708-How to Develop Staff Competencies that Support Patient Engagement

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M & J Associates

Objectives

1. Assess the current status of interventions utilized in home health care related to Care Transitions.
   - State of the research, Care Transitions; Patient Engagement
   - Implementation Science, home health care, 2014
2. Identify underlying competencies and eliciting staff engagement to implement these interventions.
   - A. Coaching
   - B. Motivational Interviewing
   - C. Teach Back
   - D. Use of Personal Health Record
   - E. Supporting patient-engagement
3. Develop an agency wide blueprint, based on implementation and systems theory, to support the required competencies.
   - A. Blueprint Development
   - B. Work Flow Analysis
   - C. Competency Assurance
   - D. Implementation barriers
Why Competencies?

- Liability
- Consistency
- Patient/caregiver satisfaction
- Enhance Critical Thinking Skills

Critical Thinking

- Surface structure vs Deep knowledge
- Deep Thinking
- What to do with the facts?
- What are the right questions to ask
Critical thinking questions:
Reflective inventory

- What surprises me?
- What puzzles me?
- Do you see any patterns or themes emerge?
- Anything you should know immediately?
- What things can wait?
- Does anything else come to mind?

Jim Keene, PhD

A Blueprint..........

- Underlying principles
- Changing paradigms
- Management of data
- Critical Thinking-using data for benefit of patient
Current Concepts

- Patient self-management
- Patient Education
  - Teach Back
  - Literacy Level
- Care Transitions
- Evidenced Based Practice

Changing Paradigms

- Coaching
  - Motivational Interviewing
- Patient Engagement
  - Access to Clinical Record
  - PHR
  - Ways to Measure/Increase Pt. Engagement
- Staff Engagement
- Value based reimbursement
- Critical thinking
- Caregiver education
- Decision aids for patients
COACHING:

- An approach of partnering with patients to enhance self-management strategies for the purpose of preventing exacerbations of chronic illness and supporting lifestyle change” (Huffman, 2007, p. 271).

Coaching vs Teaching

**COACHING**

- Facilitator
- Patient identified goals/timelines
- Patient/care partner centered
- Improved motivation
- Motivational interviewing

**TEACHING**

- Teacher
- Teacher identified goals/timelines.
- “Expert centered”
Make Information Available to Patients

- Copies of care plans
- Personal Health Record
  - Paper with info provided by you (see article for details)
  - Electronic PHR with agency downloading info into it.
- Teach them to use Blue Button, patient portals

PHR
Electronic Health Record - Kinergy Health

http://www.myp.hr.com/resources/choose.aspx
Provide Staff with Tools to Do the Job

- Access to Experts-live and on line
- Medication Reconciliation Support
- Time to learn what the “new world” expects and time to implement it:
  - Use of Motivational Interviewing
  - Coaching
  - Teach Back
  - Patient Activated Learning

Motivational Interviewing
Motivational Interviewing: OARS

- O-Open Ended
- A-Affirmations
- R-Reflection
- S-Summary

Characteristics of Open Questions

- Open ended - Cannot be answered with yes or no.
- Focus on patient.
- Asking for guidance from patient, not telling.
- Allowing patient/advocate to identify priorities.
- Non-judgmental
Examples of Open Ended?

- What is it you do not like about taking that medication?
- What is your main worry since leaving the hospital?
- What is one thing I can do for you that would make you feel less anxious?
- What can I do to help you this week?
- What symptom on this “Red Flag List” are you most concerned about?
- How important is _____ to you?
- What is the most important part of your recovery to you?
- What do you want to see happen in next 30 days?
- What would you like our agency to help you accomplish while we are servicing you?

Affirmations

Affirmations are statements that recognize client strengths. Key element in supporting patient self-efficacy.

- Remind client of prior achievements
- Tie current challenges to past successes
- Identify supports in their environment
- Praising for small accomplishments
How Can Health Coaching Be Used with “Resistant Patients?”

From an MI perspective, resistance is not a patient problem but a relationship problem.

- Avoid the “resistance trap”
- Put the choice and responsibility for change back in the hands of patients.
- People have a natural tendency to resist being told what to and respond to such advice with direct or indirect resistance.
- Called the “righting reflex” or the natural tendency to try to stop patients from doing what provider feels is wrong.
- Usually ineffective, exhausting and frustrating for the patient and the clinician!
- From an MI perspective, patient autonomy is always reinforced.

Rolling with Resistance

- Don’t lecture
- Acknowledge & validate how difficult it is to change life long behaviors
- “Back off” - ask open ended questions, don’t pressure or preach
- Clarify decision is the patient’s
- Making the effort to understand the causes of each patient’s non-adherent behavior helps tailor an approach to removing obstacles
Reflective Listening

- Reflective listening is a way of checking what is meant rather than assuming that you know

Reflective Listening to Express Empathy

- So, I think you said . . .
- Are you saying that . . .?
- So, what you are telling me is that . . .
- So, what I heard you say is . . .
- Am I hearing you correctly that . . .?
- Okay, let me see if I’m getting this right . . .
Summarizing

- Summaries communicate interest and understanding and call attention to important elements of the discussion.
- Allows clinician to assist patient in setting goals.
- Organizes information
- Confirms mutual understanding
- Presents both pros and cons patient has identified
- Helps patient identify desired goals, how to proceed

Additional information on MI may be found at:

Barriers to MI Implementation

- Literacy Issues
- Loss of Control/Role Changes (Independence)
- Time to Master
- Need for Practice
Patient Engagement

Patient Expectations of Self-Management

- Access to information
- Involved in decision making
- Identify own goals
- Dialogue care plans
Decision aids for patients

Statin Decision Aide

People at lower risk of CV events (15%) over 10 years:
- Imagine 100 people of this level of risk. In the next 10 years, about 15 (15%) of these people will have a CV event.
- Assuming everyone will be on treatment to lower the risk of having a CV event.
- About 190 people will have a CV event — but would not have a CV event if they had not been on a statin at the previous time point.
- About 10 people who do have a CV event (the red boxes below) even though they take a statin.

Testosterone:
- The testosterone should not be reduced arbitrarily in each individual person.
- All 100 people will have to take the statin for 10 years.
A Patient-Centric Definition of Participatory Medicine:

Participatory Medicine is a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners.

Minimally Disruptive Medicine

Shared decision making enables patients and clinicians to share the best available research evidence and make decisions that better reflect the patient's values and preferences. Minimally disruptive medicine focuses on pursuing the patient's goals (preventing premature death, feeling better, and living without hindrance from complications of disease or treatment) while reducing the treatment burden.
SBAR

Access to Clinical Record
Current Participants:

The door is wide open, the room is filled, and we’re ready to design new ways to give consumers/patients their own health information in the most meaningful way.

Susan Woods, 2013

Patients who had access to their medical records reported:

- **Positives:**
  - Better communication with providers
  - enhanced knowledge of health and improved self care
  - greater participation in and improved decision making
  - improved quality such as f/u on abnormal tests
  - Identified errors or inconsistencies and had corrected

- **Negatives:**
  - seeing previously undisclosed information
  - Misconstruing abbreviations

(Woods et al, 2013)
Ways to Measure/Increase Pt. Engagement

PAM 13 Question

<table>
<thead>
<tr>
<th>Level</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>When all is said and done, I am the person who is responsible for taking care of my health.</td>
</tr>
<tr>
<td></td>
<td>Taking an active role in my own health care is the most important thing that affects my health.</td>
</tr>
<tr>
<td></td>
<td>I am confident I can help prevent or reduce problems associated with my health.</td>
</tr>
<tr>
<td></td>
<td>I know what each of my prescribed medications do.</td>
</tr>
<tr>
<td></td>
<td>I am confident I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.</td>
</tr>
<tr>
<td>Level 2</td>
<td>I am confident I can tell a doctor if I have ever been treated for a disease, condition or illness.</td>
</tr>
<tr>
<td></td>
<td>I am confident I can follow through on medical treatments I may need to do at home.</td>
</tr>
<tr>
<td></td>
<td>I understand my health problems and what causes them.</td>
</tr>
<tr>
<td></td>
<td>I know what treatments are available for my health problems.</td>
</tr>
<tr>
<td>Level 3</td>
<td>I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.</td>
</tr>
<tr>
<td></td>
<td>I know how to prevent problems with my health.</td>
</tr>
<tr>
<td></td>
<td>I am confident I can figure out solutions when new problems arise with my health.</td>
</tr>
<tr>
<td></td>
<td>I am confident I can maintain lifestyle changes, like eating right and exercising, over doing times of illness.</td>
</tr>
</tbody>
</table>

Also available: PAM 6

Hibbard, J. (2005) Use with permission only. cswanson@insigniahealth.com (612) 998 6216
Writing Short-term Achievable Goals

How to write a Smart Goal

▸ Specific
▸ Measureable
▸ Attainable
▸ Relevant
▸ Time based

Source: CDC
Importance/Confidence ruler

- After goal setting:
  - Allows assessment of probability of success.
  - Aides in setting realistic goals
  - Refocuses on patient, not provider goals
Teach Back: Chunk and Check

**Chunk** - small piece of information
example: daily weights

**Check** - to see if the patient understands this small concept - “chunk”

Value based reimbursement

- Measure
- Chart
- Share
- Guide Practice
Healthcare Transformation

= data + transparency + engagement

Vivian Lee from University of Utah at MedX Conference stated that

Caregivers: Who Are They?

Who Are Caregivers?

Among all adults, the percent within each group who care for someone.

All adults ages 18+

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Educational Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>No High School Diploma</td>
<td>31%</td>
</tr>
<tr>
<td>High School Diploma</td>
<td>36%</td>
</tr>
<tr>
<td>Some College</td>
<td>44%</td>
</tr>
<tr>
<td>College+</td>
<td>40%</td>
</tr>
</tbody>
</table>

Household Income

<table>
<thead>
<tr>
<th>Household Income</th>
<th>43%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75,000+</td>
<td>43%</td>
</tr>
<tr>
<td>$30,000-$74,999</td>
<td>46%</td>
</tr>
<tr>
<td>$15,000-$29,999</td>
<td>38%</td>
</tr>
<tr>
<td>Less than $15,000</td>
<td>36%</td>
</tr>
</tbody>
</table>

Parent of Minor

<table>
<thead>
<tr>
<th>Parent of Minor</th>
<th>Parent of Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>48%</td>
</tr>
<tr>
<td>Non-Parent</td>
<td>52%</td>
</tr>
</tbody>
</table>

Race/ethnicity

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Race/ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>39%</td>
</tr>
<tr>
<td>Black</td>
<td>40%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>32%</td>
</tr>
</tbody>
</table>

Source: Pew Internet Health Tracking Survey. August 07 – September 08, 2012. N=3,014 adults ages 18+. Interviews were conducted in English and Spanish and on landline and cell phones. Margin of error is +/- 2 percentage points for results based on all adults. See Agenda for further details.

PEW RESEARCH CENTER
Caregivers: Who Are They?

- 90% of the home care needed by elders in the United States has been provided for free by more 65 million family and friends.
- Caregivers provide care an average of 20.5 hours a week.
- If were paid for, would amount to $56,000 per year per patient.
- Caregivers are typically female, socially isolated, financially stressed and feel trapped.

Caregiver education-Tips for Caregivers

- Fill the well.
- Remind yourself of you.
- Give yourself a soundtrack.
- Take care of your back.
- Find the funny.

So Where are you in the Process?

- Medications
  - Reconciliation Tools
  - Pharmacy Support
- Communication
  - SBAR-Staff and Patients
  - Motivational Interviewing
  - Teach Back
- Patient Engagement
  - Personal Health Record
  - SMART Goals
  - PAM Assessment
  - Confidence Ruler
- Measurement
  - Every patient, every time
  - SOP—every readmission

Blueprint Development

A. Work Flow Analysis
B. Competency Assurance
C. Implementation barriers
Staff Engagement

- Principles of Change Theory (Implementation Science)
  - Inclusion
  - what matters
  - attention to detail
  - Test, Revise, Test, Revise

Questions to Ask:

Questions to Ask Before Starting Implementation

- Does it have a clear purpose for all relevant participants?
- Do participants have a shared sense of purpose?
- Are the benefits likely to be valued/advantageous by potential participants?
- Does it fit with overall goals and activities of the organization?
- Will the participants see the point of the intervention easily?
- Will they be prepared to invest time, energy and work into it?
- How will the intervention affect their work?
- Will it promote or impede ability to meet agency expectations?
- Will staff require extensive training and how will it be provided?
- How compatible is it with existing work practices?
- What impact will it have on division of labor, resources, power and responsibility among professional groups?
- How are users likely to perceive the intervention once it has been used for a while?
Questions to Ask:

- During Implementation:
  - Is it clear what effect the intervention has had?
  - Can staff contribute feedback about intervention and will the information be considered in evaluating intervention?
  - Can the intervention be adapted or improved once it has been implemented?

Barriers to Implementation

“It takes too long.”

“I'm a good teacher.”

“He's just stubborn.”

“I don't have the time.”
Competency Assurance

- How do you do it now?
- What works, what doesn't?
- Teach back
- Staff Engagement
- MI for Managers
- Job Description
- Inclusion in evaluation
- Devil is in the details

Measure, Measure, Measure
# How-to Guide:

Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

**Abstract:** The page contains information about a how-to guide for improving transitions from hospital to home health care to reduce avoidable rehospitalizations. It includes process measures and questions related to medication management and education.

### Process Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach Back on managing medications.</td>
<td>Percent of patients who can teach back 70% or more of what they are taught to manage their medications.</td>
<td>Number of documented sessions of nurses where the patient or family caregiver can teach back how to manage their medications.</td>
<td>Number of documented sessions of nurses where the patient or family caregiver can teach back how to manage their medications.</td>
<td>Option 1: Observe 2 teaching opportunities per week from the pilot care team for 4 weeks a month. Option 2: Nurse documents Teach Back process rate with every teaching session. Enter data monthly.</td>
</tr>
<tr>
<td>Teach Back on correct use for a successful transition from hospital to home health care.</td>
<td>Define three or four &quot;critical&quot; elements for transition: medications, instructions, education, and follow-up support. Then track.</td>
<td>Number of patients in the sample who were able to teach back 2, 3, or 4 critical elements from the transition.</td>
<td>Number of patients in the sample where Teach Back is used.</td>
<td>- Teach Back opportunity (probability of transition). Document results of the 3 or 4 key elements of the transition. The patient is able to teach back.</td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUNFLOWERS Question 5</td>
<td>Did your health care staff ask you to see all the prescriptions to check for duplicate medications?</td>
<td>Number of patients in the survey for the month who answered ‘Always’</td>
<td>Number of surveys in the month with an answer to this question.</td>
<td></td>
</tr>
<tr>
<td>SUNFLOWERS Question 6</td>
<td>Did your health care staff talk with you about the medications you were taking?</td>
<td>Number of patients in the survey for the month who answered ‘Always’</td>
<td>Number of surveys in the month with an answer to this question.</td>
<td></td>
</tr>
<tr>
<td>HHCAHPF Question 4</td>
<td>Did your health care staff talk with you about the medications you were taking?</td>
<td>Number of patients in the survey for the month who answered ‘Always’</td>
<td>Number of surveys in the month with an answer to this question.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The document includes a reference to the Institute for Healthcare Improvement (IHI), 2012, p. 57-61.
Reference List


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