

How to Register and Setup Your Practice with HowsYourHealth

Go to the main start page of [HowsYourHealth](http://HowsYourHealth.org):

HealthConfidence.org

Your Personal Guide for the Best Health and Medical Care
It's Easy, Completely Confidential, and It Works!

Health confidence
How confident are you that you can control and manage most of your health problems?

Where are you?

If your rating is less than "7," what would it take to increase your score?

Recommended

START HERE
Your Full Health Checkup
Receive Information Designed for You and Create Your Personal Health Plan

Other Choices

- Problem Solving and Changing Habits
- Living Well if You are Very Sick or Frail
- Making Important Health Decisions
- Readings, Best Web Links, Risk Information

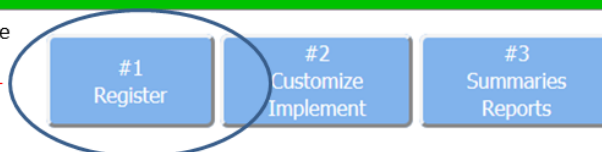
[Order and Customize: for Clinical Practices, Communities, Hospitals, and Employers](#)

[About Us: Background, Research.](#)

[WebMaster: Make it Better, Report Problem](#)

Click here to enter the provider/practice side of HowsYourHealth

Clicking on '#1 Register' will generate your practice code and password after you fill in your registration information and hit 'continue'



1. **REGISTER** to receive a unique code. The code is your basis for customizing the technology and developing summaries and reports unique to your practice.
2. **CUSTOMIZE** so that users can send responses and build a registry based on their needs. Consider adding questions and adjusting recommendations based on community resources. Receive helpful suggestions about your plans before you **IMPLEMENT** them.
3. Immediately receive **SUMMARIES** based on user responses. **REPORTS** from the registry facilitate population management. Automatic (and reimbursement when indicated) actions taken to support "Wellness", "Complex Care", "Transitions of Care", and "End-of-Life Care".

About:

[Background on HowsYourHealth](#)
[Published reference and examples for health confidence](#)
[See Sample Result \(opens new window\)](#)
[How to fit into a primary care practice "checkup".](#)
[How a practice shares summary results with its patients.](#)

Ordering:

[Common Questions and registering for HowsYourHealth](#)

After you have registered you will receive a practice code and password. Save this information!

Congratulations!
You Have Now Activated HowsYourHealth

- Your practice **code** is: TEQ983
This code will be used in all reporting and communication. It is also the code that your patients must enter into HowsYourHealth. **DO NOT LOSE THIS CODE!**
- Your **Password** is testefz51.
- The password controls access for your customization of HowsYourHealth. **DO NOT LOSE THE PASSWORD!**

To get the most out of any HowsYourHealth tool we suggest that within a month after you have registered you should:

- i. view the [brief patient video](#) about using HowsYourHealth;

Use these codes to get into buttons
'#2 Customize', and '#3 Summaries'

Button #2, 'Customize', allows you to set many options for your HowsYourHealth surveys. We've circled a few of the most common options.

- **Enable users to email their personal reports to you.** Activate the HIPAA registry at the same time. **Set up practice email to receive action plans**
- Preferred format of personal reports: **HTML** or **TEXT**
- **Obtain online consent** for condition management (such as phone follow-up) or research (such as outcome measures).
- **Direct Link from Your Website:** You may automatically enter your sitecode for your users using a HowsYourHealth link from your personal website. Insert in website HTML:

```
<p>  
<a href="http://www.HowsYourHealth.org/start?code=IMP107">Hows Your Health</a>  
</p>
```

This code produces a link from your website to the HYH survey start page prepopulated with your practice ID

[Change ID or Log Out](#)

Change Your Assessment Items	Change Your Hospital Version	Change Your Frail Version	Special Options
--	--	---	---------------------------------

[Add an open-ended question for those 9-18](#)
[Add an open-ended question for those 19-69](#)
[Add an open-ended question for those 70 and older](#)
[Modify or add 5 questions for those 9-18](#)
[Modify or add 5 questions for those 19-69](#)
[Modify or add 5 questions for those 70 and older](#)
[Compare Up to 10 Subgroups for sorting information \(ages 9-18\)](#)
[Compare Up to 10 Subgroups for sorting information \(ages 19 - 69\)](#)
[Compare Up to 10 Subgroups for sorting information \(age 70 and up\)](#)
[Offer Pre-visit Medical Check* \(9-18\)](#)
[Offer Pre-visit Medical Check* \(19-69\)](#)
[Offer Pre-visit Medical Check* \(70 and up\)](#)
*Adds 10 minutes to complete

[CAHPS configuration \(19 and up\)](#) Set up your survey to get CAHPS results
[Include/Exclude family history \(19 - 69\)](#)

[Get Patients from Registry](#) Use the registry
Planned Care Form
[View all your screens](#)

NEW CUSTOM OPTION

PROVIDE PATIENTS LINKS TO RESOURCES IN YOUR SERVICE AREA FOR THEIR MOST COMMON PROBLEMS/CONCERNS. FOR EXAMPLE, YOUR LOCAL SOCIAL SERVICE AGENCY OR EXERCISE FACILITY.

Change Your Assessment Items	Change Your Hospital Version	Change Your Frail Version	Special Options
--	--	---	---------------------------------

[Community Links](#)

Button #3 'Summaries' allows you to access your practice's aggregate data.



This [link](#) will bring you to documents that explain how to interpret and use the HYH action plan and a practice's aggregate data. (If [link](#) is not active, see below).

How's Your Health – How to Interpret and Use the Action Plan

Action Plan -Overview

This 1-3 page document appears deceptively simple, yet it contains a plethora of important primary care things about the patient in front of you that you need to know to be able to really help your patients help themselves! When delivered to you before a visit, this document rolls up the social and clinical determinants of health into one powerful little pre-visit planning synopsis so that you are prepared to help your patient overcome barriers to improving their health.

The action plan is the summary report of a systematic survey of the following important biopsychosocial determinants of health: bothersome emotional issues, inadequate social support and pain, polypharmacy and medication side effects, health confidence, nutrition, exercise, substance use and safety habits, screens for domestic violence and financial insecurity. Furthermore, the survey asks, and then engages, willing respondents in behavior change around common health risks using motivational interviewing techniques. The documentation of this interchange in the action plan provides the provider/patient dyad with a common launch pad for behavioral change to happen.

Why is it important for the provider to acknowledge and understand these determinants of health?
Let's review just a few of the common scenarios that come to light when the above questions are asked:

- if patients note inadequate financial resources for basic needs, medications may not be purchased;
- if the health care provider is not aware that emotional issues are making it difficult for their patient to function, it is likely that a complicated lifestyle and medication regimen for diabetes will not be carried out;
- if patients feel their medications are making them ill, they may stop or take less than the recommended dosage.

Sample Action Plans

The first action plan is the hypothetical response from an obese depressed hypertensive asthmatic diabetic 53 year old patient with multiple symptoms. The second action plan is from a quite well person with minimal health concerns.

ACTION PLAN, first page: 'SICK PERSON'

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: 2016-03-11 Age: 50-64 Gender: Female BMI: 53.3

WHAT MATTERS TO EVERYONE

BOTHERSOME PAIN: Present

Ask: How much is pain making it difficult for you to be confident? Making it very difficult _ making it somewhat difficult _ Not much impact

BOTHERSOME EMOTIONS: Present

Ask: How much are feelings making it difficult for you to be confident? Making it very difficult _ making it somewhat difficult _ Not much impact

POSSIBLE MEDICATION RISKS: Present

Many medicines: Ask: Have they been recently checked? Present

May be causing illness: Ask: Which ones and how?

HEALTH CONFIDENCE: Not Very Confident

What might improve health confidence? "a miracle" Ask: Problem most difficult to manage _____

ASSETS

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
None	None	None	None

NEEDS

FUNCTION (includes = clinician unaware): Difficulty with daily activities; Difficulty with feelings; Difficulty with social activities; Difficulty with pain; Difficulty with social support; Difficulty with physical fitness

SYMPTOMS/BOTHERS: Headaches; Abdominal pain; Dizziness/Tiredness; Chest pain; Menstrual/Menopausal problems; Eating/Weight/Exercise problems; Skin problems; Trouble urinating/wetting; Breathing problems; Joint pain; Back pain; Trouble sleeping; Foot problems; Eating Medications making ill

CONCERNS OR FAMILY HISTORY: Violence/abuse; Sexual issues/birth control; AIDS/sexually transmitted diseases; Health care system; Substance abuse; Exercise/nutrition needs; Preventing injuries/accidents; Preventing cancer/heart disease; Ear/eye/mouth care; Family history of heart trouble/arteries; Family history of diabetes; Family history of cancer; Family history of lipid disorder; Family history of other disease

HABITS: Smoker interested in quitting; More than 6 drinks; Told to reduce alcohol; Not Exercising

ACTION PLAN, first page: 'WELL PERSON'

Action and Planning Form

<https://howeyouthhealth.com/adult/action/inf?answers=QlpOCTFBWSZ...>

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: 2016-03-11 Age: 50-64 Gender: Female BMI: 26.6

WHAT MATTERS TO EVERYONE

BOTHERSOME PAIN: Not Present

BOTHERSOME EMOTIONS: Not Present

POSSIBLE MEDICATION RISKS: Not Present

HEALTH CONFIDENCE: Very Confident

ASSETS

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
Daily Activities - No difficulty Feelings - No problems Social Activities - No limitations Pain - No pain Social Support - As much as wanted Physical Fitness - Very heavy	Generally healthy eating Generally avoids accident risks Does not smoke Does not drink excessively Exercises Regularly	Confident self-manage	Has enough money Had pap test

NEEDS

FUNCTION (issues = clinician unaware): None

SYMPTOMS/BOTHERS: Trouble sleeping

CONCERNS OR FAMILY HISTORY: None

HABITS: None

PREVENTION: None

IMMUNIZATIONS: "flu". Should have had DPT, Varicella (if not immune-compromised).

RISK CONSIDERATIONS

Let's deconstruct these plans into their component parts. The top few lines of the action plan list some basic information including age range, BMI, gender, date of survey. The next section gathers the most important health risk factors, under a heading called "What Matters to Everyone" (the "What Matters Index", WMI) , and suggested follow up practice questions/responses to the presence of risk factors :

The next sections, health “Assets and Needs” show where and how the determinants of care are reported in the action plan. As you can see, this very ill patient has zero health assets but multiple health needs.

Action Plan – Assets and Needs

ASSETS

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
None	None	None	None

emotions, pain, fitness impacting function
poor social support and clinician not aware

NEEDS

FUNCTION (*italics = clinician unaware*): Difficulty with daily activities; *Difficulty with feelings; Difficulty with social activities; Difficulty with pain; Difficulty with social support; Difficulty with physical fitness*

SYMPTOMS/BOTHERS: Headaches; Abdominal pain; Dizziness/Tiredness; Chest pain; Menstrual/Menopausal problems; Eating/Weight/Exercise problems; Skin problems; Trouble urinating/voiding; Breathing problems; Joint pain; Back pain; Trouble sleeping; Foot problems; Eating; Medications making ill

possible problems with medications

CONCERNS OR FAMILY HISTORY: Violence/abuse; Sexual issues/birth control; AIDS/sexually transmitted diseases; Health care system; Substance abuse; Exercise/nutrition needs; Preventing injuries/accidents; Preventing cancer/heart disease; Ear/eye/mouth care; Family history of heart trouble/arthritis; Family history of diabetes; Family history of cancer; Family history of lipid disorder; Family history of other disease

HABITS: Smoker interested in quitting; More than 6 drinks; Told to reduce alcohol; Not Exercising

review habits : tobacco, alcohol, exercise nutrition, safety

of 3

3/11/2016 2:10 AM

tion and Planning Form

<https://howsthehealth.com/adult/action/epi?answers=Q1poCTFBWSZ>

inadequate finances

polypharmacy

domestic violence

Regularly; Unhealthy eating; Doesn't wear seatbelts

preventive screening

PREVENTION: Lacks essential money; More than 3 medications; Possible relationship problem; No or not sure pap test

The last section of the action plan shows this hypothetical patient's response to the motivational interview that was automatically initiated by the HYH survey. This patient is interested in changing a risk to her health - smoking – but is not quite sure how to get there. Can you help educate her about smoking cessation options, and walk her through formulating a behavior change plan?

The last section also gives patients links to excellent educational information hosted on the HYH website about medical conditions and bothersome symptoms the patient has noted while taking the HYH survey.

Action Plan – Risk / Care Management

RISK CONSIDERATIONS

Chronic Diseases: High blood pressure; Heart trouble/arteries; Diabetes; Arthritis; Asthma/bronchitis /emphysema; Serious obesity

Risk for ED or Hospital Use: High

behavior change: where to begin

Seat Belt: Sometimes does not use

Habit Change Plan for next 2 months: quit smoking but patient is not very confident of success. "less stress and my partner not to smoke around me"

SUGGESTED READING AND EDUCATION

- [Risks: What Are My Chances? \[https://howyourhealth.com/static/risk.html\]](https://howyourhealth.com/static/risk.html)
- [Exercise and Eating Well \[https://howyourhealth.com/static/adult/chapters/chapter1.html\]](https://howyourhealth.com/static/adult/chapters/chapter1.html)
- [Health Habits and Health Decisions \[https://howyourhealth.com/static/adult/chapters/chapter2.html\]](https://howyourhealth.com/static/adult/chapters/chapter2.html)
- [Common Medical Conditions \[https://howyourhealth.com/static/adult/chapters/chapter4.html\]](https://howyourhealth.com/static/adult/chapters/chapter4.html)
- [Daily Activities and Managing Limitations \[https://howyourhealth.com/static/adult/chapters/chapter7.html\]](https://howyourhealth.com/static/adult/chapters/chapter7.html)
- [Feeling and Emotional Care \[https://howyourhealth.com/static/adult/chapters/chapter8.html\]](https://howyourhealth.com/static/adult/chapters/chapter8.html)

Compare the "Assets/Needs" section of the HYH survey that a completely healthy well person would generate – this patient complains only about difficulty sleeping. As you can see, the "Assets" section is bulging with healthy stuff!

Action Plan – Well Person

No substance, exercise
 nutrition, safety issues
 no functional emotional, pain
 social, fitness issues
 ASSETS
 finances adequate
 preventive tests UTD

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
Daily Activities - No difficulty Feelings - No problems Social Activities - No limitations Pain - No pain Social Support - As much as wanted Physical Fitness - Very heavy	Generally healthy eating Generally avoids accidents/risks Does not smoke Does not drink excessively Exercises Regularly	highly confident in self care Confident self manage	Has enough money Had pap test

NEEDS

FUNCTION (notes = clinician unaware). None

SYMPTOMS/OTHERS: Trouble sleeping

CONCERNS OR FAMILY HISTORY: None

For patients that are taking the survey before an annual preventive exam, for billing purposes, a practice may wish to add a 12 point clinical review of systems to the survey. To get to the page shown below to enable the option called "Offer Pre-visit Medical Check", enter your username and password when prompted from the following link: ["Customize General HowsYourHealth"](#).

[Change ID or Log Out](#)

Change Your Assessment Items	Change Your Hospital Version	Change Your Frail Version	Special Options
Add an open-ended question for those 9-18 Add an open-ended question for those 19-69 Add an open-ended question for those 70 and older Modify or add 5 questions for those 9-18 Modify or add 5 questions for those 19-69 Modify or add 5 questions for those 70 and older Compare Up to 10 Subgroups for sorting information (ages 9-18) Compare Up to 10 Subgroups for sorting information (ages 19 - 69) Compare Up to 10 Subgroups for sorting information (age 70 and up) Offer Pre-visit Medical Check* (9-18) Offer Pre-visit Medical Check* (19-69) Offer Pre-visit Medical Check* (70 and up) *Adds 10 minutes to complete CAHPS configuration (19 and up) Include/Exclude family history (19 - 69) Get Patients from Registry Planned Care Form View all your screens			

The screen shot below shows the review of systems information as it appears at the beginning of the action form. Please note, if the patient does not endorse a symptom in a particular category, then the category does not appear on the list in the action plan

Date: 2016-03-14 Age: 50-64 Gender: Female BMI: 26.6

Purpose for Visit	Symptom Review
PE Meaning of Concern	Stomach or Bowel: vomiting
	Heart: chest pain
	Eyes: double vision
	Lungs: cough
	Nervous system: headache
	Urine: bloody urine
	Feelings: anxiety
	Bones or Muscles: joint pain
	Skin: rash
	General: fever
	Sexual: vaginal bleeding after menopause
	Ear, Nose, Mouth, or Throat: ear pain

WHAT MATTERS TO EVERYONE

BOTHERSOME PAIN: Not Present

BOTHERSOME EMOTIONS: Not Present

For Practices: How to Access, Interpret and Utilize Your HowsYourHealth Data.

You've done the work of accumulating some HowsYourHealth surveys – congratulations! About 30 surveys will give you fairly reliable information about how your practice is functioning.

I. Access your results:

First, let's review how to access your practice information: go to the main [HowsYourHealth](#) screen. Find and click the link that says: For practices: Customizing and Using. A pop up box will ask you to enter your username and password. The next screen asks you which data you would like to see. Here, note that you can sort your surveys by age group, discrete time period and by illness burden. For now let's choose all adult surveys (click button 'All Items'):

[Return to Customizations Menu](#)

Produce Summary Report(s)

Which survey(s)? ☐ adolescent ☒ adult ☐ geriatric ☐ hospital


Choose Illness Burden Level

- ☒ Low Level (0)
☒ Increased Level (1,2)
☒ High Level (3 or more)

Choose data since: All January 1

But before: All January 1

All Items

 Web Data v3.0 Last reviewed: 01/2016 © 1997-2016 FOX Corporation and Trustees of Dartmouth College. All Rights Reserved.

You can compare your own multipage summary document with the representative data sections discussed below.

Here is what the first page of the multi-page data summary looks like:

Done with Summary Reports

Anonymous Summary Report

Practice Quality

Selected IMP107 Since Beginning through Present

	All Records	Income Problems
Patient-Centered Processes	987	121
Single Measure for Patient-Centered Medical Care	71.76	60.36
Medical Home	90.62	86.38
Interaction Style	91.79	82.61
Very Good Communication for Chronic Disease	89.14	84.21
	All Records	Income Problems
Desirable Consequences	987	121
Aware of Functional Limits	69.61	66.41
Patient Confidence	61.51	38.79
Practice Benchmark	76.12	71.43
Wellness Activities	77.20	60.00
No Hospital or ED use for chronic disease	93.02	89.66
Medication management	89.59	92.00

Quality Summary Table

This Quality Summary Table is based on categories that illustrate Important Processes and Desirable Consequence of primary care. (The reason for the categories is described in "Patients Use the Internet to Enter the Medical Home.")"

II. Interpret your data:

A. Page 1 - Medical Home Summary

The upper part of the table, “Patient Centered Processes” aggregates foundational care quality metrics provided by your practice, as ranked by your patients. The lower part of the table “Desirable Outcomes” measures practice wide population health outcomes for your patients. The left column of numbers includes all surveys; the right hand column of numbers is the percentage of patients taking the survey that lack basic financial security. (This measure is used to examine health care disparities).

Two important things to know about this table are: 1) improving performance on “patient centered processes” (top half of table) leads to better population health “outcomes” (bottom half of table), and 2) benchmarks aggregated from thousands of HowsYourHealth surveys are listed in the fine print under the summary, made available for comparing your practice’s performance to the national average.

Here is an illustrative example of how to read this table for the 987 patients in this practice that have taken the survey in the specified time period:

71.76% of patients (or 710 patients) strongly agreed with the statement “I get exactly the care I want and need when and how I want it”, a single global measure of practice quality. So for this practice 28.24% or around 276 patients feel that they are not getting exactly the care they want and need. As a measure of healthcare disparities in this practice, 12.2% suffer basic financial insecurity and the difference in health metrics between the haves and have-nots is highlighted between columns 1 and 2. For example, across the practice as whole, patient confidence with self-management is 62% (612/987), but among the financially insecure, the percentage of patients that say they feel confident to manage their medical issues is only 39% (385/987).

Measure by Measure:

- Single Measure for Patient Centered Care: One question for patients on global experience of care, which correlates extremely well with aggregate CAHPS score ([Lynn Ho, MD; Adam Swartz, MD; John H. Wasson, MD. The Right Tool for the Right Job: The Value of Alternative Patient Experience Measures. 2013. J Ambulatory Care Manage](#))
- Medical Home: Patient rated practice access, continuity, efficiency and coordination (aggregate score)
- Communication: Aggregate score of provider communication style from 2 embedded CAHPS questions, if CAHPS option has been activated by the practice- CAHPS questions are: “MD respects...”, and “MD listens...”
- Very Good Communication for Chronic Disease: Aggregate score, patient evaluation of usefulness of information received from practice about any self-reported chronic disease
- Aware of Functional Limits: Patient believes that the clinician is aware of bothersome emotions, pain, functional limits (aggregate score)
- Patient Confidence: Patient feels very confident that they can manage their medical problems

- Practice Benchmark: Aggregate practice score for colonoscopy, mammogram and cholesterol screening rates, and “well controlled” self-reported scores for hypertension and diabetes metrics
- Wellness Activities: Aggregate score for healthy habits (eating well, exercising, not smoking)
- No Hospital or ER Use for Chronic Disease: Aggregate utilization measure within past year
- Meds Not Making Ill: Patient does not believe that their medications are causing illness

B. Pages 2-13: Deeper Dive into the Raw Data

HowYourHealth provides a wealth of data about your practice which is both broad and deep. These next few illustrative examples will explain how to begin parsing the raw data.

1) Page 3 screenshot - population demographics of common chronic conditions

	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Respondent Characteristics	987	749	238	488	261	143	95	223	30	42	125	116	131	121
Younger Women	49.44	65.15	0.00	100.00	0.00	0.00	0.00	33.18	10.00	26.19	18.40	49.14	41.98	47.93
Older Women	26.44	34.85	0.00	0.00	100.00	0.00	0.00	32.29	40.00	64.29	64.00	29.31	33.59	25.62
Younger Men	14.49	0.00	60.08	0.00	0.00	100.00	0.00	17.04	10.00	2.38	7.20	14.66	19.08	18.18
Older Men	9.63	0.00	39.92	0.00	0.00	0.00	100.00	17.49	40.00	7.14	10.40	6.90	5.34	8.26
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems
Respondent Diagnoses	987	749	238	488	261	143	95	223	30	42	125	116	131	121
% with Hypertension	22.59	19.49	32.35	15.16	27.59	26.57	41.05	100.00	56.67	78.57	41.60	29.31	55.73	38.02
% with Hardening of Arteries	3.04	2.00	6.30	0.61	4.60	2.10	12.63	7.62	100.00	19.05	7.20	6.03	5.34	6.61
% with Diabetes	4.26	5.07	1.68	2.25	10.34	0.70	3.16	14.80	26.67	100.00	10.40	8.62	19.08	8.26
% with Arthritis	12.66	13.75	9.24	4.71	30.65	6.29	13.68	23.32	30.00	30.95	100.00	16.38	22.14	15.70
% with Respiratory Disease	11.75	12.15	10.50	11.68	13.03	11.89	8.42	15.25	23.33	23.81	15.20	100.00	27.48	16.53
% with Obesity > 15%	13.27	13.22	13.45	11.27	16.86	17.48	7.37	32.74	23.33	59.52	23.20	31.03	100.00	19.83
% Income Problems	12.26	11.88	13.45	11.89	11.88	15.38	10.53	20.63	26.67	23.81	15.20	17.24	18.32	100.00
	All Records	Women	Men	Younger Women (19-49)	Older Women (50-69)	Younger Men (19-49)	Older Men (50-69)	Hypertension	Hardening of Arteries	Diabetes	Arthritis	Respiratory Disease	Obesity > 15%	Income Problems

This page shows that 22% of patients surveyed, or 223 of 987 patients surveyed, have hypertension. Moreover, one can see that of those with hypertension approximately 19% of 749, or 142 patients are female and 32% of 232 survey takers or 66 patients are male; and that among people with financial insecurity for basic needs that the incidence of hypertension is 38% compared to 22% in the general population. One can extract similar population data for heart disease, diabetes, arthritis, COPD/asthma and obesity.

- 2) Similar practice wide population level statistics are available for functional limitations, common bothersome symptoms, lifestyle habits:

	All Records	
Bothered (often or always) in the Past Month by:	987	7
% Limit Daily Activities	4.26	4
% Limit by Feelings	8.11	8

3 of 14

Summary Report

% Limit Social Activities	3.34	1
% Limit by Pain	15.20	1
% Limited Social Support	6.79	7
% Limited Physical Function	4.76	4

	All Records	
% Headaches	11.45	
% Abdominal Pain	7.60	
% Dizzy/Fatigue	13.27	
% Chest Pain	1.82	
% Menstrual or Menopausal	4.36	
% Eating or Weight	16.51	
% Skin	9.32	
% Urination	1.52	
% Sexual	3.44	
% Respiratory	2.13	
% Joint Pain	13.48	
% Backaches	12.06	
% Sleeping	15.30	
% Foot Trouble	5.78	

	All Records	
Habits	987	
% Current Smoker (GI)	8.51	
% Smoker Ready to Quit	6.18	
% Good Health Habits (GII)	78.42	
% ETOH 10 or more/week	5.67	
% Told to Reduce ETOH	10.03	
% Regular Exercise (GIII)	52.38	
% Confident to change a habit	36.84	

Functional limitations, p. 3-4 Bothersome symptoms, p. 4 Lifestyle habits, p. 5

To move one layer deeper into the data, we see that 8% (79/987) of patients have bothersome emotional symptoms. Of these 79 patients, we can see that 67% (53 patients) think that their doctor is aware of their emotional issues; that 68% (54 patients) received a helpful explanation about their emotional issues and that 60% (47 patients) thought that treatment had been helpful. To see how a practice uses this information, [check out this link to Dr. Jim Bloomer's website.](#)

If Limited by Feelings	987
% Clinician Awareness (EII)	67.09
% Very Good Explanation	68.09
% Help from Treatment	60.42

Bothersome Emotions, p.8

- 3) Practice wide screening rates for colon and breast cancer, Pap and cholesterol testing are available (p. 6-7). Patient self-reported rates of good blood pressure and diabetes control are also available (p.13). [Click on this link to see how these “clinimetric” numbers correlate with levels obtained from chart reviews.](#)

III. Use Your Data

A. For Practice Improvement

Because all surveys ever taken by patients in your practice are stored permanently on the HowsYourHealth server, and results can be cut by time, it is remarkably easy to try out an improvement in your practice, and then recheck the data from the time period after you have instituted the change to see if the desired improvement has occurred. After you have obtained a baseline measurement of 30- 60 patients in your practice, here is a menu of 3 simple ideas to choose from to get started:

- 1) Pull out the percentage of patients that think that their medications may be making them sick. (For the example practice, this is 10.41% (from p.1 ‘Medical Home Summary.’)) For the next 6 months, ask every patient who is taking a medication, “Do you think that your medication may be making you sick?” Discuss any positive responses to that question so that it becomes clear to both you and the patient that medications *are* or *are not* responsible for side effects. In 6 months, obtain another 30-60 surveys; use the time sorter to pick only surveys starting on or after the intervention date. An expected result would be that the percentage of patients that feel that their medications are making them sick will decrease. (Why is this important? People may either correctly or erroneously feel that their medications are making them sick. If a medication needed to control a condition is erroneously blamed for a side effect, then the discontinuation rate will be higher than it should be and people may not receive needed treatment.)
- 2) Examine your “access” rate, the percentage of people that feel it is “very easy to get medical care when they need it”. In this example practice the access rate is 82% (p. 13, “having very easy access”). Then, **do something** in your practice to improve access – implement advanced open access scheduling or email communication with the practice, add weekend or evening hours, clear your telephone tree to make it easier for patients to get through, add virtual visits, etc. In 12 months, collect another 30-60 surveys: see if your intervention worked! (Why is this important? Excellent access to care minimizes ER visits and avoidable hospitalizations, and allows patients to easily follow through with needed care for chronic conditions.)
- 3) Improve the percentage of hypertensive patients who know the basics about their condition:
This practice noticed that the percentages of hypertensive patients who answered that they knew the effects of weight and salt on blood pressure, the side effects of

their medication and what to do if they missed a dose of their medication were not at 100%. The practice decided to implement a hypertension teaching template that reviewed the above basic information with all hypertensive patients, and a teach-back method after reviewing the above, with printed information handed to the patient at the time of the visit. Results are shown in the table below:

Hypertension	2006 (n=60)	2007 (n=58)
Patient knows what to do if missed dose	68%	75%
Patient knows effect of weight/salt on hypertension	76%	82%
Patient is informed about side effects of medications	59%	79%
Systolic blood pressure <150	92%	94%

[Wasson, et.al. "Clinical Microsystems Part 2: Learning from Micro Practices about Providing Patients the Care They Want and Need" JCAHO Journal, 2008, p 445 - 452](#)

(Why is this important? In order to be able to self-manage their conditions during the approximately 363 days per year that patients are not under your direct supervision in the office, they need to understand basic information about their conditions.)

B. To Identify/Apply Interventions to High Risk Patient Groups

Five predictors culled from the HowsYourHealth Survey are associated with high cost and high utilization of health care services: bothersome emotional problems, pain, polypharmacy, medications causing illness and low patient confidence with self-management.

To access a list of patients that may need more intensive care management services as culled from the 5 predictors above, you will need to activate and use the HYH registry. From this web page:

<https://howsyourhealth.com/static/professional.html>

Click on 'Customize HowsYourHealth Survey', enter your password/user name, and then click on 'Get Patients from Registry'. The registry page will appear:

How to use it? Merely enter the registry using your code and password. Sort patient list using combinations of age, gender, and their responses. Responses can be combined by “AND” (diabetic and not confident) or “OR” (low income or poor home support). You may print or download an Excel spread sheet of the names and addresses, best time to contact as it appears on the patient list.

An Example: The Current Version for Adults Aged 18-69

May select any combination of age groups or 'All ages' to disregard this variable.		Age group <input type="button" value="All ages"/> <input type="button" value="18-34"/> <input type="button" value="35-49"/> <input type="button" value="50-64"/> <input type="button" value="65-69"/> <input type="button" value="70-79"/> <input type="button" value="80 or older"/>	Select desired gender, or 'Either' to disregard this variable. <input type="button" value="Either"/> <input type="button" value="Male"/> <input type="button" value="Female"/>	
AND		OR	AND	OR
<input type="radio"/> Poor Financial Status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHF	<input type="radio"/>
<input type="radio"/> Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Hx. Stroke	<input type="radio"/>
<input type="radio"/> Emotion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Respiratory	<input type="radio"/>
<input type="radio"/> Lacks Confidence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Last BP over 150	<input type="radio"/>
<input type="radio"/> Meds Make Ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Last Cholesterol if 200+	<input type="radio"/>
<input type="radio"/> Seeing Specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Blood Sugar > 140	<input type="radio"/>
<input type="radio"/> HBP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Mammogram not done	<input type="radio"/>
<input type="radio"/> Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> No Bowel Cancer screen	<input type="radio"/>
<input type="radio"/> BMI>30	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Poor Home Support	<input type="radio"/>
<input type="radio"/> Angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> High risk for hospital use	<input type="radio"/>

You can select a group of high risk patients with certain characteristics and apply selected strategies to that group. For example, you can select patients from the registry that have low confidence with self-management and pain, and offer these patients a referral to peer-led pain management groups; you can pull out patients with low health confidence and bothersome emotional issues and initiate referrals for virtual or real CBT; you can pull out the subgroup of patients with “meds making ill” and low confidence and refer them to your embedded pharmacy team member ; you can pull out the subgroup of patients with pain, bothersome emotional issues and low confidence and have your care manager check in regularly with this group – you get the idea? This method of assessing risk is not administratively or disease- based and thus captures a truer, broader set of your practice’s high risk and rising risk patients.