Short Medicare Action and Planning Form

Print this action form and take it to your doctor to improve the medical care you receive. This form is intended for your doctor or nurse.

Your (Patient) Name:_____

Date: **2012-02-03** Age: **70-79** Gender: **Female**

PATIENT ASSETS

FUNCTION	HABITS	KNOWLEDGE
Social Support - As much as wanted Life is going - Pretty Good	Does not smoke	Home Hazards

PATIENT NEEDS

FUNCTION (*italics = clinician unaware*): *Difficulty with feelings*; Difficulty with pain; Difficulty with physical fitness; Difficulty with overall health; doing housework; driving

SYMPTOMS/BOTHERS: Dizziness, Falling; Eating; Teeth, Dental

HABITS: Not Exercising Regularly

RISK CONSIDERATIONS

Risk for Falls: Risk of falls is higher than most.

Confidence to Self-Manage: Not very confident

Medication Misses: Sometimes I take as prescribed

Seat Belt: Sometimes does not use

SUGGESTED READING AND EDUCATION

- Risks: What Are My Chances? [risk.html]
- Exercise and Eating Well [http://howsyourhealth.org/adult/chapters/chapter1]
- Health Habits and Health Decisions [http://howsyourhealth.org/adult/chapters/chapter2]
- Common Medical Conditions [http://howsyourhealth.org/adult/chapters/chapter4]
- Daily Activities and Managing Limitations [http://howsyourhealth.org/adult/chapters/chapter7]
- Feeling and Emotional Care [http://howsyourhealth.org/adult/chapters/chapter8]
- Pain [http://howsyourhealth.org/adult/chapters/chapter9]

Planning With Health Professionals (During Visit)

ALLERGIES:

CURRENT MEDICATIONS:

IF SICK, WHO DECIDES:

ADDITIONAL PLAN FOR HEALTH CHANGES:
___ See Above Only ___See Below ___ From Problem Solving

Additional Change:
Goal:
Steps:
Barriers to Steps:
Ways to Overcome:
Confidence (0-10):
Help Needed:

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CARE Vital Signs Supports Patient-Centered, Collaborative Care

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Abstract: CARE Vital Signs refers to a standard form created by practices to *C*heck what matters to patients, *A*ct on that assessment, *R*einforce the actions, and systematically *E*ngineer or incorporate actions into staff roles and clinical processes. On its face, CARE Vital Signs is a deceptively simple tool that, when properly used, can help a practice attain levels of efficiency and quality. This article describes the rationale for CARE Vital Signs and the ways it can be used for the greatest benefit.
Key words: *behavior change*, *care team*, *collaborative care*, *patient centered*

IN CLINICAL PRACTICE, someone obtains vital signs, such as blood pressure, pulse, temperature, and respiration rate, to assess body functions before the patient is evaluated by a healthcare professional. CARE Vital Signs refers to a standard form created by practices to *C*heck what matters to patients, *A*ct on that assessment, *R*einforce the actions, and systematically *E*ngineer or incorporate actions into staff roles and clinical processes (Wasson et al., 2003). Thus, CARE Vital Signs offers a method for practices to routinely screen patients to determine whether they have common, important issues for which effective actions might be implemented without necessarily depending on an evaluation by a healthcare professional. For example, based on particular items in CARE Vital Signs, office staff might implement standing orders to provide specific screening tests or self-management education to the patient.

CARE Vital Signs has proven to be useful for both patients and practices. Patients benefit because this method offers the promise of reliable action for "what matters" to them: CARE Vital Signs supports patient-centered, collaborative care (Moore & Wasson, 2006). Practices benefit from using this approach in 2 ways. First, doctors and nurses find that knowing "what matters" to patients improves the efficiency and effectiveness of the care they deliver. For example, the presence of pain and emotional problems adversely impacts patient confidence with self-management, which, in turn, undermines the proven power of collaborative care (Wagner et al., 1996; Wasson et al., 2006b, 2008b). Second, as practices incorporate CARE Vital Signs, the professional and nonprofessional staff invariably uncover inefficient, behaviorally unsophisticated processes and invent better processes and means of deploying the practice's workforce. For example, instead of relying only on the physician, a medical assistant can be trained to help patients use valuable self-management resources for particular issues identified by CARE Vital Signs (Wasson et al., 2003).

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Appendix 3

Geriatric Care Vital Signs

Patient Self-Assessment

Today's date _____

Name _____

1. What questions or concerns do you wish to discuss?
   (please state in the space provided)

_____

_____

2. Pain score _____ (*see below*)
3. Feeling score _____ (*see below*)
4. Social support score _____ (*see below*)
5. Do you often have trouble eating well? *(circle one)*
   Yes, often Yes, sometimes No, never
6. Do you often have trouble remembering or thinking clearly? *(circle one)*
   Yes, often Yes, sometimes No, never
7. Do you often have trouble with dizziness or falls? *(circle one)*
   Yes, often Yes, sometimes No, never
8. Are your pills making you ill? *(circle one)*
   Yes No Maybe Not applicable
9. Are you confident in managing your health problems? *(circle one)*
   Yes No Maybe Not applicable
10. How do you rate your health in general? _____ (*see below*)

Thank you.

Pain

During the past 4 weeks ...
How much bodily pain have you generally had?

No, pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

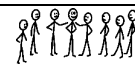
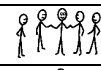
Feelings

During the past 4 weeks ...
How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or downhearted and blue?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

Social support

During the past 4 weeks ...
Was someone available to help you if you needed and wanted help? For example, if you
—felt very nervous, lonely, or blue
—got sick and had to stay in bed
—needed someone to talk to
—needed help with daily chores
—needed help just taking care of yourself

Yes, as much as I wanted		1
Yes, quite a bit		2
Yes, some		3
Yes, a little		4
No, not at all		5

Overall health

During the past 4 weeks...
How would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

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The analysis is based on 3500 responses of patients 70 years or older to the www.HowsYour Health.org Web-based survey tool.

In a majority of practices, about 40% of the patients older than 70 will have no abnormal responses, 40% will have 1 or 2 abnormal responses, and 20% will have 3 or more. However, if a practice cares for patients with low financial status, the distribution will change dramatically with only 10% having no abnormalities and 60% having 3 or more. Appendix Table 1 provides samples of diagnoses, health habits, symptoms, use of assistive devices, and instrumental activities of daily living. Also, it provides days sick in bed and previous use of the hospital. Not surprisingly, every sample marker of illness increases with the number of abnormal Geriatric CARE Vital Signs.

Appendix Table 2 illustrates the quality of care for patients who have adequate finances on the basis of abnormalities on Geriatric CARE Vital Signs. The greater the number of abnormalities, the worse is the perception of care.

ILLUSTRATIVE *ACTIONS* THAT MIGHT BE TAKEN AFTER USING GERIATRIC CARE VITAL SIGNS

Low-needs patients

Patients whose Geriatric Vital Signs have no abnormalities are very low needs patients. Although some of them have chronic diseases, they are confident in self-management and have no pain or emotional problems that will impede their ability to manage their concerns (Wasson et al., 2008a). Except for the smokers among them, the vast majority will also have about a 5 years' longer life expectancy than average for their age (Welch et al., 1996).

A clinician's job is to reassure patients of their good health status, reinforce healthy behaviors, and provide proven preventive care after informing them of their likely life expectancy. The patients should also be encouraged to continue their self-management activities by performing a health check-up annually on-line by using free, noncommercial tools such as HowsYourHealth.org. If this survey tool is used, its registry function can be used to remind them every year to complete the HowsYourHealth.org tool to make sure that they are continuing to do well. They should also be reminded to complete or update an advanced care plan.

Medium-needs patients

These patients have 1 to 2 abnormal responses to the Geriatric CARE Vital Signs. Appendix Table 3 illustrates the types of action an office might consider. (Similar lists of actions generated by expert panels are available elsewhere) (Wenger et al., 2007).

Within this category, the office staff can describe explicit actions and "standing orders" for each of the responses. Many of these actions need not be executed by a physician. In addition, group visits are a very useful enhancement for the typical office visit of a patient who has a few CARE Vital Sign problems.

Because these patients have so many other issues, a comprehensive tool such as HowsYourHealth.org might be used before the next office visit to tailor information for their need and help the clinical staff find out "what matters" to these patients. Patients with medium or high needs will often require family members assist them with the use of computers.

Appendix Table 1. A sample of patient characteristics by category of Geriatric CARE Vital Sign*

Sample patient characteristic	Abnormal Geriatric CARE Vital Signs		
	No abnormalities	1–2 abnormalities	≥3 abnormalities
Medications			
>5 medications	15	28	48
Common diagnoses			
Hypertension	41	54	61
Arthritis	34	51	63
Atherosclerotic cardiovascular disease (any manifestation)	17	26	36
Atherosclerotic cardiovascular disease (congestive heart failure)	3	6	13
Diabetes	10	16	31
Respiratory	10	15	26
Health habits			
Smoker	22	22	30
Not exercising >3 d/wk	37	49	79
Common symptoms			
Wetting	3	8	24
Constipation	4	7	23
Sleeping problems	7	16	36
Instrumental activities of daily living limits			
Cannot get out of the house without help	2	8	30
Cannot handle finances	2	7	18
Impact on life			
Using cane or wheelchair	5	19	40
Confined to bed in last 3 mo	9	15	37
Hospitalized in past year	14	22	39
Quality of life "bad"	0	2	25
Harmed by healthcare in past year	1	2	4
From CARE Vital Signs			
Not confident	0	62	88
Pain	0	30	70
Overall health fair or poor	0	15	72
Pills perhaps causing illness	0	17	54
Lacking social support	0	17	36
Emotional problems	0	5	41
Problems thinking	0	9	37
Dizzy or falling	0	3	23
Eating/nutrition problems	0	1	21

*Values given are in percentages.

High-needs patients

This group of patients represents a rather frail group of elderly patients. They invariably require many services and are at high risk for death, rehospitalizations, and harms associated with healthcare. However, despite their illness burden, about 1 in 4 do not have a clear idea about who will make decisions for them if they become too sick to speak for themselves. They also tend to overestimate their likelihood of survival.

Appendix Table 2. Quality of care reported for 70 years or older patients with adequate financial status*

Quality indicators	Abnormal Geriatric Vital Signs		
	No abnormalities	1–2 abnormalities	≥3 abnormalities
Information and assistance			
Excellent information about chronic disease(s)	50	28	15
Helped live with their problem(s)	59	53	32
Care processes			
Very easy access to needed medical care	62	47	25
Office is efficient: My time is not wasted	87	82	69
Relationship with clinicians			
I have a personal clinician	91	90	91
I have 2 or more clinicians	37	61	66
I know who is in charge	89	88	80

*Values given are in percentages.

Many of these patients will benefit from the same approaches suggested for medium-needs patients. Given these patients multiple needs, it is imperative that family members, the patient, and other providers are all on the "same page" about management issues, priorities, and goals. The special survey within www.howsyourhealth for frail patients may be invaluable for assessing their needs and providing basic education based on their needs. The tool can save much clinician time and help the family and the patient be sure they are on the "same page."

Appendix Table 3. Initial actions for abnormal Geriatric CARE Vital Signs responses

Problems from Geriatric CARE Vital Signs	Initial actions*
Not confident	1. Review understanding of confidence 2. Identify what things patients feel least confident about and why 3. Begin "campaign for confidence"
Pain	1. Source and nature of pain 2. Problem-solving strategies 3. Medication management
Overall health fair or poor	1. Reconfirm rating with patient 2. Use for "decision making in the gray" 3. Use to trigger reminder for advance care planning 4. For those who have fair or poor health have someone help them complete the special HowsYourHealth.org tool for the "very sick or frail"
Pills perhaps causing illness	1. Which pills? 2. How are they "causing illness"? 3. Impact on patient "compliance" with pill taking 4. Explore possible alternatives

(*continues*)

Appendix Table 3. Initial actions for abnormal Geriatric CARE Vital Signs responses (*Continued*)

Problems from Geriatric CARE Vital Signs	Initial actions*
Lacking social support	1. Why the response? 2. What is needed? 3. What is lacking? 4. Problem solving 5. Possible referral
Emotional problems	1. Source and nature of emotional problem 2. Problem-solving strategies 3. Medication management
Problems thinking	1. Why the response? 2. Mini-Mental State Examination or MiniCog 3. Review options based on results
Dizzy or falling	1. Explore nature of problem 2. Get up and go 3. Orthostatic blood pressure 4. Evaluate as needed with particular focus on medications
Eating/nutrition problems	1. Explore nature of the problem 2. Weight and body mass index 3. Evaluate as needed

*For more details on these initial generic solutions, refer to "Activation of Patients for Successful Self-management." Several tools are available at www.howsyourhealth.org.

If possible, the office should designate someone to look out for high-needs patients and coordinate their care. Most importantly, this member of the staff should continuously provide brief proactive reinforcement of self-management and monitoring of important health concerns by phone, if possible, or at every visit.