



RAE Practice Facilitator Training

Tools for Patient Activation

Engage. Elevate. Empower.

How we'll spend the hour

- ❑ Welcome, goals, and your role as facilitator
- ❑ Tactic 1 · Assess activation and tailor support
- ❑ Tactic 2 · Integrate behavioral health
- ❑ Tactic 3 · Expand the care team
- ❑ Tactic 4 · Shared decisions and self-management support
- ❑ Putting it together: tool selection, case, plan, measures
- ❑ Your action plan and questions

When is activation the right place to start?

Signal	What to look at	Where to find it
Cost driver: avoidable acute care	ED visits per 1,000, Frequent ED users, readmissions	RAE reports; HCPF shared savings data; Contexture alerts
Low engagement	Members not seen in 12 months, no-shows, no follow-up after ED	Attribution list; practice EHR
Weak self-management	A1c over 9%, uncontrolled blood pressure	EHR registry; HCPF quality report
Barriers and low confidence	Unaddressed depression or social needs “I don’t know what I’m supposed to do” “Nothing I do makes a difference”	EHR screening data; PAM survey

Avoidable acute care plus one more signal? Start with activation.

Costs driven mainly by referrals or high-cost services? Another strategy may come first.

What is patient activation?

Activation

A patient's knowledge, skills, and confidence to manage their own health.

-  Patients vary widely. Measuring activation lets teams right-size support.
-  Most self-management happens between visits, where momentum is often lost.
-  When all staff use MI and teach-back, patients engage and follow care plans more consistently.
-  Activation can be measured and can change; reassessment shows progress.

Four tactics, fifteen tools

1

**Assess activation
and tailor support**

Right-sized support

4 tools

2

**Integrate behavioral
health**

BH needs met in
primary care

5 tools

3

**Expand the care
team**

More touchpoints,
more trust

2 tools

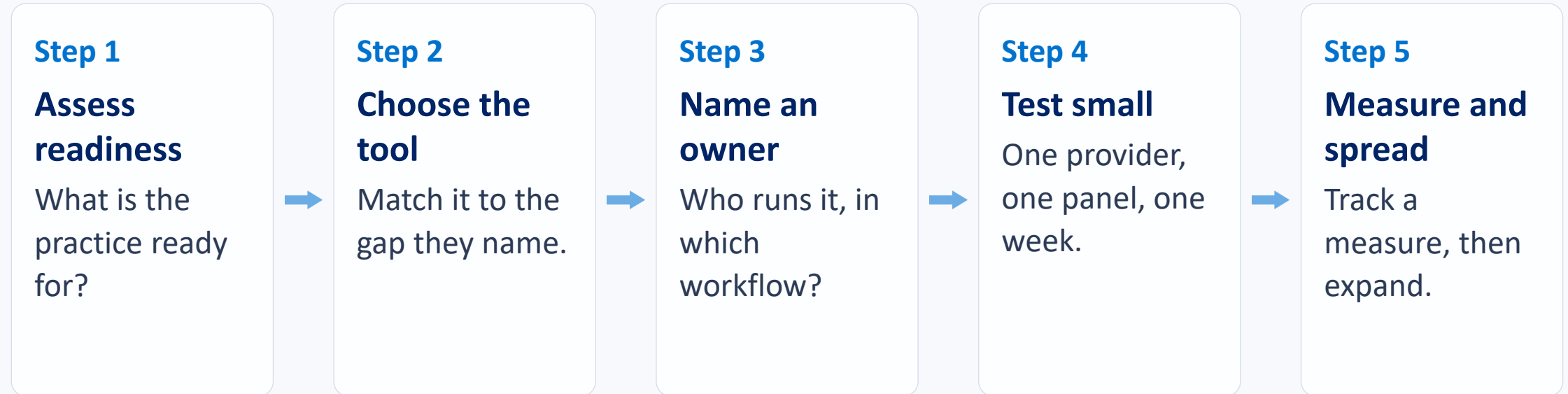
4

**Shared decision-
making and self-
management
support**

Patients as partners

4 tools

Use the Tools to Plan Tests of Change



Facilitator Tip: Every tool should end in a tested workflow with a named owner.
Use the PDSA cycles you already coach.

Tactic 1 of 4

Assess activation and tailor support

- 1 Measure activation (for example, with the PAM), starting with medium- and high-risk patients and expanding over time.
- 2 Match support to the level: small steps and hands-on help for low activation; tools and self-directed options for high.
- 3 Use motivational interviewing and teach-back routinely, across all staff, including interpreters and health coaches.

Patient
Activation
Measure

Confidence
Ruler

Self-Efficacy
Scale



Facilitator Tip: **Check first** the PAM is a licensed survey owned by Insignia Health, a Phreesia company. Confirm licensing and cost before rollout.

Tactic 1 of 4

Tailor support to the activation level

Level 1

Disengaged and overwhelmed

One small, achievable step at a time, with hands-on help from the team

Level 2

Becoming aware, still struggling

Build knowledge and confidence; confirm understanding with teach-back

Level 3

Taking action

Set goals together and build skills with action plans

Level 4

Maintaining and pushing further

Self-directed tools, with periodic low-touch check-ins to prevent slipping

Tactic 1 • Tools

Tools to measure and plan

How-to Guide

Patient Activation Measurement Guide

Walk the team through measuring activation and using each score to tailor support.

Facilitator Tip: Set the starting panel, who gives the survey, and where the score lives in the EHR.

Template

Shared Care Plan Template

Document a patient-directed, whole-person plan collaboratively with the patient and team.

Facilitator Tip: start with high-risk or vulnerable patients. Tie plan goals to activation level.

Tactic 1 • Tools

Tools to engage patients in change

Free Online Course

[Interpreter Training, Module 5: Motivational Interviewing](#)

HealthTeamWorks Free Online Course, Registration Required

Use to train interpreters, coaches, and staff to carry MI accurately across languages and cultures.

Facilitator Tip: Suggest it to teams with many patients with limited English proficiency.

Quick Reference Guide

[Motivational Interviewing Guide](#)

National Council for Mental Wellbeing Publication

A desk reference or huddle refresher on MI's spirit and everyday conversation skills.

Facilitator Tip: Bring one MI skill to each huddle for a month, then ask what changed.

Tactic 2 of 4

Integrate behavioral health



Start where resources and patient needs allow; deepen integration as workflows, staffing, and financing mature.

Screen everyone at least yearly (adults and adolescents): PHQ-2/9, GAD-2/7, and a single-question, AUDIT-C, or DAST screen.

Collaborative Care: a behavioral health care manager, a registry, measurement-based care, and a psychiatric consultant.

MOUD in primary care: buprenorphine with care management and behavioral support, focused on retention in treatment.

Tactic 2 • Tools

Plan, then choose a model

How-to Guide

The Building Blocks of Behavioral Health Integration

CU Farley Health Policy Center and Practice Innovation Program, 2022

Rate the practice on 7 foundational blocks, then choose among 4 add-on components.

Facilitator Tip: Use the gaps to guide team in setting integration priorities.

Assessment Tool

IBH Readiness & Modality Assessment Tool, with Instructions

HealthTeamWorks • Excel Workbook

Clinical, operational, and leadership staff complete it together to choose a model.

Facilitator Tip: Send the instructions ahead. Work through assessment with PCMP team. Reassess after implementation.

Tactic 2 • Tools

Implement and sustain

Library of Resources

Practice Innovation Program 1302 BHI Resources

University of Colorado

Webinars, screening tools like the PCL-5, billing guidance, ROI worksheets, and sample job descriptions.

Facilitator Tip: As appropriate for the practice, pull tools for screening, staffing and workflow to support implementation.

Tool

IBH Simplified Financial Sustainability Tool

HealthTeamWorks • Excel

Compares staffing and operating costs with expected billable behavioral health revenue.

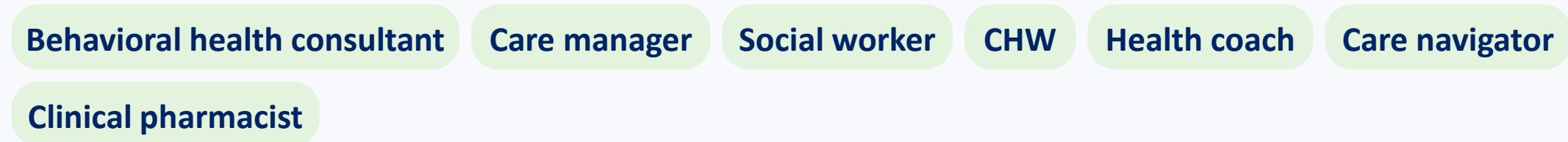
Facilitator Tip: Coach practice on identifying and plugging in appropriate behavioral health billing codes (See 1302 BHI Resources).

Tactic 3 of 4

Expand the care team

- 1 Deploy CHWs for social needs (housing, food, transportation, navigation) for high-risk members, with a structured model and supervision.
- 2 Embed a clinical pharmacist for Comprehensive Medication Management, in person or virtually, for members with polypharmacy and uncontrolled diabetes, hypertension, or asthma.

The expanded team (not an exhaustive list)



Tools for the expanded team

Guide

Expanded Care Team Roles Guide

Each role's training, focus, and contribution to activation, utilization, and navigation, plus day-to-day profiles.

Facilitator Tip: Introduce it when roles overlap or when the practice is considering adding new roles to support patient engagement and activation.

Implementation Guide

Community Health Workers: A Guide to Developing and Implementing a CHW Program

HealthTeamWorks Free Implementation Guide

Plan before hiring. Define the role, fit CHWs into workflows, and plan training, supervision, and sustainability.

Facilitator Tip: Use it as a guide as you work through it with the practice lead.

Tactic 4 of 4

Shared decision making and self-management support

When making preference-sensitive treatment decisions: Use decision aids and structured conversations for elective procedures, imaging, and medication choices.

In chronic care visits: Collaboratively build in self-management goals, such as action plans, goal-setting, and symptom tracking.

Between visits: CHWs, navigators, care managers, health coaches and pharmacists reinforce goals, with outreach by portal, text, calls, and check-ins.

Build it into standard workflows, not individual habits.

That makes it consistent and reinforces the patient's role as an active partner.

Design the program, then map roles

Implementation Guide

Self-management Support Implementation Guide

Defines self-management support, lists delivery options from group visits to technology, and walks through six steps.

Facilitator Tip: Use it at the very start of planning to add or expand self-management support.

Quick Reference Tool

Self-management Support Before, During and After Visit

An example workflow showing how the whole care team delivers self-management support across time.

Facilitator Tip: Present it as a reference as roles are set and workflows are being designed.

Tactic 4 • Tools

Train the team, then the clinicians

Quick Reference Guide

Patient Education Tactics

Four evidence-based communication techniques for anyone who educates patients.

Facilitator Tip: Use it to design staff training and as a huddle refresher.

Free Online Course

[The SHARE Approach](#)

University of Colorado • free

Three short video modules, about an hour in all, plus a facilitator's guide for in-house sessions.

Facilitator Tip: Run it as a three-session lunch-and-learn before the first decision aid.

Which tool first? Listen for the problem

If the practice says...	Start with...
"We don't know who needs the most support."	Patient Activation Measurement Guide
"Patients don't follow through on what we say."	MI Guide · Patient Education Tactics
"Many patients prefer a language other than English."	Interpreter Training Module 5 (MI)
"Our high-risk patients have no shared plan."	Shared Care Plan Template
"We want behavioral health; where do we start?"	Building Blocks · IBH Readiness Tool
"Can we afford a behavioral health provider?"	Financial Sustainability Tool · PIP 1302
"Social needs keep sending patients to the ED."	Care Team Roles Guide · CHW Guide
"Self-management support depends on the provider."	SMS Guide · Before, During and After
"Patients say decisions are made for them."	SHARE Approach training

Case practice • 10 minutes

A rural PCMP asks for help

The practice

- Rural family medicine; four providers
- About 1,000 attributed Medicaid members
- ED use rising
- Large portion of population living with diabetes and/or depression
- Part-time LCSW sees scheduled therapy only
- No care manager
- Front-desk staff interpret
- Medical director worries about cost

Discuss 6 minutes, then share

1. Which tactic would you lead with, and why?
2. Which two tools would you bring next visit?
3. Who owns the first step? What is the first PDSA?
4. What will you measure at 90 days?

Putting it together

An example facilitation sequence

Assess

- Team completes the IBH Readiness Assessment
- Rate the practice on the Building Blocks
- Pick a pilot panel with the PAM Guide and practice data

Design and test

- Map roles: Before, During and After
- Start shared care plans for pilots
- PDSA: screening and warm handoffs

Measure and spread

- Review process measures monthly
- Model costs in the Sustainability Tool
- Train the next group; expand the panel

One example for a practice starting with Tactics 1 and 2; adapt it to each practice.

Measures to watch, by tactic

Tactic	Process measure	Outcome to watch
1 · Activation	% of eligible patients with a baseline PAM % of Level 1–2 patients with a documented tailored action step % of clinical staff, interpreters, and health coaches trained in MI and teach-back	Patients moving up a level at reassessment
2 · Behavioral health	IBH Readiness Assessment score change Warm-handoff rate after a positive screening (PHQ-9, GAD-7, etc...)	Screening for Depression and Follow-Up Plan (ages 12–17 and 18+)
3 · Care team	Community Health Worker and care manager caseload and contacts per patient % of team roles with written role definitions	ED visits for supported patients
4 · Shared decisions and self-management	% of patients with a chronic condition who have a documented self-management goal or action plan	Patients confident in their next steps

Before you go

Your action plan

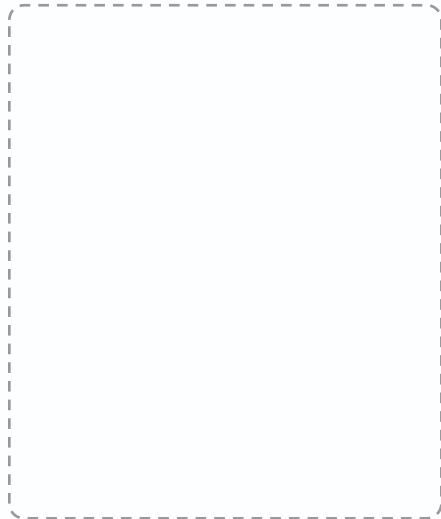
One practice

Which PCMP will you bring this to first?



One tactic

Which gap matters most to them now?



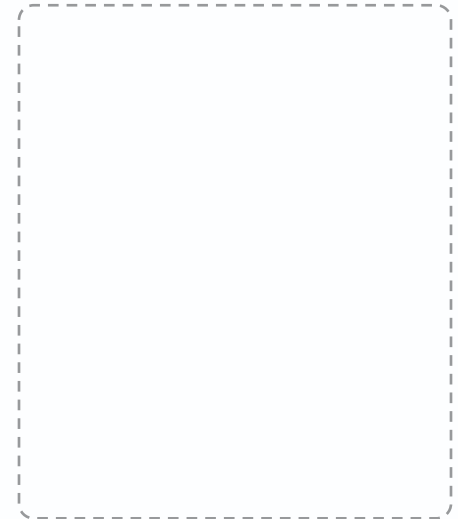
One tool

What will you bring to your next visit?



One first step

What will they try, and by when?



Thank You

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