Health Coaching: An Introduction

Facilitating Care Integration Webinar
January 21, 2016

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What Is Health Coaching?

- Health coaching assists patients to gain the knowledge, skills, and confidence to become informed, active participants in the management of their chronic condition
- Health coaching is a paradigm shift
  - From: Tell patients what to do and call them non-compliant if they don't do it
  - To: Find out what patients are willing and able to do and meet them half-way

Ghorob A. *Fam Pract Management*, May/June 2013. .

Health Coaching Evidence

- **RCT: patients with diabetes, hypertension and/or hyperlipidemia who worked with medical assistants trained as health coaches had significantly improved HgA1c and LDL-cholesterol after 1 year compared with non-coached patients**
- **In a randomized controlled trial of low-income patients with poorly controlled diabetes, patients with peer health coaches (other patients with diabetes) had significantly improved HbA1c levels compared with controls**

Willard-Grace R et al, *Ann Fam Med* 2015;13:130;

Thom D et al, *Ann Fam Med* 2013:11:137.

Health Coaching Evidence

- Ask-tell-ask
  - Engaging patients by asking what they think and what are their goals is associated with better outcomes than telling patients what to do[1]
- Know your numbers
  - Diabetic patients who know their A1c and their A1c goal have better control than a control group[2]
- Close the loop (teachback)
  - 50% of patients leave the medical visit without understanding their care 4lan. Diabetic patients whose care team closes the loop have better A1c levels[3]
- Counsel on medication adherence
  - The more actively a patient is involved, the better the med adherence[4]

1) Heisler et al, *JGIM* 2002;17:243. 2) Levetan et al, *Diabetes Care* 2002;25:2. 3) Schillinger et al, *Arch Intern Med* 2003:163:83. 4) Osterberg, Blaschke, *NEJM* 2005;353:487.

Health Coaching Evidence: Behavior-change action plans

- Action plans are agreements between a health coach and patient specifying a behavior change that the patient has chosen to make
- Diabetic patients were randomly assigned to traditional patient education or goal setting with action plans. The group doing action plans had a significant reduction in HbA1c compared with the patient education group, whose A1c levels did not change

Naik et al, Arch Intern Med 2011;171:453.

MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:

_____Work on something that's bothering me:

_____

_____Stay more physically active!

_____Take my medications.

_____Improve my food choices.

_____Reduce my stress.

_____Cut down on smoking.

2. Choose your confidence level:
This is how sure I am that I will be able to do my action plan:

10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

_____

How much: _____

When: _____

_____

How often: _____

_____
(Signature)

_____
(Signature of clinician)

Alameda County Health Coach Program

Gladys Preciado, Senior Health Coach

Jocelyn Freeman Garrick, MD Director

UCSF Center for Excellence in Primary Care Webinar

Who We Are


ALAMEDA COUNTY
EMERGENCY MEDICAL SERVICES
E M S


ALAMEDA COUNTY
HEALTH
COACH

What's the issue we are addressing?

- Low-income patients with chronic disease have limited access to primary care appointments and/or seek episodic care from the Emergency Department (ED)
- Chronic disease management in this population is less than adequate

How can we solve it?

- Through Emergency Department-initiated Health Coaching that includes:
  - Patient education
  - Home visits
  - Patient led self advocacy
  - Follow up phone calls and text messages
  - Providing motivational and emotional support

Goal

- To improve the health of community members by pairing them with culturally sensitive coaches trained in chronic disease management
- Reduce emergency room visits by improving self-care management
- Foster the growth of diverse health professionals by hiring young adults ages 18-24

Cost effective way to address health disparity need while employing young adults from the community

Patient Demographics

- Patients with hypertension and diabetes who seek care in the Emergency Department (ED) of a safety-net hospital and are likely to benefit from health coaching
- Our population is:
  - African American (42%)
  - Hispanic (25%)
  - Caucasian (19%)
  - Asian (10%), Unknown (4%), and Other (<1%)
- Most of the patient population has Medi-Cal (45%), Medicare (14%), or Health-PAC (25%) (a local form of healthcare access for the uninsured)
- This patient population was selected to determine if health coaching initiated in the ED (novel) is of benefit to patients by preventing unwanted ED visits and establishing continuity of care

Training

- Who are our coaches?
  - Alumni from an Alameda County program EMS Corps
  - College graduates interested in health careers
  - Community College students
  - Alumni from various pipeline programs
- Health Coaches complete a 3-month (180+hour) training
- Training includes:
  - Community Health Outreach Worker Curriculum (Berkeley City College)
  - Motivational Interviewing (Certificate Awarded) led by UCSF CEPC
  - HIPPA and Human Subjects Research
  - Hypertension
  - Diabetes
  - Nutrition & Exercise
  - Mental Health First Aid (Certificate Awarded) led by Oakland Crisis Support
  - Affordable Care Act Enrollment

IRB Approved Research Study

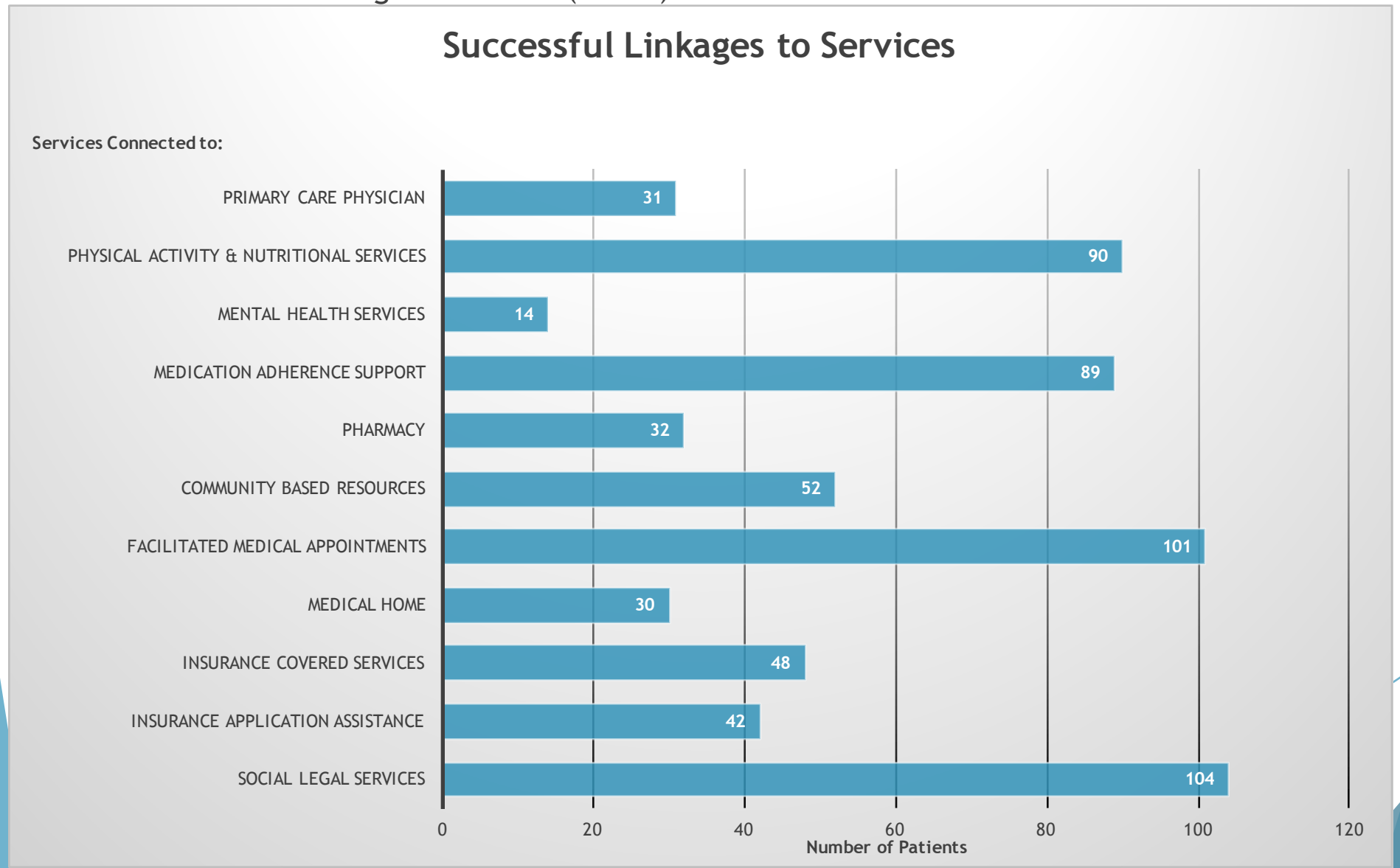
- PROBLEM: Many patients with chronic diseases struggle to navigate the health care system and understand the impact of their disease on their overall health and quality of life. Those with low-income or low socio-economic status are especially at risk
- INTERVENTION: Pilot a program that can evaluate if Health Coaching initiated in the Emergency Department (ED) improves clinical outcomes in patients with diabetes and hypertension
- OBJECTIVE: The aim is to reduce subsequent ED visits, increase primary care visits, and positively impact health-related outcomes in patients with uncontrolled diabetes and/or hypertension

Health Coaches Provide

- Patient education
- Home visits
- Follow up phone calls and text messages
- Translation services (Spanish, Mandarin, Tongan)
- Motivational and emotional support
- Provider appointment accompaniment
- Medication reconciliation
- Patient advocacy
- Coordination & referrals to resources and services

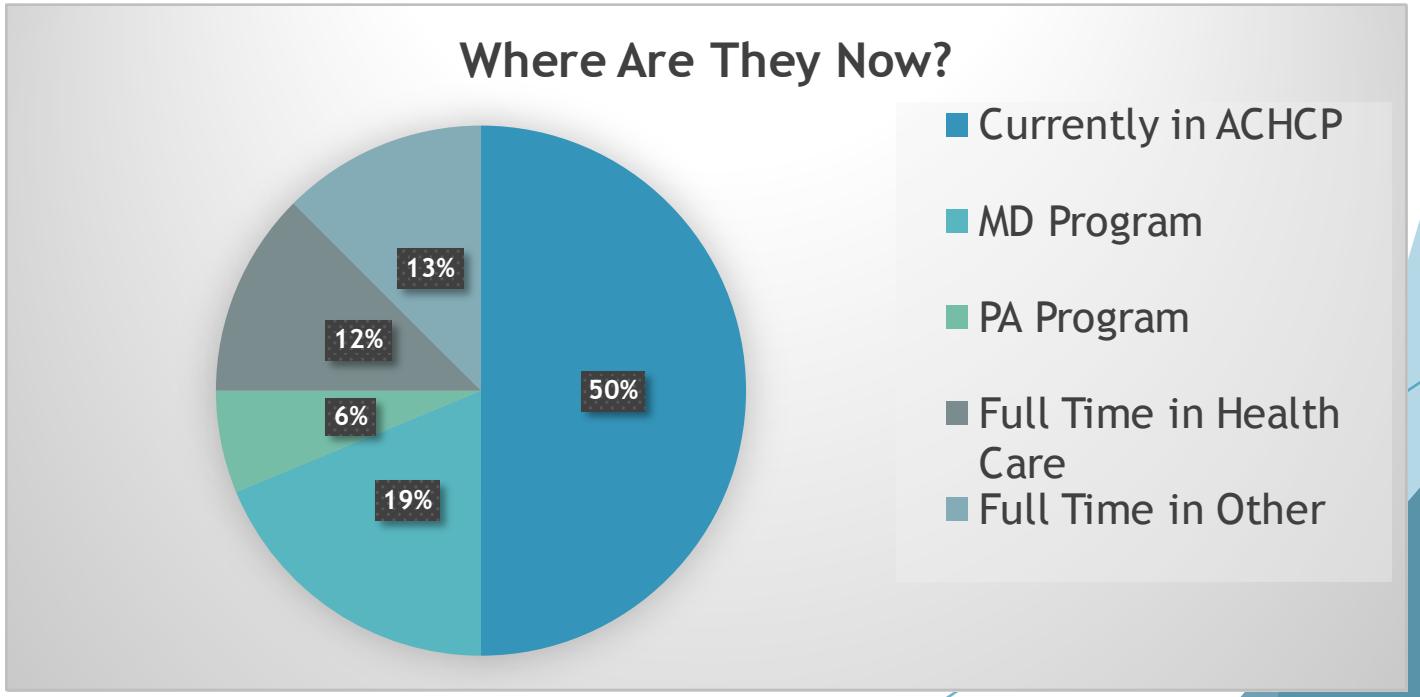
Brenda's Story

- Since its launch in March 2014, Alameda County Health Coaches:
  - Provided Health Coaching to 1023 patients and enrolled 180 patients into research study (9/15)
  - Data below through June 2015 (n=120)



Services & Support for Coaches

- Professional Development
- Networking Opportunities
- Career Counseling
- Mental Health Training
- Ongoing Health Coach Training



Long Term Goals

- Establish a sustainable program model
  - Now institutionalized and supported by Alameda County funding
  - Expand locations where coaches can serve beyond the ED
  - Build partnerships with other clinical sites & expand labor market for HC
- Increase the number of diverse health professionals

Contact Information

- Jocelyn Freeman Garrick, MD Director
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- Gladys Preciado, Senior Health Coach
  - Email: Gladys.Preciado@acgov.org

Health Coaches as Agents of Humanity:

Changing the Work & Changing the Force in Primary Care Delivery

Ali Khan, MD, MPP, FACP
UCSF Center for Excellence in Primary Care | Center for Care Integration | January 2016

A Rapidly Changing Landscape

SPECIAL ARTICLE

Changes in Health Care Spending and Quality 4 Years into Global Payment

Zirui Song, M.D., Ph.D., Sherri Rose, Ph.D., Dana G. Safran, Sc.D., Bruce E. Landon, M.D., M.B.A., Matthew P. Day, F.S.A., M.A.A.A., and Michael E. Chernew, Ph.D.

N Engl J Med 2014; 371:1704-1714 | October 30, 2014 | DOI: 10.1056/NEJMsa1404026

- Cohort study of Blue Cross Alternative Quality Contract in MA linking shared savings under a global budget to performance on quality and patient experience metrics.
- 6.8% less spending growth in AQC compared to non-AQC cohort.

Journal of the American Board of Family Medicine

The Impact of Health Coaching on Medication Adherence in Patients With Poorly Controlled Diabetes, Hypertension, and/or Hyperlipidemia

A Randomized Controlled Trial

David H. Thom, MD, MPH, PhD, Rachel Willard-Grace, MPH, Danielle Hessler, PhD, Denise DeVore, BS, Camille Prado, BS, Thomas Bodenheimer, MD, and Ellen Chen, MD | Disclosures

J Am Board Fam Med. 2015;28(1):38-45.

- RCT of 1 year of health coaching from uptrained MAs increased medication documentation/reality concordance (28%)

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A Rapidly Changing Landscape

What We Hoped in a Post-ACA Nation…

- New Demand: Newly Insured Lives (thanks, DFA!)
- New Value-Based Payment Schemes
  - Care Management Capitation
  - ACOs + Shared Savings
  - Performance + Quality Incentives
- Innovative Use of Teams
  - Integrated Behavioral Health
  - Health Coaching + Peer Support
  - Pharmacy Lead Programs
- New Work for Teams
  - Increased EMR Uptake, Steps toward Interoperability
  - The Promise of Big Data
  - Health and Behavior Change Apps

A Rapidly Changing Landscape

…And What We Didn't Expect:

- The Not-So-Good
  - Incentives Remain Small/Beyond Provider Control
  - Culture Change within Established Systems Challenging
  - EMRs still built for billing
  - The Whack-a-Mole problem
- The Fantastic
  - Market Forces Driving, Provoking Change
  - Payors Making Moves – New Actors, New Tools, New Mission
  - Coordinated Care for Vulnerable Populations
  - Wraparound Tools to Accelerate Integrated Delivery
  - The Quadruple Aim: Joy in Practice

The Workforce Future: An Open Question

- Too **few** physicians, nurses, staff?
  - Chronic underinvestment, especially in primary care
  - Payment system that rewards the wrong things

  Solution: More money for more bodies

  OR

- Too **many** physicians, nurses, staff, just doing the wrong work?
  - Administration work that does not benefit patients
  - Little innovation away from sick visits
  - Lack of ability to sustain & scale creative solutions

  Solution: Radically change the way we care for patients

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The Iora Health Vision of Primary Care

Amazing People + Adaptive Processes: Care model innovation

- Engaging relationships
- Serving patients, persons and populations
- Teams: health coaches, huddle
- Culture of extraordinary service

Technology innovation

- Smarter systems that use clinical data and analytics to inform intervention
- Remove barriers: open access scheduling, transparency

Payment model innovation

- Reward quality and savings
- De-link payment from visits
- Increase investment in primary care by starting with trust

Flexibility to innovate: freedom of Iora payment model
Motivation to innovate: focus of Iora clinical model
Tools to innovate: Iora integrated IT model

About Iora Health

- Founded in December 2010 by Rushika Fernandopulle, MD after 10 years of primary care redesign work
- Venture-backed primary care provider based in Cambridge, MA; closed Series B financing in 1Q-2013 and Series C in 1Q-2015
- 150 employees nationally, headcount has doubled each year
- 29 practices across 10 states to date, contracted with insurers as well as self-funded and fully insured groups
- Expanding into 4 new states in 2016
- Deep experience managing complex populations: 974 patients 60+ years old who average 7+ visits/year, and practices with average $12,000+ PMPY costs

Recent Press

BusinessWeek Forbes msnbc THE NEW YORKER USA TODAY the Atlantic

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A Model Team

Culinary Extra Clinic
An Iora Health Practice

- Fully staffed team of 16
  - Led by Our Patients
  - 9 Health Coaches
  - 1 Behavioralist
  - 2 Operations Assistants
  - 2 Providers
  - 1 Nurse Innovator
  - 1 Medical Director

- Technology to support teamwork and capture learning

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The Core: Health Coaches

Culinary Extra Clinic
An Iora Health Practice

- Point of contact
- Cultural and language concordance
- Hired for attitude
- Background varied (+/- health care)
- Training:
  - Motivational interviewing
  - Service
  - Basic MA tasks
  - Chronic disease mgt

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Defining the Core

Culinary Extra Clinic
An Iora Health Practice

Roles

- In the Visit
  - Goals
  - Action plans
  - Simple history taking
  - Data gathering
- Between Visits
  - Tracking / Monitoring
  - Coaching / Motivating
  - Coordinating
  - Availability (phone, email, in the home)
  - Advocacy

Resources

- IT
  - Marker sets
  - Collaborative chart
  - Robust task assignment
- Processes
  - Daily huddle
  - Co-location
- People
  - Behavioralist
  - Social Worker

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The Transformation of the Provider Role

Assembly Line Worker	→	System Architect
Lone Ranger	→	Team Leader
Patient's Protector	→	Patient's Guide
Referral Expert	→	Primary Manager

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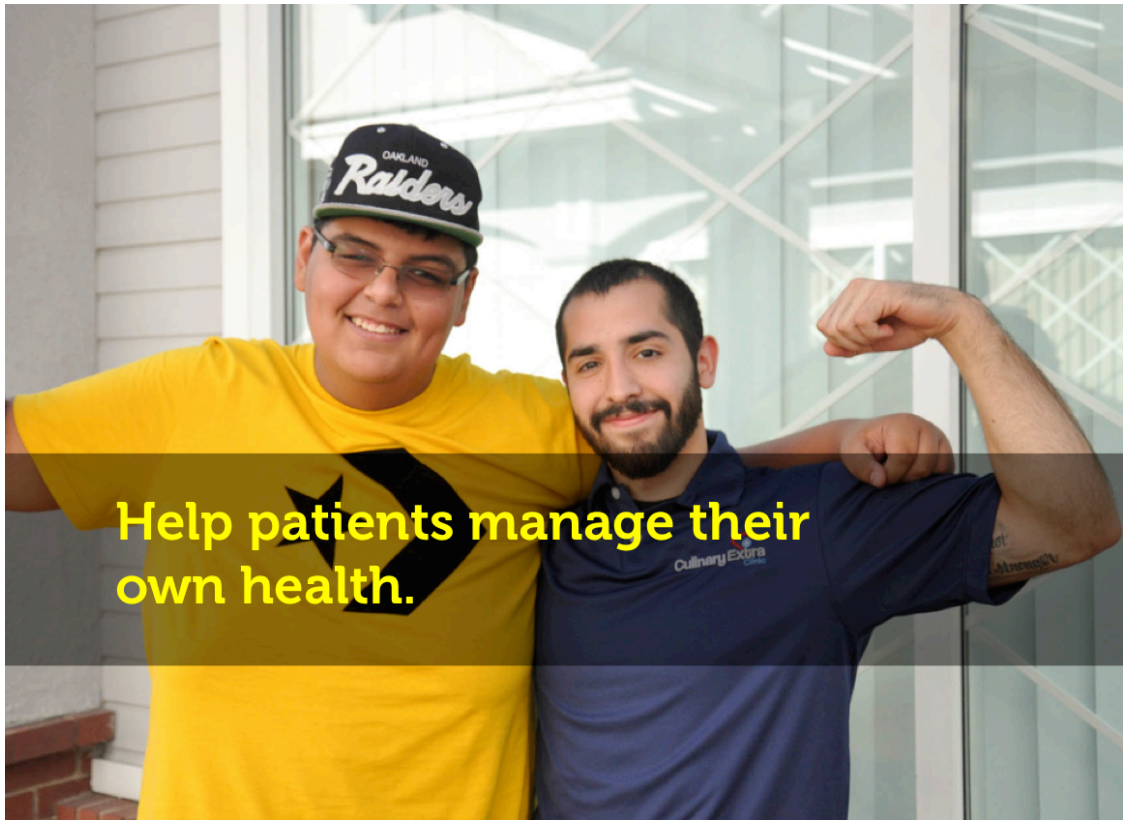
Changed Lives

Culinary Extra Clinic
An Iora Health Practice



14M, High School Student
1st Visit May 2012:

- 309lbs
- A1c >7
- On Metformin
- No confidence he could control his health

100 Days with Iora Health:

- 50 pounds lighter
- A1c 5.3
- Feeling great, in control of his life

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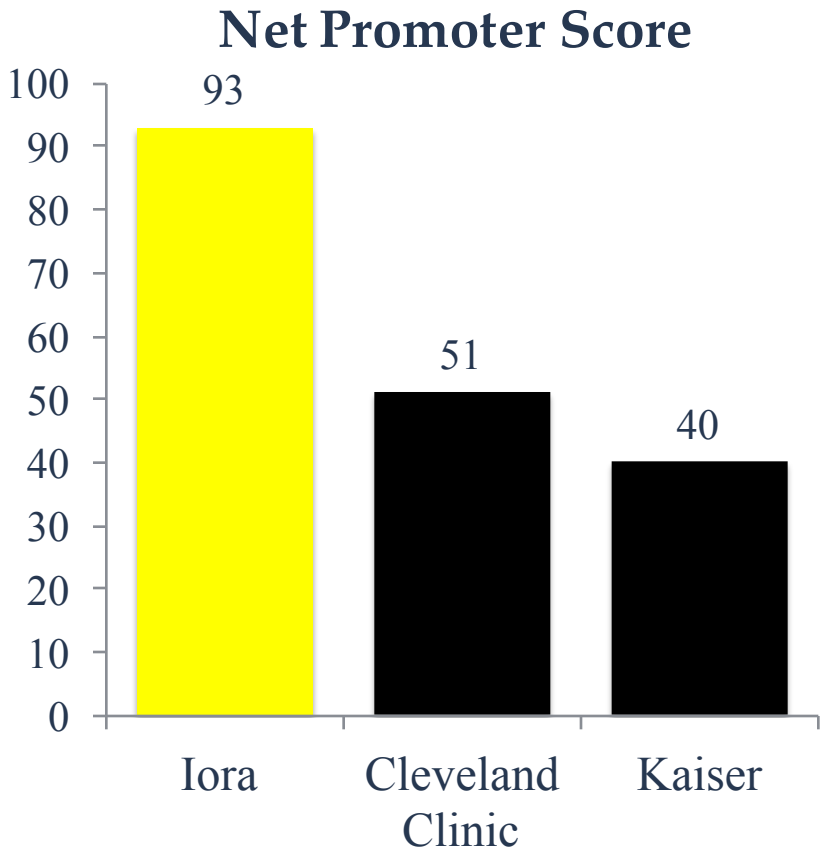
Real Love



Net Promoter Score = % Promoters – % Detractors
Question: *"How likely is it that you would recommend Iora practice to a friend or coworker?"*

"I love walking in and being greeted by my name. Just knowing that I can call the doctor if I am having issues is a relief and makes me feel better. The doctors and staff really care about us! Which means better results!

New way of life this clinic. I feel like it is family. I am glad to be here. Thank you."

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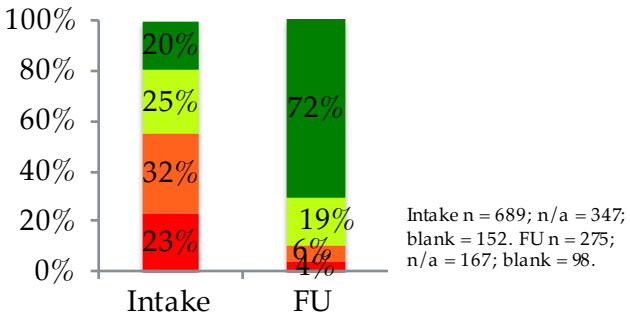
Real Results

"Before I didn't go to the doctor much. Now I feel like I am going to see my friends. I am not joking."

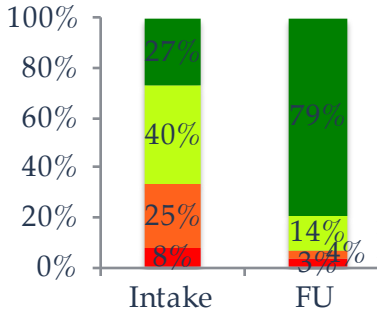
-50 y/o patient who has lost 32 lbs in 6 months

Primary care provider was informed about visits to specialists they referred?



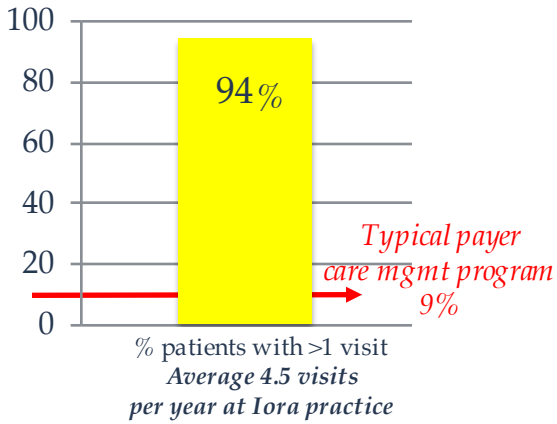
Intake n = 689; n/a = 347; blank = 152. FU n = 275; n/a = 167; blank = 98.

Got an urgent appointment with primary care provider?



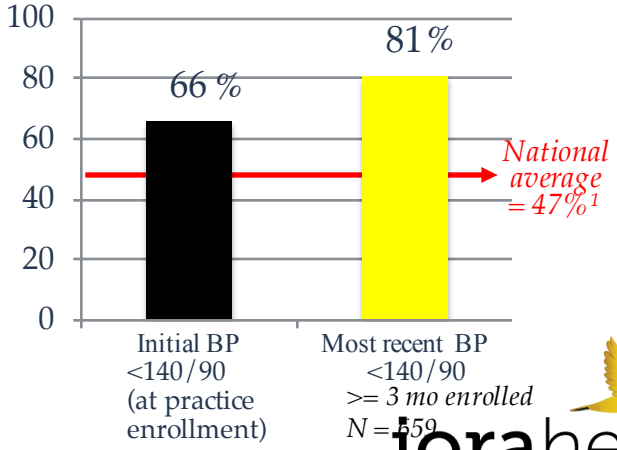
Intake n = 696; n/a = 286; blank = 146. FU n = 271; blank = 96.

Patients are engaged



Hypertension Control

Initial vs. Most Recent Blood Pressure

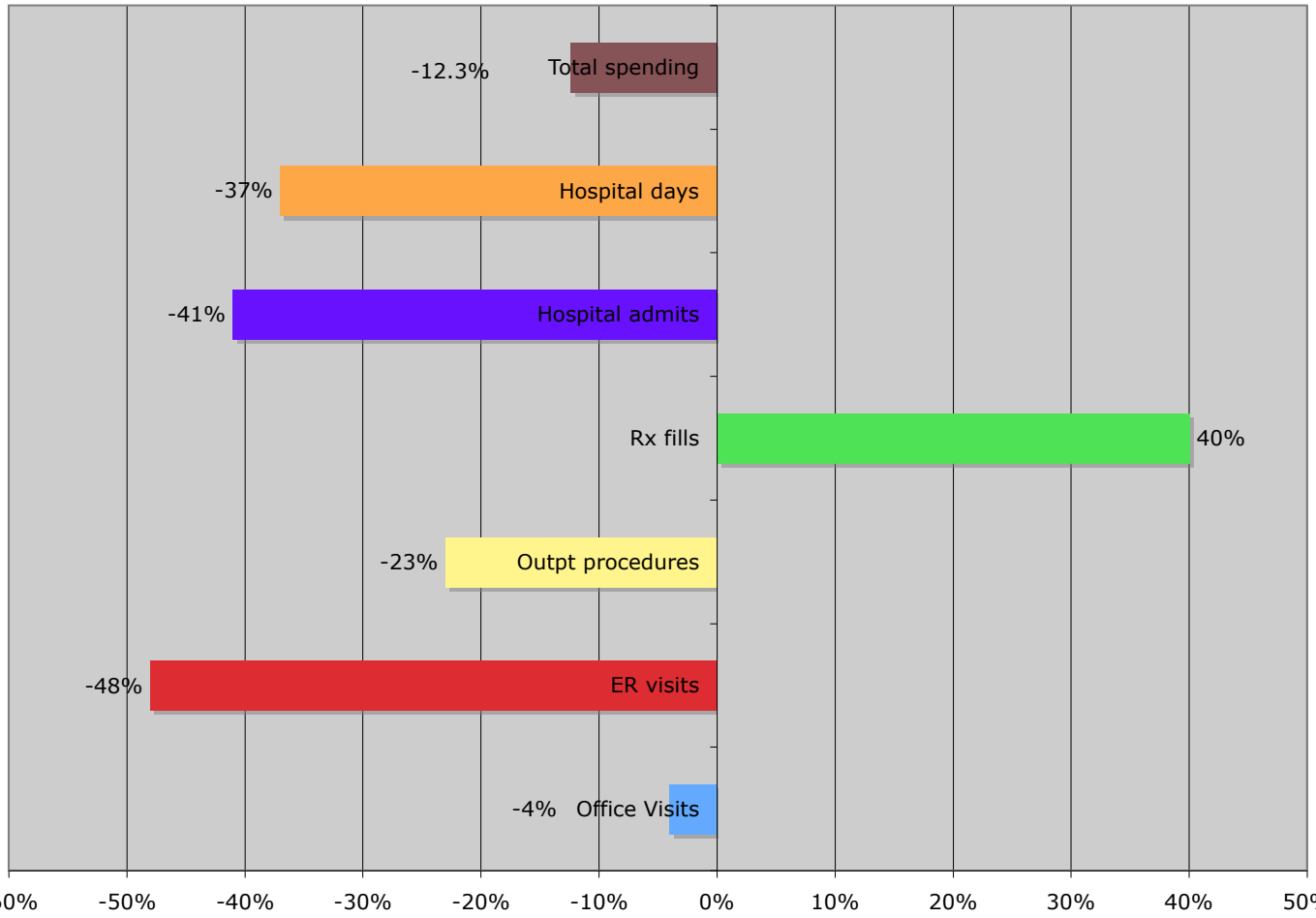


Patient Experience results: Based on CAHPS survey at one Iora practice

Hypertension benchmark: CDC. Vital signs: prevalence, treatment, and control of hypertension. MMWR. 2011;60(4):103-8

Real Savings

Total spending dropped a net of 12.3%



For all SCC patients enrolled in 2009, relative to control group created using propensity matching.

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The Workforce Future: An Open Question

- Too **few** physicians, nurses, staff?
  - Starting with smaller panel sizes, but envision growth
  - Different payment model
  - Deep sense of shared mission + passion, continually reinforced

AND

- Too **many** physicians, nurses, staff, just doing the wrong work?
  - Focus on building relationships and problem-solving
    - With patients: Believe in our patients' ability to succeed
    - With payors: Minimize top-down, nonsensical work
    - With each other: Work hard to protect and develop our culture
  - Try anything that works for our patients
  - Commit to a learning system that grows and scales

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We are restoring humanity to health care