

Identifying Health Priorities

Manual for Guided Priorities Identification

(for all settings)

IDENTIFY HEALTH PRIORITIES

- Values (What Matters most to the patient)
- Actionable, specific, realistic health outcome goals
- Health care preferences (which care the patient finds helpful and which burdensome) and any tradeoffs
- “One Thing” - the health problem (burdensome symptom, health care task, or medication) the patient most wants to address to help them achieve their health goal.

ALIGN CARE WITH HEALTH PRIORITIES

Consider if current and potential care is:

- Consistent with health outcome goals including patient’s “One Thing”?
- Consistent with care preferences?

Use the patient’s priorities:

- As the focus for communication with the patient
- As the goal for serial trials to start, stop or continue interventions
- To prioritize care decisions, especially where differing perspectives exist

This guide covers the Identify Health Priorities step of the Patient Priorities Care approach.

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Welcome to ‘My Health Priorities’

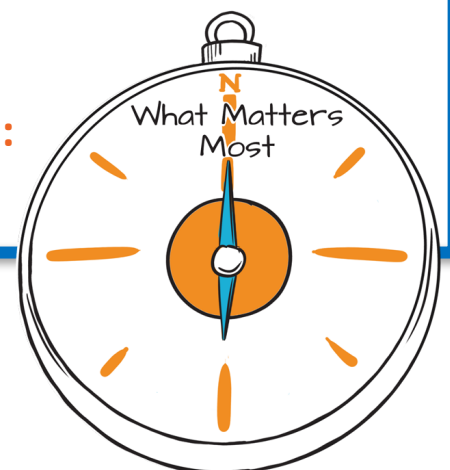
What is Patient Priorities Care (PPC)? PPC is an approach to care that helps patients, their care partners, and clinicians focus care decisions on what matters most: patients’ own health priorities. There are two core steps to PPC: 1) Identify Health Priorities; and 2) Align Care with Health Priorities. This guide focuses on the first step.

The goal of PPC facilitation is to identify patients’ health priorities, the health goals that a patient most wants, and the healthcare that they're willing and able to do to achieve those goals. This provides their clinicians with information to align health care with patients’ health goals and care preferences.

Using the Patient Workbook or [MyHeathPriorities](https://myheathpriorities.org) website and this guide, you will walk the patient through a 5-step process. As you proceed, answers from each step are recorded and will become an individualized Health Priorities Summary that can be used by clinicians in communicating and decision making.

NOTE: These instructions and guides assume you have completed training in Health Priorities Identification and understand the concepts and purpose of PPC. This is a supplement, rather than a substitute, for training.

If you have not completed training, **access it here:**
<https://patientprioritiescare.org/training/>



Important Definitions

Care Preferences: Health care tasks, medications, procedures, and health care visits patients are willing (or unwilling) and able (or unable) to do.

Facilitator: Any member of the patient's care team who has good interview skills and is trained in health priorities identification can do it.

Health Goals: Specific, realistic, and actionable activities the patient wants to do that their health care can help them achieve.

Health Priorities: The health and life goals patients most desire within the context of their care preferences.

My Health Priorities Summary: This is where the patient's answers to the questions in each step of the health priorities identification are filled in. The patient, care partner or facilitator (you) fills in the summary throughout the discussion. Copies available at the end of the Patient Workbook or online at patientprioritiescare.org/patient-facing-materials/.

The One Thing: Health problem (burdensome symptom, health care task or medication) the patient finds most burdensome and most wants to address to help them achieve their health goal.

Tradeoffs: The concept of **tradeoffs** may come up. Tradeoffs occur when a patient needs to balance the benefits and burdens of care; a desired outcome with what they are willing and able to do. Tradeoffs are the **difficult choices that patients must make** about which treatments are worth the discomfort or burden because they help reach their goals.

For example, a treatment may help with a goal, but require effort or create additional symptoms. Make notes when discussing tradeoffs; these will be helpful to their health care team to **help them navigate care choices**.

Values: What matters most in a patient's life and health; what gives life meaning, purpose, joy, or satisfaction. Values tend to remain stable, even with life and health changes.

Note: These concepts are further explained throughout this guide.

How to do Priorities Identification

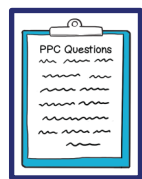
The Health Priorities Identification process can be completed in several ways:

1. **Self-directed:** a patient (with or without a care partner) uses online or paper materials to create a Health Priorities Summary.
2. **Facilitated:** a patient works with a member of the healthcare team, like you, to complete a Health Priorities Summary.

Modes of Priorities Identification. Your facilitator training materials and this guide apply to both methods.



Website method: [MyHealthPriorities.org](https://myhealthpriorities.org) is an online version where information is typed in or selected from checklists, and a Health Priorities Summary automatically populates at the end. Instructions will walk you through the steps.



Patient Workbook: A printed/PDF version called “My Health Priorities: A Guide for Older Adults and Care Partners” is used. The workbook can be used across multiple patients. Each patient uses a blank one-page Health Priorities Summary to record their responses.

You can find copies of the workbook or print additional summary sheets on <https://patientprioritiescare.org/patient-facing-materials/>. Make sure to have a copy with you during the Health Priorities Identification session.

You may need to revisit the patient’s Health Priorities as their life and health change.



General Overview

This is meant to be used as a **reference guide** for facilitators using either the My Health Priorities website or the paper Patient Workbook. Many facilitators find they reference this for help as they begin facilitating and decrease their use as they become more comfortable with the PPC facilitation process. **Rather than a step-by-step instruction guide or script to read from, it is meant to provide additional information, suggestions, and troubleshooting.**

This guide includes: 1) The purpose and tasks for each PPC step; 2) Results of each PPC step; 3) Additional information on concepts related to each PPC step; 4) Tips, prompts, and helpful language to consider.

Facilitation Logistics:

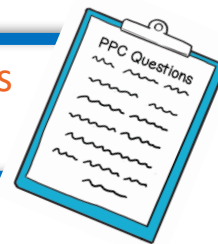
- Helping patients identify their health priorities can **occur in the clinic, at an in-home visit, or via telehealth.**
- These sessions are **never completely linear.** You may need to circle back or jump ahead as a patient brings up an important issue. Sometimes patients may go off topic; listen briefly and sympathetically and then **redirect** them back to the topics at hand.
- In a single patient visit, you may complete a single PPC step or multiple steps. This will depend both on the needs of the patient and on your experience as a facilitator. **Timing** of completing the steps, resulting in a Summary, should take about 20-30 minutes.

Note: Patient instructions and sample patient (Mr. K) examples for each step are **not duplicated here.** Please use the patient-facing materials (website or Patient Workbook) to reference these specific directions. For more about the **Mr. K** examples, see page 11.

Suggested language to use with patients is italicized and presented in blue. Although helpful prompts and questions are provided at times, feel free to use whatever language is most natural and understandable.

Best Practices for Facilitators

Note: It may be helpful to take notes along the way; a note sheet is available at the back of this guide.



The health priorities identification process can include both the patient and care partner/family members who are important to the patient.

These are best practices for facilitation sessions:

1. **Active listening** is an important skill to ensure you help patients identify their own values, goals and care preferences. Use non-verbal cues like nodding to show your interest and verbal cues like summarizing to show you understand the patient.
2. At each step, **validate** what the patient tells you by conveying a non-judgmental attitude and recognizing the validity of what they are saying.
3. The patient's **voice and body language** may show you what is most important and meaningful; you can follow up by asking more about how they feel about their health and healthcare.
4. It is common for a patient to provide information early on about areas you will ask about later. For example, when you ask about what matters most (Step 1), they may focus on their bothersome health problems (Step 3) and treatments they are pursuing for these (Step 4). Listen intently and make note of these. Later (in Steps 3 and 4), **you can start with the information you already know and expand if needed.**

Best Practices for Facilitators Con't

5. Sometimes patients will be confused about what we are asking. They likely have never been asked to identify values, goals, or care preferences in this way before. You may refer to the Mr. K example from the Patient Workbook or the [MyHealthPriorities.org](https://myhealthpriorities.org) website.

6. Remind patients there are **no right or wrong answers** and they can feel free to be honest with you. This is about the healthcare *they* want, not what their clinicians want.

7. When care partners are present, always **emphasize the patient** during your interactions. If needed, gently ask a care partner to please pause to allow the patient a chance to speak, reassuring them that they will also have the chance to contribute. (There will occasionally be patients who defer to their care partner, and you can ask the patient if that is how they make health decisions. If this is the case, verify that they agree with the care partner's responses.)

8. Your role as a facilitator is to **stay objective** and respect the priorities of the patient. There may be times that patients might want something you disagree with or think is the wrong direction for them, but your role as a facilitator is to help each patient achieve their goals and live according to their values to the degree possible.

9. Patients won't be familiar with terms like values, health goals, preferences, and health priorities. Explain these terms and make sure the patient understands what you are referring to.

For more tips, visit: <https://patientprioritiescare.org/implementation-toolkit/>

Introducing Patient Priorities Care

It is important to **welcome the patient** and make sure they understand the purpose of identifying health priorities. When introducing PPC, **emphasize that the health care team wants to know what matters most to them and align care around their priorities**, and that they are also an important part of the team.

Make sure the patient understands that you are part of their healthcare team, will be communicating with their doctors, Provide a **brief overview** of the 5 steps (refer to the visual overview in the patient’s materials). Give the patient **time to ask questions** before beginning.

Sample introduction: *“I work with [patient’s clinician], and they want to know more about what matters most to you so they can help you make the best choices about your care. We’ll go through 5 steps together and begin with discussing what matters to you in life and health. This will help us select a specific health goal that you want your health care to help you achieve. We’ll record your thoughts as we go, which will give us a Health Priorities Summary at the end you can share with your care team. Do you have any questions before we get started?”*

Tip: If the patient asks, “Doesn’t my doctor already know all this?” You can respond: *“The more you and your health care team know about what matters most to you, the better you can work together to line up your health care decisions with your Health Priorities”.*

Tip: If you are the PCP with an established relationship with the patient, you can say: *“We’ve worked together for a while, and I feel that I know a lot about you and what matters to you. However, I know there may be aspects of your life that are very important to you that we haven’t discussed before. We know over time people may have different goals for their health and vary in what they are willing and able to do for their health conditions. Knowing your priorities for your health can help me make sure your healthcare helps you do what matters most to you. I would like to talk about that in more detail today.*

Introducing Mr. K



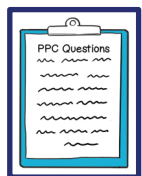
The **Mr. K example** will be used throughout. Orient patients to the character and the intended use. Remind them that Mr. K's answers are simply examples to help illustrate the concepts—their own answers may be much different because this is unique to each person's life. It is not necessary to use his examples, but they can **help bring PPC concepts to life**.

Note: The Mr. K example may be confusing to patients with cognitive impairment. Avoid these examples if the patient seems confused by them.

The 'Mr. K examples' differ between the website and the Patient Workbook.



Website: Mr. K is introduced before Step 1. Click on the Mr. K image on the top left part of the screen (above the Navigation Menu) to see his examples. You are not required to view these in order to progress through the website.



Patient Workbook: Mr. K is introduced later, during Step 1, on page 9. His examples are integrated with the content to help illustrate concepts and directions. They appear during each step, typically right before the patient completes their answers. Mr. K's completed Health Priorities Summary is at the end of the Patient Workbook as a sample.



“Mr. K is an example of another patient who went through this process. Remember that what matters is different for everyone; everyone has their own health priorities and there are no right or wrong answers.”

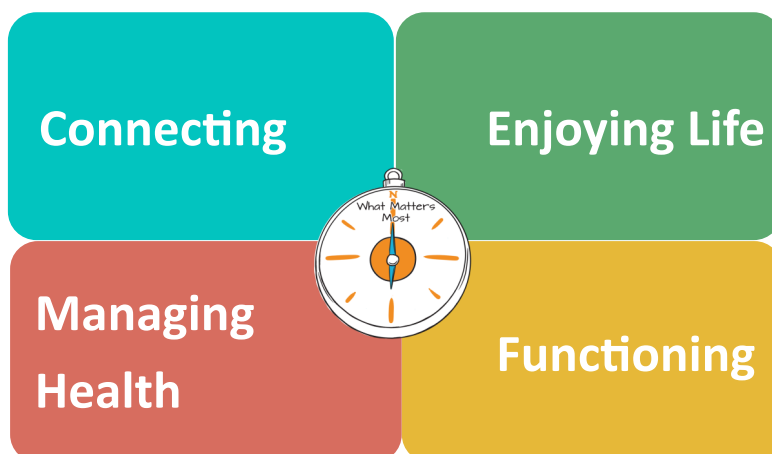
Introducing Step 1: Identify What Matters Most

In **Step 1**, you will help the patient identify what matters most to them, which we call **values**.

Values tend to remain stable, even with life and health changes, and will directly lead to the patient's goals and health care preferences. The goal here is to **understand what matters most to a patient** within the context of their life and health. Clarifying values early on is important for the PPC steps that follow.

When introducing this concept, it's important to know that the word **"values"** can be difficult to understand and can mean different things to different people. Instead of using this term, try saying: *"what matters most to you"* or *"what's most important to you in life and health."*

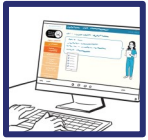
In general, there are four broad domains of values that are most relevant to older patients. Using the Patient Workbook, show the image of these four domains and provide a few examples from the materials. *"First, we're going to talk about what matters most to you in life, and what you want your healthcare to be able to help you do. What matters most differs for each person, but tends to fall in the 4 overall categories that you see here: Connecting, Enjoying Life, Managing Health, and Functioning."*



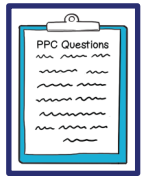
Overview of Step 1:

Identify What Matters Most

➔ **At the end of Step 1**, the patient will have identified one thing that matters most to them:



Website: You will have a list of pre-populated valued activities to select from. First, the patient identifies up to four valued activities. As much as possible, use the “Other” selection to write in patient-specific details about what matters most. Then, from this list, the patient will select which one of these four to focus on first.



Patient Workbook: You or the patient will write two examples of what matters most onto the written Health Priorities Summary. Then, the patient will select which one of these two to focus on first.

There are various ways to ask about what matters most to a patient. It helps to have a handful of open-ended questions to ask about this in different ways. As you become more comfortable with facilitating, you will find which questions work best and you will likely use fewer examples.

It's typically best to start with more open-ended questions, moving on to more specific questions as needed:

- *“What comes to mind when I ask, ‘What matters most to you?’”*
- *“What would you be doing if you were having a good day? “*
- *“What gives your life meaning, purpose, joy, or satisfaction in these four areas?”*
- *“Which activities do you find most important or fulfilling?”*
- *“What things would you like to spend more time doing?”*
- *“What would you most like your health care team to support you with?”*

Tips for Step 1:

Questions Linked to Important Life Areas

These **optional** questions can help direct you and the patient to what matters most.

| DOMAINS | QUESTIONS |
|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Connecting | <ul style="list-style-type: none"> • Which relationships or connections are most important to you right now? • Who are the most important people in your life? • How often do you get to see them? • What kinds of things do you do together? |
| Enjoying Life | <ul style="list-style-type: none"> • Which activities do you do that you find so important and enjoyable that you can't imagine living without them? • What brings you the most enjoyment, pleasure, or comfort? (if the patient says "Nothing right now," ask, "In the past year or so, what was the thing that gave you the most enjoyment or pleasure"?) • What could you do before that you would like to do now? • What do you do now that you'd like to keep doing? |
| Functioning | <ul style="list-style-type: none"> • When taking care of yourself, what is most important to you right now? • What does a good day look like and what does a bad day look like? • When it is a good day, what goes right? • What kinds of things are you able to do/not able to do? • How do you feel about asking for or accepting help? |
| Managing Health | <ul style="list-style-type: none"> • What do you hope your healthcare can do for you? • In what ways do your health conditions and treatments limit your ability to do what matters to you? • What is more important to you: comfort and function, or living longer? |

Tips for Step 1:

Identifying What Matters Most

1. If you feel the patient is telling you what they think you or others (such as a clinician or family member) want to hear, **stress that there are no right or wrong answers**. *“I want to make sure I understand what matters to you, not what others (like your loved ones or health care team) think you should care about. There are no right or wrong answers to these questions.”*
2. If the patient is **having difficulty stating what matters most** but instead can discuss an activity that they enjoy doing, you can note this and explore it later as a possible goal linked to one of the value domains.
3. Sometimes patients delve immediately into their bothersome symptoms, health problems, or burdensome health care tasks or medications. Pay attention and listen empathetically. You can learn much about their care preferences from what they describe, so **note this information for later steps** (steps 3-5).

Then, **gently redirect the discussion** to focus on values. You can do this by asking the patient how the symptom or problem is interfering with living a life that's meaningful to the patient.

- *“What would you be doing more of if you didn't have to do (burdensome care task) or didn't have (bothersome symptom or problem)?”*
- *“In what ways do your health conditions and treatments limit your ability to do what matters most to you?”*
- *“What is (bothersome symptom or problem) getting in the way of?”*

4. Observing patients' **non-verbal cues** can help indicate when you've struck upon a valued area.

Introducing Step 2:

Set a Health Goal

In **Step 2**, you will help the patient translate **what matters most** (from **Step 1**) into a *specific, realistic*, and actionable **health goal**.

Health goals are the ways that people put their values into action and are activities the patient wants to do that their health care can help them achieve. A health goal helps clinicians act on and measure what matters most to the patient, by designing healthcare that aligns with the patient's goals. These could be things the patient is currently doing—and wants to do more of or maintain—but could also be something they want to do soon.

For example, a value of *family* might lead to a goal of being mobile enough to attend family outings. A value of *spirituality* might lead to a goal of managing fatigue to attend church.

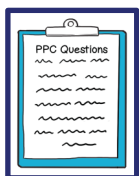


As you introduce the concept of a health goal, it's important to reinforce that goals need to be linked to what matters most. The goal should also be *specific* and *realistic* within the context of the patient's life and health.

➔ **At the end of Step 2**, the patient will have one health goal:



Website: What matters most from **Step 1** will populate next to the space for a related health goal. You will be prompted to ask the patient to rate how realistic the goal is. This is a good gauge for whether you can move on or need to work further on the goal.



Patient Workbook: There is no formal rating of a goal being realistic. However, as a facilitator, it is important that you assess the realistic potential of the goal before proceeding. The Summary has space to write a revised goal.

Overview of Step 2:

Set a Health Goal

You will ask the patient to identify activities that they already do or would like to be able to do, to live out their value. *“In Step 1, you chose (insert patient’s answer) as what matters most to you right now. Next, we are going to think about what activities you want to do that reflect this area that matters most. We will make a health goal based on this.*

First, we need to understand what we mean by a health goal, and what a good health goal looks like. A health goal can be something you want to keep doing or something you would like to be able to do more of. For example: ‘Be able to walk enough so I can go to family outings’.

Health goals are activities that reflect what matters most to us. It’s important for a goal to be realistic and specific so your health care team can work with you on making sure your healthcare is focused on achieving that goal. And it’s OK if these goals change over time—we will be flexible as your health changes.

What activities do you already do or would like to do in the future that reflect (restate value patient identified)?”

.....

A goal may start as a general idea, but after discussion it should be a **specific** activity that is **realistic** and actionable with attainable improvement in life and health.

To define the terms specific and realistic as applied to health goals, the Patient Workbook has an overview of these concepts, followed by **Mr. K’s** example. Reviewing **Mr. K’s** example is particularly important here to help demonstrate how an unrealistic goal can be adapted.

If needed, the sections covering **specific** and **realistic** health goals can be revisited. There is extra space on the Summary to write in a revised goal.

Tips for Step 2:

Set a Health Goal

1. It's important to assess a patient's **current level of engagement** in a values-based goal. *“Your goals for the future may involve continuing to do what you currently do or may involve expanding what you are able to do. What do you already do that you’d like to keep doing in the future or do more of? What don’t you do now but would like to start doing?”*

2. You may have an idea of a patient's goal based on what's already been discussed. If so, ask **follow-up questions** to gauge their current engagement in this activity and any possible changes. *“You told me that going to church is most important to you. How often do you do this now? Does this feel doable? Would you like to keep doing this, or change how often you attend?”*

3. If a patient has difficulty articulating a goal, go back to what mattered most. *“You told me that your relationship with your grandchildren is important to you. What kinds of activities do you do together that are meaningful to you or that you would like to be able to do together?”*

4. Many patients have declines and losses in what they are able to do. **Allowing a person to feel and express grief** about this can be important. Make sure they feel heard and validated.

5. You should ensure that a goal is: 1) linked to what matters most (from Step 1); 2) **specific**; 3) **realistic**; and 4) actionable (meaning health care interventions or community/support services can help achieve the goal) within the context of the patient’s life and health. A health goal must be something the patient’s clinicians can act upon.

If a goal doesn’t meet this criteria, it must be revised before proceeding.

6. Health goals can be **updated** over time as health and life circumstances change.



Tips for Step 2: Supporting Specific Goals

Is the Health Goal Specific and Realistic?

| Goal | Specific? | Realistic? |
|----------------------------------------------------------------------------------|-----------|------------|
| I want to be healthier. | ✗ | ✓ |
| Starting this week, I'll watch my grandchildren after school 2-3 times per week. | ✓ | ✓ |
| I will start jogging a mile every day before breakfast. | ✓ | ✗ |

SPECIFIC:

1. To help get **specific and clarify** exactly what the patient wants to be doing, you may need to probe further. *“What would you do specifically? What would be the first step to make that happen?”*
2. Something that is specific should be able to be **clearly observed and measured**. You should be able to know exactly what the patient wants to do, and how, and know how to tell if this has been completed. If it is not observable or quantifiable, it is likely not specific enough. *“Exactly what do you want to do; what does it require to do this activity?”* or *“What are you going to do, when, where, with whom, how often, and for how long?”*
3. If the patient’s goal is **focused on avoiding a feeling**, condition, or state (e.g., *“I don’t want to feel tired”*), encourage the patient to think of an activity they would do if the symptom of feeling resolved or improved. *“What would you do more of if you weren’t so tired?”*
4. The **effects of health** on the patient’s ability to achieve their goal can provide valuable information about bothersome health priorities and tradeoffs that will be used in later steps. *“How does your health get in the way of... (insert goal)?”*

Tips for Step 2:

Supporting Realistic Goals

REALISTIC

1. To determine if a **goal is realistic**, review if the patient is able to do it currently, or could in the future with intervention or support. *“When was the last time you were able to do this activity? How **doable** does this feel if your health could be improved or you had access to useful treatments or services?”*

2. If you and the patient determine that a **goal is unrealistic**, it helps to understand the underlying value. Find out why they want to do this—what value underlies the goal? Then, you can collaborate on more realistic options that still allow them to live out that underlying value. *“As time has gone by, you have had a number of changes in your health and seem to be in a different place now. Let’s think about other ways we can help you feel engaged in your community.”*




3. Another way to revisit an unrealistic goal is to break it down into something **more manageable**: *“It seems that something about this is a bit much right now. Maybe we need to work our way up to that—what do you think is a good place to start?”*

4. An unrealistic goal may follow a notable **change in life or health**. It can be hard to accept that goals that may have been realistic in the past are no longer realistic. Try to guide the patient through this realization.

Introducing Step 3:

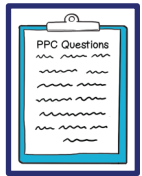
Health Symptoms and Problems

In **Step 3** you will learn about which **symptoms or health problems** are most bothersome to the patient, either because the symptoms/health issues are burdensome themselves or because they interfere with the patient's ability to do what matters to them.

 **At the end of Step 3,** the patient will have identified up to two of their most bothersome problems or symptoms:



Website: You will have a list of pre-populated health symptoms or problems to select two from. Additionally, an “Other” option is available to write in patient-specific details.



Patient Workbook: You or the patient will write two of their most bothersome symptoms and problems on their Health Priorities Summary.

This step only requires that the most bothersome problem or symptom be identified and doesn't require written explanation of why it is bothersome or interferes with the goal. However, making note of these details can be important for bringing things together at the end.

The MyHealthPriorities website and Patient Workbook have several examples of bothersome problems or symptoms that you can provide. Also, by this point a patient may have already shared their problem with you. If so, you can build on that. *“Earlier, you mentioned that (patient-specific symptom/problem) is bothersome to you. Is that your most bothersome problem, or are there other symptoms or health problems that interfere more with your goal of (patient-specific goal)”?*

Tips for Step 3:

Health Symptoms and Problems

1. First ask the patient about their **most bothersome symptoms or health problems** that impede their goal. *“So that your health care team can help you with your goal to (state patient’s health goal), we need to know which of your health symptoms or problems make it hardest for you to work on your goal”.*
2. **Rephrase as necessary.** Patients may not understand or relate to the word “bothersome.” You can use phrases like *“what worries you,” “what bothers you the most,”* or *“what feels difficult?”*
3. **Summarize to confirm** that these symptoms or health problems are particularly bothersome because they are interfering with the patient’s ability to work on their specific goal. *“Of all of your symptoms and health problems, it sounds like the ones that are the most bothersome and most interfere with your health goal to (reference patient-specific goal) are: (list patient-identified bothersome symptoms). Did I get that right?”*
4. The materials have a **limit of two** bothersome problems or symptoms. This is to **help focus things**, yet patients will often list several. Ensure that the patient feels that all of their bothersome problems or symptoms are heard. It can be helpful to take notes on these additional symptoms.
5. If a patient **needs more assistance** identifying bothersome symptoms or problems, you can prompt them by asking about their specific health conditions and the symptoms they experience. Be sure to ask about how a symptom or problem is particularly related to their goal. *“How does having (patient-specific symptom or problem) get in the way of your goal? Which symptoms make it hardest to do what matters to you?”*

Introducing Step 4:

Health Care Tasks and Medications

In **Step 4**, we will ask how the patient feels about their current healthcare tasks and medications. After identifying what they are doing as part of their health care, you will help them assess if these tasks are “**helpful**” or “**burdensome**.”

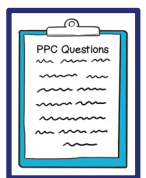
Health care tasks include: 1) self-care or at-home tasks, 2) tests, treatments, and procedures, 3) health care visits, and 4) community programs, services, and supports.

Finding out what is “**helpful**” and what is “**burdensome**” about their care gives concrete information to clinicians to align care to reflect the balance between the **health goal** the patient desires, and the tasks they are willing and able to do to achieve the goal. This balance is their **health priorities**.

➔ **At the end of Step 4**, you will have a list of helpful and burdensome health care tasks and medications with an explanation of what makes something burdensome:



Website: Examples from each category of health care task are separately reviewed for identification of the patient’s current health care tasks. Use “Other” to expand on patient-specific details. This first creates a personalized list of the patient’s health care tasks, then prompts selection of which are helpful and which are burdensome (up to two each). Then, medications are reviewed for which are helpful and burdensome (up to two each).



Patient Workbook: From a single, combined list of examples of health care tasks, encourage the patient to consider all of their current tasks across each of the 4 categories. The patient records up to two each of helpful tasks and medications and burdensome tasks and medications all at one time.

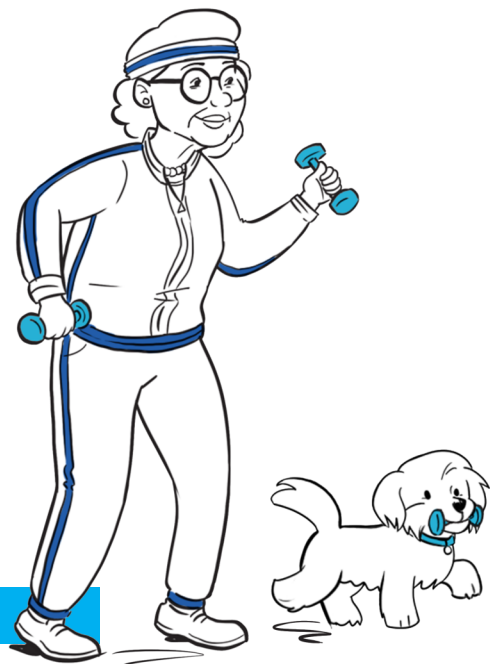
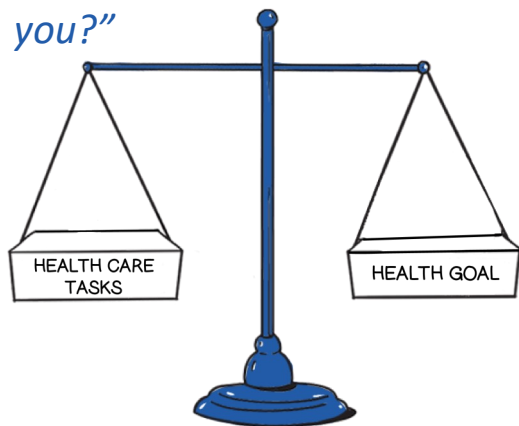
Overview of Step 4: Health Care Tasks and Medications

By this point, it is common that patients will have already shared some of the **tasks** they do for their health care and some of the **medications** they take. You will likely have heard examples of **helpful and burdensome** care already. Start with these to illustrate the concepts and expand from there. It is important to cover the range of types of health care tasks. Examples are provided in the materials.

- *“Now it will be time for you to tell me about the things you are doing for your health and functioning. These may include at-home tasks you do to care for yourself, doing treatments or procedures, going to health care visits, and allowing services to support you in your activities. This also includes the medications you take.”*

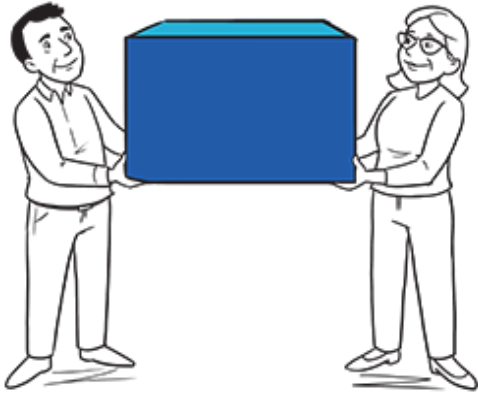
First, we will review all the things you are doing, and then discuss how you feel about these. Some of these activities and medications may be uncomfortable, burdensome, or interfere with your ability to do what matters. However, your health care team may not know how burdensome certain tasks or medications are. If they understand better, they can discuss the pros and cons and make treatment decisions with you.”

- *“What daily tasks do you do for your health conditions?”*
- *“What clinicians and health professionals do you visit regularly?”*
- *“What treatments, tests, or procedures have you done recently or would consider soon?”*
- *“What supports do you receive from community or in-home services to help you?”*



Overview of Step 4: Helpful and Burdensome Health Care Tasks and Medications

Helpful care is care or medications that are working well and are helping the patient meet their goal. It includes care and medications they are willing to keep doing. **For example:** A patient may be willing to take a diuretic even though it makes them urinate often because it makes them less short of breath, so they can do what matters.



- *“What do you think is working well with how your health conditions and diseases are managed?”*
- *“What about your health care do you find useful and helpful to you?”*
- *“Which parts of your health care are really helping?”*

Burdensome care is care or medications that are difficult, uncomfortable, time-consuming, or causes problems. Ask which tasks don't seem to help, are difficult or bothersome, they would like to stop or do less of, or cause problems that interfere with their goal. Look for concrete information about exactly what makes a task burdensome. When discussing burdensome medications, ask specifically about adverse side effects.

- *“Which of your tasks or medications are taking the most of your time? Does this feel worth it?”*
- *“What about your healthcare is too difficult or uncomfortable to do?”*
- *“Are there tasks you do or medications that you take for your health that that aren't helping, that you would like to stop doing or do less of?”*
- *“Is there anything in your healthcare that is making it difficult or not helping you meet your goals?”*



Tips for Step 4:

Health Care Tasks and Medications

1. To spur discussion, you may need to **ask specific questions**. *“Are you noticing any side effects from your treatment? How often do you have medical appointments?”*
2. **Assess** the patient’s perception of what’s working well for them in their health care and what does not feel worth the effort.
3. If a patient doesn't answer any of the questions to provide you with a bothersome care option, try asking questions that prompt the patient to think about **adverse outcomes**. *“When you see your doctor or health care provider next, what do you hope to discuss? What about your [health problem] do you worry about if there needs to be a change in treatment?”*
4. A patient may worry about being seen as **non-compliant**. You can alleviate this concern by acknowledging it. *“It’s OK to tell me what you really think. Your doctors and health care team want to know what matters most to you.”*
5. A patient may have agreed to treatments but not complied because they didn’t know how to tell their health care team that it was burdensome. This is an opportunity for them to have **input when discussing the care** they don’t think is worth it and refocus on what matters most.
6. When reviewing community supports, services, and supports, this is a good place to ask if **family members** are involved in their health care or daily life.
7. This is a good section to discuss **tradeoffs**—refer back to pg. 5. *“You mentioned some things that are bothersome and you may not want to keep doing. You may have to make hard choices about which treatments are worth the discomfort because they help you achieve your health goals; these are called tradeoffs. You should discuss these with your doctors and health care team.”*

Introducing Step 5: Choose The One Thing to Focus On

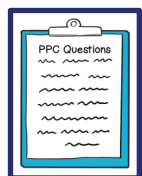
Step 5 will involve helping the patient select The One Thing they most want to focus on right now. This is the one bothersome symptom, health problem, or health task/medication that is most bothersome or most interferes with the patient's health goal and that they want to focus on first. **Reassure the patient that their clinicians will still address other problems, but this helps to prioritize what matters most.**

Note: This is similar to the “chief complaint” in the traditional medical history with more explicit connection to what matters most.

➔ **At the end of Step 5,** patients will select the one bothersome symptom, health problem, or health task/medication that most interferes with their health goal:



Website: The One Thing is selected from a pre-populated list of the patient's prior selections for bothersome symptom, problem, health care task, or medication.



Patient Workbook: You and the patient review relevant sections of their Health Priorities Summary (Steps 3 and 4) and write The One Thing and the health goal (from Step 2).

This is an important time to **review the patient's answers** in each area, to confirm their answers before selecting the One Thing. **State back your understanding** of the patient's:

- Health goal
- Most bothersome symptom or health problem impeding their goal
- Helpful care tasks: medications, self-care tasks, tests, and appointments
- Burdensome care tasks: medications, self-care tasks, tests, and appointments

Tips for Step 5:

Choose The One Thing to Focus On

1. When asking about the One Thing, always **link it with the patient's health goal**. *"Your most important health goal is [insert patient goal]. Of the bothersome symptoms, health problems, health tasks, and medications you mentioned, what One Thing do you most want to focus on so that you can do [insert patient goal] more often or more easily?"*

2. Reassure the patient that their **clinicians will still address other problems**, but choosing the One Thing helps prioritize what matters most. *"Prioritizing the One Thing will let your health care team know what you would like to start working on first. This doesn't mean they won't address other problems, it's just a way to get started on what matters most to you."*

3. It is important to make sure that the One Thing is selected **based on its interference with the patient's specific health goal**. That is, the reason to address this symptom or problem is because it is getting in the way of a meaningful goal. If not, revise the One Thing. If a patient has **difficulty choosing only one area**, reassure them that it is a starting point and that other problems will also be addressed. Some people may still select more than one problem. That is OK; list them all. *"It sounds like you have a lot of aspects of your health and health care that you find burdensome or bothersome. Your clinicians want to know about all of these.*

To help them get started, it's important that we really focus on which of these symptoms or health care tasks interfere most with what matters to you in daily life. Of the things you listed, which make it hardest for you to work on your goal to [insert patient's health goal]?"



Concluding Information: Supporting Health Priorities Facilitation

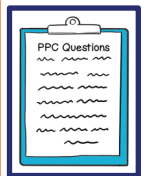
After the patient identifies The One Thing, **the Health Priorities Summary is complete**. Show this to the patient and review it.

You should also **encourage patients to bring their Health Priorities Summary to their next appointment**. Remind them that their clinicians want to know this information about them.



Website: Select “Review and print your summary” at the top left, above the Navigation Menu. You can print, save, or copy the report text.

Let the patient know whether this information will be transmitted to their clinicians through the electronic health record.



Patient workbook: It is highly encouraged to make copies of the completed Health Priorities Summary. In some settings, this could also be scanned for the patient’s medical record.

You may need to problem solve how to remember to bring this to their next appointment. For example, perhaps they could keep a copy with the appointment reminder card or take a picture with their phone so they have a digital copy.

Acknowledge that health priorities are **likely to change** and can be updated.

“Don't worry, I know that your priorities may change, and we can check in when they do. Knowing your priorities allows the healthcare team to continue to focus on helping you achieve your goals and do more of what matters to you.”

Note: Facilitators should follow their practice’s workflow to document the patients’ priorities.

Optional Content:

Tips for Communicating Health Priorities

In this optional section, invite the patient to review with you a final section about **tips for communicating their priorities to their health care team**. These Tips begin on pg. 28 of the Patient Workbook and can also be found on the concluding pages of the MyHealthPriorities Website.

If you run out of time, you can guide them to review the tips on their own. This helps **promote a partnership between the patient and their clinicians** by activating the patient to communicate their priorities to their clinicians.

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The patient may not think their clinician wants to know information about what matters most to them. Remind patients that **knowing what matters most helps their health care team recommend the care and treatments that are most focused on what they want from their health care**.

“Next, we are going to review some tips for how to communicate your health priorities when talking with your health care team, and how to be an active partner in making health care decisions. When you share your goals with your care team it also helps us to make sure that everyone on the same page regarding caring for your multiple conditions.”

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Many people **feel intimidated** to bring up their opinions or ask questions at medical appointments. They may not know they can discuss their health goals and care preferences with their clinicians. **It is important to encourage the patient to share all the things they’ve identified in this process with their health care team**. Additionally, you may ask extra questions to assess whether they have any difficulties speaking up or whether there are difficulties in patient-provider communication that could be addressed.

“Here are some tips for good communication with your health care team. Before we go through these, how comfortable do you feel talking openly with your team about your goals and preferences?”

Optional Content:

Tips for Communicating Health Priorities

The materials have some **example language** to use when **starting this conversation with clinicians**. Review these with the patient and encourage them to select a few that might apply. Patients can practice the wording with you, or do so later with a family member.

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Clinicians and teams respond to specific patient “asks and tells.” For example, **help your patients learn to phrase things** like: *“Since I want to be able to continue to go kayaking, will this medication cause dizziness?”*

These statements **emphasize the importance of linking the health goals to care preferences**, for example, *“The One Thing I want most to work on is (burdensome symptom, problem, or health care task) so I can (health goal).”*

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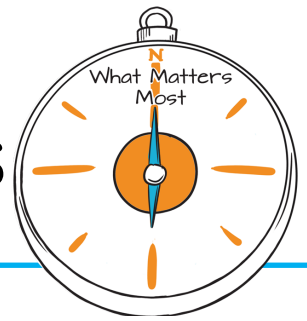
Some patients **need permission to discuss bothersome care**, including adverse effects of medications, multiple clinician visits, unwanted or unnecessary procedures, and how certain care recommendations can affect current functioning. You can help **provide that permission by reassuring the patient that their health care team wants to know these** to be able to work towards a mutually agreeable solution.

.....

Encourage the patient to be as direct and specific in statements as their comfort allows. Clinicians cannot act on subtleties. Through transparency, the patient-clinician partnership can be strengthened and space can be created for the patient to be candid with their health care team.

“Your health care team wants to be able to link your care with your health goals, and they can only do that if they know what parts of your health care may be bothersome or getting in the way of achieving your goals.”

Additional PPC Resources



Thank you for participating in the Patient Priorities Care process!

In addition to this guide and the resources from your facilitation training, the following resources are available:

PPC Website: PatientPrioritiesCare.org includes resources for facilitators, clinicians, and patients

Annotated Health Priorities Template: Gives quick tips on questions to ask the patient for each section of the template (or summary), found at patientprioritiescare.org/ongoing-preparation/

Online course: Module through the American College of Physicians called “Helping your patients identify their health priorities” available at patientprioritiescare.org/training/

My Health Priorities website: www.MyHealthPriorities.org

Decisional Guidance: <http://decisionguide.patientprioritiescare.org/>

VA-Specific Toolkit: <https://vappctools.patientprioritiescare.org/>

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Health Priorities Notes

Step 1: What Matters Most

Step 2: Health Goal

Step 3: Most Bothersome Symptoms or Health Problems

Notes, Pg. 2

Step 4: Current Health Care Tasks and Medications

Helpful

Burdensome

Step 5: The One Thing to Focus On

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