



HEALTH COACH MODEL: A GREAT OPTION FOR DIABETES CARE



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CHINLE SERVICE UNIT



Canyon de Chelly, Chinle, AZ



Pinon Health Center



Chinle Comprehensive Healthcare Facility



Tsaile Health Center

CHINLE SERVICE UNIT (CONT.)

- **Chinle Service Unit is a federally run Indian Health Service site with 60 bed hospital and 3 ambulatory health care centers.**
- **Population: Almost 37,000 Native Americans in 17 chapters (communities) in the central part of the Navajo Nation.**
- **180,000 outpatient visits annually.**

MEDICAL HOME MODEL: PRIMARY CARE BASED

- Chinle has embraced the Medical Home primary care model, including Team Care.
- Teams consist of primary care physicians, nurse practitioners, health techs (medical assistants), MSAs, and nurses, supported by health coaches, nurse care managers, Native Medicine, and a pharmacist and nutritionist in clinic.

CSU DIABETES SERVICES PROGRAM

- Population management for approximately 4500+ diabetic patients across CSU.
- Provides care coordination/case management and support for complex diabetic patients in Chinle outpatient clinic, as part of an integrated care team (about 40% of diabetic patients are seen by health coaches)
- Daily consultation for diabetes patients in the inpatient unit and to Urgent Care and ER as needed.
- Multiple internal and external partnerships in quality improvement work, including pharmacy, Counseling Services, Office of Native Medicine, Teen clinics, PHNs and CHRs, COPE, Johns Hopkins Together on Diabetes, Wellness Center.

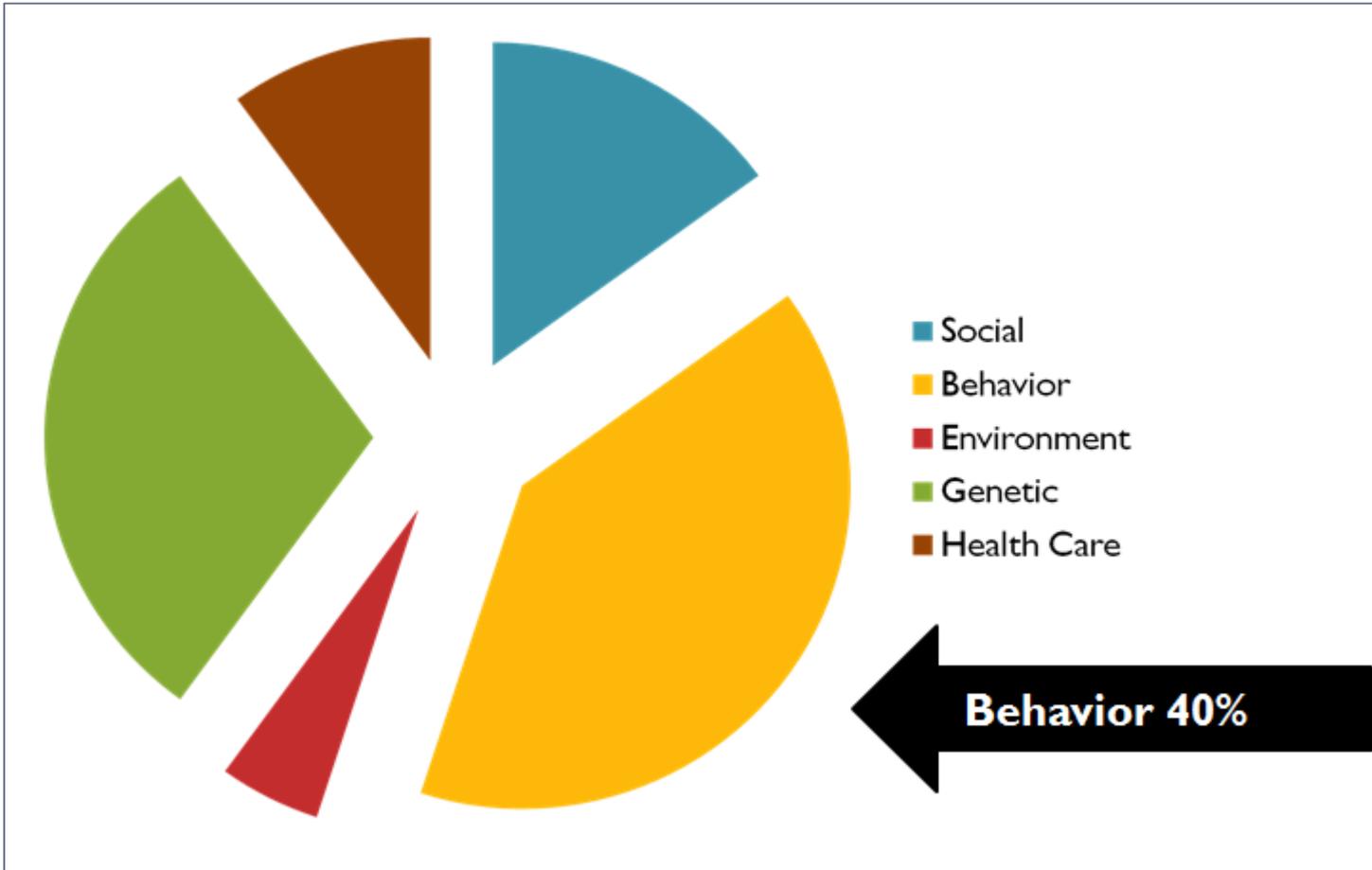
STAFF



- **Matthew Werito, Health Coach, Miranda Williams, Diabetes Coordinator, Farrah Begay, Health Coach, Ivan Salabye, Health Coach, Adrian Jumbo, Informatics Tech, Krista Haven, Nurse Improvement Specialist, Phillip Lee, Health Coach, Tasha Harvey, Office Assistant, Craig Avery, Health Coach, Shanna Nez, Health Coach, Dr. David Goldberg, DM Clinical Consultant (missing from picture: Lynn Jishie, OAA)**

WHY HEALTH COACHES?

LEADING DETERMINANTS OF HEALTH



WHY HEALTH COACHING?

- Patient's health largely depends on their own behaviors - including not only lifestyle issues, but also taking medications, checking blood sugars at home, getting preventive screenings, chronic disease services like foot and eye exams, immunizations, etc.
- Ultimately, patients have to take care of themselves: **SELF-MANAGEMENT.**
- Health care personnel can provide support (SMS), education (SME).

WHAT IS HEALTH COACHING?

- Health coaching helps patients gain the knowledge, skills, tools, and confidence to become active participants in their own care. Health coaches help patients set their own health goals and then support their efforts to achieve these goals. (BAP).

Ref: Health Coaching: Teaching patients to fish. Amireh Ghorob, MPH Director of Training, Center for Excellence in Primary Care, UCSF Family Practice Management May/June 2013

WHO CAN DO HEALTH COACHING?

- PCPs main function is to diagnose undifferentiated complaints and recommend appropriate medical Rx for acute and chronic diseases.
- Due to lack of time and training, PCPs are not always as proficient at helping patients change behavior.
- Other team members (nurses, pharmacists, case managers, educators, medical assistants and even patients) can be trained to provide health coaching.

WHO ARE OUR COACHES ?

- **Local Navajo tribal members**
- **Variable educational backgrounds:**
 - High school grads
 - College graduates: health promotion, nutrition
 - Medical assistants
- **Non-licensed professionals**
- **Selected for experience, ability and potential**
- **Trained on the job with a designed curriculum**

TRAINING DIABETIC HEALTH COACHES

- Initially, live classes, workshops, and on-line modules with the basics of diabetes pathophysiology and management, self-management support, Navajo Wellness model, motivational interviewing.
- Ongoing education with weekly classes coordinated by Diabetes Improvement Nurse, includes case reviews, advanced topics in diabetes management, behavioral health issues, etc.
- Diabetes competencies; knowledge and skills; eg, glucometer, insulin starts, foot exams.

AADE: LEVEL ONE COMPETENCIES FOR DIABETES EDUCATORS

Level One Characteristic: Level 1 includes community healthcare workers and other non-professional healthcare providers who have little expertise in diabetes education and/or management, but provide and/or support healthcare services to individuals with diabetes. This level includes, but is not limited to: health promoters, health educators, and community health workers. Level One Definition: This level comprises healthcare workers who do not have a clinical background, but who nonetheless work with persons with diabetes in supportive or clinical environments.	Basic Need to develop skills & confidence in this area		Developing Making some progress and have begun to acquire skills & confidence		Proficient Skills and confidence have developed significantly (Can perform "teach-back")		Advanced Highly proficient level of skills and fully confident. Can teach/mentor other employees (Consistent positive patient change in outcome)	
	Self Assessment Initial/Date	Mentor Assessment Initial/Date	Self Assessment Initial/Date	Mentor Assessment Initial/Date	Self Assessment Initial/Date	Mentor Assessment Initial/Date	Self Assessment Initial/Date	Mentor Assessment Initial/Date
Domain One: Pathophysiology, Epidemiology, and Clinical guidelines of diabetes. Competency: Demonstrates familiarity with pathophysiology, epidemiology, and clinical guidelines consistent with diabetes care for a provider level one.								
Lifespan 1. Identifies and refers high risk and/or patients with unstable diabetes to diabetes care providers 2. Encourages use of family and community support systems 3. Identifies support systems								

SIX TYPES OF CASE MANAGEMENT

Case Management	Goal
Pre-DM Patients	Educate pre-DM patients with updated handouts and Wellness Center and nutrition referrals
Newly Diagnosed DM patients	Engage new DM patients in care, support their personal journey with DM, educate them about DM and its management, and treat with lifestyle interventions and medications
Primary Care – DM patients with an A1C, B/P, or LDL not in target range	A1C below 8 Blood pressure below 140/90 LDL below 100 To decrease cardiovascular risk
Inpatient - DM Patients	Influence patients to use their care teams for follow-up and introduce Diabetes HC model-of-care
ER/UC – DM patients	Influence patients to use their care teams for care and introductions to DM HC
Case Management of High risk, High cost patients (eg, A1C>11, alcohol abuse, frequent hospitalizations)	Determine what are the behavior barriers/drivers that cause patients to be high risk, then intervene, utilizing intensive case management for 3 months.

HOW DO DIABETES HEALTH COACHES FUNCTION AT CHINLE?

DIABETES HEALTH COACHES: PRIMARY ROLES

- Provide diabetes education using motivational interviewing strategies:
 - Ask Tell Ask
 - Brainstorming
 - Teach Back
 - Action planning
- Enhance understanding by addressing language and health literacy barriers.
- Provide culturally sensitive communication.
- Promote shared decision making and collaborative relationship with providers.

DIABETES HEALTH COACHES: PRIMARY ROLES (CONT.)

- **Help patients change behavior (SMS and SME):**
 - Understanding readiness for change.
 - Recognizing and addressing behavioral barriers.
 - Teaching skills of problem solving, realistic goal setting and action planning.
 - Utilizing Healthy Heart, Balancing Your Life in Diabetes, Lifestyle Balance curriculum.
- **Provide care coordination and follow-up.**

HOW CHINLE SERVICE UNIT USES HEALTH COACHES IN CLINIC

Integrated
MEDICAL
HOME Team
Model

INTEGRATED HEALTH COACH MODEL OF CARE (1)

- Diabetes coaches are assigned to work with specific primary care teams.
- Usually 2-3 coaches are at every clinic session in Adult OPD.
- Diabetes coaches preview the daily clinic schedule to identify potential Healthy Heart patients, including high risk diabetic patients, such as newly diagnosed or poorly controlled diabetics (Pre-visit planning):
 - A1C
 - Lipid levels
 - Blood Pressure

INTEGRATED HEALTH COACH MODEL OF CARE (2)

- Diabetes coaches meet with providers at the beginning of each session to review which patients to see (Huddle).
- Diabetes health coaches will then see the patient in the exam room before, during, and/or after the visit with the primary care provider.
- Treatment plans are reviewed with the providers and patients.

INTEGRATED HEALTH COACH MODEL OF CARE (3)

- Diabetes coaches can do brief focused SMS teaching in the exam room such as:
 - Glucometer training
 - Reviewing meds
 - Problem solving
 - Goal-setting
 - Teach back
 - Action planning
- If the patient needs more extensive time, the diabetes coach can take to a separate office area (e.g., insulin starts).

RESULTS OF THE INTEGRATED MODEL

- Health coaches are now well accepted and in demand by providers.
- High satisfaction scores from patients and staff.
- Marked increase in patient encounters with diabetes coaches.
- Improved diabetes performance measures.
- CSU SUEC recently approved request to make health coach positions permanent.

PHYSICIAN COMMENTS

- Working with the Diabetes Health Coaches is a rewarding experience that has improved the efficiency and care of my patients with diabetes, as well as the overall health visit experience.
- *Joe Salay, MD*
- This (Diabetes Health Coach model-of-care) improves my show rates and helps me manage a patient more efficiently.
- *Mary Evans, MD*
- They (Diabetes Health Coaches) take a complex health care system and make it more accessible and less confusing for the patient, no longer having them in clinic would be a true loss.
- *Andrew Baker, MD*
- Many of the physicians and nurse practitioners have come from the best teaching hospitals in our country, but have never worked with Diabetes Health Coaches. They are amazed at what these non-licensed, highly trained local individuals can accomplish with our patients.
- *Stephen Flynn, MD*

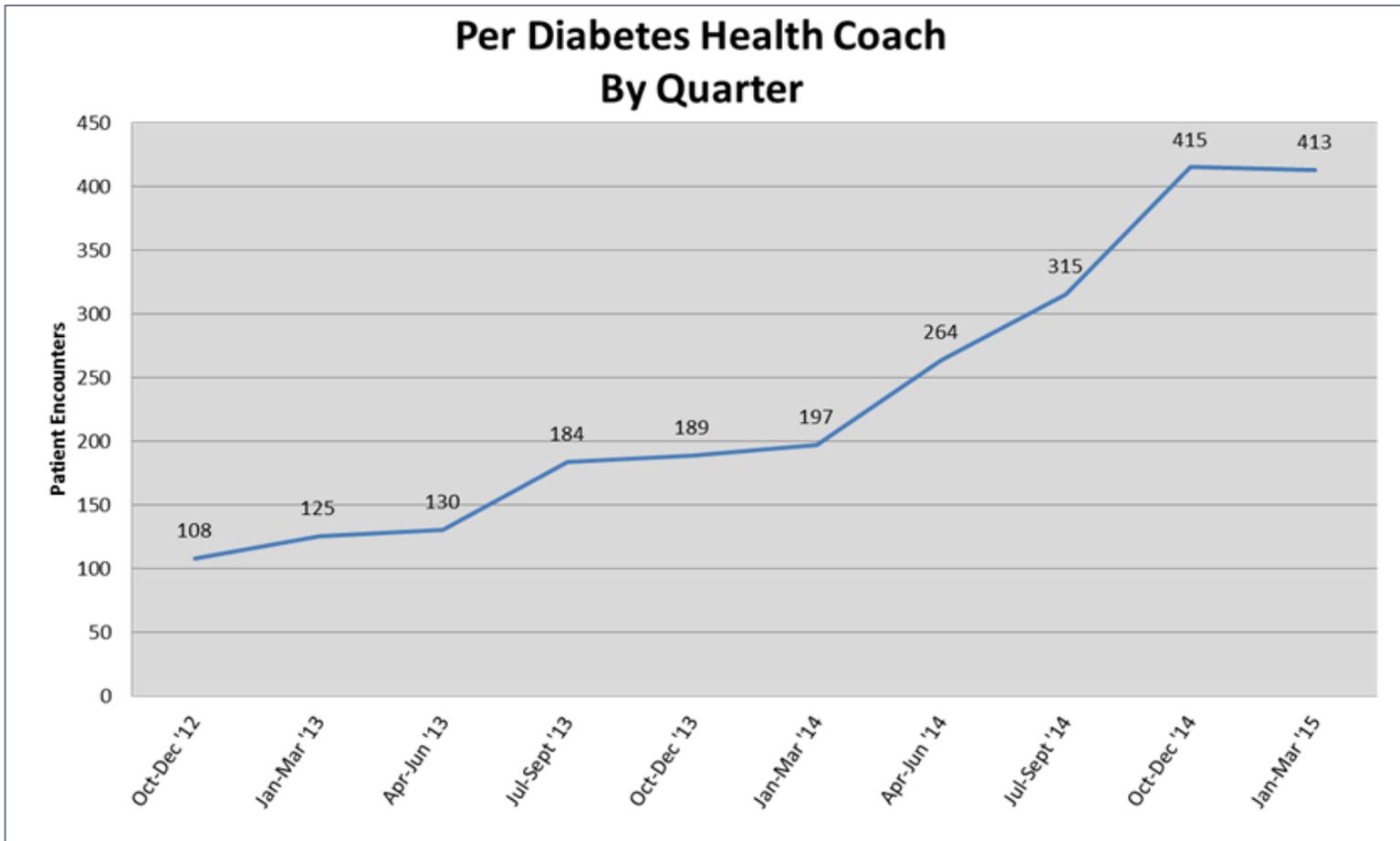
MORE PHYSICIAN COMMENTS

- The Diabetes Health Coaches are dedicated to supporting patients with this chronic diagnosis and their lives are improving. *- Cindy Norris, RN*
- The Diabetes Health Coach role, from an emotional, cultural, and medical perspective, is essential. *- Nurit Harari, MD*
- Having come from a facility where this type of support did not exist, I can attest to the fact that the health coaches make a huge difference in accomplishing both clinical and patient goals. *- Andrea Cuff NP*
- Given the disease burden that diabetes represents in our community and the numerous barriers to consistent diabetes management, the health coaches (and diabetes team as a whole) have been integral to successfully caring for patients. *- Rick Smith, MD*

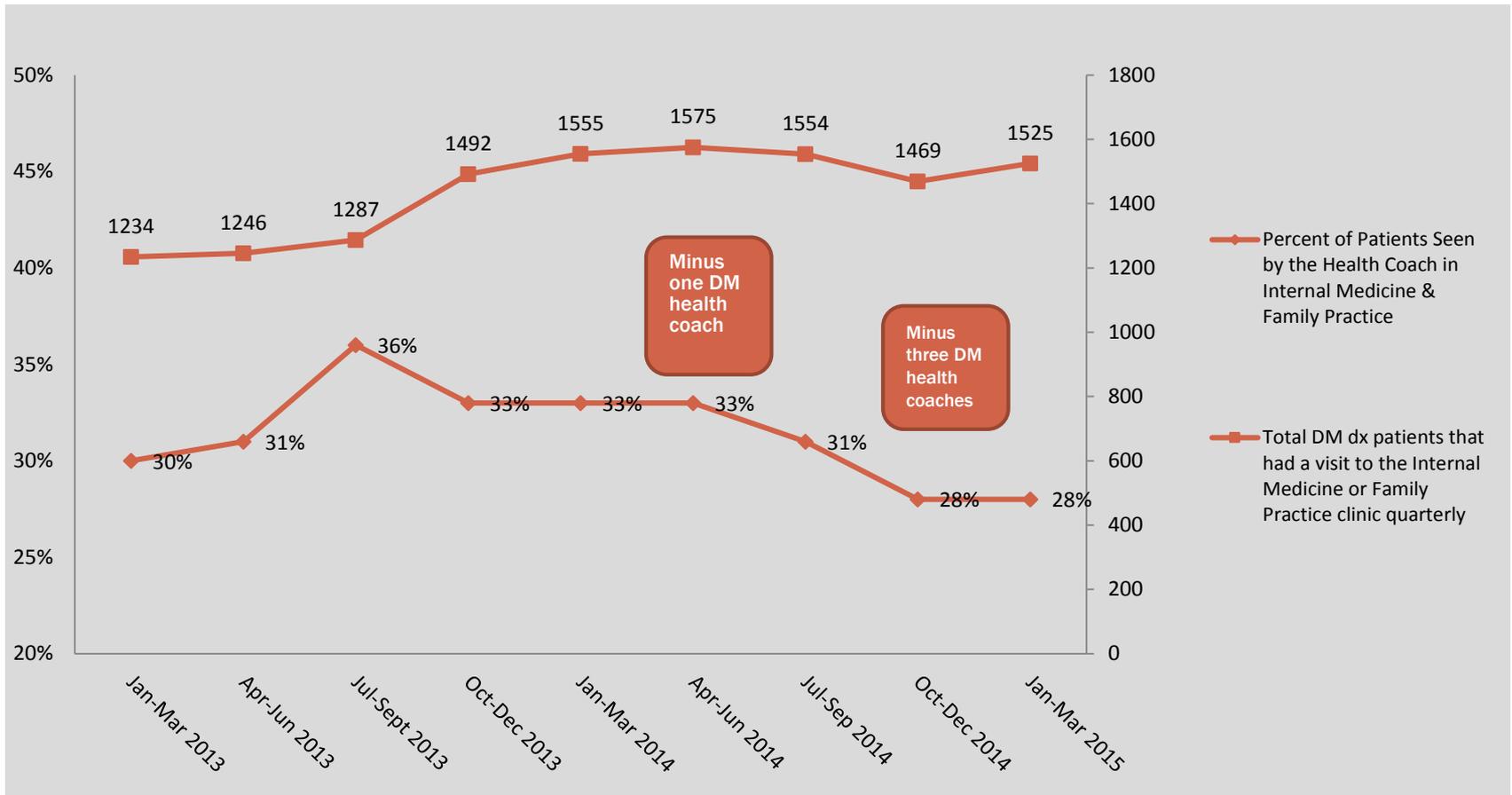
PATIENT COMMENTS

- With the help of my Diabetes Health Coach I am able to keep up with my exercise, checking my blood sugar, and eating healthy. They have helped me come to terms with diabetes. - *Theresa*
- We need the Diabetes Health Coaches in every clinic to make a change! This program will help those learning to deal with diabetes. - *Leo*
- The Diabetes Health Coaches helped me stay on top of my blood sugar with monthly follow-ups. Just knowing that I can call them when I have questions puts me at ease. - *Delphina*
- I have learned a great deal from the Diabetes Health Coaches because they have explained what it means to be diabetic, how it affects the body and how to control diabetes. - *Lynette*
- I'm very grateful for all the support and education my Diabetes Health Coach has shared with me.
- *Monthly patient experience survey*

AVERAGE PATIENT ENCOUNTERS



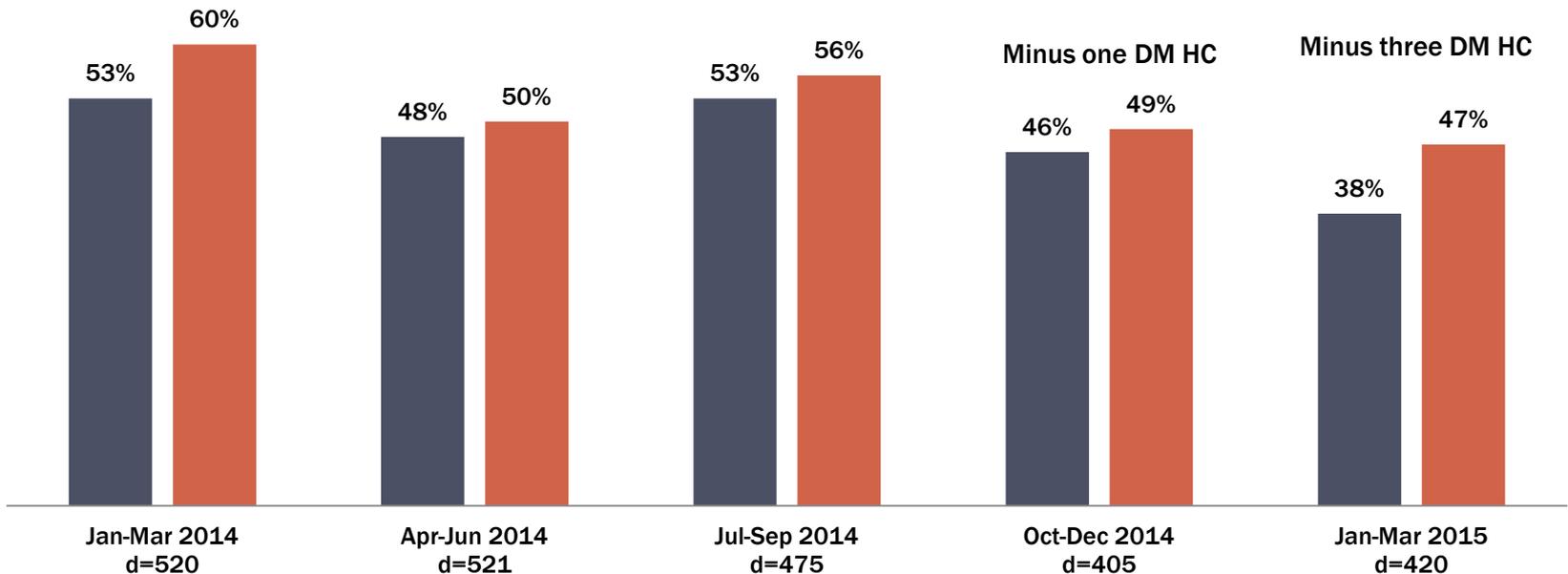
PERCENT OF DIABETIC PATIENTS WITH A HEALTH COACH VISIT AT CHINLE HOSPITAL, 2011-2013



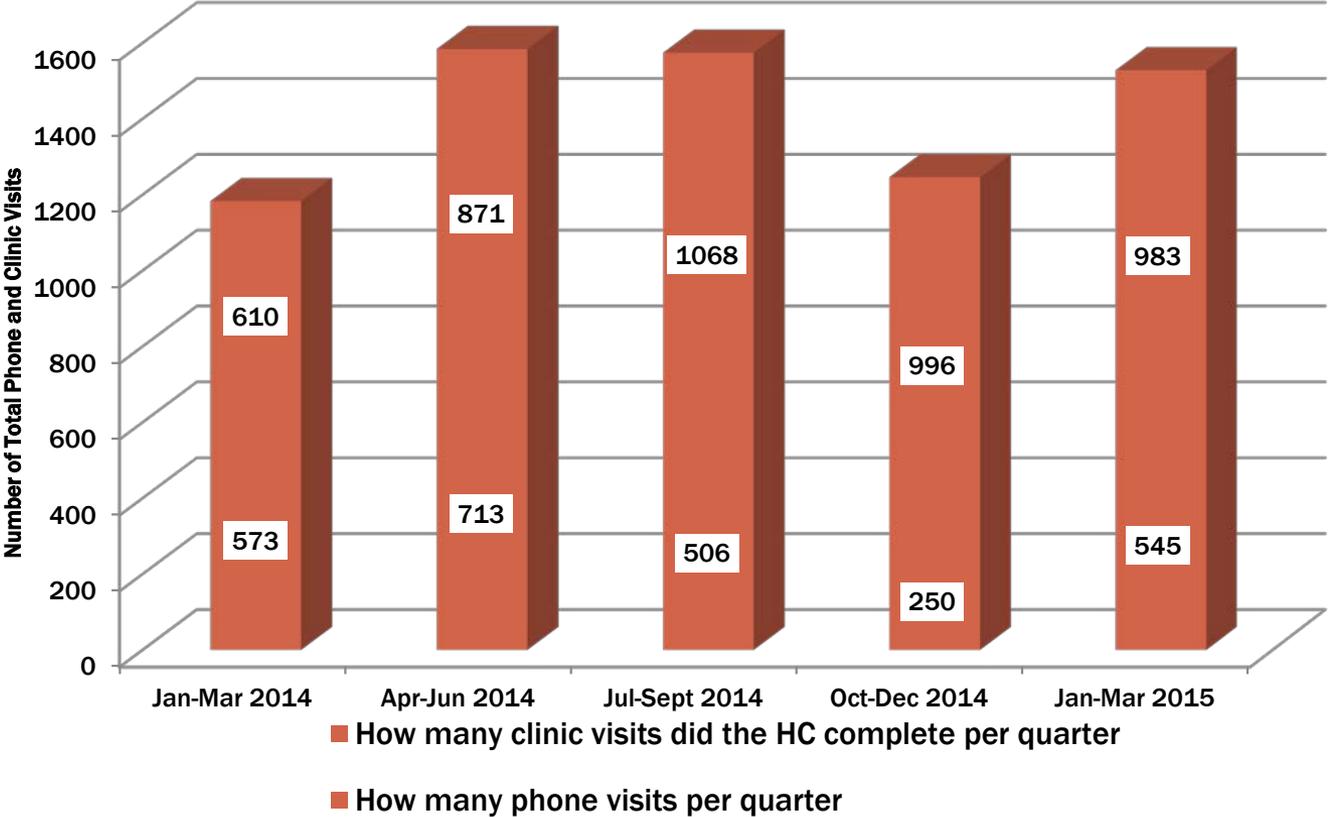
HEALTH COACH FOCUS ON HIGH RISK

Percent of High Risk Patient's Seen by Health Coach

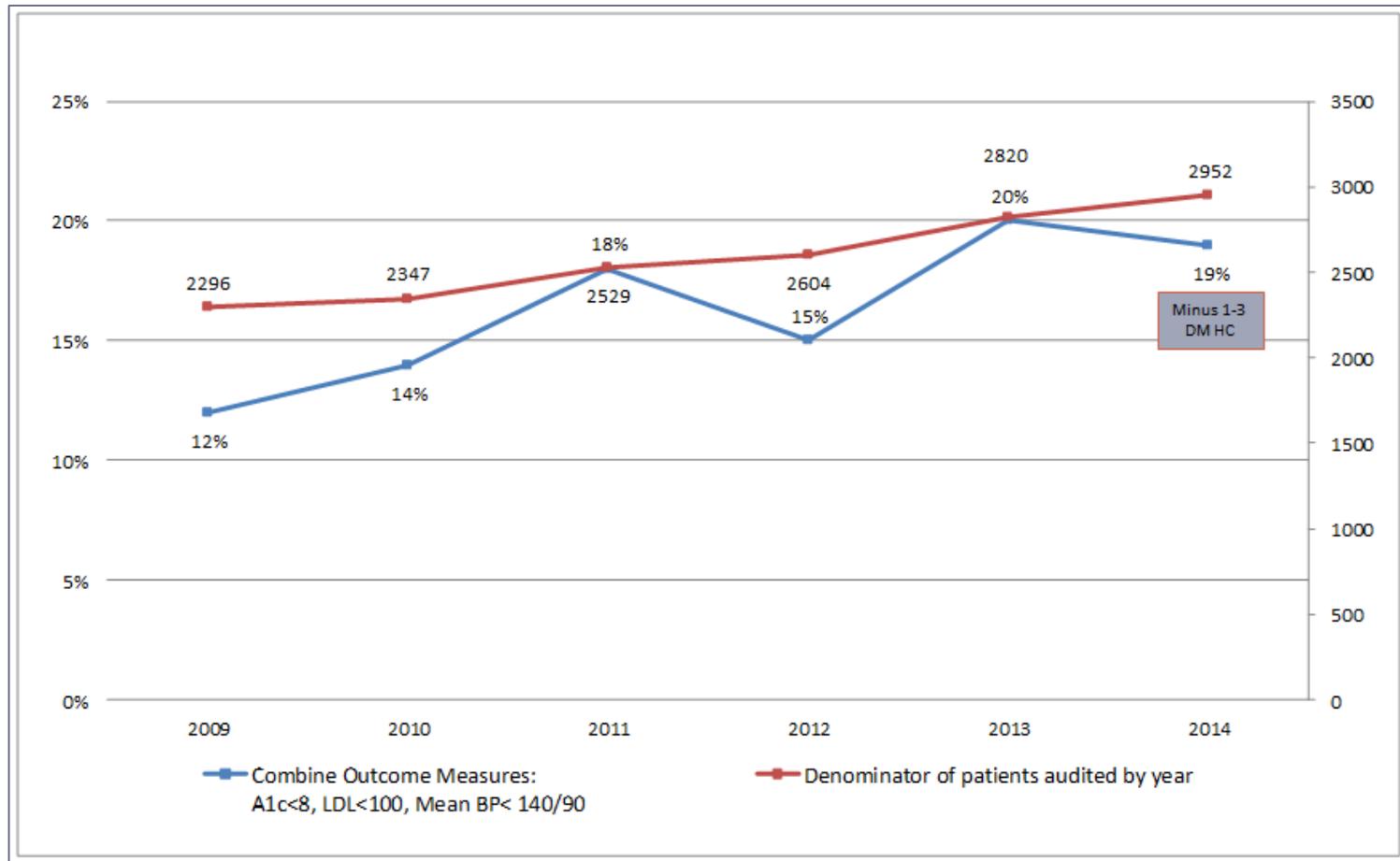
- DM dx patient that came into the Internal Medicine or Family Practice clinic and had an A1c over 9.5 during the quarter and saw a health coach
- DM dx patient that came into the Internal Medicine or Family Practice clinic and had an A1c over 11 during the quarter and saw a health coach



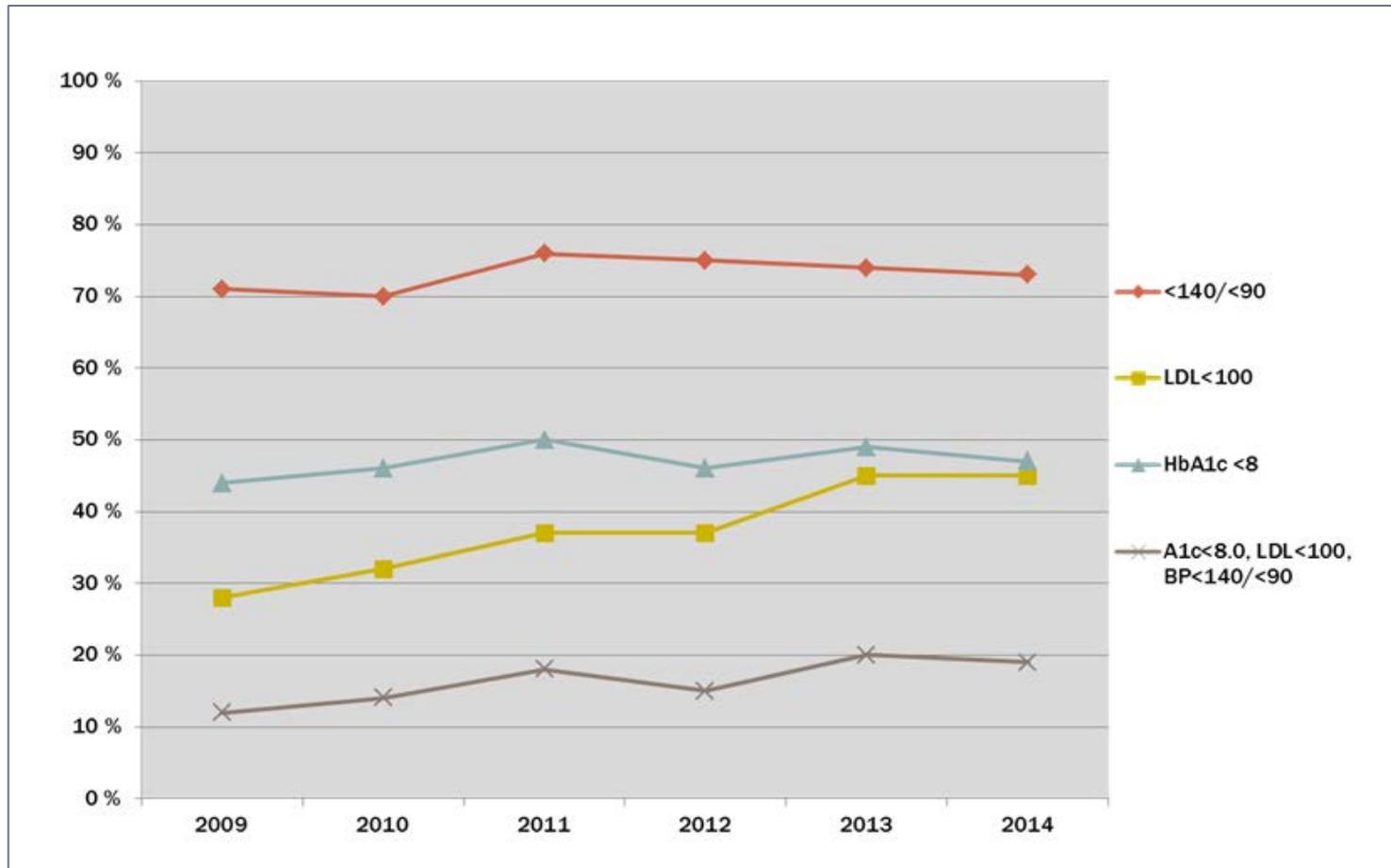
NUMBER OF PATIENT CONTACTS SEGMENTED BY PHONE CALL AND CLINIC VISIT PER QTR, JAN 14 - MAR 15



DIABETES OUTCOME BUNDLE: A1C, BP, AND LDL IN CONTROL



DIABETES OUTCOME BUNDLE BY COMPONENT



ONGOING

- Continuing to find sustainable ways to improve diabetes services and to try to spread to population management for all diabetes patients.
- Evaluating patient experience utilizing patient satisfaction survey.
- Ongoing tracking of clinical outcomes.

GETTING STARTED

- Can be incorporated into quality improvement projects (Tests of change, Rapid cycle PDSAs).
- Pick a model that works for you: who will do the coaching? Who has the time and ability?
- Provide ongoing training in SMS, IM, diabetes care.
- Start small – microsystem or teamlet model and scale up from there.
- Create a work flow to integrate coaching into day-to-day operations.

Adapted from Health Coaching: Teaching Patients to Fish by Ghorob

GETTING STARTED (CONT.)

- **Create standing orders to allow coaches to become meaningful part of care delivery (e.g., ordering labs or making referrals for eye exam).**
- **Ensure coaches have protected time to work with patients during and between clinic visits (by phone or in person).**
- **Continuing development of coaches through mentoring and monthly (weekly) forums for case discussions, reviewing successes and challenges.**

QUESTIONS?