

## Million Hearts MRC Guide

### GUIDE FOR MRC VOLUNTEERS

#### PHONE CALL #1

##### Initial contact:

- Introduce self to patient, explain why you're calling and your role as a volunteer patient navigator/community health worker.
  - Example: "Hi Ms. Smith, my name is Amy and I'm a volunteer community health worker with the Richmond City Health District. We are calling to follow-up with all patients diagnosed with high blood pressure to offer support and to help you connect to the right community resources for your diagnosis. Would this be something you're interested in?"
- [Depending on how much patient information is available to be transmitted electronically], find out the patient's age, race, insurance/financial situation, neighborhood of residence, all diagnoses/comorbidities, and any existing medications.
  - Example: "Before we move on I need to ask you some basic questions to help me get a better picture. May I ask how old you are? What do you consider your race to be? Do you currently have health insurance? Do you have any other health issues, like diabetes, asthma, COPD, that you're being treated for? Do you take any medications for your health conditions/high blood pressure?"
- Determine the patient's understanding of his/her disease. If necessary, explain the basic principles of the disease and the importance of treatment compliance.
  - Example: "Since you've been diagnosed with hypertension/high blood pressure (use patient's language) has anyone explained what that means? Do you feel like you have a good understanding of the disease? Can I help to explain it if you don't feel like you understand?" Use manual to assist with explanation.
  - Example: "You said you take medication for your high blood pressure. Do you take it regularly?" If they don't, help patient understand why it's important to take regularly. Find out why they don't take medicine regularly and help to find a solution.
- Based on the patient's neighborhood, language, insurance, and comorbidities, consult the resource list to find provider(s) close to the patient. Give the patient the relevant information and encourage him/her to call and make an appointment if he/she has not already done so.
  - Example: "It's really important to see a doctor regularly when you have high blood pressure so that you can keep it under control. Do you have a primary care doctor that you see? If not, I'd like to help you find one."
- Make a plan with the patient to make an appointment within the next 2 days and follow-up.
  - Example: "Now that we've found a doctor for you to see it's going to be important to make an appointment soon so that you can be seen. Do you think its possible for you to call by \_\_\_\_\_ (2 days from now) to make the appointment? Great, I'll follow up with you on \_\_\_\_\_ (2-3 days from now) to make sure everything went well."
- If the patient has an appointment already scheduled, encourage him/her to go.
  - Example: "It's great to hear you already have an appointment. Would it be OK for me to call the day before to make sure you have everything ready?"

- Work with patient to create an action plan. Pick one area that they would like to work on to help lower their blood pressure. If they're not sure what to work on make suggestions like diet changes, smoking cessation, increasing physical activity, decreasing alcohol consumption, and medication management.
  - Example: "If you have a few more minutes, I'd like to work with you to create a plan of action to help lower your blood pressure. What is something you WANT to change (help them pick something \*S.M.A.R.T.)? What are some reasons you've never tried it before? What are some solutions to this problem? What are some barriers to keep you from being successful? On a scale of 1-10 with 1 being not confident at all and 10 being extremely confident, where do you think you would rate your confidence in achieving this goal? Do you think you can try it for 2 weeks?" If they don't think they could REALLY try it for 2 weeks help patient pick another more attainable goal.
  - Use "Action Plan: Hypertension Management" worksheet to assist.
- Wrap-up phone call. Ask if they have any other questions. Summarize your action items and what they agreed upon. Thank patient for their time.
  - Example: "Do you have any other questions for me? I will follow up with you in \_\_\_ days/before your appointment to see how things are going with (state goal). Thank you so much for your time today, Ms. Smith."
- DOCUMENT the encounter -- did the patient pick up the call? Did the patient seem responsive and agreeable to the relationship and interested in learning more about available resources? Did the patient indicate any barriers to receiving care? What was patients' agreed upon goal? When will you follow up?

\*S.M.A.R.T Goals:

A S.M.A.R.T. goal is defined as one that is specific, measurable, achievable, results-focused, and timely. Example SMART Goal: Instead of saying "Be more active" a SMART goal would be "I will walk for 30 minutes, 5 times per week for 2 weeks."

**Specific:** Specific is the What, Why, and How.

**Measurable:** Goals should be measurable so that you know that you have accomplished the goal.

**Achievable:** Goals should be achievable; they should stretch you slightly so you feel challenged, but defined well enough so that you can achieve them. No pie in the sky...be realistic.

**Result-focused:** Goals should measure outcomes, not activities.

**Timely:** Goals should be linked to a timeframe that creates a practical sense of urgency, or results in tension between the current reality and the vision of the goal. Without such tension, the goal is unlikely to produce a relevant outcome.

PHONE CALL #2

**Follow-up**

If patient had a previously scheduled doctor's appointment this call will serve as a reminder. This phone call should be made the day before the appointment. Otherwise, follow questions listed below:

- Find out if patient was able to make an appointment with the health care facility agreed upon.

- Example: “Hi, Ms. Smith. How are you? I’m following up to see how everything is going. Were you able to make an appointment at \_\_\_\_\_?”
- If they WEREN’T able to make an appointment find out why. What barriers kept them from completing this task? Encourage them to try again and emphasize the importance of seeing a doctor to control their high blood pressure. Try to find a solution to help the patient take this step.
- If they WERE able to make an appointment congratulate them on this first step into creating a healthy lifestyle.
  - Example: “I’m so glad to hear you were able to get an appointment on \_\_\_\_\_ (date). That’s fantastic!”
- Discuss important questions the patient should be asking his or her doctor at said appointment.
  - Use the “Preparing for Your Appointment” sheet as a guide.
- Follow-up on agreed upon S.M.A.R.T. goal. Has the patient been able to try it and stick with it? What has gone well? What has been a challenge? Encourage them to keep trying for the full 2-weeks. Use confidence ruler to gauge patients’ confidence today. Has it changed?
- Wrap-up phone call. Ask if they have any other questions. Summarize your action items and what they agreed upon. Thank patient for their time.
- Example: “Do you have any other questions for me? I will follow up with you in \_\_\_\_\_ days/after your appointment to see how things went with the doctor. Thank you so much for your time today, Ms. Smith.”
- DOCUMENT the encounter -- did the patient pick up the call? Did the patient seem responsive and agreeable to the relationship and interested in learning more about available resources? Did the patient indicate any barriers to receiving care? What was patients’ agreed upon goal? When will you follow up?

### PHONE CALL #3

#### **Follow up after appointment**

- Find how the patients’ appointment went.
  - Example: “Hi, Ms. Smith. How are you? I’m following up to see how everything went at your appointment on Tuesday?”
- If they did not attend their appointment find out why. What barriers did they encounter? Can you work through those barriers to reschedule? Encourage patient to reschedule; emphasize importance of going to the doctor for follow-up care.
- What did they learn from the doctor? What questions did they have answered? Do they understand everything the doctor said?
- Ask about any instructions the doctor gave. Make sure the patient understands all instructions.
- Were they prescribed medication? Do they understand how to take it, when to take it, and why it’s important? Emphasize that even if they start to feel better they still need to take the medication to keep their blood pressure under control.
- Follow-up on agreed upon S.M.A.R.T. goal. Has the patient been able to stick with it? What has gone well? What has been a challenge? Encourage them to keep trying for the full 2-weeks. Use confidence ruler to gauge patients’ confidence today. Has it changed?

- Wrap-up phone call. Ask if they have any other questions. Summarize your action items and what they agreed upon. Thank patient for their time.
  - Example: “Do you have any other questions for me? I will follow up with you in \_\_\_\_ days to see how everything is going with (state goal). Thank you so much for your time today, Ms. Smith.”
- DOCUMENT the encounter -- did the patient pick up the call? Did the patient seem responsive and agreeable to the relationship and interested in learning more about available resources? Did the patient indicate any barriers to receiving care? What was patients’ agreed upon goal? When will you follow up?

#### PHONE CALL #4

##### **Follow-up – Last contact with Patient**

- Find out how patient has been doing since your last phone call.
- Follow-up on agreed upon S.M.A.R.T. goal. Has the patient been able to stick with it? What has gone well? What has been a challenge? Use confidence ruler to gauge patients’ confidence today. Has it changed? Do they feel that they were successful? If not, what could they do differently? If it didn’t work, that’s ok, try something new!
- Encourage patient to create a new action plan with you and to follow it for 2 weeks on their own. Use “Action Plan: Hypertension Management” worksheet to assist.
- If there are any lingering appointment issues (Patient still has not made an appointment, Patient did not show up at appointment, etc.) try to work through the barriers. What is keeping them from moving forward?
- Wrap-up phone call. Ask if they have any lingering questions. Summarize your action items and what they agreed upon. Remind them that this is your last phone call. Thank them for taking the time each week to work towards a healthier lifestyle.
- DOCUMENT the encounter -- did the patient pick up the call? Did the patient seem responsive and agreeable to the relationship and interested in learning more about available resources? Did the patient indicate any barriers to receiving care? What was patients’ agreed upon goal? When will you follow up?