checking on the plan is addressed on page 2. Question #1 of Brief Action Planning is introduced in interactions after rapport has been established.

1. Ask Question #1 to elicit ideas for change. "Situation" may be substituted when appropriate.
   "Is there anything you would like to do for your health in the next week or two?"
   a. If an idea is shared and permission received, help the person make the plan SMART - Specific, Measurable, Achievable, Relevant and Timed. You may need to explain what a plan is.
      "Many people find it useful to get very specific about their plan. Would that work for you?"
      With permission, complete as many details as are welcomed or helpful.
      "What?" (type of activity, specific behavior or action; consider giving an example or examples if useful.)
      "When?" (time of day, day of week)
      "Where?"
      "How often/long/much?" (often: once, three times, five times; long: minutes, days; much: servings, meals)
      "When would you like to start?"
   b. For individuals who want or need suggestions, offer a behavioral menu.
      i. First ask permission to share ideas.
         "Would you like me to share some ideas that others have used or that might fit for your situation?"
      ii. Then share two to three ideas ALL AT ONCE. The ideas are relevant to their goal, not too specific, and varied. Use the last idea to prompt one of their own.
         "Some things you might try are _____, _____ or maybe you have an idea of your own that occurs to you now."
      iii. Then ask what they want to do.
         "Do any of these ideas work for you?"
      iv. If an idea is chosen, with permission, specify the details in order to make the plan SMART (1a above).
   c. After the individual has made a specific plan, elicit a commitment statement.
      "Just to make sure we both understand the details of your plan, would you mind putting it together and saying it out loud?"
2. Ask Question #2 to evaluate confidence. The word "sure" can be substituted for the word "confident." Words, gestures, images or analogies (such as climbing a mountain) can be substituted for numbers. Scaling confidence without numbers often requires judgment. Use non-verbal cues and clarifying questions as needed to make an assessment about whether or not the person may or may not benefit from further problem-solving.
   "I wonder how confident you feel about carrying out your plan. Considering a scale of 0 to 10, where '0' means you are not at all confident or sure and '10' means you are very confident or very sure, how confident are you about completing your plan?"
   a. If confidence level is greater than or equal to 7, go to Question #3 below.
      "That's great. It sounds like a good plan for you."
   b. If confidence level is less than 7, problem solve to overcome barriers or adjust the plan. Explain the reason to boost confidence.
      "5 is great. That's a lot higher than 0, and shows a lot of interest and commitment. We know that when confidence is a 7 or more, people are more likely to complete their plan. Do you have any ideas about what might raise your confidence to a 7 or more?"
   c. If they do not have any ideas to modify the plan, ask if they would like suggestions.
      "Would you like to hear some ideas that might raise your confidence?"
   d. If the response is "yes," provide two or three ideas (behavioral menu). Often the following menu applies:
      "Sometimes people cut back on their plan, change their plan, make a new plan or decide not to make a plan. Do you think any of these work for you or is there an idea of your own?"
   e. If the plan is altered, repeat step 1c and Question #2 as needed to evaluate confidence with the new plan.

Video Break! All Skills

How Do I Apply All This In Practice??

What is Patient-Centered care?

Patient-Centered care is a model of care that actively involves you when making decisions about your options for treatment with the support of your entire health care team.

Why is Goal-Setting important?

Because patients who work on a goal at home lead healthier lifestyles.

How do you make a SMART goal?

For a goal to be **SMART**, it must be Specific, Measurable, Attainable, Realistic, and Timely:

Specific: Answer the questions, what, why, and how you will accomplish it.

Measurable: State how you will prove that you have accomplished the goal.

Attainable: Challenge yourself, but be realistic.

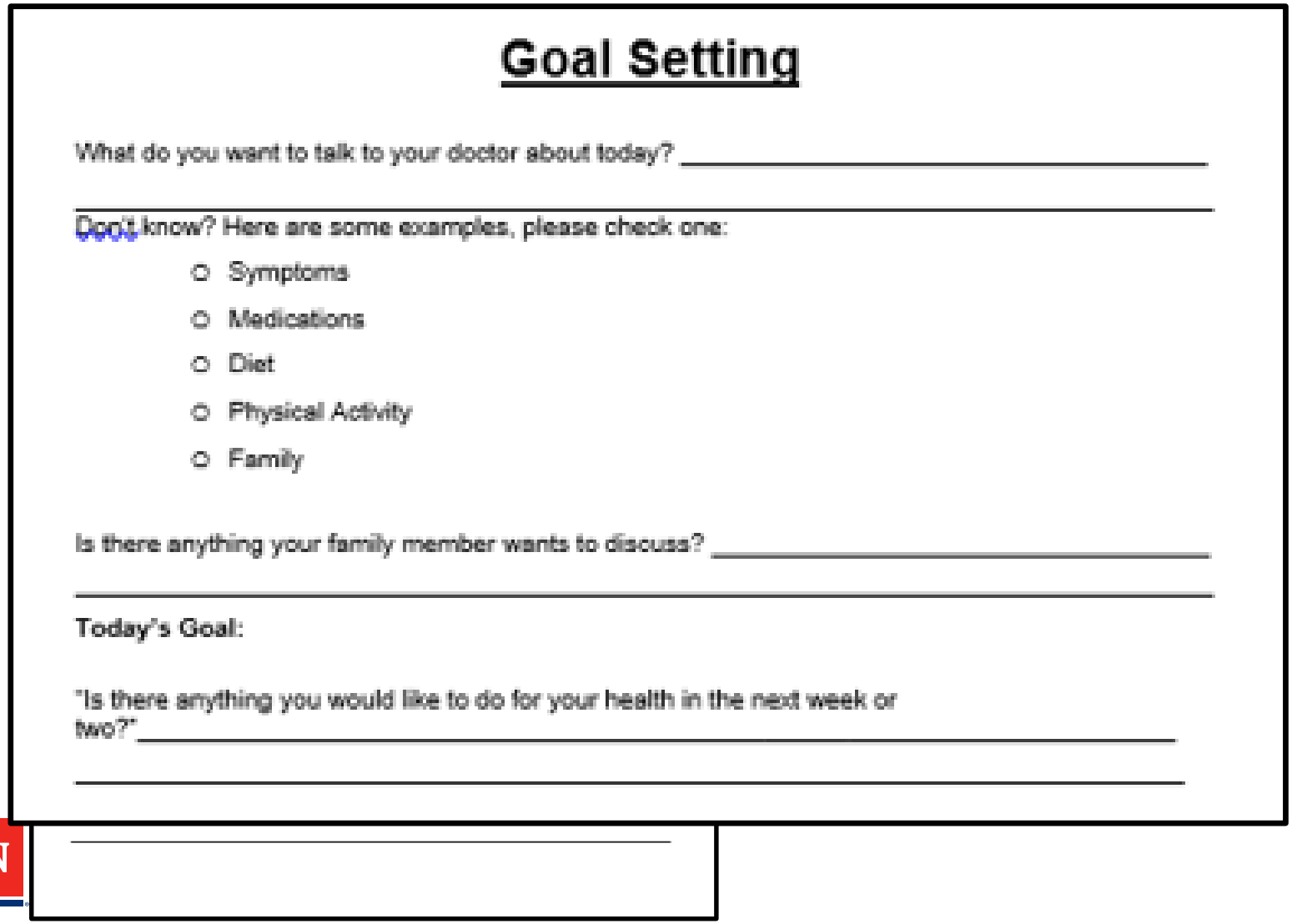
Realistic: Be honest about what you can do.

Timely: Set a date to complete it.

Now that you know about SMART goals, please complete the attached **Goal Setting Form.**

Our clinical staff is here to help you. They will be talking with you about this form as part of your visit today. Your provider will also be talking about this plan with you today. They will set a specific treatment goal with you which will be added to the bottom of the form.

Goal Setting Sheet



Goal Setting

What do you want to talk to your doctor about today? _____

_____

Don't know? Here are some examples, please check one:

- ○ Symptoms
- ○ Medications
- ○ Diet
- ○ Physical Activity
- ○ Family

Is there anything your family member wants to discuss? _____

_____

Today's Goal:

"Is there anything you would like to do for your health in the next week or two?" _____

_____

_____

Goal Setting Sheet

What small change can you think of to help you move towards this goal?

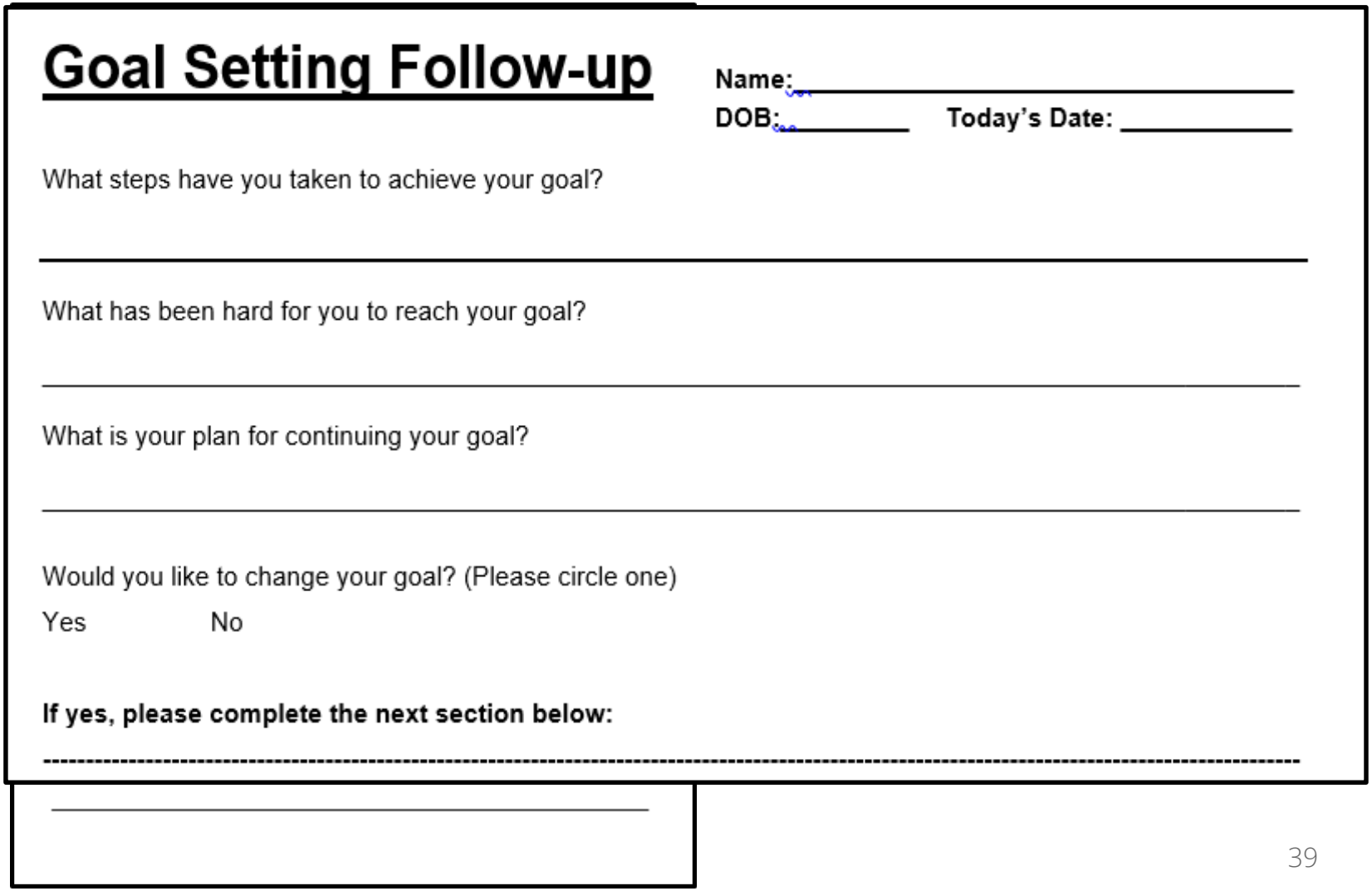
What might make it hard to do this (what might get in the way of your progress)?

How confident are you that you can make changes?
Please circle a number.

For Provider use only:

Your Provider's goal for you is:

Goal Setting Follow-up Sheet



Goal Setting Follow-up

Name: _____

DOB: _____ Today's Date: _____

What steps have you taken to achieve your goal?

_____

What has been hard for you to reach your goal?

_____

What is your plan for continuing your goal?

_____

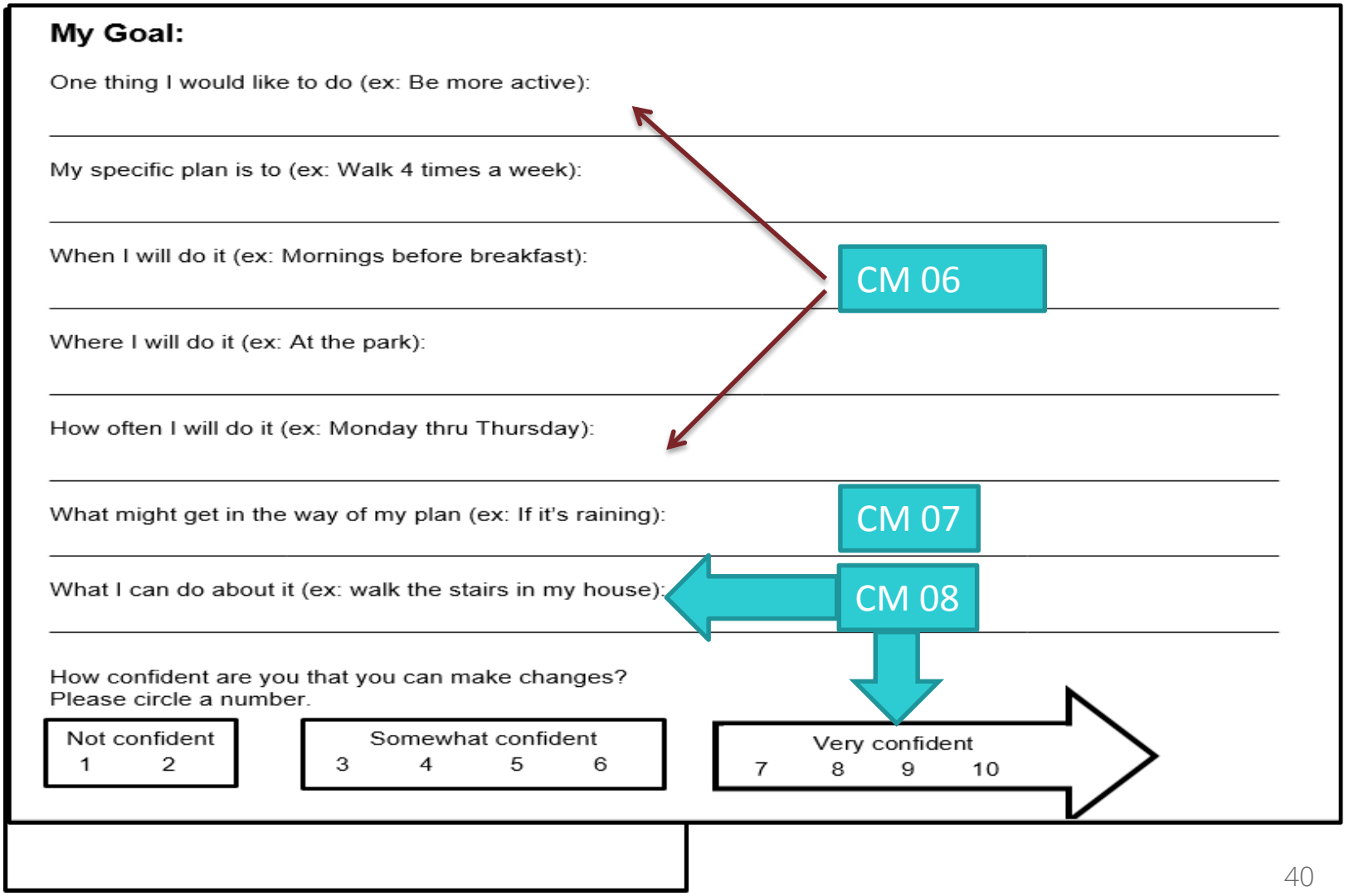
Would you like to change your goal? (Please circle one)

Yes No

If yes, please complete the next section below:

_____

Goal Setting Follow-up Sheet



Or, You May Like This One!

Taking Care of My Health or Well-Being

16 Mar 2015

Today's Date: _____

My health or well-being goal is: _____

1) Make an action plan:

Is there anything you'd like to do for your health or well-being in the next week or two? If there isn't anything you'd like to do for your health or well-being right now, you might want to consider this again in the future. If yes, fill in the following details. Some of these may not apply. Try to be as specific as possible.

My Action Plan	My Answers	Comments
What would you like to do?		
Where?		
When and how often? (What time of day will you do this? If it happens more than once—how often will it happen?):		
How long or how much? (minutes, servings, etc.)		
When will you start?		

2) Review your plan

2a) How sure or confident are you that you will be able to accomplish your plan?

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

***Note:** If you chose 6 or lower, go to question 2b. If you chose 7 or higher, go on to question 3.

2b) How might you change your plan to make it possible to raise your number to 7 or higher?

_____

3) Check how you are doing

- ☐ I will do this myself
- ☐ I will check with someone else (a family member or a healthcare team member)

  Who is that person? _____

How and when would you like to check in (i.e. in a week or a day, by phone or in person)

_____

Adjust your plan as needed. Remember to celebrate things that went well!

Or, You May Like This One! (continued)

Taking Care of My Health or Well-Being

16 Mar 2015

Today's Date: _____

EXAMPLE

My health or well-being goal is: *I want to lose some weight.*

1) Make an action plan:

Is there anything you'd like to do for your health or well-being in the next week or two? If there isn't anything you'd like to do for your health or well-being right now, you might want to consider this again in the future. If yes, fill in the following details. Some of these may not apply. Try to be as specific as possible.

My Action Plan	My Answers	Comments
What would you like to do?	*I'd like to get some exercise by walking.*	
Where?	*In the park near my house*	
When and how often? (What time of day will you do this? If it happens more than once—how often will it happen?):	*Mon, Wed, Fri from 1-1:30 in the afternoon*	*I'll do it after I eat lunch.*
How long or how much? (minutes, servings, etc.)	*for about 20 minutes*	
When will you start?	*I'll start today!*	

2) Review your plan

2a) How sure or confident are you that you will be able to accomplish your plan?

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

***Note:** If you chose 6 or lower, go to question 2b. If you chose 7 or higher, go on to question 3.

2b) How might you change your plan to make it possible to raise your number to 7 or higher?

_____

3) Check how you are doing

☐ I will do this myself

☑ I will check with someone else (a family member or a healthcare team member)

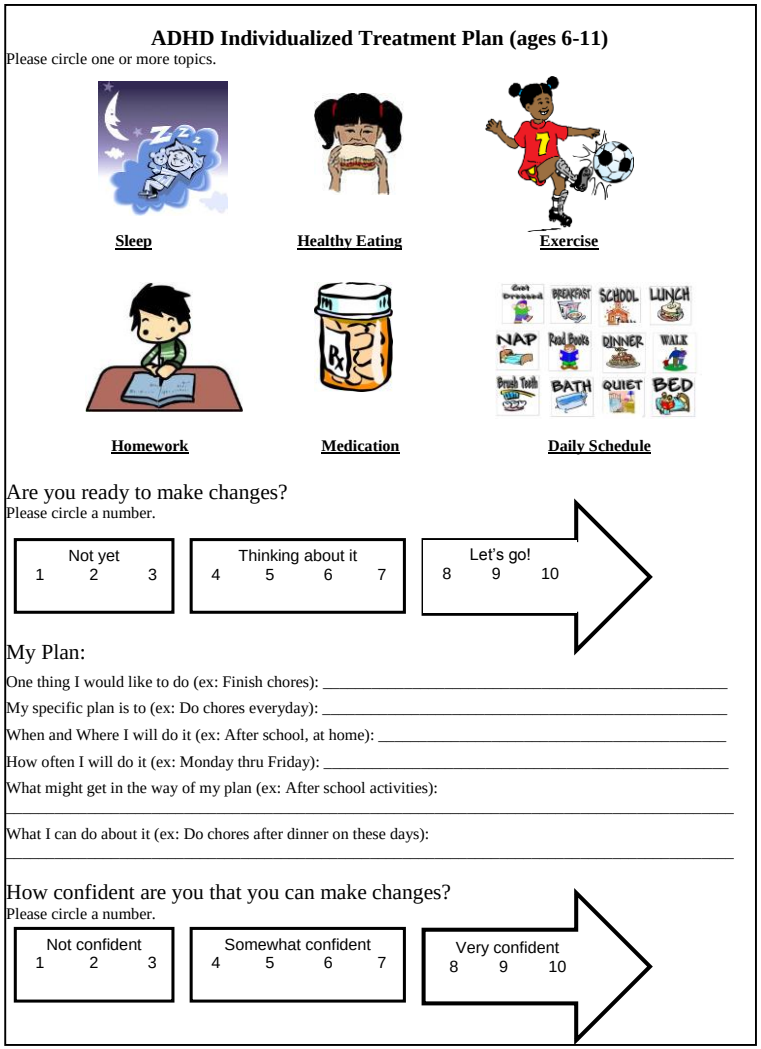
Who is that person? *My wife*

How and when would you like to check in (i.e. in a week or a day, by phone or in person)

I will check in with her in the evenings over dinner

Adjust your plan as needed. Remember to celebrate things that went well!

Care Plan Example



ADHD Individualized Treatment Plan (ages 6-11)

Please circle one or more topics.

Are you ready to make changes?

Please circle a number.

Not yet	Thinking about it	Let's go!
1 2 3	4 5 6 7	8 9 10

My Plan:

One thing I would like to do (ex: Finish chores): _____

My specific plan is to (ex: Do chores everyday): _____

When and Where I will do it (ex: After school, at home): _____

How often I will do it (ex: Monday thru Friday): _____

What might get in the way of my plan (ex: After school activities):

_____

What I can do about it (ex: Do chores after dinner on these days):

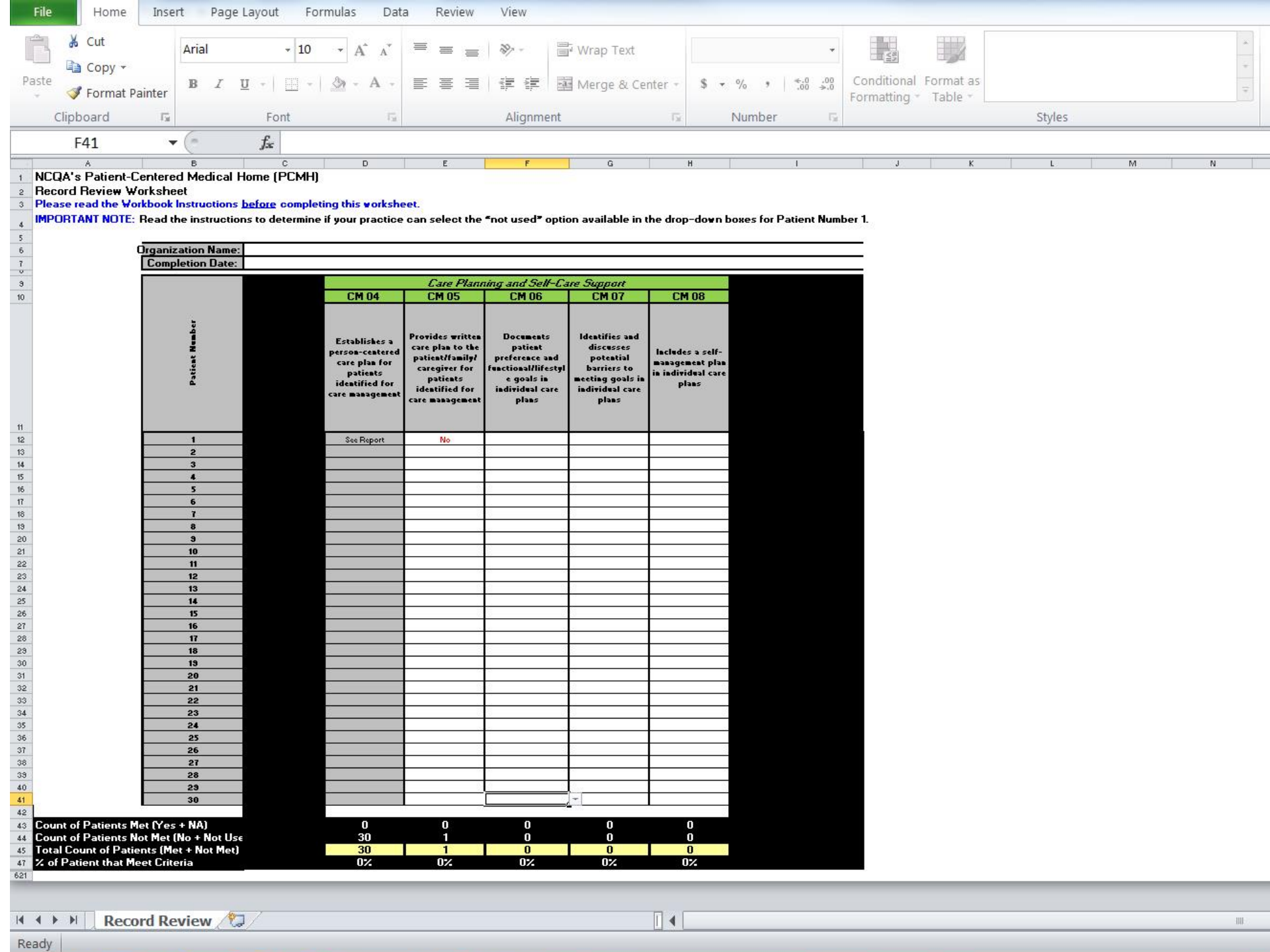
_____

How confident are you that you can make changes?

Please circle a number.

Not confident	Somewhat confident	Very confident
1 2 3	4 5 6 7	8 9 10

- 2017 NCQA Standards Met:
  - CM 04 (core)
  - CM 05 (core)
  - CM 06 (1 credit)
  - CM 07 (1 credit)
  - CM 08 (1 credit)



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Arial 10 Font

Wrap Text Merge & Center Alignment

Number

Conditional Formatting Format as Table Styles

F41

NCQA's Patient-Centered Medical Home (PCMH)

Record Review Worksheet

Please read the Workbook Instructions before completing this worksheet.

IMPORTANT NOTE: Read the instructions to determine if your practice can select the "not used" option available in the drop-down boxes for Patient Number 1.

Organization Name:

Completion Date:

Patient Number	Care Planning and Self-Care Support				
	CM 04	CM 05	CM 06	CM 07	CM 08
	Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/ caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1	See Report	No			
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
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19					
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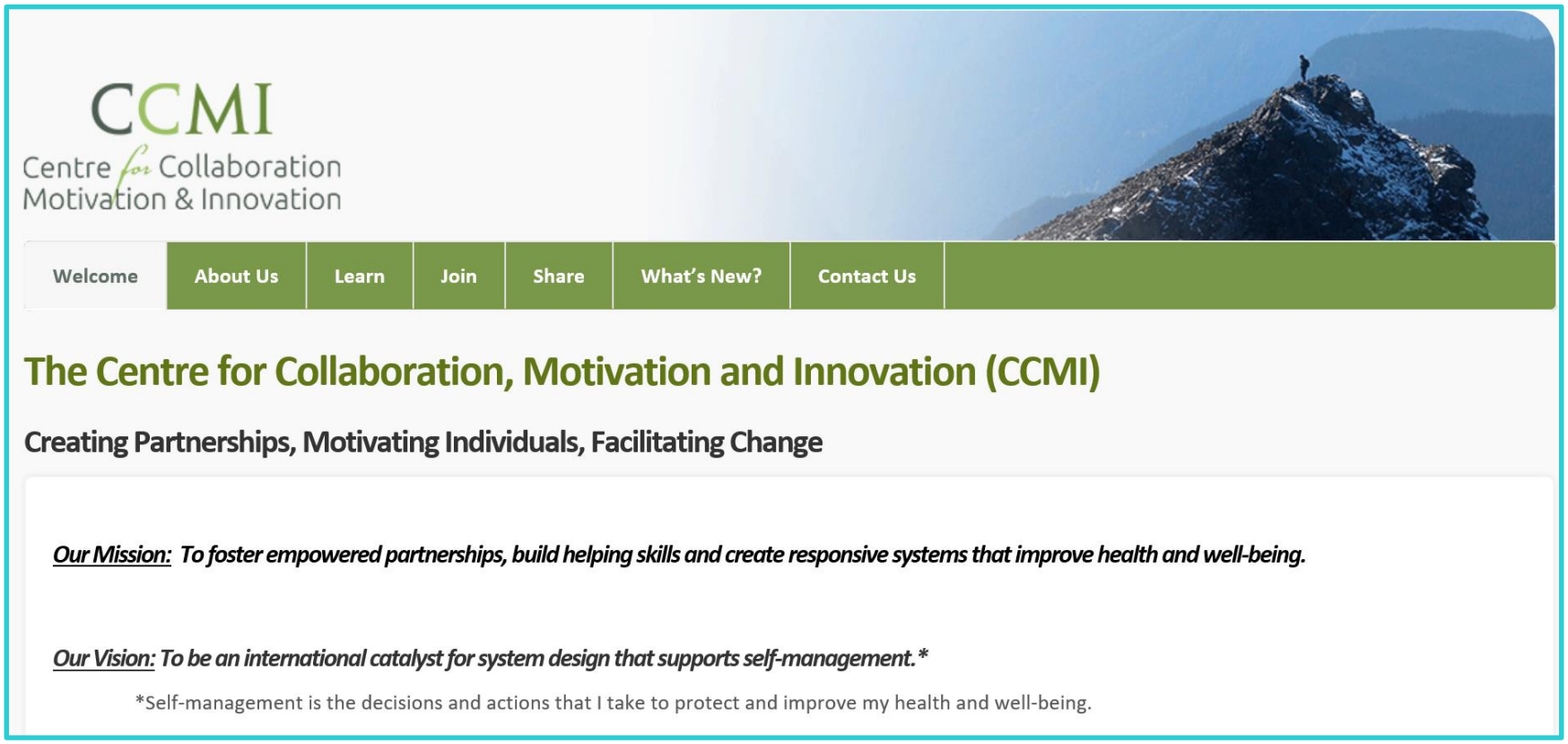
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
Count of Patients Met (Yes + NA)	0	0	0	0	0
Count of Patients Not Met (No + Not Use	30	1	0	0	0
Total Count of Patients (Met + Not Met)	30	1	0	0	0
% of Patient that Meet Criteria	0%	0%	0%	0%	0%

Record Review

Ready

Further Resources for BAP



Collaborative Discussion

- ✓ Best Practices
- ✓ Challenges
- ✓ Novel Ideas
- ✓ Questions

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking