



Stanford Coordinated Care (SCC) Change Package

**Ambulatory ICU 2.0
Model**

Purpose

Drs. Ann Lindsay and Alan Glaseroff co-founded Stanford Coordinated Care (SCC) to address the needs of patients with complex, chronic conditions through provision of comprehensive and intensive primary care. While retired from SCC, both Drs. Glaseroff and Lindsay continue their passion for patient-centered team care by offering team training sessions. The sessions are based on their work at SCC, and Dr. Glaseroff's approach as the Director of Workforce Transformation in Primary Care at Stanford. This document will provide you guidance for implementing SCC's ambulatory ICU model into your practice.

How to Use the Guide

This document includes the following sections:

- **Stepwise approach:** The stepwise approach outlines specific tasks the team can take to implement each part of the intervention.
- **Appendix:** This includes example tools and resources to use and reference.

Who Should Use the Guide

All primary care practice staff, including physicians, nurses, medical assistants, behavioral health specialists, physical therapists, and front office staff.

Stepwise Approach Overview

Activity 1: Identify the patient population that stands to benefit from the SCC model and understand the successes in their current care as well as their unmet needs

- Conduct segmentation analysis to assess need of patients
- Conduct interviews with five patients within segment threshold
- Synthesize segmentation analysis and interviews, and identify emerging themes
- Develop and test a patient outreach plan to encourage recruitment into the model
 - Modify based on results (interview people who declined enrollment as well as those who enrolled)

Activity 2: Identify local leadership who will be involved in implementing the SCC model for patients at risk of complex, high cost care

- Identify relevant and multi-disciplinary practice team members to participate in implementing the model
- Identify a project lead to drive implementation
- Identify clinician champion to advocate for work

Activity 3: Choreograph workflows to reflect the SCC model of care

- Reflect on emergent themes from the interviews and answer questions about the practice's ideal state
- Create a shared vision statement for the practice
- Determine new team-based care workflows
- Identify leading indicators (both process and outcome) and post regular progress on a Visibility Wall in the team room so all team members can see

Activity 4: Provide adequate training and protocols to ensure each member is operating at the top of his/her scope of practice

- Provide additional training on an ongoing basis, as necessary
- Establish protocols or standing orders to expand the roles of non-clinician staff

- Establish a new hire training program that includes the newly established roles and responsibilities
- Use A3 problem solving approach when problems arise with the goal to address new problems within one week
- Establish measurement system than can track the practice's performance

Activity 5: Establish regular meetings to discuss related achievements and barriers

- Establish regular meetings
- Use a “stop the line” approach to address problems and develop solutions together
- Institute team engagement strategies to prevent burnout

Activity 6: Develop a process and written brochure/compact for patients receiving care in the new model, including patients' compact

- Develop a strategy for future recruitment of patients including those who have declined care
- Create patient promotional content with patient's input to describe practice's model

Activity 7: Actively engage patients through techniques used in motivational interviewing, problem solving, and behavioral activation to identify patients' goals and tangible steps to reach those goals

- Inquire about patients' self-identified goals and establish the importance of the goal to the patient (scale 1-10)
- Develop a reasonable, detailed action plan with the patient to achieve said goals via small steps
 - Establish confidence that they can succeed in each sequential action plan (scale 1-10), affirming action plans with a confidence score of at least 7
- Set up timely follow-up of action plans to cheer successes and problem solve when success is not achieved
- Review EHR systems capability to document patients' action plan so that they are visible to all staff “touching” the patient within the team

Stepwise Approach

The following steps outline some of the key activities to implement Stanford Coordinated Care's (SCC) Ambulatory ICU 2.0 Model.

Activity 1

Identify the patient population that stands to benefit from the SCC model and understand the successes in their current care as well as their unmet needs



Task – Conduct segmentation analysis to assess needs of patients: Before implementing the SCC model, it is crucial for the practice team first to understand the prospective patient panel and their unmet needs.

1. Assess baseline data capabilities within your practice. Data sources can include claims data, hospital utilization data (e.g. emergency department (ED) visits, hospital admissions), or direct feedback from providers if claims data not available.
2. Select a threshold to segment the patient panel in order to identify patients with complex needs. Examples of the segment thresholds could include:
 - Predictive risk scores >2.5:1
 - Prevalence of clinical conditions among high cost patients
 - Patient has 1 or more emergent inpatient admissions (e.g. acute, mental health, long-term care) in the past 6 months
 - Patient has had 2 or more ED visits within the past 6 months
 - Patient with multiple chronic conditions and/or serious mental illness
 - Patient has 5 or more medications and/or specialists
3. Collect and analyze available data to identify individual patients within the segment threshold and determine commonalities among those patients (e.g. diagnosis, comorbidities, functional limitations, demographics). Base exclusion criteria on current capabilities within your organization (exclude if a tailored program already exists or if the organization lacks the core competencies to care for a specific population, such as serious mental illness or patients on dialysis or with advanced cancer).



Task – Conduct interviews with five patients within segment threshold: Ask the care team to identify five patients from the target population in the practice.

- **Where:** If the time and resources allow for it, consider conducting the interviews at the patients' home rather than at the practice, as the patient generally deals with their chronic diseases within the context of their own life, not just when attending a clinic visit.
- **Reimbursement:** If possible, consider offering a reward (\$50-100 gift card or cash). Reimbursement can help get patients' attention and make sure they show up or are at home at the appointed time.
- **Interview:** Before the interview begins, have the patient sign a consent form to allow interviewees to take notes and share the patient's story with others without identifying the source. Each interview should take about 1 hour to complete and should have two staff members present. One staff member will lead the interview while the other takes notes. It can also help to make a recording of the interview with the person's permission. During the interviews, use the following questions as a guide:
 1. What do you struggle with the most?

2. What is the worst thing that happened to you while receiving care?
3. What has helped you improve your health?
4. What have health care providers done that has helped you?
5. What have health care providers done that was not helpful?
6. Tell me about a time you went to the emergency department or were admitted to the hospital, and how you coped after you returned home.

At the end of the interview, thank the person, review how what they shared will be used to improve care, and have them sign a receipt if they received a gift card.

- **Guidelines:** During patient interviews, follow certain guidelines to promote trust and conversation with the patients. Specifically:
 - Empathize with the patient and try to understand their perspectives rather than challenging or correcting them.
 - Have an open mind; do not judge or jump to conclusions.
 - After asking a question, give the patient time to reflect and answer.



Resources – Patient interview consent form: Before interviewing patients and sharing interview notes with the practice team, be sure to get a written consent indicating that they gave interviewers permission and, if applicable, received a gift card. See [Appendix 1.1](#) for an example consent form and gift receipt form used by the SCC team.



Task – Synthesize segmentation analysis and interviews, and identify emerging themes:

1. Review the interview notes and segmentation analysis.
2. Copy the key points from the interviews and segmentation analysis onto sticky notes – focusing on the root causes for the high utilization of health care.
3. Begin grouping the sticky notes together by themes.
4. Write up the themes, including quotes from people when relevant.
5. Present the themes to the broader team to fine tune potential solutions to identified needs via brainstorming. There are no right or wrong answers at this stage, so the more potential solutions, the better. This is an iterative process, so feel free to discuss, talk through, and rearrange the categories as themes emerge.
6. Continue this until everyone is satisfied with the final themes.
7. Consider going back to the interviewed patients to get their reactions to the themes you produced. Consider recruiting interviewees as ongoing patient advisors to your program.



Task – Develop and test a patient outreach plan to encourage recruitment into the model; modify based on results

1. Based on the patient threshold established during the segmentation analysis completed in the first task of this activity, discuss ways to outreach to eligible patients about enrolling in the model.
 - One way to conduct direct outreach is by asking eligible patients to enroll when they come to the hospital, the ED, or to other gatherings in the practice such as open houses. Often, patients will refer other patients to enroll in the model if they are satisfied, which will help boost enrollment.
2. Test
3. Modify – interview people who declined enrollment as well as those who enrolled



Resources – Consent for interview about ED usage and discussion guide: Direct outreach with eligible patients already utilizing ED can provide an opportunity to educate potential patients about the program. Providing participants a small gift (ex: \$50 gift card) can increase the likelihood of their participation. See [Appendix 1.2](#) for more information about outreaching to patients in the ED.



Resources – Hospital Admission Risk Multiplier Screen (HARMS-8): If other patients or clinicians outside of the practice refer patients to enroll in the model, consider using a validated screening tool, like the HARMS-8, to identify intervention areas for patients with high-risk medical conditions, as well as to determine whether they meet the threshold identified during the segmentation analysis. See [Appendix 1.3](#) for tool and scoring instructions.

Activity 2 Identify local leadership who will be involved in implementing the SCC model for patients at risk of complex, high cost care



Task – Identify relevant and multi-disciplinary practice team members to participate in implementing the model:

1. Identify relevant team members in the practice who will have a role in the implementation of the model. Make sure that the team is multi-disciplinary and includes physicians, nurses, medical assistants (MA), and administrators. If relevant to the practice, also include behavioral health specialists, physical therapists, licensed clinical social workers (LCSW), and pertinent information technology staff. Hire based on expertise dealing with the issues likely to affect prospective patients.
2. Consider including patients or family caregivers on the design team to ensure that the patient perspective is included throughout the implementation of this model.



Task – Identify a project lead to drive implementation:

1. Identify at least one **project lead** within the practice to be involved in and lead the elements of this model. Having a project lead is critical to the success of this intervention. Not only do they act as a point person for this initiative, they also help drive the implementation process. The ideal project lead should:
 - Be a respected staff member with strong interpersonal and communication skills,
 - Be passionate about implementing the SCC team-based care model, and
 - Develop and drive the project implementation plan to ensure that the team is meeting expected deliverables and timelines



Task – Identify clinician champion to advocate for work:

1. Identify a **clinician champion** to help advocate for the work. While the project lead will be responsible for the day-to-day implementation of the model, the clinician champion will support the work by promoting buy-in and awareness across the practice site. Similarly, the ideal clinician champion should:
 - Have strong interpersonal and communication skills,
 - Be passionate about patient-centered care into primary care, and

- Have some authority over time and resource allocation

Activity 3 **Choreograph workflows to reflect the SCC model of care**



Task – Reflect on emergent themes from the interviews and answer questions about the practice’s ideal state:

1. Bring together the multi-disciplinary practice team members to participate in the model design and implementation.
2. Brainstorm as a team on how to incorporate the themes identified in the patient interviews and segmentation to meet patients’ needs, by creating two lists – “Current State” – a list of what characterizes the current care system from the patient perspective; and “Future State” – a list of what an optimal approach would include from the patient perspective.
3. Have each team member answer the following questions from their perspective:
 - What does this practice need to do in order to meet your patients’ needs (the “Future State”)? (e.g. improved coordination, access to timely care, educational information and guidance, etc.)
 - How does this fit into your organization’s overall mission?
 - How likely will instituting these changes improve the health of your patients?
 - What are your biggest hopes for implementing these changes?



Task – Create a shared vision statement for the practice: Creating a shared understanding of a common purpose and future goals is an important process that enables the team to clarify the practice’s intention, motivate people beyond the status quo, outline a compelling reason for change, and build commitment among the practice team.

1. Have each team member share his/her answers to the questions in the previous task to create a shared vision statement for the practice.
2. Work together and discuss any discrepancies in their vision until there is agreement on a final vision statement. Throughout the implementation of the model, the practice team should regularly revisit the vision statement and make necessary adjustments.



Task – Determine new team-based care workflows: Underlying the SCC model of care is the fact that the practice team truly works as a team and allows practice members to work to the limits of their credentials. In traditional primary care workflows, the burden of chronic disease monitoring, preventive medicine interventions, managing acute complaints, and following up with medication refills and test results fall on the provider before distributing these tasks to their support team (see **Figure 1**). The SCC model of care redesigns the workflow to follow a parallel model, where each practice team shares the various responsibilities in panel management (see **Figure 2**).

Figure 1: Traditional Workflows

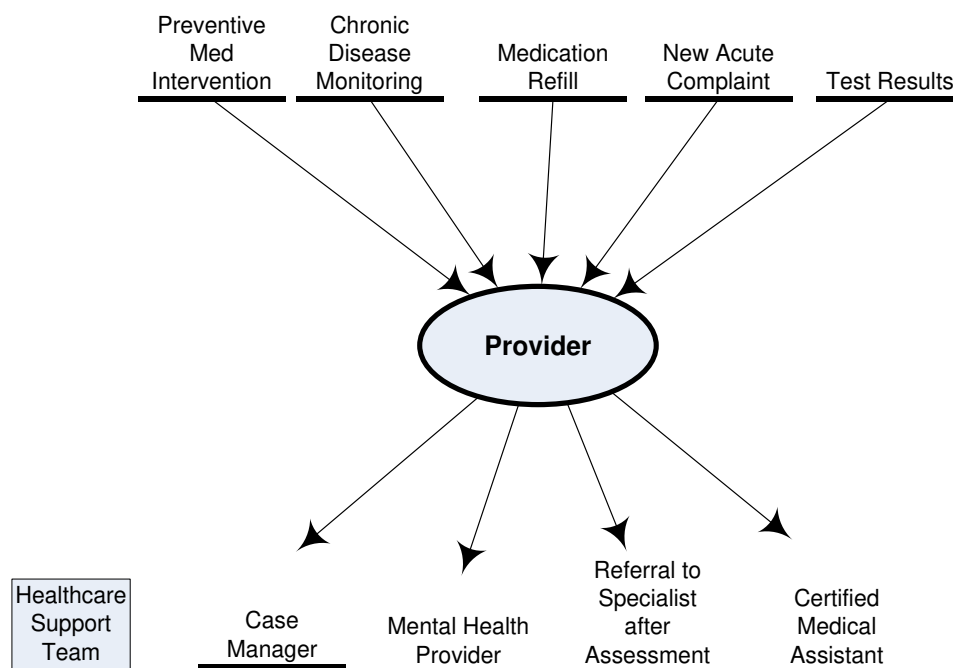
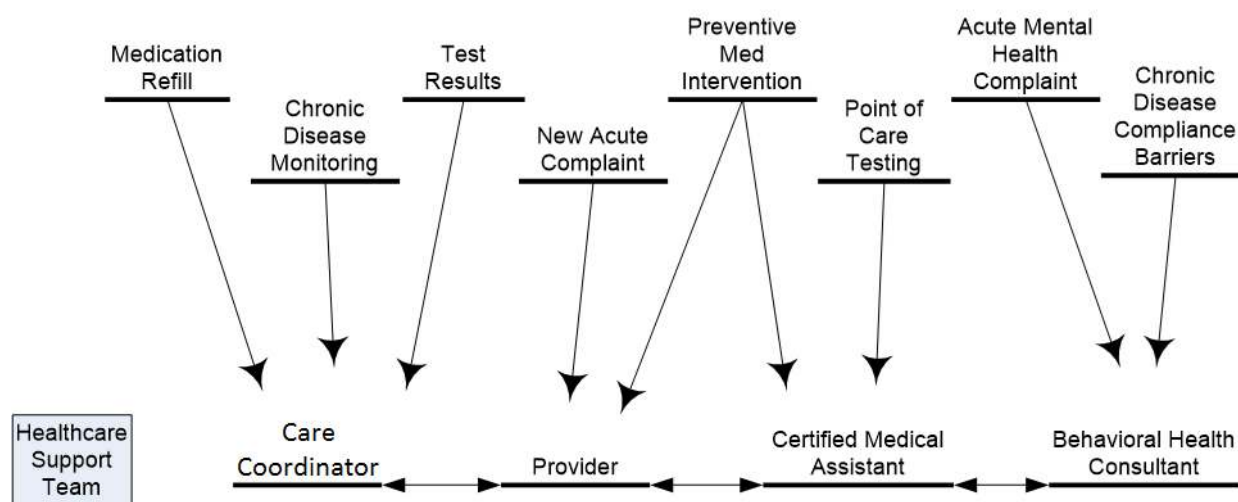


Figure 2: Parallel Workflow Redesign



SCC's workflow for new patients included:

- 30-minute orientation to the clinic and care model by the care coordinator
- 60-minute clinical visit with a physician
- 30-minute action-oriented follow-up visit with a care coordinator

SCC's workflow for standard follow-up visits included:

- 15-minute check-in with a care coordinator
- 30-minute clinical visit with a physician

- 15-minute “close-the-loop” follow-up visit with a care coordinator
1. Outline each team members’ current roles and responsibilities for treating and managing the target population.
 2. Discuss amongst the team how to allow each team member to work to the limits of their scope of practice or licensure to meet the current gaps in care. When discussing this, consider staff interests and talents and align these with available opportunities in the practice. Consider mapping out the workflows for clinic visits, after-hours calls, and emergencies in the clinic.
 - A good exercise for everyone to complete after identifying necessary responsibilities is first to determine what tasks front desk and receptionist staff can oversee. After that, determine what tasks front desk and reception staff are unable to do because of scope of practice restraints, and assign those tasks to the MAs, who maintain the core relationships with their patients. After outlining the MA’s tasks, determine what tasks MAs are unable to do because of scope of practice limits, and assign those tasks to the registered nurses (RN). Repeat this exercise with the RN. The remainder of the work falls to the clinicians, whose job it is to manage the aspects of care no else on the team can do.
 3. Determine the distinct roles and responsibilities in the transformed care team. In the SCC model, the panel management responsibilities are divided as such:

| Panel Management Responsibilities | Provider | Care Coordinator | Front Desk MA | Advanced Practice RN |
|---|------------------------|-------------------------|----------------------|-----------------------------|
| Pre-visit planning, chart scrubbing | Reviews | Responsible | | |
| Greeting the patient | | | Responsible | |
| Ordering lab tests and collecting vital signs by protocol | | Responsible | | |
| Delivery of routine protocol-based preventive services | | Responsible | | |
| Medication reconciliation | Co-signed | Responsible | | |
| Reviewing and reconciling problem list | Responsible | | | |
| Patient navigation | | Responsible | | |
| Self-management goal setting and action planning | Responsible | Responsible | | |
| Patient telephone/ email follow-up | | Responsible | | |
| Injections and venipuncture | | Responsible | | Reviews |
| Triaging phone calls and emails | Consulted as necessary | Responsible | | Consulted as necessary |
| Care and transition management | | | | Responsible |
| Referral management | Responsible | Assists patient | | |
| Independent visits by non-providers (RN, MA, health coach) | | Responsible | Responsible | Responsible |

Consider empaneling MA care coordinators. In SCC's complex care model, care coordinator panels contained roughly 100 patients per 1.0 FTE across physician panels (physician panel sizes are approximately 300 patients per 1.0 FTE). Panel sizes were determined based on the care coordinator's experience and the patients' first languages.

4. Create a process map to envision how these roles and responsibilities fit in the clinical workflow and to document the new staff roles and responsibilities. Process maps can be created using tools such as Visio to map workflows. See [Appendix 3.1](#) an example of a SCC's workflow design. After drafting the clinical process map, observe staff in practice and adjust the process map as necessary. This will provide a visual overview of how the practice plans to approach depression care.



Resources – Bellin Health workflow videos and example job descriptions: To get an idea of how other primary care practices have changed team roles to meet their patients' needs, see the videos and example job descriptions listed below. The videos show examples of how Bellin Health establishes their workflow during office visits and in-between visits in a way that maximizes their team's abilities. These job descriptions can also provide examples of the types of roles and responsibilities MAs/care coordinators and nurses have within the SCC model.

- Bellin Health Team-Based Care: The Model in Action—In Between Visit Workflow <https://youtu.be/83E95xahBil>
- Bellin Health Team-Based Care: The Model in Action—The Office Visit https://youtu.be/pXatZM_Rie8
- SCC care coordinator job description example (see [Appendix 3.2](#))
- SCC nurse job description example (see [Appendix 3.3](#))
- SCC scribing workflow example ([Appendix 3.4](#))

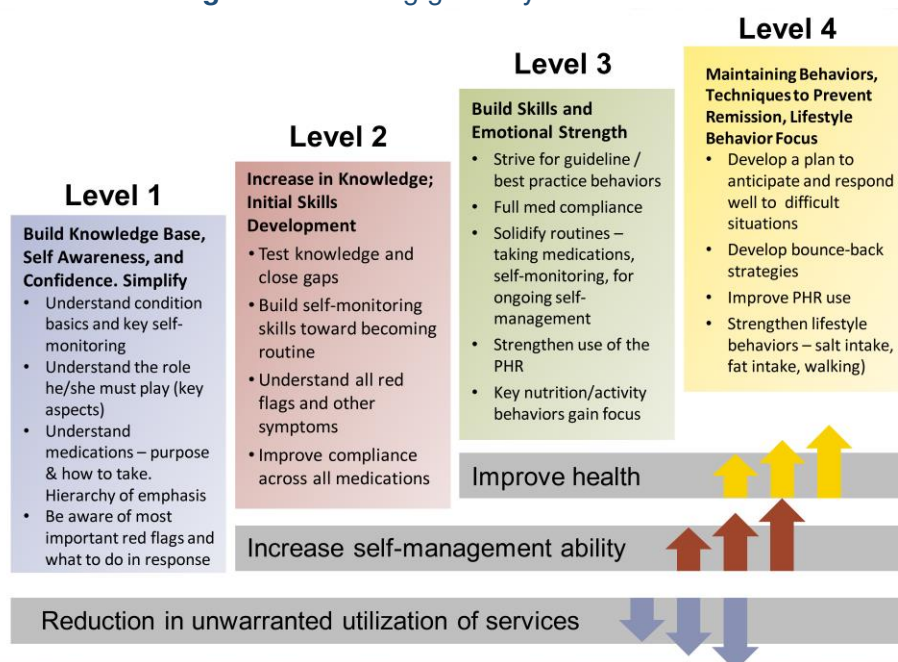


Task – Identify leading indicators (both process and outcome) and post regular progress on a Visibility Wall in the team room so all team members can see:

1. Based on the target population, identify 5-10 potential measures of success to quantify the impact of implementing the model. Consider using various outcome, cost, patient satisfaction, and practice team satisfaction measures so that they encompass all components of the “Quadruple Aim”. Examples of potential measures of success include:
 - ED visits per 1000/year
 - Hospital admissions 1000/ year
 - Total cost of care
 - Total bed days per 1000/year
 - Patient experience of care
 - Practice team joy at work
2. Decide whether to collect and analyze these measures at the individual-level or group-level.
3. Consider measuring a return on investment (ROI) for implementing this model. For an example of an ROI calculator developed by the SCAN Foundation, see [Appendix 3.5](#).
4. Also consider using the Patient Activation Measure (PAM) as a leading indicator of practice success. PAM can also inform the practice team about the type of support needed by an individual patient and guide the frequency of outreach to that patient. PAM can be useful because it is a validated tool for tracking a change in the level of

activation for individuals having difficulty with self-managing, as described below (see **Figure 3**). For more information about this tool, see [Appendix 3.6](#).

Figure 3: Tailoring goals by activation level



Activity 4

Provide adequate training and protocols to ensure each member is operating at the top of his/her scope of practice



Task – Provide additional training on an ongoing basis, as necessary: Depending on the teams’ training and comfort level with their new responsibilities, consider additional training so that they feel comfortable executing them effectively. Job mentorship and shadowing allows staff to pass down good habits and knowledge, as well as empower staff mentors. Some examples of trainings that may be relevant to the practice include:

- Motivational interviewing
- Advanced Care Planning/Goals of Care
- Medication reconciliation and managing refill requests
- Trauma-informed care
- Anxiety and depression
- Embracing diversity
- Health coaching
- Panel management
- Smoking cessation
- Cultural humility



Resources – SCC scribing policy: One of the responsibilities of SCC’s MA care coordinators is to scribe during physician visits with their ascribed panel. Having the

MA/care coordinator scribe both offloaded tasks from physicians, as well as increased efficiency and care coordination. See [Appendix 4.1](#) for SCC's scribing policy.



Task – Establish protocols or standing orders to expand the roles of non-clinician staff. Using protocols or standing orders for non-clinician team members, such as MAs and nurses, can help empower and enable them to practice at the top of their scope.

1. Based on each team member's newly established roles and responsibilities, create or update existing protocols or standing orders for non-clinician team members to take these new roles into account.
2. If new protocols or standing orders are created, train the relevant practice team members how to use it properly. Practice team members affected should have a designated staff member involved in writing new protocols or standing orders. Consider supervising current non-clinician staff when first using the protocol or standing order to make sure they are being used correctly.
3. Consider using relevant protocols or standing orders created by other departments or organizations, if they have been proven to be effective.



Resources – SCC care coordinator diabetes protocol: At SCC, the care coordinator had the responsibility of collecting certain vitals from patients. To facilitate this, SCC created a protocol that clearly outlines the specific tests and thresholds the care coordinator should complete and look out for. For more information on the protocol for this, see [Appendix 4.2](#). More protocols can be found under SCC resources on the CERC website [here](#).



Task – Establish a new hire training program that includes the newly established roles and responsibilities: This training program can include education and shadowing depending on your practice's needs and capacity. Training competencies can include:

- Protocols on medication refills, vaccines, diabetes, asthma care, procedures, etc.
- EHR workflow training (e.g. in-basket management, prioritization, triage)
- Article review on motivational interviewing, teamlet model, etc.
- MA competencies (e.g. point of care testing, phlebotomy, procedures)
- Medication administration
- Health coaching and role plays
- LCSW modules (e.g. depression, anxiety, therapeutic boundaries, domestic violence, abuse, neglect)
- Motivational interviewing (videos providing simple strategies for providers to use with patients can be found [here](#))
- Advanced Care Planning/Goals of Care
- Interdisciplinary team roles (e.g. pharmacist, physical therapist, LCSW)



Task – Use A3 problem solving approach when problems arise with the goal to address new problems within one week:

- When the team encounters any barriers that need to be addressed, use an A3 template (see [Appendix 4.3](#) for the full and simplified versions of the template) to help identify the source and solve the problem. The A3 is a tool used in process improvement to identify and solve any problems that occur, thereby minimizing the potential for frustration to build up in individual staff members. To use this tool, complete the following steps:

1. **Identify the problem:** In the top of the A3 template, define the problem. Make sure to frame the problem statement so that it describes the current state and not the perceived solution or cause. An example of a good concise problem statement is “poor medication adherence among patients with hypertension”. After identifying the problem, fill out the “Background” section. Why does the problem matter and why is your team addressing this issue?
2. **Assess current state:** After identifying the problem, observe how this process is executed in practice. Direct observation will provide clarity on how the process actually works and elucidate potential solutions. After observing this, describe the current state in the “Current State” box. Visual representations or process maps can be used to complete this.
3. **Understanding why the problem exists:** As the team observes and describes the current state, write why the problem occurred in the “Analysis” section. One method of completing this is to use the “5 Whys” method where someone asks themselves “why did this happen?” five times until you get to the root of the problem. For more complex problems, use a fish-bone diagram to break down the many causes that lead to an effect. For more information about this method, see [Appendix 4.4](#) for IHI’s instructions on using fish-bone diagrams and template.
4. **Describe ideal state and propose solutions:** In the “Ideal State” box, describe as a team what the ideal state is for this problem. This will help uncover potential solutions to the problem. Based on what the team comes up with, describe some countermeasures – or how the practice can change current processes or work flows to get to the ideal state – in the “Proposal” box. Countermeasures should address root causes of the problem.
5. **Implement and track the solution:** Based on the proposed countermeasures, develop the implementation plan to execute these tasks. The plan should list out what the action is, who is responsible, when the action should be completed by, the status of the action (or when it was complete), and any notes or decisions made along the way. This is an iterative process and may require pilot testing before rolling it out across the entire team. One method of testing is using small tests of change, or Plan-Do-Study-Act (PDSA) cycles. As this occurs, make sure to describe any issues or remaining problems in the “Follow Up” box and discuss these at the next team meeting.



Task – Establish measurement system that can track the practice’s performance:

Tracking performance measures is critical to understanding the quality of care that is provided as well as potential areas for improvement.

1. Depending on the measures of success that were identified in activity 3, discuss how the practice can operationalize collection of these metrics. Work with the practice’s EHR systems and see whether it is capable of providing a care gap report. If the practice’s EHR system cannot produce such a report, external measures commonly reported by these practices, such as the Healthcare Effectiveness Data and Information Set (HEDIS) or National Quality Form (NQF) measures can be used. Don’t let the perfect get in the way of the good – at times an Excel spread sheet or even legal pad and a pencil can get you started on measurement!
2. Consider using other metrics that have existing data available. These may include the number of telephone calls answered within a specific time, percentage of patients scheduled on first call, time spent by providers working on the EHR after business hours, percentage of patients within specific clinical parameters (e.g., hemoglobin A1c,

low-density lipoprotein control, influenza vaccinations, cancer and other screenings), and percent of patients on certain medications.

3. Consider no-tech metrics to measure goals that change periodically based on the practice's priorities. Examples of no-tech metrics include A3s or kata coaching (drawn from Lean).
4. If applicable, consider tracking clinician's individual performance against the goals established in activity 3. Ideally the population health metrics can be sorted by provider and care coordinator. It can be helpful for individuals to see their performance in relation to the practice's goals.

See an example of SCC's analytics risk dashboard below (see **Figures 4 and 5**). Figure 4 is the health analytics dashboard created by Stanford Coordinated Care. This is an example of a care gap reported created in accordance with the practice's EHR. Figure 5 is the HEDIS score dashboard - an external measure Stanford was required to report.

Figure 4: SCC population health analytics risk dashboard

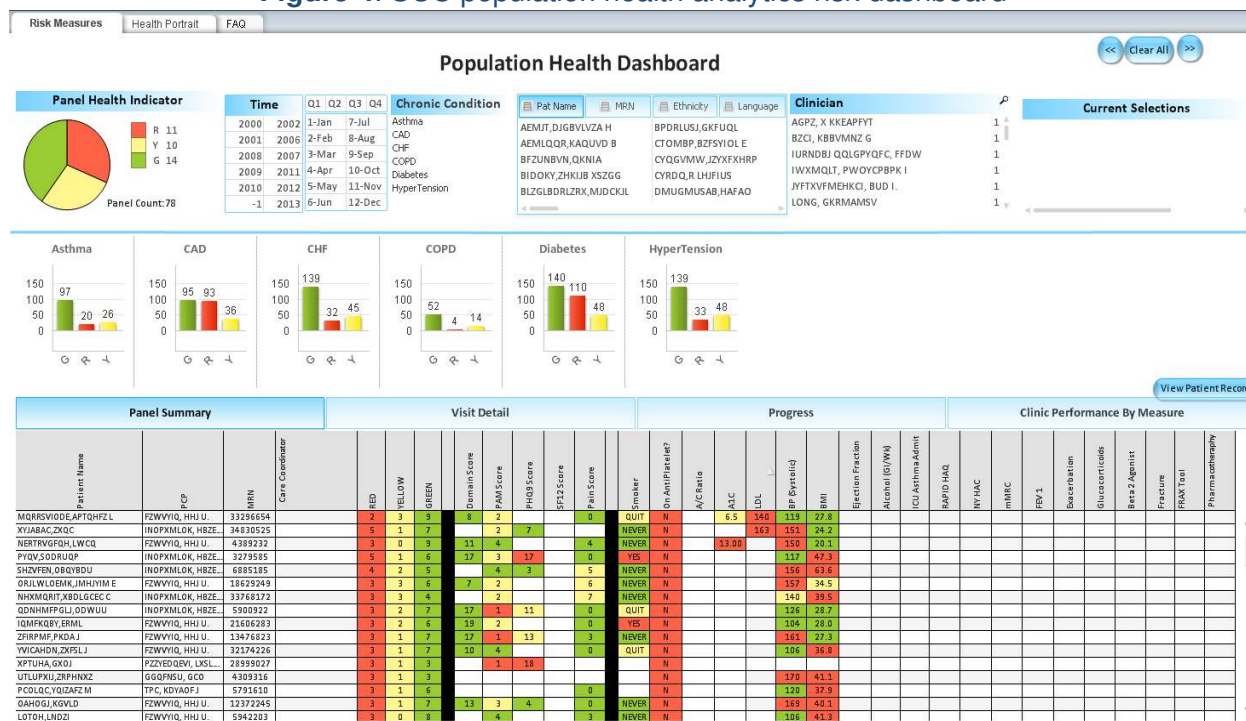
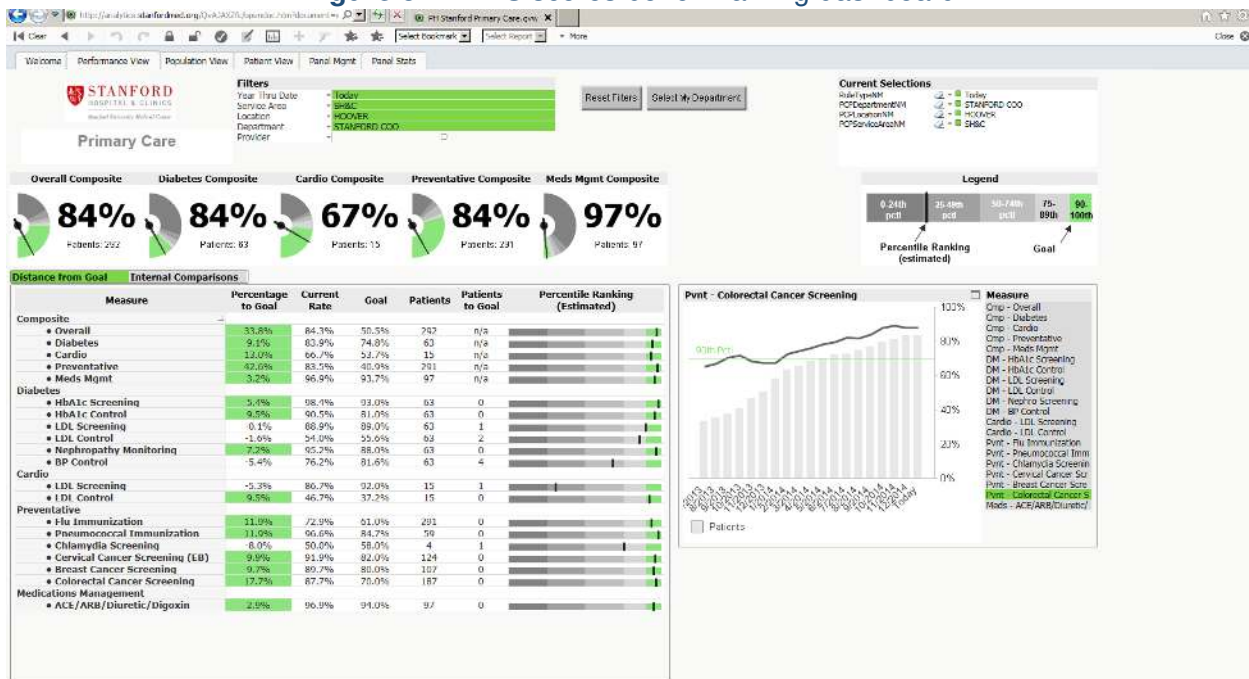


Figure 5: HEDIS scores benchmarking dashboard



Activity 5

Establish regular meetings to discuss related achievements and barriers



Task – Establish regular meetings: After documenting the roles and responsibilities, establish regular meetings with practice staff to review the clinical process map, share successes, and discuss any barriers staff are encountering related to the roles and responsibilities identified in the earlier activities.

- **Frequency:** Meetings should be every other week at the beginning of the model implementation until roles and responsibilities are more clearly established. Meetings can become monthly after the initial phase is over, although more frequent meetings can be beneficial. However, “time is money.”
- **Length:** 45 minutes – 1 hour
- **Location:** Meetings should be located in convenient, private areas of the clinic where staff can talk openly about specific patients.
- **Format:** Ideally, the project lead will lead the discussion and create an agenda and action items for each meeting, as well as continue to engage and encourage participation among staff. Each meeting agenda can be roughly structured to include:
 1. Complete 5-minute mindfulness exercise or icebreaker
 2. Care coordinators present cases (5 minutes for each care coordinator)
 3. Review challenging patients and patients at risk for a poor outcome by care team (5 minutes for each team)
 4. Review deaths
 5. Update on operations, including issues impacting clinic flow, staff morale, etc.
 6. Review measures of success (identified in activity 3)
 7. Thank and recognize individuals or care teams doing a good job

8. Summarize action items for the next meeting, including due dates and who will be responsible for their delivery
 - Make sure that someone takes notes and shares the notes with everyone in order to document each meeting.

In addition to the monthly meetings, consider implementing a daily huddle where the practice team can communicate and coordinate efforts around the initiative on a regular basis. Huddles usually last between 5-15 minutes and occur in the morning before the practice starts seeing patients. For more information about implementing team huddles, see [here](#) for AMA's "Implementing a Daily Huddle" educational module.



Task – Use a “stop the line” approach to major errors: The purpose of a “stop the line” approach is to prevent ongoing but avoidable patient harm and create a culture of patient safety. A second purpose is to avoid developing cynicism within the team – the “nothing ever gets better” attitude that is poison to high functioning teams. Also, “whistleblowers” must be protected when they surface problems. Remember, complaints are “gold.”

1. Draft a “stop the line policy” that outlines policy definitions, procedures and guidelines on following the policy, and examples of situations when a “stop the line” approach should be used.
2. Gather feedback from practice team members on the policy draft and make edits as necessary.
3. Obtain final approval from appropriate hospital leadership.



Task – Institute team engagement strategies to prevent burnout: A key foundation of success for the model is team engagement and promoting good relationships among all practice team members. Some ways to promote employee wellness and decrease the chances of burnout include the following:

- Have new care coordinators shadow an experienced care coordinator for a month.
- Co-locate and co-chart in a team room.
- Establish a “Praise Jar” that allows team members to recognize great work by individual members of the practice team.
- Have an open-door policy where staff feel open to talking to the practice manager or clinic leaders.
- Debrief with team members on an issue in a supportive and non-judgmental manner.
- Establish fair workloads and responsibilities, time off, and other clinic activities.
- Create opportunities for sustained supervision or mentoring for staff.
- Create opportunities for staff to safely bring up problems and propose solutions.
- Include a short mindfulness meditation before team meetings.
- Establish a “Book Club” within the team that allows for co-learning amongst all members of the team.

Activity 6

Develop a process and written brochure/compact for patients receiving care in the new model, including patients’ compact



Task – Develop a strategy for future recruitment of patients who have declined care: If patients are reluctant, indicate that care is available in your team when the patient is ready and that you understand that they do not feel ready to participate.

1. Partner across team roles to clearly outline a path from recruitment to care provision. For more information, see A3 used by SCC to recruit patients ([Appendix 6.1](#)).
2. Create simple and effective referral mechanisms (e.g. a pre-scripted letter that the physician or practice team can give the patient during the appointment, explaining the program)
3. Engage with the physicians on the practice team to help them understand the benefits of the model to patients. Encourage them to use any materials created to enroll patients.
4. Establish learning systems to continually improve recruitment (e.g. root cause analysis on unsuccessful engagement strategies)



Task – Create patient promotional content to describe the practice's model:

1. Create promotional content that clearly articulates the specific services the practice provides and why. These materials should encompass the principles of health literacy and can be specific to individuals in the target population.
2. Get feedback from patients on the promotional products developed. If possible, consider reaching out the 5 patients who were interviewed in activity 1.
3. Update and make edits to the promotional content as necessary.



Resources – SCC tri-fold brochure and onboarding materials: Placing informational brochures in frequented care locations for complex, chronic patients can provide as a gateway to the program. The onboarding packet can be provided to patients upon their enrollment on the program. See [Appendix 6.2](#).

**Activity
7**

Actively engage patients through techniques used in motivational interviewing, problem solving, and behavioral activation to identify patients' goals and tangible steps to reach those goals



Task – Inquire about patients' self-identified goals and establish the importance of the goal to the patient (scale 1-10): In order for a patient to achieve their goals, they must believe that self-management is worthwhile and that there is hope and benefit in actively doing so.

1. Become familiar with and use the following communication techniques, including the following:
 - **Begin with the patient's interest.** The agenda must be personally meaningful for the patient. Start with questions, not information. "What questions should we make sure to address today?"
 - **Believe that the patient is motivated to live a long, healthy life.** You and the patient are on the same side.
 - **Do not offer any help or unsolicited advice.** Zero in on an area for behavior change, get the details, explore relevant beliefs, and summarize and restate the total story.
2. Help your patient determine exactly what they might want to change. The patient must have a clear and achievable plan for self-management. Be sure to identify and respect

ambivalence. Consider administering the PAM measurement tool at intake (see [Appendix 3.4](#)).

- Patients with a low PAM score may not have the information, confidence, or ability to maintain healthy behaviors. If this is the case, the practice team may need to provide additional support and schedule weekly visits or phone/e-mail check-ins with the patient until the patient begins to feel improvements in their health. Always “reward success.”
 - SCC typically reassesses patients with the PAM every 6 months to measure changes in confidence. If a patient has difficulty achieving their goals, consider having a LCSW administer the Adverse Childhood Experiences (ACE) Survey to identify potential sources of dysfunction. See [Appendix 7.1](#) for the tool and scoring instructions.
3. When meeting with patient, begin with the patient’s interests. Start with questions like, “what questions should we make sure to address today?” and “what’s been driving you crazy about your chronic condition?” As the patient answers these questions, listen carefully and limit questions.
 4. Summarize what the patient shares back to the patient. For example:
 - “It sounds like you’re inclined in two different directions. On the one hand, you’re worried about the possible long-term effects of your illness if you don’t manage it well. It’s pretty scary to think about such things. On the other hand, you’re young and enjoy doing what you like to do, eat what you like to eat, and the long-term consequences seem far away. You’re concerned, and at the same time you’re not concerned. Do I have it right?”
 5. Help the patient determine exactly what they want to change.



Task – Develop a reasonable, detailed action plan with the patient to achieve said goals via small steps. Establish confidence that they can succeed in each sequential action plan (scale 1-10), affirming action plans with a confidence score of at least 7:

Providers can leverage key components of behavioral activation to set specific, measurable, and achievable, relevant and time-bound (SMART) goals with the patient. Behavioral activation works by surfacing aspects of life that are most important to patients, then developing concrete action plans (small steps) to achieve their goals. As with all new activities, start working with 5-10 individuals in creating action plans before using these techniques across the entire patient panel, learning as you go.

1. Brainstorm with the patient which identified goals are the most important to them (e.g. feeling better, sleeping better, losing weight, exercising). As you help the patient generate their goal(s), ask the patient why each goal is uniquely important to them. Make sure that the list of goals really matters to the patient and that they are specific and measurable (e.g. “get organized” vs. “organize my kitchen”).
2. Ask the patient, on a scale of 1-10, how important is the goal they surfaced and listen to their response. When the patient selects the level of importance, ask them why the goal isn’t less important (and listen as they defend the goal’s importance to themselves).
3. Focus on 1-2 concrete actions to start. Ask the patient (again, using a 1-10 scale) how confident they are that they can succeed with their action plan. If confidence is <7, simplify the action plan until confidence is at least a 7. See [Appendix 7.2](#) for an example of an activity tracker that patients can use to track their progress on these goals. If possible, leverage the patient’s own resources (e.g. self, family, community groups).
4. If relevant, include community partners as an extension of the SMART goals (e.g. religious supports, housing case managers, Boys and Girls Club counselors) in order to increase confidence with their selected action plan.

5. Follow up with the patient to see the status of their SMART goals, hopefully within a day or two of the action plan being carried out. Remind your patient that decisions may be reviewed and changed if they are not working well.
6. Stay alert for common obstacles. These may include:
 - Social devastation (e.g. poverty, homelessness, lack of access to health care services, etc.),
 - Lack of information,
 - Cultural disconnect,
 - Low functional health literacy,
 - Relative lack of life skills, and
 - Anxiety/disease specific distress and depression.



Task – Set up timely follow-up of action plans to cheer successes and problem solve when success is not achieved. Using motivational interviewing, problem solving, and behavioral activation techniques is an iterative process for both the patients and the team. As such, the process requires feedback to allow the practice to continually improve in this area.

1. Consider using the CollaboRATE survey to track and measure the patients' feedback on the shared decision-making process in real time. The tool is a simple 3-question survey that patients can fill out after each visit to the practice. See [Appendix 7.3](#) for the survey tool and scoring instructions.
2. To implement the CollaboRATE survey, have the MA give the form to the patients to fill out anonymously and ask them to drop it off in a box in the waiting room or with the front desk staff. The practice can review the results of the survey and discuss what is going well and what are the opportunities for improvement during weekly or monthly team huddles or meetings.



Task – Review EHR systems capability to document patients' action plan so that they are visible to all staff “touching” the patient within the team: Integrating a patient's goals and action plans into the practice's EHR systems is an important step to keeping track of the practice's patient panel.

1. Work with the practice's EHR systems and see whether it is capable of integrating the patient's goals and action plans. This document should be accessible to both the patient and practice staff.

Appendix

1.1 Patient Interview Consent Form and Gift Receipt Form Example

INFORMED CONSENT FORM

WHY WE DOCUMENT SESSIONS

TO REVIEW AT A LATER DATE

Documenting sessions allows us to spend less time writing notes during the session, and more time focusing on the discussion with you.

TO SHARE WITH FUTURE MEDICAL SYSTEMS CLIENT AND COLLEAGUES

Not all clients and colleagues on the project team may be present to observe this discussion and benefit from your contribution. Documenting the session allows us to confidentially share the content of this observation at a later time with our team members and extracts of the session with our client.

RIGHTS TO THE MEDIA / DOCUMENTATION

I UNDERSTAND THAT DIGITAL OR AUDIO RECORDINGS AND / OR PHOTOGRAPHS (“MEDIA”) WERE MADE OF MY SESSION. I waive my right to review or make comments on the Media prior to its use. I grant Future Medical Systems permission to use the Media or derivative works based on it for the reasons mentioned in this form. I understand that, other than as mentioned in this form, Future Medical Systems will keep my personal data confidential unless I otherwise agree in writing. I understand that Future Medical Systems has the exclusive rights to all feedback, both oral and written, and any ideas, concepts or suggestions and may use such feedback, ideas, concepts or suggestions for any purpose.

CONFIDENTIALITY

YOU MAINTAIN FUTURE MEDICAL SYSTEM’S CONFIDENTIALITY

All information FUTURE MEDICAL SYSTEMS discloses to me during this session is confidential. By signing this form I agree to not disclose any information / feedback discussed during this session to any third party & I will not use such information for any purpose except to provide feedback to FUTURE MEDICAL SYSTEMS.

FUTURE MEDICAL SYSTEMS MAINTAINS YOUR CONFIDENTIALITY

All information you disclose to Future Medical Systems during this session is confidential. Future Medical Systems agrees not to disclose to any third party beyond the project team any information you provide to us, without your permission. The project team includes Future Medical Systems colleagues and our client.

RELEASE OF CLAIM FOR HARM

I understand there are no known physical, psychological or emotional risks in performing the tasks in this study. However, I hereby agree that should I develop any condition that I believe to represent physical, psychological or emotional harm caused by my participation in the study, I release Future Medical Systems and its employees, officers and agents from any and all claims for damages or compensation of any kind in connection with such condition.

OPTIONAL MEDIA USE BY FUTURE MEDICAL SYSTEMS, LLC

SHARING INTERNALLY, CHECK IF AGREED

- ☐ Future Medical Systems community shares media through our protected, internal network. Sharing allows us to build knowledge & continue to design relevant & desirable products and experiences for people like you. Future Medical Systems may use the Media collected for its internal purposes to promote human-centered design via reports, presentations, & internal website — as well as within the Future Medical Systems network in business development, & with other Future Medical Systems clients & projects.

SHARING EXTERNALLY, CHECK IF AGREED

- ☐ Future Medical Systems may use the Media collected from you today publicly on its website or in press, publications, and products.

CONFIRM UNDERSTANDING

Yes, I’ve read the above & agree to these conditions.

NAME _____

PHONE _____

ADDRESS _____

SIGNATURE _____

SIGNATURE _____

(PARENT OR GUARDIAN IF UNDER 18 YEARS OF AGE)

SIGNATURE _____

(CHILD AGE 12-17, IN ADDITION TO PARENT SIGNATURE)

OBSERVER NAME, TITLE: _____

FUTURE MEDICAL SYSTEMS, LLC

PROJECT NAME _____ TODAYS DATE _____

This is to confirm that _____
received a gift card for \$50 as compensation for an
interview on experience getting health care at Stanford
Hospital Emergency Department and other locations. This
represents the entire compensation for my participation in
this needs assessment interview.

| | |
|---------------------|------------------------|
| _____ | _____ |
| name of participant | name of Stanford staff |
| _____ | _____ |
| date | date |

1.2 ED Patient Outreach Interview Discussion Guide and Consent Form

Introduction / Purpose

Thank you for participating in this needs assessment. We greatly appreciate your time.

- We are [introduction of name and title] and we are interested in how we can improve the health care experience for people who visit SHC ED frequently.
- For this project, we are meeting with people who have been to SHC ED at least 5 times in the past year.
- Understanding your experience could help us improve the experience of care for others seen at SHC ED or local clinics.

Guideline

- Feel free to be as candid as you'd like – your honest feedback (both positive and negative) will help us design the best tools for SHC.
- There are no right or wrong answers.
- Give examples wherever appropriate.
- We want you to be comfortable, so if you don't understand something, just ask, and if you would rather not answer a question, please just say so.

Consent Form/Payment

Self-Portrait

First, we'd like to begin with some general questions about you, how you spend your time, where you live and what kind of things you enjoy doing.

- Please tell us a little bit about how you spend your time?
- Where do you live? How long have you lived there? Do you expect to have to change your living situation soon?
- What are some things that you struggle with from day to day?
- What do you like to do?

Daily Life

- Now, we'd like to get an idea of your daily life.
- Glimpse of a day – tell us about your day yesterday, from waking up to going to bed, who you interacted with, where you went, etc.
- How have your health issues affected your daily routine?
- In what moments do you think most about your health?
- What do you consider when deciding where to get medical care? Recent examples?

Health Stories

- How has the healthcare you have received helped you feel better?
- How has the healthcare system been not so helpful?
- What's the worst moment you have had in regards to your health issues?
- How did you go beyond that moment (e.g. "What helped?")? What did you need in that moment?

Information Sources / Care Network

Now we'd like to talk about where you get health care.

- Where do you go most frequently for health care?
- Do you have issues getting transportation to care?
- What sources do you trust the most? Least?
- Are you able to follow through with recommendations by your doctors?

- Please tell us about the last time you sought health care.
- Do you feel you get the health care you need, when you need it? Any area that is lacking?
- Are you able to get and take recommended medications? If not, why?
- Are you able to eat food to maintain your health?

Support Relationship Map

Who are the people in you can rely on? Please draw you in the middle. Now draw those who help you manage your health around you. Feel free to draw stick figures, circles, or anything you like to represent people. You can draw the most important sources of support the largest, and less key figures smaller. Specialists, primary doctors, nurses, and other clinic staff? Family, friends? Any others?

- How do these people relate to one another?
- Who is the source of the most support and care? Emotionally? Physically?

Decisions about new offerings

- Tell us about any services you recently came across for health care.
- What is it, what attracted you and how do you plan on following up?
- What are your next steps?

Insurance Plan

- What kind of health insurance do you have, if any?
- What was the experience of enrolling in your plan like (what questions did you have? Who helped you, if anyone? What resources did you use?)

Analogous Inspiration

- Think about the last time you had a great experience getting health care. Where were you? What made it great? (This does not have to be health-related – anything goes!)

Stanford Hospital and Clinics

Consent for Interview about Emergency Department Usage

DESCRIPTION: We are interested in learning about your experience accessing health care at Stanford Hospital Emergency Department and other places.

After you have read, understood and signed this form, you will be asked be interviewed. We will interview approximately 5 people in total. The interview will include questions on what you have found helpful and what might have been frustrating in getting health care. This interview will last 60-90 minutes. We would also like your permission to look at your health records to check on your use of health care services.

During the interview, we will take notes and audiotape the session to check our notes for accuracy. However, your name will be removed from the notes from the interview and from the review of your medical records and replaced with a code. Please note that some identifiable health information will be kept for use by a service design team. The recording will be destroyed after the notes are processed. All materials will be kept in locked filing cabinets and on password-protected encrypted computers.

The information that you provide us and the information from your medical records will be kept confidential and will be added to the information of the other participants. No information on individual participants will be disclosed.

RISKS AND BENEFITS: The risks associated with participation in this assessment are minimal. There is no guarantee or promise that you will receive any personal benefits from this assessment; however this assessment would improve our knowledge regarding the needs of people getting care at Stanford Emergency Department.

TIME INVOLVEMENT: Your participation in this interview will take between 30-60 minutes.

PAYMENTS: You will receive a \$50 gift card for participation. Payments may only be made to U.S. citizens, legal resident aliens, and those who have a work eligible visa.

CONTACT INFORMATION:

Questions & Concerns: If you have any questions or concerns about this assessment, its procedures, risks and benefits, you should ask the Project Director, Dr. Ann Lindsay. You may contact her now or later at 650.724.1800. You may also email her at adlindsa@stanford.edu. Her mailing address for questions about the assessment is:

Ann Lindsay MD

211 Quarry Rd, Suite 402 M/C 5995

Palo Alto, CA 94304

Independent Contact: If you are not satisfied with how this assessment is being conducted, or if you have any concerns, complaints, or general questions about the assessment, please contact Deepti Randhava, 650 724 1800 (drandhava@stanfordhelthcare.org)

If you cannot make the scheduled interview, you can also call Dr. Lindsay at the same number, (650)724-1800. The photocopy of this consent form is for you to keep.

Part A: I give consent to participate in this assessment.

Please initial: ___Yes ___No

Part B: I give consent to be audiotaped during this assessment:

Please initial: ___Yes ___No

Signature of Participant

Date

Signature of Person Obtaining Consent

Date

1.3 Hospitalization Admission Risk Monitoring System (HARMS 8)

INTRODUCTION

The HARMS 8 has 3 components:

1. Vital Conversations: Screening and Monitoring
2. Identifying and Documenting the Problem(s)
3. Implementing Actions/Interventions for Risk Reduction

I. Vital Conversations: Screening and Monitoring

The Goal of Screening: Avoidable hospitalizations can occur even when a patient is on optimal medical management. There are no simple questions or simple answers that have been shown to reveal the complexity of non-medical issues that can destabilize high-risk patients. Like Vital Signs that monitor key physiologic processes, Vital Conversations are intended to open up inquiry with the patient around key areas of social-behavioral risk. Just as the medical "Review of Systems" standardizes inquiry around all physiologic sub systems, Vital Conversations attempts to standardize inquiry around key areas of social-behavioral risk. In both cases, the goal is to identify critical issues amenable to intervention.

Whom to Screen: Chronic illness patients at risk for hospitalization due to non-medical reasons include those with a confirmed diagnosis of CHF, COPD, Diabetes, Asthma, or Hypertension. For these patients, and others with chronic illnesses, hospitalization risk and the potential benefit from screening is increased if:

1. The patient is on 5 or more prescription medications daily
2. The patient has a history of substance abuse
3. The patient has a diagnosis of anxiety, depression, schizophrenia, schizoaffective disorder, or bipolar disease?
4. The patient's provider or team answers "No" to the questions: "Would you be surprised if the patient were to die within the next year?"

When to Screen: Consider screening all new high-risk patients as part of an initial assessment and updating information on a yearly basis. All questions do not have to be asked at once and can subsequently be useful as specific issues arise.

- The health beliefs question could be useful in anyone with anxiety, depression or somatization.
- The health knowledge questions could be useful whenever discussing medications or chronic condition self-management.
- The physical functioning questions could be useful with any frail elderly patient or whenever dealing with issues of pain, activity level, or in case of falls or injury.
- The problem solving questions could be useful when discussing a chronic condition self-management or action plan.
- The social support questions can be useful in any older patient.
- The self-confidence patient can be useful with all patients who have a chronic illness, whether or not it is high risk.
- The resilience and stability questions can be useful after any ED visit or hospitalization.

How to screen: Any member of the health care team can do HARMS 8 screening. However, simply asking the questions and recording answers will rarely be useful. The questions are "starters" for inquiry. They are meant to "open doors" to further exploration of each area of risk to discover whether intervention is warranted and possible. Except for the first question on Health Beliefs, each question is based on actual behavior or experience in order to make exploration of the risk domain as real and revealing as possible.

Documentation of the results would ideally be dated and easily available in the medical record. Creating a "Non-Medical Problem List" displayed prominently in the record, similar to the traditional medical problem list, could be very useful, especially for patients who interact with multiple providers and points of care. An example is attached.

HARMS-8: Vital Conversations

1. **Health Beliefs:** Do both the patient and the provider have the same realistic assessment of the patient's health status?

In general, how would you rate your current health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

For all, **“Why do you rate it that way?”**

2. **Health Knowledge:** Does the patient really understand their medical regimen and its importance?

How many prescription medications are you currently taking every day?

☐ None (*Skip to question 3*) ☐ 1-2 ☐ 3-4 ☐ 5 or more

During the past WEEK, how often did you forget to take or decide not to take one or more of these medications?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

How sure are you that you understand the reason you are taking each of these medications?

☐ Very sure ☐ Somewhat sure ☐ Not very sure

Unless Never/Very Sure: **“What is most difficult for you in taking your medications?”**

3. **Physical Functioning:** Does the patient's functional limitations put them at risk in their current living situation?

Think about your usual daily activities, such as bathing, toileting, dressing, grooming, feeding, housework, family, or leisure activities. Which of the following best describes your situation in the last MONTH?

☐ I have no problems with performing my usual activities.
☐ I have some problems with performing my usual activities without assistance.
☐ I am unable to perform my usual activities without assistance.

Unless no problems: **“Do you think you need help managing at home? If so, what kind?”**

4. **Problem Solving:** Is the patient able to think through problems as they arise?

In the last MONTH, how often did you have trouble with remembering or thinking clearly?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

Unless Never, **“What do you do when that happens?”**

5. **Social Support:** Does the patient have critical supports in case problems arise and they need help?

If you needed immediate help for a health problem, how many friends or relatives do you feel close to such that you could call on them for help?

☐ None ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 or more

5_a) Who are they?

5_b) How often do you communicate with them?

If None or unclear, **“Is there someone who might be willing to help if they were asked?”**

6. **Self Confidence:** Is the patient comfortable managing their medical conditions?

Think about your current medical conditions. How confident are you that you can manage these medical conditions day-to-day?

☐ Very confident ☐ Somewhat confident ☐ Not very confident ☐ I don't have any health conditions

Unless Very confident: **“What is most challenging for you about your health?”**

7. **Resilience:** How well is the patient actually managing without feeling overwhelmed?

During the past 6 MONTHS, how many times did you go to the emergency room?

☐ None (*Skip to question 8*) ☐ 1-3 times ☐ More than 3 times

If any ED use in the past 6 months: Do you think it is likely you will need to go to the emergency room again in the next 6 MONTHS?

☐ Not likely ☐ Somewhat likely ☐ Very likely

Unless Not likely, **“What do you think would help to keep you from needing to go to the emergency room?”**

8. **Stability:** How well is the patient actually managing without the need for hospital care?

During the past 6 MONTHS, how many times did you stay in the hospital overnight as a patient?

☐ None (*END*) ☐ 1 or more times

If any hospitalizations in the past 6 months: Do you think it is likely you will need to be hospitalized again in the next 6 MONTHS?

☐ Not likely ☐ Somewhat likely ☐ Very likely

Unless Not likely: **“What do you think causes your condition to get so bad you need to be in the hospital?”**

HARMS 8: Documenting Hospital Admission Risks

Below is a potential list of socio behavioral risks that could be part of a "Non-Medical Problem List" in the patient's chart. Ideally it would be in a prominent place similar to the standard medical Problem List. It could be formatted in EHRs as a pick list, ideally with date of entry and comments.

This allows the information gained by going through the HARMS 8 Vital Conversations to be retained in the record as easy reference to all providers. It would not necessarily replace more detailed documentation.

The list below follows the Risk Reduction Action Guide and is presented as an example only.

Socio-Behavioral Problem List (Indicate all that apply)

- Lack of knowledge/literacy about health conditions
- Anxiety over health status
- Adherence issues with critical medications
- Lack of knowledge about medications
- Some difficulty performing daily activities
- Assistance with daily activities from caregiver required
- Some difficulty in remembering or thinking clearly
- Difficulty problem solving
- Severe cognitive deficits
- Adequate social supports lacking
- Social isolation
- Lack of self-confidence to self-manage medical issues
- Unable to follow self-management red flag action plan
- Not engaged/motivated in self-management
- Prefers ED as source of care
- Mental health condition complicating self-management
- Active substance abuse complicating self-management
- Other _____

Testing Feedback – Testing the HARMS-8:

1. How many patients (or patient records) did you test this tool with?
☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21+
2. Did you test the current patients during a visit, or did you do a retrospective review?
☐ Current patients during a visit ☐ retrospective review ☐ both
3. How long did it take you to complete the patient questionnaire portion of the tool (HARMS -8)?
☐ 1-5 min ☐ 6-10 min ☐ 11-15 min ☐ 16-20 min ☐ 21+ min
Tell us more about this: _____
4. How easy or difficult was it for you to gather this information from patients or caregivers?
☐ Very easy ☐ Easy ☐ Somewhat difficult ☐ Very difficult
5. Did you modify your approach for gathering this information based on learning what occurred when you were testing?
☐ Yes ☐ No
Tell us more about this: _____
6. How easy or difficult was it for you to work this into your team or clinic workflow?
☐ Very easy ☐ Easy ☐ Somewhat difficult ☐ Very difficult
Tell us more about this: _____
7. Did you modify your approach for working this into your team or clinic workflow based on learning that occurred when you were testing?
☐ Yes ☐ No
Tell us more about this: _____
8. Did you learn anything new about these patients that you otherwise would not have known?
☐ Yes ☐ No
Tell us more about this: _____
9. Did you identify any risk domains or areas of concern that you feel could be modified from within primary care (even if the intervention/assistance needed is outside your clinic but a critical referral could be made by your team)?
☐ Yes ☐ No
Tell us more about this: _____
10. We would like your input on this risk tool. Are there risk domains that are not covered by this tool or questions that you do not believe are relevant? What are they? Do you have other suggestions that would improve this tool?

3.2 Stanford Coordinated Care (SCC) Care Coordinator Job Description Example

Job Title: CARE COORDINATOR - SCC

Job Summary: This paragraph summarizes the general nature, level and purpose of the job.

The Care Coordinator for SCC (Stanford Coordinated Care) functions as the central member of the clinic patient team as both the medical assistant and outreach worker as directed by the Clinic Manager or designee. The Stanford Coordinated Care (SCC) is part of a new clinic model design supporting patients (employees) with chronic disease. The Care Coordinator acts as the key point of contact for patients managing their chronic diseases and advises patients on goal setting and action plans as the primary focus of managing their disease. Works directly with patients and their caregivers to monitor their care. Identifies and facilitates completion of preventative and follow-up care as it related to assigned patients. Occasionally conducts home visits at the patient's home if and when appropriate.

Essential Functions: The essential functions listed are typical examples of work performed by positions in this job classification. They are not designed to contain or be interpreted as a comprehensive inventory of all duties, tasks, and responsibilities. Employees may also perform other duties as assigned.

Employees must abide by all Joint Commission Requirements including but not limited to sensitivity to cultural diversity, patient care, patients' rights and ethical treatment, safety and security of physical environments, emergency management, teamwork, respect for others, participation in ongoing education and training, communication and adherence to safety and quality programs, sustaining compliance with National Patient Safety Goals, and licensure and health screenings. Must perform all duties and responsibilities in accordance with the Service Standards of the Hospital(s).

- Administers medication following approved procedures and only after verification of medication and dosage by a licensed person.
- Advises patients on goal setting and provides action plans for managing their disease.
- Assists physicians with sterile and non-sterile procedure set-ups, patient procedures and examinations.
- Assists with direct patient care procedures and related tasks; rooms patients, assists in obtaining patient histories, takes vital signs, prepares charts, and assists with medical examinations.
- Conducts home visits occasionally to chronically ill patients and visit individuals at high risk of health problems if required.
- Coordinates communications and transactions between patient, ancillary services, consultants, and physicians. Coordinates authorization required by insurance.
- Documents clinical information, including patient phone calls, accurately and completely and within the specified time.
- Maintains clean and orderly exam rooms, hallways and work areas.
- Prepares patient for examination or treatment and performs routine screening tests. Explains treatment procedures to patients. Provides patient instructions according to physician orders and established guidelines.
- Prepares the necessary equipment and supplies for exam. Maintains inventory of supplies in examination rooms, replenish as required.
- Reports patient's concerns and symptoms, reactions, changes (appropriate to age) to licensed clinic personnel.
- Schedules appointments (new and return) and ancillary tests/surgeries. Responsible for new patient coordination. Registers new patient in the scheduling system; obtains new patient authorization; schedules appointment; ensures patients receive new patient information.
- Tracks the flow of medical records and patient information through the clinic.
- Under the direction of the physician, ensure that patient receives results of laboratory and diagnostic tests, special test instructions, and other information in a timely manner.
- Works with insurance companies, HMO staff when needed to assist patient.

Minimum Qualifications: Any combination of education and experience that would likely provide the required knowledge, skills and abilities as well as possession of any required licenses or certifications is qualifying.

- Education: High School diploma or equivalent. Completion of all requirements in a recognized Medical Assistant training program or equivalent completion of the minimal training requirements as outlined in section 1366 of the Business and Professions Code.
- Experience: Two (2) years of progressively responsible and directly related work experience

Knowledge, Skills, and Abilities: These are the observable and measurable attributes and skills required to perform successfully the essential functions of the job and are generally demonstrated through qualifying experience, education, or licensure/certification.

- Ability to demonstrate customer service skills in interactions with all patients, families and staff, including high volume and stressful situations

- Ability to educate patients and/or families as to the nature of disease and to provide instruction on proper care and treatment
- Ability to plan, organize, prioritize, work independently and meet deadlines
- Ability to solve problems and identify solutions
- Ability to speak and write effectively at a level appropriate for the job
- Knowledge of computer systems and software used in functional area
- Knowledge of inventory management practices
- Knowledge of medical terminology
- Knowledge of sanitation, personal hygiene and basic health and safety precautions applicable for work in a clinic setting. Knowledge of infection control procedures and safety precautions
- Knowledge of sterile techniques and special procedures that are applicable to work performed

3.3 Stanford Coordinated Care (SCC) Nurse Job Description Example

Job Title: CLINICAL NURSE SPECIALIST (CNS) - SCC

Job Summary: This role would primarily work with the patients in chronic care support program at SCC in collaboration with a LCSW. The CNS would assess patient's appropriateness for the program using standard tools, create health goals and action plans with patient through motivational interviewing, provide health education, help patients' access resources in the community and provide follow up either in person or by phone. The CNS would also promote better communication between patient and providers (for example: accompany patient to a specialty visit), make recommendations to primary care physician and/or specialist to promote patient's goals/needs. The CNS would help patient access information about medications, procedures, and diagnoses and collaborate with patient's care team to obtain orders for varied services (e.g., physical therapy, Registered Dietician, speech pathology). He/ She would follow-up with patient after his/her hospitalization to help him/her follow care plan. The CNS in the primary care plus program would provide back-up support for Care Coordinators and Doctors to assist with minor procedures, draw blood, and administer medication. The CNS would lead multidisciplinary case presentations to present patients in the chronic care support program. He/she would order medications and lead the clinic in ever readiness by educating staff on quality standards, performing checklists, and how to manage point of care testing quality logs. He/she would be signing off on competencies for care coordinators and participating in building competencies for ambulatory care that impact the care coordinator role. Participation in daily huddles, operations meetings, recruitment and outreach calls to new patients for the practice is an integral component of the role.

Essential Functions: Clinical Nurse Specialists are Master's Degree prepared advanced practice. Registered Nurses in roles characterized by the following responsibilities:

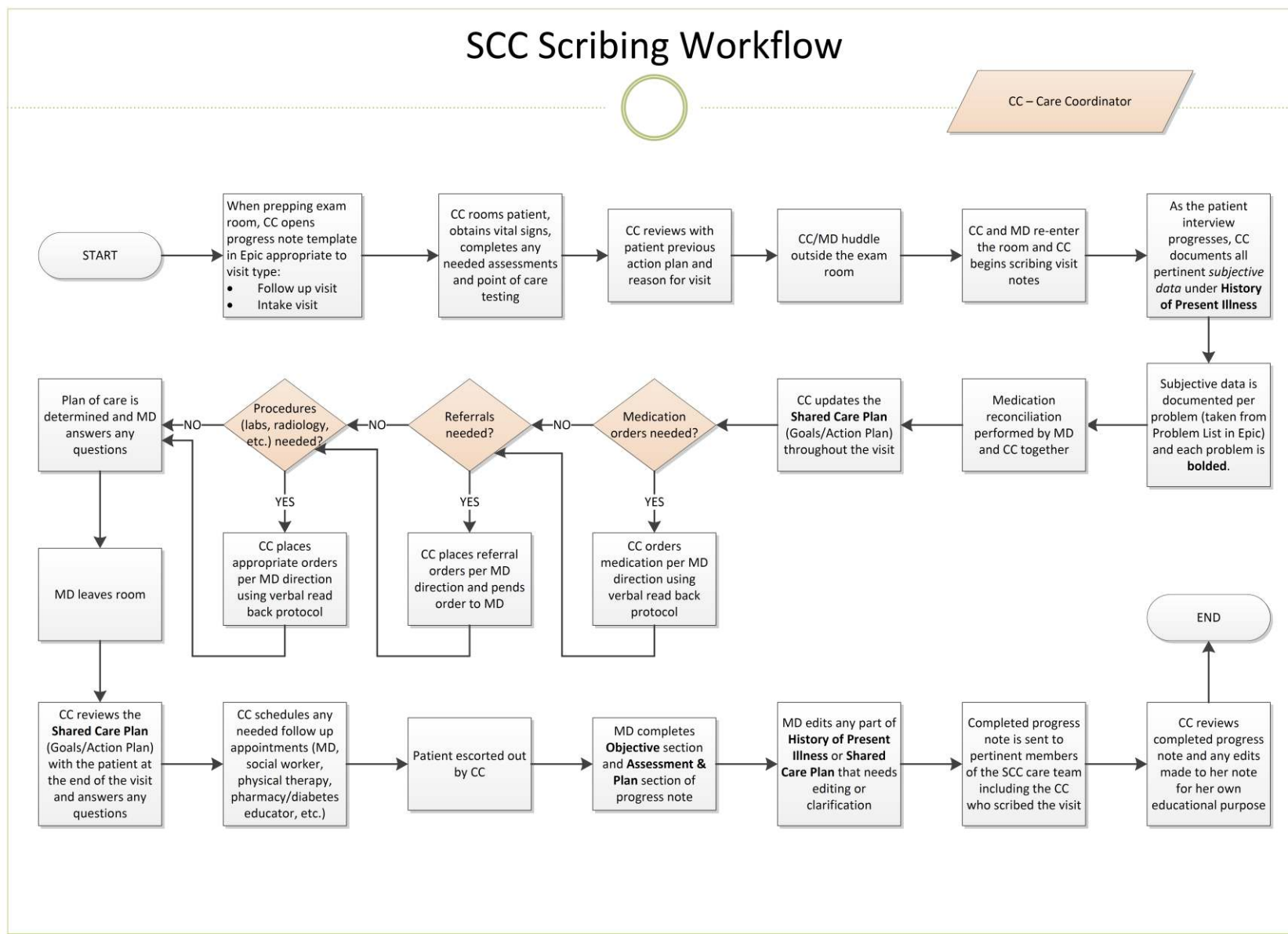
- 1) Provide care for patients with multiple or complex health needs within a specific clinical area;
- 2) Use advanced clinical skills in the assessment, diagnosis, treatment and evaluation of patients;
- 3) Use theoretical and clinical expertise to assist health care providers and patients in promoting or achieving optimal health;
- 4) Develop and implement standards of nursing practice;
- 5) Serve as a consultant or expert resource person for other health providers;
- 6) Facilitate an interdisciplinary and collaborative approach to meeting the needs of patients;
- 7) Seek consultations and make referrals as needed; and
- 8) Promote research to improve clinical nursing practice.

Clinical Nurse Specialists assess, plan, provide and evaluate specialized nursing care of patients by advancing the quality and scope of nursing practice through clinical practice, education, research, consultation, and administrative roles in the area of clinical expertise (e.g., diabetes, cardiology, respiratory, pediatrics, etc.) for a specified patient population.

Minimum Qualifications: Any combination of education and experience that would likely provide the required knowledge, skills and abilities as well as possession of any required licenses or certifications is qualifying.

- Education: Master's degree in a work-related discipline/field from an accredited college or university
- Experience: Three (3) years of progressively responsible and directly related work experience
- License/Certification: CA Registered Nurse (RN)
- License/Certification: CNS - Clinical Nurse Specialist clinical nurse specialist, CNS, nurse, nurse specialist, nurse education.

3.4 Stanford Coordinated Care (SCC) Scribing Workflow Example



3.5 SCAN Foundation ROI Calculator for Person-Centered Care (website link to excel file: https://www.thescanfoundation.org/sites/default/files/roi_calculator_for_person_centered_care_blank.xlsm)

The screenshot shows the Microsoft Excel interface with the 'SCAN Foundation ROI Calculator - Excel' workbook open. The ribbon includes File, Home, Insert, Page Layout, Formulas, Data, Review, View, and ACROBAT. A security warning states 'Macros have been disabled' with an 'Enable Content' button. The formula bar shows 'A1'.

The main content area features the SCAN Foundation logo and navigation buttons: 'Scenario Tool', 'Navigation', and 'Report Writer'. Below this is a blue banner for the 'Return On Investment Calculator for Person-Centered Care Program' with a 'NEXT 2' button.

A 'Calculator Instructions' button is present. To its right, an 'Open Document' button is accompanied by the text: 'Once opened, press CTRL and the Contents Item to move to that section.'

A 'Contents' table of contents is displayed, listing sections and their corresponding page numbers:

| Contents | |
|---|---|
| INTRODUCTION: THE CALCULATOR, THE BUSINESS CASE AND PERSON-CENTERED CARE..... | 2 |
| USES FOR THE CALCULATOR..... | 2 |
| HOW THE CALCULATOR OPERATES..... | 3 |
| CALCULATOR FEATURES..... | 3 |
| GUIDE TO THE SHEETS..... | 4 |
| SCENARIO TOOL INSTRUCTIONS..... | 6 |
| CREATE AND SAVE SCENARIOS..... | 6 |
| LOAD A SCENARIO..... | 7 |
| DELETE A SCENARIO..... | 7 |
| OVERWRITE A SCENARIO..... | 7 |
| EDIT NAME AND DATE ONLY..... | 7 |
| DECLARE A SCENARIO AS THE BASELINE..... | 8 |
| LOAD A BASELINE..... | 8 |
| CLEAR ALL INPUT DATA..... | 8 |
| SCENARIO COMPARISONS..... | 8 |
| NAVIGATION AND CONTROL..... | 9 |
| NAVIGATE USING THE NAVIGATION FORM..... | 9 |

At the bottom, a navigation bar shows tabs for different sections: '1.START' (selected), '2.Flow', '3.Population Data', '4.Costs', '5.Additional Utilizations', '6.Medical Utilization', '7.Revenue Enhancements', '8a.Summary', and '8b.Scenario Comp: ...'.


3.6 Patient Activation Measure (PAM) Tool

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.


If the statement does not apply to you, circle N/A.

| | | | | | | |
|-----|--|-------------------|----------|-------|----------------|-----|
| 1. | When all is said and done, I am the person who is responsible for taking care of my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 2. | Taking an active role in my own health care is the most important thing that affects my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 3. | I know what each of my prescribed medications do | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 4. | I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 5. | I am confident that I can tell a doctor concerns I have even when he or she does not ask. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 6. | I am confident that I can follow through on medical treatments I may need to do at home | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 7. | I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 8. | I know how to prevent problems with my health | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 9. | I am confident I can figure out solutions when new problems arise with my health. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |
| 10. | I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress. | Disagree Strongly | Disagree | Agree | Agree Strongly | N/A |

4.1 Stanford Coordinated Care (SCC) Scribing Policy

**Stanford**
HEALTH CARE

Scribing for Primary Care 2.0
Building the HPI

**Stanford** | MEDICINE

Course Objectives

At the end of this course, the student will be able to:

- ▶ Define HPI
- ▶ Construct an appropriate topic sentence
- ▶ Identify key elements of the HPI
- ▶ Recognize pertinent positives and pertinent negatives
- ▶ Construct an appropriate HPI

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What is HPI

HPI stands for **H**istory of **P**resent **I**llness

The HPI is a chronological description of the development of the patient's present illness or reason for visit.

The HPI in many cases is the most important part of a medical noted. It is not necessary to use extensive medical terminology in this section. It should be written in plain terms from the patient's point of view, however, can often be simplified by substituting some common medical terms. When possible, you can use "quotes" from the patient to help describe the experience.

Often, there are multiple complaints. If so, these complaints should be separated and given their own paragraph. This aids in distinguishing between complaints.

- **Headache:**
- **Rash:**

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3

The Topic Sentence

The topic sentence is the first sentence of the HPI.

The topic sentence should include specific information about the patient.

- ▶ Name
- ▶ Age
- ▶ Gender
- ▶ Pertinent past medical history
- ▶ Chief complaint/concern, or reason for visit
- ▶ Ideally, you would include 1-2 descriptors about the CC.
- ▶ This is also where you can mention who is present at the visit with the patient, and/or if an interpreter is being used.

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4

Examples of Topic Sentences

- ▶ Jane is a 52 year old female with history of hypertension and diabetes who presents today with a complaint of chest pain for one week.
- ▶ Samuel is a healthy 25 year old male who comes in today for evaluation of a left shoulder injury.
- ▶ Jeffrey is an 11 year old male with history of asthma who presents today with his father for sports physical.
- ▶ Elaine is an 82 year old female with history of osteoporosis and status post left hip replacement who presents for evaluation of hip and knee pain after a fall this morning.

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Pertinent Past Medical History as part of the Topic Sentence

You may not initially know what **pertinent** past medical history to list in your topic sentence. It's a good idea to review past medical history and/or the problem list prior to the visit in order to gain a little background knowledge about your patient.

This information can be added later once you hear more from the patient and realize what might be related.

As you continue to take notes and scribe during visits, you will gain more knowledge and understanding about several different diagnoses. In addition, future lessons will cover many of the most common medical complaints and diagnoses to give you a little more background.

- ▶ Example of inappropriate mention of past medical history:

Jane is a 52 year old female with history of gastroesophageal reflux who presents today with a complaint of right knee pain.

(Her reflux or heartburn is irrelevant to anything that could be causing knee pain.)

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Creating a story

- ▶ Each patient comes with a story about how and why he/she has presented to clinic. A chronological account of events can help to set the stage and help to determine the course of the problem, and sometimes the cause of the problem. In developing the story, there are certain elements that should be included to help narrow the spectrum of possible diagnoses.

- Onset
- Duration
- Severity
- Quality or Character
- Location
- Timing/Frequency
- Modifying Factors
- Context
- Associated Symptoms

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Elements needed to create the story

- ▶ **Chief Complaint** – Brief reason for visit (symptom or known diagnosis)
- ▶ **Topic Sentence** – Summary of pertinent information about the patient to set the stage for the story.
- ▶ **Onset/Duration** – When symptoms began and for how long they lasted or have been ongoing
- ▶ **Severity** – How intense the symptoms are and/or how bothersome the symptoms are
- ▶ **Quality or Character** – The way the patient describes his pain or symptom (cramping, burning, sharp, pressure-like, etc.)
- ▶ **Location** – Where the patient is experiencing the symptoms
- ▶ **Timing/Frequency** – Different from onset/duration, it is more about how often the symptoms occur or if there is specific pattern
- ▶ **Modifying Factors** – What makes it better or worse
- ▶ **Context** – What precipitating factors, risk factors, previous diagnoses or treatments were used. Was there a specific event associated with onset of symptoms?
- ▶ **Associated Symptoms** – are there any other symptoms associated with the chief complaint?

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The Story

Chief Complaint: Nausea and abdominal pain

George is a 35 year old male with no significant past medical history who presents today complaining of nausea and abdominal pain. He first noted the symptoms three days ago. The patient rates the abdominal pain as a 5 out of 10 in intensity at its worst, currently a 3. The abdominal pain is dull and localized to the right upper quadrant. He states that the pain is intermittent, and worst after eating. The nausea is alleviated by taking Pepto Bismol. He reports that the symptoms started after eating Indian food. He states that he has had some constipation, but denies any fevers, chills, vomiting, or blood in his stool.

- Topic Sentence
- Onset
- Severity
- Quality or Character
- Location
- Timing/Frequency
- Modifying Factors
- Context
- Associated symptoms

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Acronyms that can help you remember the elements

- ▶ **OPQRST** (Onset, Provocation/Palliation, Quality, Radiation, Severity, Timing)
- ▶ **OLD CARTS** (Onset, Location/Radiation, Duration, Character, Aggravating, Relieving, Timing, Severity)
- ▶ **SOCRATES** (Site, Onset, Character, Radiation, Associations, Time course, Exacerbating/Relieving factors, Severity)
- ▶ **COLDERAS** (Character, Onset, Location, Duration, Exacerbation, Remitting factgors, Severity)
- ▶ **SCHOLARS** (Symptoms, Character, History, Onset, Location, Aggravating, Remitting, associated Signs and Symptoms)
- ▶ **CLEARAST** (Character, Location, Exacerbation, Alleviation, Radiation, Associated symptoms, Severity, Time frame)

As you can see here, the elements do not need to be in any particular order, as long as your story flows well.

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Elements of HPI

- ▶ It is also not necessary to answer every one of these questions every single time. Depending on the problem, some of these questions might be irrelevant.

For example:

- A fever does not radiate or have character.
 - A cough does not have a location.
- ▶ Including as many elements as possible is important to help build the story, narrow the potential diagnoses, and to support billing practices. More on this to come in future lessons.

Pertinent Positives and Pertinent Negatives

- ▶ Pertinent – relevant or applicable to a particular matter
 - Synonyms: appropriate, significant, applicable, suitable, fitting
- ▶ Pertinent Positives are symptoms that are present that are related to the complaint.
 - Cough accompanied by **fever and chills**
 - Pain with urination accompanied by **low back discomfort**
- ▶ Pertinent Negatives are symptoms that are not present that could potentially be related to the complaint.
 - Sore throat, but without **cough or fever**
 - Abdominal pain, but without **nausea, vomiting, diarrhea, or constipation**

Pertinent Negatives

The pertinent negatives help to support or disprove differential diagnoses.

- ▶ CC: Chest pain...
- ▶ "...There was no fever, cough, sputum, radiating chest pressure, nausea, vomiting, bloating, or hematemesis. He has no prior history of trauma to the chest, prior coronary artery disease or anxiety."
- ▶ In this scenario, other causes of chest pain to consider are pneumonia (fever, cough, sputum), coronary artery disease (radiating chest pressure, nausea), peptic ulcer disease (nausea, vomiting, hematemesis), anxiety or musculoskeletal disease.

In time, you will begin to recognize which symptoms should be included in the HPI, and which symptoms are merely part of the general Review of Systems.

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HPI Examples – Can you identify the elements

Here are a few examples of HPIs.

See if you can identify the key elements of an HPI in each.

CC: Lower abdominal pain.

HPI: Jennifer is an 11 year old female who presents to the clinic today with her mother with a complaint of lower abdominal pain.

Abdominal pain: For the past 3 days she has had an aching/cramping feeling to her lower abdomen. The cramping is most intense after she eats a meal. She denies urinary changes. Her last BM was yesterday. She reports she had to strain to pass stool and the pain felt a little better afterwards. Her Mother notes that Jennifer has recently stopped taking home cooked meals for lunch and is eating school prepared lunches. No nausea or vomiting. No family members or schoolmates are sick.

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HPI Examples – Can you identify the elements?

CC: Chest pain.

HPI: Janet is a 56 year old woman who presents to the clinic with complaint of chest pain starting 6 months ago. She first noted an episode of sharp chest pain in the middle of her chest 6-7 months ago. The pain lasted 5-10 minutes and then gradually resolved. When the pain began, she was sitting and about to eat breakfast. She denies having a cough or cold at the time. The pain did not radiate and was tender to touch. In the past six months, she has had 4 other episodes of similar pain. She has been unable to identify a triggering factor. Subsequent episodes were not associated with food, cough, SOB, diaphoresis, fever, or radiation of pain to her arm or neck. The pain always resolved after less than an hour. She has not tried any medications for relief. No family history of Asthma.

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HPI Examples – Can you identify the elements

CC: Low back pain.

HPI: Ms Wright is a healthy 30 year old female who presents to the clinic with a 6 month history of low back pain.

For the past six months, she has been experiencing low back pain radiating from the right lower back down the right lower extremity to the foot. Severity is rated as an 8/10 and described as, "a lightening bolt shooting down my leg". Pain is aggravated most when she is standing, walking, running, and bending forward. It is alleviated by lying down. She reports occasional numbness and tingling in the right foot. No lower extremity weakness.

What other elements do you think would be helpful to include?

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Summary

- ▶ The HPI or History of Present Illness is a chronological description of the development of the patient's present illness or reason for visit, including some pertinent background information about the patient.
- ▶ The HPI is a story to help solve a mystery about what is going on with his or her body, mind, or health in general.
- ▶ The topic sentence is the first sentence of the HPI and should include specific information about the patient: Name, Age, Gender, and pertinent PMH.
- ▶ Key elements are details about the complaint that help to build the body of the story and include: Onset, Location/Radiation, Duration, Character, Aggravating, Relieving, Timing, Severity
- ▶ Pertinent Positives and Negatives are associated symptoms that help to support or disprove differential diagnoses.
- ▶ In time, you will become more familiar with identifying what information will tell the best story.



Diabetic Care Protocol

Who: All patients with Diabetes type 1 &2



When: At every office visit



What:

Hemoglobin A1C

Urine microalbumin/
Creatinine Ratio

Lipid profile with direct LCL,
hepatic function test,
creatinine, potassium

Ophthalmology dilated exam

Better Choices Better
Health/ Chronic Disease Self
Management Program

Hemoglobin A1C & Urine Microalbumin/Creatinine ratio

If patient has had the test **done in the last 3 months**, no action is required.

Test done 3 to 6 months ago

- If previous A1C <7, no action is required unless patient desires A1C, in which case the Care Coordinator should order Point of Care A1C in EPIC, perform the test in-office and record the results in EPIC before the clinician visit. Share results with the patient and remind him/her that the results are posted in My Health.

Test done 6 months ago or more

- Care Coordinator should order POC A1C in Epic, perform the test in-office and record in EPIC before the clinician visit. Share the results with the patient and remind him/her that results are posted in My Health.

If the patient already has a diagnosis of diabetic nephropathy, no test is needed.

If the patient does not have the diagnosis of diabetic nephropathy

- If test **done in the last year**, no action is needed. If the test **not done in the last year**:
 - Give patient the specimen container and instructions to collect urine sample. Order urine microalbumin/creatinine ratio in EPIC, prepare the specimen for laboratory pickup. Remind patient that results are posted in My Health.

Lipid profile with direct LDL, hepatic function test, creatinine, and potassium

If the patient has had the test done in the last year no action is required except:

If the test will be due within 3 months: queue order for performance when due with tickler to remind patient when lab is due.

If it has been 3 months or more after a statin or niacin was started, or dosage adjusted

If the patient has also not had a potassium and creatinine in the last year order lipid panel with direct LDL and comprehensive metabolic panel. If the patient has potassium and creatinine in the last year, order a lipid panel with direct LDL and hepatic function panel.

Draw blood sample and send to lab. Remind patient that results are posted in My Health . LDL goal is <100

If the patient has not has the test done in the last year

If the patient has also not had a potassium and creatinine in the last year order a lipid panel with direct LDL and comprehensive metabolic panel.

- Fasting is not required for direct LDL test, draw sample now and send to lab.

If the patient has a diagnosis of hyperlipidemia and is on lipid lowering drugs (e.g. statins, niacin)

If the patient has also not had a potassium and creatinine in the last year order lipid panel with direct LDL and comprehensive metabolic panel. If the patient has potassium and creatinine in the last year, order a lipid panel with direct LDL and hepatic function panel.

Draw blood sample and send to lab. Remind patient that results are posted in My Health . LDL goal is <100

Ophthalmology Dilated Exam

Start annual ophthalmology exams 5 years after diagnosis of diabetes.

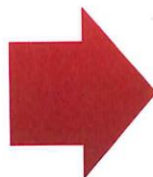
Type 1 & 2 Diabetics:

- If done in the last year, no action is required unless due before next office visit.
- If not done in last year, queue referral order in EPIC for clinician to complete
- Inform patient that an eye exam is due

Better Choices Better Health

Chronic Disease Self Management Program

If the patient has completed the BCBH/CDSMP at some point, no action is required.



If patient has not completed the BCBH/CDSMP program:

- Ask if the patient knows about the program and explain it if needed.
- If the patient agrees, complete a referral to CDSMP and set a time for phone or email follow up
- Document in EPIC if patient declines and reassess interest at next visit.

Refer to other protocols that may also apply to people with diabetes:

- Influenza and pneumococcal vaccination, TDaP, mammogram, colon cancer screening

3/22/2012
Ann Lindsay, MD


Approved By:
Tim Engberg, RN

4.3 A3 Template (full)

| | | |
|-----------------|--------------|--------------|
| PROBLEM: | NAME: | DATE: |
|-----------------|--------------|--------------|


BACKGROUND:

- Why does the problem matter?
- Why are you addressing the issue?




CURRENT STATE:

- What is currently happening right now?
- Be visual – use visual representations or process maps



ANALYSIS:

- Why did it happen?
- Use the “5 Whys” method, fish-bone diagrams, or other root cause analysis tools



IDEAL STATE:


- What should happen?

PROPOSAL:

- How do we keep it from happening?
- List out your proposed countermeasures

IMPLEMENTATION PLAN:

| Action | Responsible | Notes/Decision | Due | Status/Date Complete |
|--------|-------------|----------------|-----|----------------------|
| | | | | |
| | | | | |
| | | | | |



FOLLOW UP:

- How will we know it worked?
- What other issues or problems have come up?

4 Steps of A3 Thinking: The Simple A3

1. What is the problem or gap?
(What are we trying to improve?)

→ 2. What causes are preventing us from meeting our target(s)? What are the "root" causes?

4. Which actions will address the most important causes?

↓ 3. Based on data, what are the causes in order of importance?

| Goal (Cause) | Actions | By When/ By Who |
|-----------------|---------|--------------------|
| | | |
| | | |
| | | |



QI Essentials Toolkit: Cause and Effect Diagram

A common challenge for improvement teams is determining what changes they can test to improve a process. A cause and effect diagram is an organizational tool that helps teams explore and display the many causes contributing to a certain effect or outcome. It graphically displays the relationship of the causes to the effect and to each other, helping teams identify areas for improvement.

The cause and effect diagram is also known as an Ishikawa diagram, for its creator, or a fishbone diagram, for its resemblance to the bones of a fish. Teams list and group causes under the categories of Materials, Methods, Equipment, Environment, and People.

IHI's QI Essentials Toolkit includes the tools and templates you need to launch and manage a successful improvement project. Each of the nine tools in the toolkit includes a short description, instructions, an example, and a blank template. NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

- | | | |
|---|------------------|-----------------------------|
| • Cause and Effect Diagram | • Flowchart | • Project Planning Form |
| • Driver Diagram | • Histogram | • Run Chart & Control Chart |
| • Failure Modes and Effects Analysis (FMEA) | • Pareto Chart | • Scatter Diagram |
| | • PDSA Worksheet | |

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Instructions

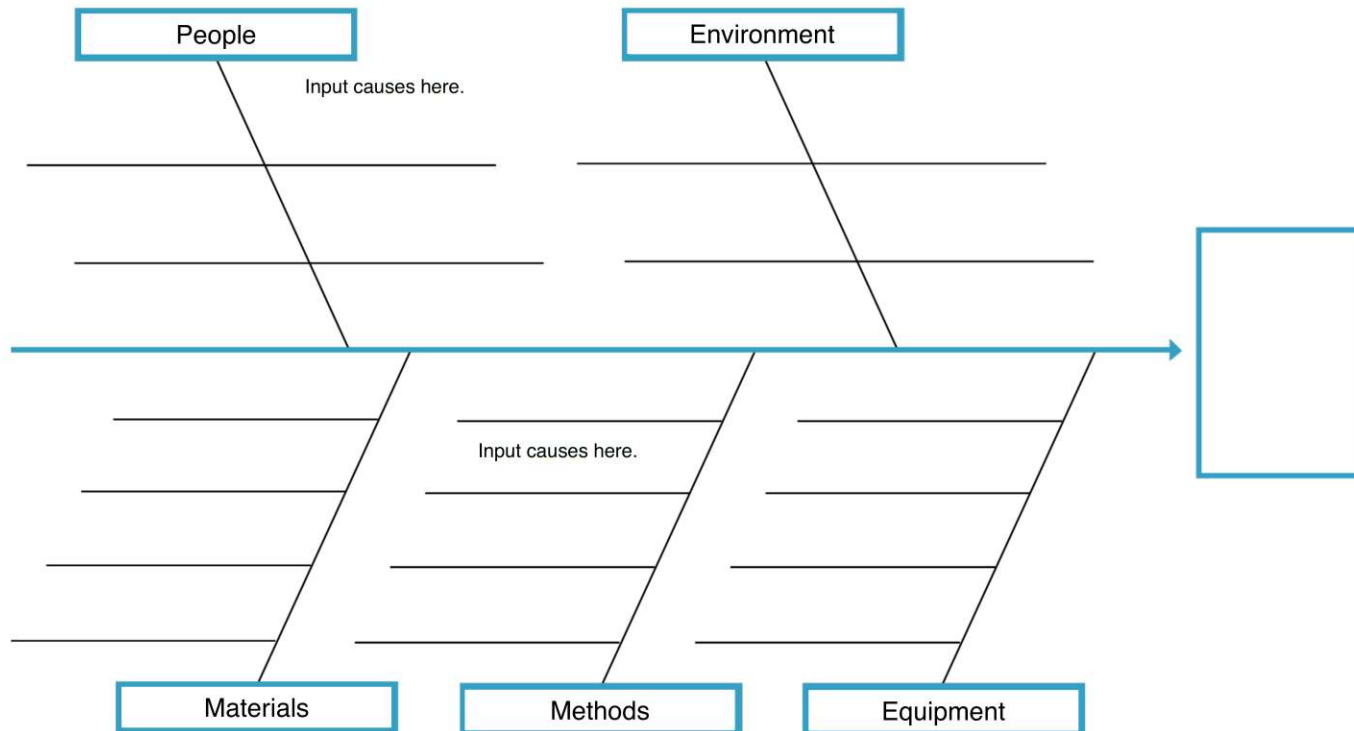
- 1) Write the effect you wish to influence in a box on the right-hand side of the page.
- 2) Draw a horizontal line across the page to the left, starting at the box you just drew.
- 3) Decide on five or six categories of causes for the effect. The standard categories in a classic cause and effect diagram are Materials, Methods, Equipment, Environment, and People.
- 4) Draw diagonal lines above and below the horizontal line to create “fishbones,” and label each line at the end with one of the categories you have chosen. Draw a box around each label.
- 5) For each category, generate a list of the causes that contribute to the effect. List the causes by drawing “branch bones.” As necessary, draw additional branch bones from the causes to show sub-causes.
 - Tip: Develop the causes by asking “Why?” until you have reached a useful level of detail — that is, when the cause is specific enough to be able to test a change and measure its effects.

Before filling out this template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: Cause and Effect Diagram

Team: _____ Project: _____

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.



6.1 Stanford Coordinated Care (SCC) A3 Example for Recruiting Patients into Model



Accountability:
Sponsor: Deepti Randhava
Team Leader: Samantha Valcourt

Stanford University Medical Center

SCC Recruitment of Stanford Inpatients

Project Team: Alan Glasseroff MD, Ann Lindsay MD, Kathan Vollrath MD, Susan Shughrue, Coleen Travers, Jen Harpe, Deilla Coleman, Setsumi Felipe, Jane Ferguson, Valerie Meausoone, Wayne Dewey, Michelle DeNatale, Karen Hendrich, Lisa Alexandrian

DRAFT
10/23/13 Version 1

Issue / Problem Statement:

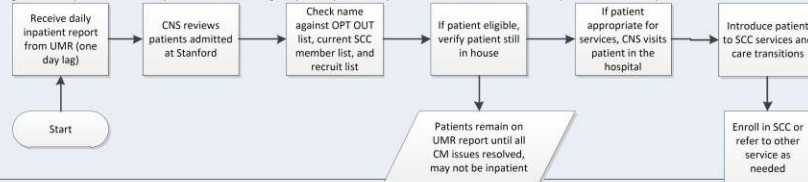
Provide a brief description of the issue/problem and include data if possible. Try to state the issue through the eyes of customer or patient. This is an objective statement (factual). Stanford Coordinated Care (SCC) offers comprehensive services, including care transitions services, to eligible Stanford employees/dependents with chronic conditions. At the time of hospital admission is an ideal opportunity to engage potential patients and provide this service.

Background and Importance:

Clarify the issue with additional background information that explains significance. Consider downstream effects of the overall problem. Also, consider the history of the problem. SCC is continually looking for ways to extend our services to eligible patients. At the time of hospital admission is an ideal opportunity to introduce potential patients to their eligibility to receive this service. Enrollment into Chronic Care Support (CCS) or PC Plus (PCP) could begin with a care transitions program that would effectively bridge the transition between hospital and home.

Baseline:

If possible, include a graphic representation of the baseline/current state. This is an ideal place to enter a high level process map. Include major pain points (i.e., waste, barriers to process flow).



Goals / Dashboard Metrics:

Include goal statements here as well as current state statistics for important dashboard metrics.

1. All eligible patients will be seen by CNS while admitted to Stanford Hospital and SCC services and Care Transitions will be offered to them.
2. Provide care transitions intervention to 100% of hospitalized patients who become members of SCC.

Problem Analysis:

Break down the problem here. You may consider using an ishikawa diagram (fishbone) or 5 Why's analysis. Why do we want to engage eligible patients while admitted?

Because chronically ill eligible patients may be more willing to see benefits of our services at the time of hospital admission and can offer care transitions intervention just in time. Hospital admission may be indicator that patient's condition is not optimally managed in outpatient setting.

Why?

Comprehensive services provided by SCC may have avoided the hospital admission. Care transitions can help patients self-manage their care after their hospital discharge.

Why?

SCC follows patients with chronic conditions very closely and offers 24/7 access to physicians including care coordination with multiple providers

Why?

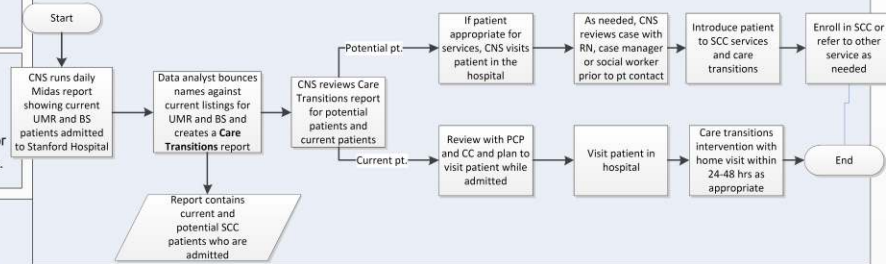
Patients with complex chronic conditions require more than routine primary care is currently set up to provide.

Why?

People with chronic illnesses often have to navigate the health care system on their own without the support they need.

Future State and Countermeasures:

Describe the target/future state condition and what you will do to achieve that condition. You can visually demonstrate the future state using a new process map.



Implementation Plan:

Use a Gantt chart to create a high level timeline of project milestones or countermeasures to be implemented. Show individual accountability.

| ID | Task Name | Responsible | Start | Finish | Duration |
|----|---|--|-----------|----------|-----------|
| 1 | Obtain UMR inpatient list | Michelle Denatale, Karen Handrich (UMR) | 7/2/13 | 9/12/13 | 2 months |
| 2 | Start seeing eligible inpatients | Sam V. | 8/6/13 | Ongoing | |
| 4 | Add Sam V. to UMR distribution | Lisa Alexandrian (UMR) | 10/15/13 | Ongoing | |
| 4 | Create Midas report to show UMR and BS inpatient | Wayne Dewey (Midas), Valerie Meausoone, Sam V. | 9/17/13 | 10/3/13 | 2.5 weeks |
| 5 | Create tracking report to notify stakeholders of recruiting outcome | Valerie Meausoone, Sam V. | 10/23/13 | 10/30/13 | 1 week |
| 6 | Have Crimson tool to bounce admitted BS patients against entire employee/dependent list | Valerie Meausoone | Nov. 2013 | | |

Follow-Up:

Describe how the project will be monitored and how new processes will be confirmed as hard-wired. You may also include next steps.

1. Working with data analyst to create weekly report to provide to stakeholders.
2. Created Visio of standard workflow process.
3. Continue to introduce and educate Stanford inpatient departments (social work, case management, inpatient nursing) of SCC services available to increase referrals.

Sustain Results:

Provide the most recent measurement of project metrics. You may include graphics or tables.

Weekly report of SCC recruiting/hospital visit outcomes to be sent to stakeholders starting 10/30/13

6.2 Stanford Coordinated Care (SCC) Tri-fold Brochure and Onboarding Materials

www.alanannMD.com



Ann Lindsay MD and Alan Glaseroff MD have raised a family and partnered with their patients in Humboldt since 1983.

"We believe that people are the most important factor in their own health, and that our job is to help build the knowledge, skills, and confidence our patients need to allow them to live long and feel well"

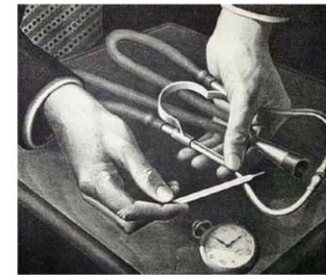
Ann Lindsay MD and
Alan Glaseroff MD

1318 H St
Arcata, CA 95521
707 822-7041
www.alanannMD.com



Ann Lindsay MD and
Alan Glaseroff MD

A True Family Practice



**"Care you want and
need, from those you
know and trust"**

Phone: 707 822-7041



Ann Lindsay MD

A Partnership...

"We believe that quality health care requires a partnership between patients and those who care for them"

Our job: To provide care that is timely, efficient, continuous, coordinated, safe and effective, and is based on your wishes, needs and preferences.

Your job: Come to visits prepared with a list of concerns and questions, prioritized by what you want accomplished as time permits.

Pre visit: Have regular ordered lab tests performed ~ 5 days prior to your visit when possible.

Maintain a list of your medications that you carry with you to all appointments. We recommend that you keep this in your wallet.

Contact Information

Telephone: 707 822-7041

Fax: 707 822-0655

Portal: www.alanannMD.com

Hours of Operation

Monday through Friday: 8:30 am–5:00PM (closed for lunch).

Fasting Blood Draw: Tues-Thurs 8:45AM

Medication Refills

Local Pharmacies: Please contact your local pharmacy directly for refills (have the number of the prescription with you when you call).

Mail Order Refills: Contact your mail-order pharmacy either by phone, letter, or via their website. If you refill a prescription electronically through our office, we need to know where to submit the prescription.



Alan Glaseroff MD

Insurances accepted:

Most insurance accepted, including HMO. ***Bring a copy of your insurance card to your visit***

Co-Payments expected at the time of visit.

Lab and radiology results will be made available at www.alanannMD.com within 48 hours of receipt. If preferred, results can be sent via postcard or phone call (if no upcoming appointment scheduled).

What To Do After Hours:

- **Please call us first** before going directly to the emergency room unless you feel that you cannot safely wait a few minutes to speak to us (**707 822-7041**).
- We will make every effort to offer you an appointment the next day for urgent problems if the problem can safely wait until morning.
- In major emergencies, call 9-1-1 for an ambulance or proceed directly to the nearest emergency room.
- Patients registered for the Patient Portal (@\$10/month added fee) can submit e-mail questions to us at www.alanannmd.com for questions that can wait up to 2 days for an answer (most answered same day).



**STANFORD
COORDINATED
CARE**
Care with the Patient at the Center

Welcome to Stanford Coordinated Care (SCC)! Thank you for choosing to make us partners in your care.

Here are some benefits and guidelines for patients in SCC's "Primary Care Plus" program:

- ✓ You have prompt access to your SCC care team during weekday business hours, with extended clinic hours on Mondays and Wednesdays until 7 pm.
- ✓ We offer 30 or 60 minute visits with your SCC doctor, on the same or next day, to our patients with urgent/acute needs, as available.
- ✓ You have 24/7 access, 365 days a year, to your SCC Primary Care doctor by calling **(650) 724-1800**. If you have a serious issue after business hours that cannot wait, please call our clinic. You'll speak with someone who will put you directly in touch with your doctor.
 - Your SCC doctor will discuss your specific issue with you, provide support or reassurance, and together you'll decide what your next steps may be. For example, you may decide to make an appointment with Stanford's Express Care (SEC), or go to your local Emergency Department (ED). If available, an SCC appointment for the next business day may also be offered. We want to help, so please consider calling us first.
 - *In a major emergency, always call 9-1-1.*
 - If you are unexpectedly admitted to the hospital, please have someone contact us at **(650) 724-1800** as promptly as possible, or within 24 hours of your admission. We want to assist and support you.
- ✓ For your convenience during a scheduled visit, your Patient Care Coordinator will draw your blood for testing within the SCC clinic, for which you'll not be charged an administration fee.
- ✓ If you are attending a visit with a specialist, please ask him or her to send a copy of the visit notes to your SCC Primary Care doctor, so we are informed and can further coordinate your care. This is especially helpful if your specialist orders tests, procedures, or makes a subsequent referral.

Our Primary Care Plus patients also have access to services from members of our multidisciplinary team during regular business hours:

- ✓ Our **Clinical Nurse Specialist** is available to support our patients before, during and after hospital admissions, whether it's planned or unexpected, as a part of SCC's "Care Transitions" program. When schedules permit, she can attend specialty visits with you upon your request.
- ✓ Our dedicated **Patient Care Coordinators** (PCC) coordinate your care, advocate on your behalf, and are your link with your Primary Care doctor. Your PCC assists in providing refills, arranging referrals made by your doctor, offers health coaching, schedule appointments, and more. When schedules permit, your PCC can attend specialty visits with you upon your request.
- ✓ Our **Pharmacist** is available to review your medications (including supplements and over-the-counter products), addressing any concerns or questions you may have as well as provide support.
- ✓ Our **Licensed Clinical Social Worker** provides behavioral health services and community resources to our patients who are referred by their doctor. She can offer strategies and ideas to reduce your stress, provide counseling on a short-term or longer basis, possibly refer to outside clinicians, and work with you to understand how your health, mood, and spirit may be intertwined.
- ✓ Our **Physical Therapist** is here three days a week and is available to help you with pain, range of motion, and other goals using the Feldenkrais Method. Due to her limited schedule, she only sees patients with a direct referral from your doctor.
- ✓ Our **Registered Dietician** is available, several days each week, to meet with you in the SCC clinic to discuss your goals regarding nutrition, weight loss, evidence-based food plans/diets, etc.
- ✓ **Stanford's Health Library** is ready for your complex questions! SHL's on-site library is open on the 2nd floor of Hoover Pavilion. SHL Librarians are also on your team, offering free personalized research and assistance in finding material that is diagnosis-specific and/or health-related

Questions? Please call SCC at (650) 724-1800

WELCOME

Stanford Coordinated Care (SCC) is eager to start working with you! As a member of **Primary Care Plus**, you have agreed to receive primary care services by the SCC team which includes a physician, nurse, care coordinator, physical therapist, pharmacist, and clinical social worker.

We are going to help you take control of your life and health. We believe that quality health care requires a partnership between patients and those who care for them. We also believe while you are the expert about your own life and health, it can be hard to face chronic conditions alone. The SCC team provides care that is timely, coordinated, safe and effective. We promise prompt service, good communication with providers, and coordination of your health care that is based on your wishes, needs and preferences. Our team is here to help you with the medical, social, and emotional aspects of trying to live in the healthiest way possible. We are here to help you manage your chronic illness, coordinate your medical care no matter how many specialists you see, and provide you with quality primary care.

In order to have an effective encounter everytime you visit, please come prepared with a list of concerns and questions, prioritized by what you want to accomplish. We ask that you try to take care of medication refills and health concerns during clinic hours. We will hold clinic slots open for same day service for urgent issues. The physicians will take calls at night for serious issues that cannot wait until the clinic is open. Please call us first before going directly to the emergency room, unless you cannot safely wait a few minutes to speak to us. In major emergencies, call 9-1-1.

Below is a reminder of other benefits while enrolled in SCC:

- \$0 copay at SCC to see your provider and care team*
**If you are a member of the Stanford University High Deductible PPO Plan, a contribution by your employer will be made for the initial months of participation. For Hospital employees in the PPO Plan, if you have not met the deductible the Hospital waive 2 months of your participation in SCC, a \$572 value.*
- 24/7 direct access to a member of your care team
- Same day and next day clinic appointments for urgent needs
- A care coordinator with time to listen and help you plan and access your care
- Access to Stanford's *Better Choices, Better Health* chronic disease self-management workshop
- Pharmacist review of your medications
- Coordination of your complex care needs
- In office labs at no cost
- Behavioral Health & Physical Therapy clinicians on-site

As a member of the SCC, the line of communication between you and your care team is very important. We want you to be able to give and receive feedback regarding your health care at any time.

Clinic Telephone: 650.724.1800
Fax: 650.736.2550
Email: coordinatedcare@stanfordhealthcare.org

Again, welcome! We are looking forward to building and learning with you. **We've got your back!**

Regards,
Stanford Coordinated Care team

7.1 Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that you made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often**...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you **often** feel that...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often** feel that...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No

If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No

If yes enter 1 _____

10. Did a household member go to prison?

Yes No

If yes enter 1 _____

Now add up your “Yes” answers: _____ This is your ACE score.

Activity Planning Worksheet

Instructions: Write some specific activities that you recorded on the "Values, Pleasure, and Mastery Activities List" in the "activity" column. Place a check in the "completed" column to indicate if you completed the scheduled activity. Record a mood rating in the last row; mood is rated between 0-10 ("0" indicating "most negative" and "10" indicating "most positive.")

| | Activity | Completed | Mood rating |
|-----------|----------|-----------|-------------|
| 5-7:00 am | | | |
| 7:00 am | | | |
| 8:00 am | | | |
| 9:00 am | | | |
| 10:00 am | | | |
| 11:00 am | | | |
| 12:00 pm | | | |
| 1:00 pm | | | |
| 2:00 pm | | | |
| 3:00 pm | | | |
| 4:00 pm | | | |
| 5:00 pm | | | |
| 6:00 pm | | | |
| 7:00 pm | | | |
| 8:00 pm | | | |
| 9:00 pm | | | |
| 10:00 pm | | | |
| 11:00 pm | | | |

Scheduled Activities for (name): _____ Day of week/date _____

7.3 CollaboRATE Survey and Scoring Instructions



10 point anchor scale

Thinking about the appointment you have just had ...

1. How much effort was made to help you understand your health issues?

| | | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|---|--------------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| No effort was made | | | | | | | | | Every effort was made |

2. How much effort was made to listen to the things that matter most to you about your health issues?

| | | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|---|--------------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| No effort was made | | | | | | | | | Every effort was made |

3. How much effort was made to include what matters most to you in choosing what to do next?

| | | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|---|--------------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| No effort was made | | | | | | | | | Every effort was made |

Alternate opening statements are:*

Thinking about the visit you had with your health care provider today ...

Thinking about the conversation you had with your [insert health care provider] today about [insert issue]...

Thinking about the appointment you have just had, please show how you feel by choosing a number from 0 to 9.

*Please note that these alternate opening statements have not undergone psychometric validation.

Scoring **collaboRATE**

This page describes two methods of scoring **collaboRATE**.

Preliminary data suggests that there are no substantial differences between the two scoring methods in the validity and reliability of **collaboRATE** (Barr et al., 2013), although we tend to favor the 'Top Score' approach for its interpretability.

Irrespective of the scoring method chosen, we recommend that a **collaboRATE** Score only be calculated when all three **collaboRATE** items have been completed for at least 25 clinical encounters for the particular provider, clinic, or other group of interest.

We have noted in preliminary testing that ensuring respondent confidentiality is critical to observing variation in scores.

collaboRATE Mean Score

Categorical or continuous? Continuous

Possible range? 0-9

How to calculate? Exclude cases where a response to one or more of the **collaboRATE** questions is missing. Calculate the mean of the three **collaboRATE** responses for each encounter. Then, calculate the mean of all encounters of interest. This number is the **collaboRATE** Score.

How to interpret? Higher scores represent more shared decision making.

collaboRATE Top Score

Categorical or continuous? Continuous

Possible range? 0-100

How to calculate? Exclude cases where a response to one or more of the **collaboRATE** questions is missing. Code each encounter as either '1', if the response to all three **collaboRATE** items was 9, or '0' if the response to any of the three **collaboRATE** items was less than 9. Then, calculate the percentage of all encounters that were coded as '1'. This number is the **collaboRATE** Score.

How to interpret? Higher scores represent more shared decision making. This number also corresponds to the proportion of patients for whom there was 'gold standard' shared decision making.