

# 3M<sup>SM</sup> AssessMyHealth Tool Playbook

## An introduction to 3M AssessMyHealth

### Introduction

Below is a description of 3M AssessMyHealth, providing background on and rationale for use of the tool followed by implementation and use strategies addressing frequently asked questions.

### Background

3M AssessMyHealth is a licensed version of HowsYourHealth, a suite of tools developed by John H. Wasson, MD, Emeritus Professor of Community and Family Medicine and Medicine at the Geisel School of Medicine at Dartmouth.

Extensively researched with numerous peer-reviewed publications, HowsYourHealth (HYH) is a behaviorally sophisticated means to unmasking issues that can get between people and optimal outcomes.<sup>1</sup>

### Rationale

Disease is one of many factors influencing outcomes for people and populations.<sup>ii</sup> When we limit our focus to disease, we may (for example) see medication non-adherence as “non-compliance,” missing opportunities that might improve outcomes. Non-adherence can stem from many reasons. Among them:

- They may believe the medicines are making them ill
- They cannot afford to take the medicines as prescribed
- The drug regimen is too complicated for the person
- They don't understand the reason for taking the medicine
- Low family support may make it difficult to get to the pharmacy or doctor's office

As an additional support to their work on disease, providers benefit from having a means to systematically unmask non-disease factors that can heavily influence outcomes. People benefit when they can share issues that matter to them, especially when that sharing leads to recommendations and treatment plans better suited to the individual's needs.

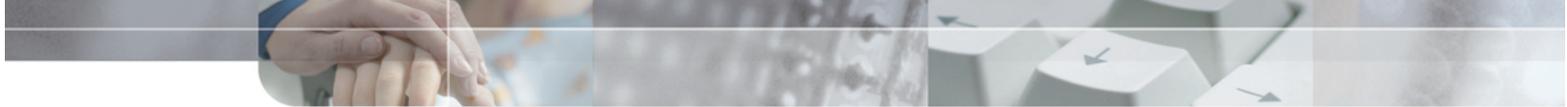
### Getting started with 3M AssessMyHealth

3M AssessMyHealth is a web-based assessment tool that is relatively easy to use, though implementation will go more smoothly with thought, discussion and planning. The work of implementing 3M AssessMyHealth involves figuring out who in the practice will perform specific roles as well as how those roles fit into the busy work flow.

The suggestions here are based on common experiences of practices small and large as they have worked through issues related to implementing the use of this tool in their practices. Alter the recommendations to fit your local circumstances.

### Communicate early and often

A phased implementation approach, starting with your most interested and engaged provider, can move a new process more quickly through a practice or group. Let everyone in the practice know about the intent to implement 3M AssessMyHealth. Share the rationale, encourage everyone to go through the assessment him or herself so they can understand the experience, and provide a venue for discussion. Develop an implementation team to pilot the tool in a contained environment (e.g. for one willing provider), and scale to the rest of the practice as soon as possible.



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## Consider using a formal framework for testing new processes in practice

Making changes in day-to-day work can be challenging. Failure to change is sometimes rooted in an inability to identify problems and solutions in a way that is transparent to all involved. A model for changing workflow improves your chances of success. As you get started developing a new workflow, use the Model for Improvement's Plan-Do-Study-Act (PDSA) framework or a similar methodology to test your solutions and quickly work out kinks.<sup>iii</sup>

## Consider trying it out on a sub-population and then scaling it to everyone

Pick a focused sub-population for the initial test so as not to overwhelm the practice. If the prospect of asking every patient in the practice to complete 3M AssessMyHealth is daunting, consider starting with a focused sub-population. Because the rate of patient acceptance is highest when asking people to complete the assessment just prior (no more than about two weeks) to a visit with their provider, many practices start by asking those who are scheduled for a wellness/preventive visit. Some practices focus on those coming in for a planned chronic condition visit.

## Develop a process for tracking if/when a person has completed the assessment

While the 'very important' questions can be helpful for high-risk individuals at each encounter, the full assessment is usually done no more than once a year. It is a good idea to track when a person has completed 3M AssessMyHealth so the office knows when to recommend an assessment.

## Improving the probability that a person will complete the assessment when asked

The likelihood that a person will complete the assessment is based in part on who was asking and how they were asked. Here are steps used in more successful implementations:

**Timing – ask just prior to an upcoming visit:** People are more likely to complete the assessment when asked within a short time prior to an upcoming appointment – generally no more than 2 weeks. Letting them know that their provider will review it with them at the upcoming appointment is key. This has been done successfully with email appointment reminders that have embedded links to the assessment site, or when during an appointment reminder call.

**Who is asking – the request is coming from the person's physician/NP:** Let people know that their PCP is the one who wants the patient to take the assessment. This does not mean the provider must do the asking, but if the 'ask' is coming from the provider - "Dr. M would like you to complete this so he can review it with you next week." – it is more likely to work than a postcard from an institution.

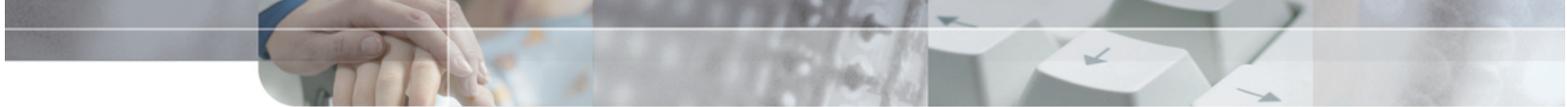
**Words matter – this is an assessment not a survey, we are doing this to help the patient get the care they need:** Through numerous trial-and-errors we notice that people are less likely to respond to "will you do this survey" and are more likely to respond to "Dr. M wants you to do this online checkup so that he can be sure to leave no stone unturned and provide you the best care possible." The latter is 'we are here to help you' while the former is 'will you do this thing for us.' Most practices find the use of a script to be to their advantage.

**Ask with confidence:** When people hear their clinicians (or staff representatives) asking with confidence, they are more likely to follow through. Clinicians and staff are more likely to have confidence asking when:

- They have taken the assessment themselves and understand what they're asking of others
- They have had their own questions/concerns regarding the tool and its impact on the practice and patients addressed
- They have a script to follow
- The people in the practice (especially the clinical staff) support its use

## **Sample script**

"Hello Mr. Smith, this is Dave from Middleton Family Medicine. I'm calling to remind you of your appointment with Dr. Anan in two days. In preparation for the visit, she would like you go to take an online checkup that will help her be sure she's identifying your medical needs and provide you the best care possible. Please go to



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[www.AssessMyHealth.com](http://www.AssessMyHealth.com) and when asked, enter her access code so you can securely answer the questions. Her access code is: XXX###. Thank you.”

## What to do with the results

Upon completion of the assessment a person’s responses are distilled into a simple Action Form. The Action Form will show people who have few if any (low), some (medium) or many (high) needs. We’ll address general approaches to these categories then delve into specific needs.

### Low needs

These individuals tend to have many assets and none of the very important issues (i.e. bothersome pain, emotions, medication problems, low confidence) and are able to purchase essentials.

“Thank you so much for completing the assessment. Your responses confirm that you’re doing well. We’ll check in again next year.” This lets people know that this was a good thing to check and not a waste of their time.

### Medium Needs

These individuals may have one or two of the very important issues (pain, emotions, medication problems, and confidence, unable to purchase essentials) and other needs.

The action form is hierarchical. We recommend starting with the very important issues, note the person’s assets, and as time and interest permit, move on to other needs and risk considerations.

Responses in the very important section highlight issues likely to have a significant impact on this person’s ability to achieve good outcomes. The action form provides follow up questions that a medical assistant can ask on rooming the patient. The follow-up question is meant to get the ball rolling on interventions often referred to as “Self-Management Support.”<sup>ivv</sup>

### High Needs

These individuals often have more than one very important issue plus multiple other needs and risk considerations and usually few, if any, assets.

Clinicians and practices call upon their existing skills when faced by needs that exceed today’s allotted time and resources. Negotiate priorities, do what is possible, schedule follow-up.

## Addressing non-clinical factors that impact outcomes

### Very important issues

People with bothersome pain, emotions, medication problems and/or low health confidence are much more likely to have major difficulties than people without these issues.<sup>vi</sup> They are likely to be the root cause of failure to achieve good condition management – significant pain, for instance, gets in the way of effective diabetes management. When a person has more than one condition, addressing the common root cause may lead to improvement across conditions.

As noted above, interventions similar to ‘self-management support’ can be helpful. Simple interventions can apply across multiple conditions. The Ahles study addressed chronic pain in primary care practices, providing ‘problem solving support’ via telephone and achieved improvement up to the 24 month follow up date.<sup>vii</sup> Because the intervention addresses the root cause of behavior change, it can be applied to bothersome emotions, medication adherence, low health confidence, smoking cessation, etc.

As with any self-management intervention, it is good to start by asking the person if this is something on which they would like to work. If the answer is “no,” then action planning, problem solving and the rest are not likely to be helpful. Better to work on readiness-to-change interventions.<sup>viii</sup>



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## Medication problems

Three questions may trigger the “medication problems” in this section.

1. How often do you have trouble taking medicines the way you have been told to take them?
2. How many different prescription medications are you currently taking more than three days a week?
3. Do you think that any of your pills are making you sick?

Follow up questions are meant to find out more about their challenges without placing blame. Number two (above) is triggered if the person is taking more than five (5) regular medicines and the response is meant to stimulate a review of medicines.

## Health confidence

Health confidence is the final step before effective management. A person who is confident is likely to have received good information about their condition(s), have adequate finances, and not have dramatic problems with pain or emotions. Good health confidence (a health confidence score of 8 out of 10 or above) means there is likely a good plan in place and outcomes will follow.<sup>ix</sup>

The health confidence section of the assessment is designed to help people with low confidence think about and begin to take the next steps.

## Unable to purchase essentials

People unable to purchase essentials face such daunting hurdles every day that issues with their health – even when severe – may be secondary. Those who report inability to purchase essentials and also report problems with health confidence, pain, emotions and medications have dramatically greater chances of ending up in the hospital or emergency department. Once aware of this, we can ask how our treatment plans fit within their reality and adjust accordingly. Some may not engage with treatment plans because they are facing other challenges. In addition to connecting this person with social workers, it is essential to check with the person to see if the treatment plan has any chance of working.

## Chronic diseases

In many cases you’ll already be aware of this person’s chronic conditions. The point of asking here is in the follow-up questions:

- In the past year have you been in a hospital overnight or visited an emergency department for these problems?
- In general, how would you rate the information given to you about these problem(s) by your doctor or a nurse?

People who answer ‘yes’ to the first question are much more likely to end up in the hospital or ED again and might benefit from more intense oversight. People who do not recall good information are less likely to achieve good condition management and are likely to benefit from iterative tailoring of information support. In one study the key to knowing that the information support was effective was when the person reported good confidence.<sup>x</sup>

## “Other needs” section

As time permits, the practice can ask the patient if any issues flagged in Other Needs are something the person would like to work on now. “You responded that you have difficulty with social activities. Is that something you’d like us to work on together?” Problem-solving support is a useful technique for many of the issues. Here is a link to a simple resource people can use themselves or with a clinician:

- <http://howyourhealth.com/pblmslv/>



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## Frequently Asked Questions

### ***“The assessment takes too long.”***

It takes the average person 10-15 minutes to complete this assessment. It is best done by the person prior to coming to the office. While it can be completed in the office, this adds to staff time. Extensive experience leads us to recommend working to your utmost potential to engage people in use of computers and internet prior to the office visit.

The benefit to people from unmasking and addressing multiple determinants of their health is immense – arguably as beneficial as (if not more than) a colonoscopy.<sup>xi</sup> We are comfortable asking people to undergo a very uncomfortable prep over several days and an appointment that takes up at least half a day. Our patients benefit when we gain this level of comfort asking them to complete an assessment with so much potential to help.

### ***“My patients don’t have internet access or computers.”***

There are some people who cannot/will not use computers or who have a language barrier we cannot surmount at this time. We cannot expect all people to complete the assessment. But diligent effort can support computer access and use in many cases. Dr. Regina Benjamin (past US Surgeon General) had an overwhelming majority of her practice population complete the full HYH survey – in rural Alabama.<sup>xii</sup> She and her staff worked to get people to use computers of friends or the library.

### ***“Can we use an iPad or kiosk in the office to administer 3M AssessMyHealth?”***

Yes, this has been done well by some practices, though it does increase demands on staff (find the iPad, set up the Kiosk, explain how to use the device, etc.).

### ***“Can we call people and administer the assessment by phone?”***

Yes, though it places significant demands on staff time and may cause some people to answer questions differently than if they had done it themselves online.

### ***“Can high confidence be a bad thing – when someone says they’re confident but they’re incompetent?”***

This could happen, and you’ll know because you’re tracking condition variables and other indicators (e.g. blood pressure, HbA1c, etc.). But for the overwhelming majority of people high health confidence goes hand-in-hand with good outcomes. It is a very useful marker of ‘patient activation’ and ‘patient engagement.’<sup>xiii,xiv,xv</sup>

### ***“We already ask these questions. We already know the answers.”***

Some practices may already use tools like this, but most practices do not ask about these issues in a systematic and routine manner. We think we ask and we think we know, but in too many cases we do not.<sup>xvi</sup> There are questions in the assessment the answers to which you are likely aware – most practices are aware of their patients’ diabetes or asthma. The reason we ask in 3M AssessMyHealth is to elicit additional information around the person’s understanding and consequences of their condition(s). This provides clinicians with more insight into why a person with a condition may not be achieving desired outcomes as well as which people are at greater risk.

### ***“Some responses raise issues we are not prepared to address”***

The basic issue/need exists whether you ask or not. We are daily confronted by patient needs that are beyond our capacity to address. Every clinician and every practice has already developed ways to address this problem. The information from these assessments provide data that can support decision making.

By asking you are able to build a better understanding of unmet needs in the population you serve, and can help make the case for resources to address those needs. You have specific information on issues beyond your practice’s ability to address that have impact on patient outcomes. And ideally, this information can make it easier to prioritize the work of engaging with external resources or developing new internal resources that meet your patient’s needs.



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## **“What is the reading level of the *HowYourHealth* assessment, upon which 3M *AssessMyHealth* is based?”**

### Reading Ease

A higher score indicates easier readability; scores usually range between 0 and 100.

#### Readability Formula Score

Flesch-Kincaid Reading Ease      69.6

### Grade Levels

A grade level (based on the USA education system) is equivalent to the number of years of education a person has had. A score of around 10-12 is roughly the reading level on completion of high school. Text to be read by the general public should aim for a grade level of around 8.

#### Readability Formula Grade

Flesch-Kincaid Grade Level      7.2  
Gunning-Fog Score              10.2  
Coleman-Liau Index              10.1  
SMOG Index                      7.5  
Automated Readability Index    6.6  
**Average Grade Level            8.3**

1. Our earliest observations in inner city Philadelphia and Baltimore. In those settings we translated HYH into Spanish and had the kiosks read the questions to patients in their native language. This showed us:

- a) The best way to determine if wording was “simple enough” was to translate into a second language (and back) to eliminate jargon and complexity of sentence structure. In other words it is not the highbrow nature of a word that matters but its context that matters more. HYH is a result of that translations effort.
- b) Despite their education level some patients need help completing HYH because of infirmity (e.g. poor vision) or functional illiteracy regardless of educational level. Therefore, we focus on HYH as a SERVICE and not just a SURVEY so that patients will have an incentive to seek out family or friends to help them get the most out of it. We also simplify layout (e.g. lots of white space, no distracting ads or pictures).
- c) Serving patients depends on much more than asking questions and printing out low reading level information. Therefore, HYH provides outputs for clinicians and patients in several different formats. We are continuously testing and upgrading these formats as widespread technology allows and users provide feedback.

2. In summary, the question about reading level is somewhat anachronistic. The much more important question is how will HYH be built into practice flow so that it offers the greatest probability to serve all our patients? Patients will always interact with clinicians who will use words that are not part of everyday parlance. Circumlocution and simplification very often are impractical solutions for the more complex set of issues such as format, interactivity, jargon, “reaching” etc. A Flesch-Kincaid score just does not help with the issues that relate to serving patients.

3. Of the current HYH users who are poor about 5% have a high school education or less and 2% a grade school education or less. (1% of the non-poor have a high school education or less).

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<sup>i</sup> <https://howyourhealth.com/static/html/whereWhy.html>

<sup>ii</sup> R G Evans and G L Stoddart, “Producing Health, Consuming Health Care,” *Social Science & Medicine* (1982) 31, no. 12 (1990): 1347–63.

<sup>iii</sup> <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

<sup>iv</sup> [http://improvingchroniccare.org/index.php?p=Self-Management\\_Support&s=22](http://improvingchroniccare.org/index.php?p=Self-Management_Support&s=22)

<sup>v</sup> <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/index.html>

<sup>vi</sup> Wasson, John H. private communication May 2015 paper to be submitted for publication

<sup>vii</sup> Ahles et al., “A Controlled Trial of Methods for Managing Pain in Primary Care Patients with or without Co-Occurring Psychosocial Problems.”

<sup>viii</sup> G. L. Zimmerman, C. G. Olsen, and M. F. Bosworth, “A ‘Stages of Change’ Approach to Helping Patients Change Behavior,” *American Family Physician* 61, no. 5 (March 1, 2000): 1409–16.



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<sup>ix</sup> John H Wasson et al., “Clinical Microsystems, Part 2. Learning from Micro Practices about Providing Patients the Care They Want and Need,” *Joint Commission Journal on Quality and Patient Safety / Joint Commission Resources* 34, no. 8 (August 2008): 445–52.

<sup>x</sup> Ibid.

<sup>xi</sup> Tim A Ahles et al., “A Controlled Trial of Methods for Managing Pain in Primary Care Patients with or without Co-Occurring Psychosocial Problems,” *Annals of Family Medicine* 4, no. 4 (August 2006): 341–50, doi:10.1370/afm.527.

<sup>xii</sup> John H Wasson et al., “Patients Use the Internet to Enter the Medical Home,” *The Journal of Ambulatory Care Management* 34, no. 1 (March 2011): 38–46, doi:10.1097/JAC.0b013e3181fff641.

<sup>xiii</sup> Jessica Greene et al., “When Patient Activation Levels Change, Health Outcomes And Costs Change, Too,” *Health Affairs* 34, no. 3 (March 1, 2015): 431–37, doi:10.1377/hlthaff.2014.0452.

<sup>xiv</sup> Judith H. Hibbard et al., “Taking the Long View How Well Do Patient Activation Scores Predict Outcomes Four Years Later?,” *Medical Care Research and Review* 72, no. 3 (June 1, 2015): 324–37, doi:10.1177/1077558715573871.

<sup>xv</sup> Judith H. Hibbard, Jessica Greene, and Valerie Overton, “Patients With Lower Activation Associated With Higher Costs; Delivery Systems Should Know Their Patients’ ‘Scores,’” *Health Affairs* 32, no. 2 (February 1, 2013): 216–22, doi:10.1377/hlthaff.2012.1064.

<sup>xvi</sup> M. B. Hamel E S Magari and John H. Wasson, “An Easy Way to Measure Quality of Physician-Patient Interactions,” *The Journal of Ambulatory Care Management* 21, no. 3 (1998): 27–33, doi:10.1097/00004479-199807000-00006.



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