

This important self-management support strategy can produce quality outcomes for your patients and your practice.

ENGAGING PATIENTS IN Collaborative Care Plans

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Lynne has diabetes and has tried to lose weight unsuccessfully for four years. Whenever she sees her family doctor, he offers suggestions for weight-loss strategies. The suggestions are never as easy to implement as they seem when in the doctor's office. At subsequent visits, she has not lost weight. Both she and her physician are getting discouraged.

At her next diabetes visit, her doctor asks her to create an action plan for weight loss. Instead of offering suggestions, he has her brainstorm things she can do to lose weight. She leaves his office with a printed action plan that even includes strategies for her to overcome barriers she identified. The action plan has her start with just one step, instead of starting a full diet. All she has to do is bring an apple to work three days a week and eat it instead of the office doughnuts.

Two weeks later, her doctor's assistant calls her to check in. Lynne admits that she did great the first week, but yesterday the office had a birthday party for a coworker. Her apple went uneaten, replaced by a piece of cake. She feels like a failure.

The medical assistant congratulates her on her progress and offers encouragement, reassuring her that everyone slips now and then. Together they brainstorm solutions for birthday parties and update her action plan. After this phone call, Lynne feels more positive about continuing the apple snack and decides to bring an apple at least four days a week. In three months, she loses three pounds.

Over half of adults have at least one chronic condition, and many have two or more.¹ The great majority of these adults lack the knowledge, confidence, and skills to manage their

conditions.² The time their physicians need to effectively address chronic conditions, provide recommended preventive health care, and treat acute problems far exceeds the number of hours available in a physician's day.^{3,4}

Although medications for chronic illnesses play a major role in prolonging lives, patient lifestyle modification is a critical determinant of health quality. While family physicians are well aware of the importance of patients becoming active managers of their own health, many family physicians have not been trained to engage patients in successful self-management. The realization that time constraints and new skill training need to be addressed has led to increasing emphasis on a teamlet model⁵ of primary care combined with innovative applications of the electronic health record (EHR).⁶ In this article, we propose that well-trained teamlets using EHR tools for creating collaborative care plans will improve the health outcomes of patients with chronic conditions and help family medicine practices thrive in the future as payment models based on quality of care become the norm.

A new mindset

Effective engagement of patients in their self-care requires a new mindset on the part of the health care team. Most clinicians resort to using logic, facts, and persuasion to modify patients' behavior. Physicians spend a good deal of



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time *telling* patients the changes they need to make and warn of the consequences of being “noncompliant.” When the patient returns for a follow-up visit having been unsuccessful in making recommended changes, the physician tends to repeat the admonitions for change, perhaps a bit more urgently and forcefully. Unfortunately, these techniques are rarely successful and do not instill intrinsic motivation in the patient.⁷

Physicians need to move beyond simply telling patients what to change and instead jointly develop a plan.

Team-based care can deal with the time constraints that prevent provider-patient collaboration.

Collaborative care plans help patients set goals and identify specific steps to achieve them.

William Butler Yeats is credited as once saying, “Education is not the filling of a pail, but the lighting of a fire.” We suggest that primary care teams avoid filling pails and instead think of their role as kindling the fire of patient activation. This approach will encourage patients to become more engaged in their care. *Dance* with your patients, rather than wrestle or argue. Primary care team members can coach, offering encouragement and tips for success. (To learn more about health coaching, see the article on page 40.) Instead of dictating plans to patients, ask questions (for example, “Help me understand. Why is this difficult?”) to learn about the patient’s world view. Said differently, if people do not adopt healthy habits, there is always a reason. Our job is to understand these reasons and help the patient address barriers to healthier living.

Even with a collaborative approach to patient care embedded in the mind of the team, it remains difficult to find the time and tools to successfully assist patients in setting realistic health goals and action plans. We propose combining five ingredients to improve patient self-management:

- Communication skills that promote time management,
- Problem-solving skills,
- Teamwork between the family physician and medical assistant or nurse,
- Training,
- Using the EHR to support this effort.

Time management

In the rush of a busy office practice, time to have important conversations with patients

is often lost to the “tyranny of the urgent,” professional agendas, and feeling overwhelmed. Team-based care can ease this burden. Family physicians have to balance addressing acute problems, preventive care, and chronic care with what the patient chooses for self-management. Learning to collaboratively set the agenda with each patient is essential to managing time and decreasing time-management anxiety.^{8,9}

While rooming the patient, the clinical assistant should initiate agenda setting. In some practices, this will be the nurse, and in others, a medical assistant. In addition to acknowledging the documented reason for the visit, the assistant should ask, “Is there something else you want to discuss with us today?” This question should be repeated until the patient has nothing to add. For the subset of patients who have lists that are obviously too long for a single visit, the assistant can add, “We may not be able to do a good job on all of these problems in one visit, so let’s pick the ones that are most important to you.” Clinical assistants should also ask whether there are any refill requests or forms the patient needs to have completed.

After greeting the patient and re-establishing rapport, the physician should acknowledge and confirm the agenda. For example, “I see that you have several things you want to discuss today, and Christine tells me that your ongoing low-back pain is most important to you. Have we missed anything more important?” A more detailed description of collaborative agenda-setting can be found in an earlier issue of *Family Practice Management*.¹⁰

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This important technique helps to organize time used in an office visit and protect time for self-management. A large study⁸ testing this method found that patients *and physicians* were less likely to bring up new “oh by the way” issues in the closing moments of the appointment. On average, visits with trained physicians were 90 seconds shorter compared to control physicians (while this finding falls shy of statistical significance, $P = 0.1$, it has clinical significance). Saved time can be devoted to creating viable care plans with patients.

Create a collaborative care plan

Research suggests that problem-solving and creating a goal and a feasible action plan improves outcomes¹¹ for problems such as diabetes,¹² weight loss,¹³ and depression.^{14,15} We call this a collaborative care plan. Effective problem-solving emphasizes patient centeredness and avoids the clinician imposing goals and plans on the patient. “Building a collaborative care plan,” shown below, presents the steps

in goal setting and action plan development with tips, suggested questions, and examples of patient responses. Every interaction does not require using every step. A flexible approach is needed based on the clinician’s experience, the nature of the goal, and the patient’s pre-existing problem-solving skills. Adopting a patient-centered approach to enhance patient self-management represents a major challenge in clinician attitude and behavior (the table on page 39 summarizes differences between provider-determined versus patient-determined goals).

Once a realistic action plan has been developed, printed, and given to the patient, follow-up can be arranged. It is critical to include this step; regular, early follow-up is highly correlated with the patient’s likelihood to complete the plan.¹¹ Often follow-up is offered by other members of the medical team, as will be discussed below. A sample of a collaborative care plan that an EHR might produce is shown on page 38. A template can be downloaded from the online version of this article at <http://www.aafp.org/fpm/2013/0500/p35.html>. ►

BUILDING A COLLABORATIVE CARE PLAN, STEP BY STEP

1. Help the patient focus on a specific goal.

Tip: Make it the patient’s goal more than yours.

Script: “Can you think of a goal to improve your health? We want to help you.”

Example: “Weight control.”

2. Brainstorm activities to accomplish the goal.

Tip: Ask the patient to list some possible ways to achieve the goal. Hold back sharing your suggestions and let the patient identify ideas first.

Script: “What are some different ways you can accomplish your goal? List anything that comes to mind.”

Example: “Consult a nutritionist; exercise more; snack less; eat less chocolate; use smaller portions.”

3. Choose an activity.

Tip: Help the patient choose one activity. Too many choices may be overwhelming and less feasible, increasing the risk of failure.

Script: “These are all good ideas, but I suggest you start with one activity.”

Example: “Exercise.”

4. Focus the activity.

Tip: The more specific the activity, the more likely it will be accomplished. A second round of brainstorming may help determine the activity most likely to be adopted.

Script: “Can you think of one kind of exercise that you are most likely to accomplish?”

Example: “Walking.”

5. Identify how often or how long the activity will occur.

Tip: Help the patient be specific but realistic. If he or she is too ambitious, counsel the patient to set a less ambitious goal at the outset and then increase frequency or duration.

Script: “How often will you exercise?”

Example: “Three times a week for 15 minutes.”

6. Identify when the activity will take place.

Tip: The patient may need a little time to ponder when it is feasible to do the activity.

Script: “When would you like to take a walk?”

Example: “Mondays and Tuesdays during my lunch hour and on Saturday mornings.”

7. Consider barriers.

Tip: Identifying barriers helps the patient refine the plan, increasing feasibility and probability for success.

Script: “What barriers can you foresee that might prevent you from reaching your goal?”

Example: “I might not walk if it is raining or if I feel lonely and want company.”

8. Assess confidence on a scale of 1 (low) to 10 (high).

Tip: Rating one’s confidence helps identify social or psychological barriers. Once named, these barriers may have less power.

Script: “How would you rate your confidence if 1 is the lowest chance of success and 10 is a sure thing?”

Example: “I think my confidence is a 7.”

9. Identify ways to increase (or sustain) confidence

Tip: Having patients think about ways to increase confidence helps reduce the influence of all barriers.

Script: “What can you do to increase your confidence? How can we help you?”

Example: “Maybe it would be helpful to talk about this with my husband and coworkers. They could walk with me sometimes.”

Teamwork: Use of teamlets

The “teamlet” model,⁵ which involves physicians and clinical assistants working together in a flexible way that includes collaborative care planning, can provide better care for larger patient panels.¹⁶ The assistant, often a medical assistant or licensed practical nurse (LPN), starts this process by initiating agenda setting as described above. He or she can then introduce self-management as a potential agenda item by asking for and documenting a patient’s health care goal. Depending on the flow of the day, the assistant can continue working through the problem-solving steps with the patient. This work is documented in the EHR, and the physician completes the action plan where the clinical assistant stopped.

Planned follow-up is critical for improving health outcomes.¹¹ The clinical assistant plays an equally important role in the follow-up of patients’ action plans by checking on goal accomplishment in the agenda-setting phase of the visit. For example, “I can see that last time you were in, you planned to begin walking for 20 minutes in the mornings twice a week. How has that been going for you? Should we protect time to discuss this today?” Clinical assistants can be trained to empathize with patients and normalize behavior change challenges. The assistant can help patients revise goals and encourage them to address challenges with the physician: “I am glad you brought up these challenges. They are common, and we want to help.

I will let Dr. Smith know (pointing to the EHR note), and I encourage you to bring it up.”

Training

Physicians, medical assistants, LPNs, and other members of the health care team can be trained in problem-solving counseling. We propose a two-step training protocol for teamlets.

In step one, a medical assistant and a physician who regularly work together role-play using agenda-setting and problem-solving skills with one another. It works best when the participants focus on a real behavior they want to change and take time after each role-play to debrief, reflect on their own experience, and give feedback.

Step two is to practice with real patients. Plan a practice clinic in advance. Schedule patients in expanded time slots – a 20- to 25-minute appointment in a 50- to 60-minute slot. Both teamlet members see the patient, taking turns observing one another and practicing selected agenda-setting and problem-solving skills. Allow time at the end of the appointment to debrief. Integrate this practice cycle a few times a week until your teamlet feels comfortable with its skill. Although this takes time and decreases office revenue, the increased efficiency and skill mastery is well worth the cost. A recent pilot study¹⁷ of teamlets using problem-solving skills showed dramatic differences in patient interactions compared to control teamlets. It is unlikely that team members will learn new skills without protected time for practice.

EHR tools

EHRs can serve four functions related to collaborative care planning:

- Facilitating communication between team members and patients,¹⁸
- Engaging patients in problem-solving,
- Training team members to use specific skills,
- Enhancing communication between team members.

Agenda-setting information should be placed in the progress note started by the clinical assistant and completed by the physician. Updates occur following a phone conversation or a patient portal interaction, or at a subsequent office visit. Face-to-face interactions can include sharing the screen, which may help to engage the patient. For example, the clinical assistant or the physician points to problem-solving sections and acts as both

SAMPLE COLLABORATIVE CARE PLAN

Can you think of a goal to improve your health? We want to help you.
I would like to have better eating habits.

What are some different ways you can accomplish your goal?
List anything that comes to mind.
Snack less in the evening; drink less alcohol; eat fewer desserts;
eat more low-calorie vegetables.

Pick one activity. Make it feasible.
Drink less alcohol.

Can you be more specific about this activity?
No more than one glass of wine at a time or one glass of beer.

How often will you do this activity?
Twice a week.

When will you do this activity?
Only in the evenings on Saturday and Sunday.

What barriers might prevent you from reaching your goal?
My wife enjoys having wine with our dinners.

How would you rate your confidence where 1 is the lowest chance of success and 10 is a sure thing?
Six

What can you do to increase your confidence? How can we help you?
I should ask my wife to drink wine only on weekends.

PROVIDER-DETERMINED VS. PATIENT-DETERMINED GOALS

	Provider determined	Patient determined
Goal	Disease focused	May be derived from a large behavioral domain including relationships at home and at work
Pros	Helps with disease management	Builds patient investment
Cons	Greater resistance is likely	Requires more patience and may not be disease focused at first

EHR-focused, collaborative care planning timely. As payment models continue to shift, it will be easier to allocate clinical time to this important function. **FPM**

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a counselor and a scribe, recording the patient’s ideas. The EHR simultaneously prompts the team member to ask key questions and engages the patient in problem solving. Easy access to the care plan for any team member facilitates team communication and team support of the patient.

For the collaborative care plan to be most effectively used, it should live in the EHR *outside* of a single progress note, ideally on the chart face page, and care plan details should auto-populate the patient instruction sheet or visit summary form. Patient access via a secure portal would allow for asynchronous updates and problem solving. The care plan could be modified as the patient updates goals and action plans. Creative, proactive solutions are needed to integrate the care plan, some of which might require assistance from your vendor or an information technology consultant, depending on the capabilities of your EHR.

Conclusion

Introducing effective self-management support strategies into routine primary care practice requires significantly changing attitudes about patient and clinician interactions, learning new communication skills, and using time differently. Successful transformation requires teamwork, practice, the creation of a learning culture, and a willingness to learn from one’s missteps. Team use of a collaborative care plan in the EHR holds great potential to improve the quality and cost of patient care.

In a fee-for-service environment, setting aside time to make these changes is more difficult but not impossible and prepares your practice for evolving reimbursement models and medical home certification. The current fee-for-service reimbursement system is beginning to change with some insurers paying per-patient-per-month care-management fees, usually linked to quality outcomes. Incentives to use the EHR to engage patients also make

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