



Health Coach Model for Diabetes Care

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Miranda Williams:

Hello, I am Miranda Williams. I am the Diabetes Coordinator for the Chinle Service Unit in Navajo Area. I've been with the Chinle Service Unit for about four and a half years. My academic background is in the area of nutrition and dietetics. I've been working in diabetes for over 15 years with 15 years of experience in program development, **implementation**, and evaluation within the American Indian communities. I'm interested in different strategies used to influence positive behavioral change in the clinical and community setting. And I'll go and pass it to Krista so she can introduce herself.

Krista Haven:

Good afternoon, my name is Krista Haven. I'm a Registered Nurse. I have worked in nursing for over 25 years, which tells my age so, I don't like doing. But I've practiced as a school nurse, home health nurse, med-surg. nurse, tele-nurse, critical care nurse, educator, and then as a director for various hospital units. I joined Chinle Service Unit in 2012 as a diabetes nurse improvement specialist and I received my CDE in 2013. Since I've been working with Indian health, I've learned a lot about health management support, motivational interviewing, brief action planning and I like to just spread the news. So, I currently work with paraprofessionals, which is our health coach model that we're going to talk about today and they're level one diabetes health care providers who speak the Diné language and they're part of the local Navajo community. So I'm excited to help present today.

Miranda Williams:

Okay, great. Thank you, Krista. So we're going to be talking about the health coach model, a great option for diabetes care.

So the Chinle Service Unit has one main facility in Chinle, the Chinle Comprehensive Health Care facility which is on your lower left-hand corner. And then we have two health care centers, one in Pinon and one in Tsaille. And there's a picture on the upper left-hand corner of our beautiful Canyon de Chelly in Chinle. So the Chinle Service Unit is a federally run Indian Health Service site with a 60-bed hospital and three ambulatory health care centers. Our user population is approximately 37,000 American Indians and they are in 17 chapters. We're in the central part of Navajo and we have about 180,000 outpatient visits annually.

So, the Chinle Service Unit has really embraced the medical home primary care model, which includes team care. And the team consists of primary care physicians, nurse practitioners, health techs which



are medical assistants, medical support assistants and nurses as well as our health coaches, our nurse care managers, Office of Native medicine, pharmacy and nutrition in clinic.

So we have population management for approximately 4,500 diabetic patients across the Chinle Service Unit. We provide care coordination, case management and support for these complex diabetes patients primarily in house and the outpatient clinic as part of integrated care. We reach about 40% of our diabetes patients, our health coaches, and we provide that daily consultation for these patients, as well as inpatient as well as the urgent care and ER as needed. We also work with multiple partners internally and externally in our improvement work, which includes pharmacy, counseling services, Office of Native medicine, teen clinics, PHNs and some of our external partners, which include the community health representative, John Hopkins Together on Diabetes, and the Wellness Center.

So this is a picture of our team and our team consists of six diabetes health coaches, one diabetes improvement nurse specialist, an informatics tech who does our data management, our diabetes clinical consultant, our diabetes coordinator which is me, and then we have our program assistants.

Krista Haven:

So, why health coaches? Among the leading health determinants, social, behavior, environmental, genetic and health care, behavior is the largest part of the pie, which is 40%. So patients' health largely depends on their own behaviors and this is not just lifestyle issues. This also includes taking their medications, checking their blood sugars at home, getting preventative screenings such as foot and eye exam, immunizations. And they're ultimately in charge of their own health, so self-management. Our health care personnel can provide this self-management support and education in a clinical setting.

So health coaching helps gain the knowledge, skills and tools for a patient to be confident and become actively part of their own care. And so the health coaches help these patients set goals and support them in their efforts to achieve them. Part of that is through the brief action planning. We're going to be talking a little bit more about that.

I'm going to just tell a little story so that you kind of get a picture of what our clinic looks like. So when we're going to these slides, you'll understand kind of how we set it up. In the clinic, we have family practice and internal medicine and on each side of those clinics, we have approximately three to five providers working at one time. And so on each side, we take a couple of health coaches and we have them pre-plan for all those providers' patients. So there could be up to 50 patients in one day that they're looking at. We go through eye care, we figure out which patients are diabetic and we go ahead and preplan their A1C, blood pressure, to see if they're on statins or what their lipid levels are. Some of the providers like to have the patient or to have the health coach go in the visit with them, some like the health coach to go before. So if there is a waiting time, the patient has someone that they're talking to or sometimes the health coach will go after the provider has already spoken with the patient and just kind of clarify the plan that they've all made.

And so I'm just going to start -- I just wanted to make sure that you can actually picture a room with a health coach in it because they're not going to another facility, they're actually in the primary care clinic. So these PCPs main function is to diagnose undifferentiated complaints. So, they recommend appropriate medical, prescriptions for acute and chronic diseases. And due to the lack of time and training, PCPs aren't always as proficient as helping patients change behavior. And other team members such as nurses, pharmacists, case managers, educators, medical assistants and even patients can be trained to provide this health coaching. But we've found that the health coaches who we hire as local Navajo Tribe members and they have different background, high school grad, college grad, medical assistants, we've even had a medic from the Army, these are non-license professionals and they're selected for just experience, ability, potential, their personality and they're trained on the job with designated curriculum. We found that these health coaches do miracles and they have the time to do them.

The way we train our diabetic health coaches is initially, we just do live classes, workshops, online modules, all about diabetes with just the basics with diabetes, pathophysiology management, health management, Navajo wellness model, motivational interviewing. And then we have ongoing education with weekly classes. I'm the diabetes improvement nurse. I coordinate it. I don't do all the classes myself. I might have a dietitian come in, I might have a psychologist come in, and we talk about more advanced diabetes management. And sometimes we talk about just behavioral health issues. We've had patients that built relationships with the health coaches and then call in when they're drunk and they have suicidal tendencies. And we teach our health coaches how to refer them to the right people even if we have to call the police or if we just refer them to the counseling center or walk them over to pharmacy or take them over to Native health.

And so, the diabetes competencies, they learn knowledge and skills but they also know how to do basics like glucometer starts, insulin starts, foot exams. So they know the pathophysiology but they also know the hands-on material as well. We have this five-page competency for diabetes level one educators. When I develop the form notes, five different domains, the first one you can see on the screen is pathophysiology. And the way we grade each one of the health coaches is they grade themselves. They have a self-assessment. Are they basic, are they developing, are they proficient or are they advanced? And we have a yearly score that we do, so that each year we can see if they need more training or if they feel successful. And then we have the mentor assessment and that can be done by our clinical consultant who is a medical doctor. That can be done by myself depending on which level we're at. It could be done by a nutritionist if it's on diet.

So the health coaches have six different types of case management. And really it's our diabetes program that has six types of case management because sometimes the health coaches are just part of getting education materials together.

So for example, you've got to run through the different types of case management, pre-diabetic patients, we just educate with the patient's handout. We might refer them to the wellness center. They might have a nutrition referral and a lot of times, the medical professional can do that, the primary care provider can do this but also the health coaches can do this. The health coaches see the newly diagnosed diabetic patients so they engage the patients and they make a plan with the patient.

I'm going to bring in just a little bit of what brief action planning is. This is the time when they're engaging a patient. They want to set a goal with each visit. And so they just take a few minutes, sometimes less than 10 minutes to find out what the patient wants to work on and they ask a basic question. Is there anything that you want to do about your health today? And this is where a newly diagnosed diabetic patient may say, "Yes, I don't want to take any medication. I need to talk to my family about what's happening and just think about what's going on". And they may set appointment the next day, two days later, a week later, a month later depending on where that diagnosis is.

The health coaches also go to primary care which is what we've talked about, and do the preplanning. And so they see patients on the inpatients. They have one health coach mainly that follows up with those patients. We have a plan. We have seen that urgent care and ER patients and just make introductions to get them to come into primary care and we're actually going to build on that. But I won't talk about that today. And then case management of high risk patients.

So we have high-risk, high-cost patients that have an A1C over 11 or they may have an alcohol abuse problem or they may have frequent hospitalizations. These are the types of patients that the health coaches see, trying to get down to the barriers that the patients have in controlling their diabetes.

How do the diabetes health coaches function at Chinle, so I talked a little bit about integrated team care. And so they provide diabetes education using motivational interviewing and they ask- tell – ask. They ask the patient what's going on, and then what do you know about diabetes, then they let the

patient explain it, then they may make suggestions, they may educate, and then they ask the patient at the end, “So can you just tell me what you’ve got from this session?” And then they do some brainstorming with patients. They do teach-back with patients. They do action planning with patients. They really address language and health literacy barriers. They try to help the patient understand just by repeating things with family members with the patients, with a support person, and they provide culturally sensitive communication.

Our coaches speak Navajo and so when they’re speaking with the patient, sometimes they are the go-between the doctor and the patient and they promote shared decision-making and collaborative relationship. So for example, if the physician or the providers have been in a room and they’ve made a plan with the patient, the patient went along with the plan and then the health coach goes in and they ask the patient, “So what’s going to happen?” And the patient goes, “Well, I’m not going to do what I just said I was going to do.” Or they just say, “I don’t think I’m going to take that medication.” Because they’re speaking in the same language they have the same culture, there is more of an expression from the patient a lot of times.

One of the roles of helping patients just change behavior through self-management and through self-management education. So, understanding readiness for change. We train coaches to know each stage of readiness for change. Recognizing and addressing behavioral barriers. If the patient needs more understanding of medication and they can’t help, they take the patient, they will walk the patient to a pharmacy and wait with the patient to talk to the pharmacist or they’ll take the patient over to the Native practitioner if there is a cultural barrier. They may take the patient to the counseling center and say, “Diabetes is the least thing on the list right now. We need to talk about other things.”

They teach skills of problem solving, realistic goal setting and action planning. They utilize Healthy Heart, Balancing Your Life and Diabetes, and Lifestyle Balance curriculum. And so they provide care coordination and follow up. And as we go through, I’m going to go over some of the data slides that we have and kind of show you some of our visits are in-person and some of our visits are telephone and we follow up with those patients. And that’s part of the brief action planning, we make a plan with the patient and then we ask the patient, “When can I call you? When can I contact you and get a hold of you so that we can just follow up in a week or two and see how you’re doing.”

So we have an integrated medical home team model. I already talked about this so I’m not really going to dive too much into it, but the diabetes coaches, they are assigned to work with primary care teams, they usually have two to three coaches in every clinic session and they preview the schedule. A lot of times they see the patients, they have to prioritize because we may have more diabetes patients than they can actually see in one day. So they may just choose all the patients that have an A1C over 11 or 9.5. And so they may see all the newly diagnosed, they always see the newly diagnosed and they always see patients that start on insulin or have a huge insulin change. Maybe they go from injecting insulin to getting an insulin pen. And so these pre-visit planning, the hemoglobin A1C, and the lipid levels and the blood pressures are done every day before clinic starts.

The integrated health coach model of care, we talked about this already as well. The diabetes coaches meet with those providers and we call it the huddle. They see the patient either before, during, or after the visit and the treatment plans are reviewed with the providers and patients. And so if there’s a change that the patient makes after the provider made a plan, the health coach will go to the provider and say, “I think that the patient doesn’t want to do this plan. Can we make a new plan?” Or the patient said that they’re not going to take their metformin because it makes their stomach hurt, is there something else that we can do? Or can we have more communication about that metformin?

The diabetes coaches do the self-management teaching in the exam room, the glucometer training, the reviewing the meds, the problem solving, the goal setting, the teach back, the action planning. They may bring a nurse in for the actual insulin demonstration but they do all the teaching ahead of time and they do it in small chunks. They don’t give everything all in one day. They have the patients come

back. The doctors and providers decide when they want the patient to come back and they'll come back more frequently at first if the patient is a new diabetic or a new insulin start. And if the patient needs more extensive time, the coaches go ahead and take the patient to a separate office so that the provider can use that room.

So the results we've seen with the integrated model is that they're very well accepted and in demand by the providers. So we definitely had some concerns from the beginning that they would interrupt clinic flow but over time as the health coaches work with the providers, they have their own way of doing things. Sometimes it just depends on how the provider wants to do things and the health coach just works with the provider. So it's a really good match. And then we also do surveying with our providers and our patients and we have over time have built high satisfaction scores among our patients as well as our staff. And we've had a marked increase in our patient encounters with diabetes health coaches and Krista is going to be looking at or showing a slide and we have some really outstanding results in that area. We have improved diabetes performance measures and we have some wonderful slides that show that as well. And then through the Chinle Service Unit Executive Committee just with the outcomes we've been able to show with this health coach model, our model has now been approved and through the SUEC committee, and our positions are now permanent.

So we just wanted to share with you just a few comments from our physicians. The first one I'm going to share and you can read over the other ones, but the one that I'm going to share from this slide is the top one from one of our providers who's been here at the Chinle Service Unit for years and has gone through many different types of test of change. He said, "Working with 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."

And then the next slide, I wanted to share the last comment with one of our other well-respected providers Rick Smith. "Given the disease burden that diabetes represents in our community and the numerous barriers to consistent diabetes management, the health coaches and the diabetes team as a whole have been integral to successfully caring for patients."

And then we have some patient comments we just wanted to share with you too because this is really important to the work that we do and this is going to -- you can go ahead and read through. I'm just going to share one of the comments and it's from Delphina, which is the third bullet. "The diabetes health coaches help me stay on top of my blood sugar with monthly follow-ups just knowing that I can tell them when I have questions puts me at ease".

I just wanted to talk about the average patient encounters. When we look back on this quarter, October to December 2012, this is the very beginning of our health coach model. We had been in another building so the diabetes program was outside of our primary care building and so patients would be referred to a diabetes educator, through a consult tab and they might be pointed in the direction of the building that they were supposed to go to and they were seeing maybe 24 patients a month at the most. They just weren't making contact. So when we started the health coach model, it was around October to December 2012 when we had one extra health coach. We moved into primary care clinic and already bumped up to a hundred and eight a quarter.

As you look at this slide, we go from a hundred and eight per quarter all the way up to October through December of 2014, we're up in the 400s. So the patients are being seen on a regular basis by the health coaches and are readily available because they just go right into the room. They don't have to go to a different building. There's not consult tab, the health coaches are waiting right there at the nurses' station and have preplanned and are ready to speak with the patient.

The percentage of diabetic patients with the health coach visit at the Chinle Hospital site actually is about 1,500 per quarter and at the start of 2013, there was about 1,200 patients being seen and the percentage is about 30, 31, 36 and then has gone down as low as 28%. Three of our health coaches

moved on, went back to school and so we have six total and we only had three working and they were still seeing 1,500 patients, which was still 28% of the diabetic population. And we know here in Chinle that about 50%, 55% of their patients are under control. They don't need to be seen. It's more of 45% and then they're the percentage of those patients that diabetes isn't the number one thing that they need to work on. They have many other issues, cancer, just lots of other things that they're working on. And so this just shows the progression that our program is making.

So again, this is the percent of high risk patients seen by a diabetes health coach. In the blue column, these are the patients that came into internal medicine or family practice and had an A1C over 9.5 and were seen by a health coach. And then in the yellow, these patients had an A1C over 11% and they were seen by a health coach so that's about 60. So most months, you're going to see a higher percentage of patients that are over 11% that are getting seen, so that's where we put our focus. First, over 11 and then next, over 9.5 and then after that, it's more continuity of care. If we have a relationship with the patient and we know they are trying to meet a goal, we'll meet with that patient. So, if their goal is to be under seven and they are 8.5, we're still going to see that patient but they might not be prioritized at the top if there was no health coach available.

The number of patient contacts I wanted to bring this up because -- let's just go straight to the January to March 2015, those yellow, the bar that has the half of the yellow, the 545 mark, that's how many phone visits were made per quarter and then the 983, that's how many clinic visits that the health coaches completed per quarter. So every time they see the patient, they make a goal and if the patient allows them to call and set up an appointment, a phone call appointment, they'll go ahead and call and sometimes the patients just say, "I have to come back in two weeks. Anyways, I'll let you know how I'm doing with my goal at that time." And so not only are they seeing the patients in clinic, they're also making contacts and making goals over the phone.

Our diabetes outcome bundle is the hemoglobin A1C, blood pressure, and LDL in control. In 2009, we were meeting this bundled goal at 12%, which is very low and we still are low at 19% in 2014. We'd like to be higher but it is a whole lot better than 12% and so with the health coach model of care, we're just seeing a progression towards where we would like to go.

This is just the diabetes outcome bundle by components. The blood pressure is over 70%. The A1C under eight is up by 48%, 50% and then the LDL is right in the 45% range.

Miranda Williams:

So moving forward, we like to continue to find ways to improve our diabetes services and try to spread this to population management and for all diabetic patients and we're continuing to evaluate patient's experience using patient satisfaction surveys. It's really important to get that feedback from patients to make sure what we're doing is working for them and knowing what's working for them and we're continuing to do that.

Krista Haven:

I'm going to just make a comment. One of the things that we do every quarter is we take all of the patient comments that are made and all the patients surveys and we have the health coaches and I and we literally brainstorm on ways that we can address their concerns. So, if they say, "I don't know how to go shopping and buy affordable food that's nutritious and good for a diabetic" then we actually address that in the clinic visits and we address that with the dietitian and nutritionist and find different ways. So I know about a year and a half ago, that was something that we weren't talking enough about. So we went ahead and brought the Native plate out and we started giving out copies of the Native plate and talking about the different food groups on that, and we had grocery store tours so we could explain to patients how they could go through a grocery store and buy affordable foods that were actually healthy for them.

And so one of the other comments that they made was, “How do I bring my tradition into this? We have a lot of ceremonies and at the ceremonies, people bring all these different types of foods.” And that’s where we were able to start talking about portion control with patients and actually having specific conversations about portion control at ceremonies with patients.

Miranda Williams:

Thank you Krista and I just wanted to extend onto this, it is with patient experience. So we’ve done a lot of things based on patient feedback and some of these things that have resulted from that is our diabetes shared medical appointments, so we have group visits with patients who receive support, additional support and education through their clinical care team as well as their peers, which has really proven to really help patients when they’re going through challenges and getting that feedback from their peers. And other things that have resulted is, we have patients’ success stories as well as digital stories where the patients are now wanting to kind of tell their journey, and experience they’ve had with management of their diabetes.

And so those are some other things that have kind of resulted from the patient experience. And then we have on the last bullet, ongoing tracking of clinical outcomes, so we’re always tracking our data kind of seeing where we’re at and we share it within the team but we also share it with our partners, with internal medicine, family practice, the partners that we work within clinic as well as our other internal partners with pharmacy, with the other sites, Pinon and Tsailé. We run data for different forums so that people know where we’re at and what can we do together to work on improvement initiatives.

So with the health coach models, this is something that different programs are looking at and possibly doing within their program. These are some of the lessons learned that we wanted to share with you is these sort of changes can be incorporated through quality improvement projects such as test of change, rapid cycle PDSAs and we started with a microsystem back in 2012 and just with a small portion of patients within one clinical care team and we spread it within internal medicine and that was the clinic we started with, and then we implemented it there and then we spread it to the family practice. Not everything worked as smoothly as we thought it was going to of course but we have a lot of lessons learned from that. So we started out small and we spread that.

Krista Haven:

So some of the lessons learned was, we needed to make templates for the EHR visits so we could add so that there was better communication to the providers and then we had to bring in the templates and bring in the vital signs and different things into the notes so that the health coach, when they’re actually writing their note had specific detail in their note so that it made sense for others when they read the notes.

Miranda Williams:

So what’s important is picking a model that works for you. So for Chinle, the health coach model worked for us and with who did the specific health coaching was community members, individuals who spoke Navajo which was very important specifically for some of our sites such as Pinon, and who has the time and ability, and so our health coaches who work in clinic, they have the time, that extra time to work with that patient on setting goals and so that could be within a provider visit. They have that 10 to 15 minutes window of time to set a goal with that patient and then if they need more time with them, they take them into another room.

So that’s the model that works for us here. There could be another model that works better for your site, Who has the time to do the coaching, provide that ongoing training for self-management support, motivational interviewing diabetes care so that staff who are doing this can continue to build the skills

that they have around these areas. It's really important as we've had lessons learned with doing self-management support training with clinical staff but they need that ongoing coaching on how they can kind of work through some of the problem solving, some of the issues they're having with trying to set goals and trying to move those numbers with patients.

So, along with the top bullets and start small, a microsystem or teamlet model scale up from there. And create a workflow to integrate the coaching into day-to-day operations. That way, it's adaptable to however your clinical team is set up.

Create standing orders to allow coaches or staff who are going to be health coaches to become a meaningful part of care delivery, so ordering labs or making referrals for eye exams.

Krista Haven:

So, when it comes to the standing orders, a lot of times as an RN, it needs to go through me but there are specific things that the health coaches are allowed to order, and that's just the A1C. They're allowed to order the microalbumin urine and a lipid level and they can also make the referral for the JVN which we have right there in our clinic. And so they just walk the patient over if they see that there is a reminder that has popped up for those patients.

Miranda Williams:

So, just another part that was very important to our health coaches, just making sure they have that protected time to work with patients during and between clinical visits either by phone and in person. So, a large part of what the health coaches do as far as patient's follow-up which is very important in moving those numbers is having the phone call follow-up so they can check on these patients, particularly those who've had medication change, who are new insulin starts or adjustments or who are new diabetic are followed up on between one to three days.

Krista Haven:

To continue on protecting those health coaches, the diabetes health coaches, they do not wear scrubs. So when they are in clinic, they are dressed in professional clothes. They wear an outfit that the community member may wear to a doctor visit. And so when they come in, the health coaches are part of the team but they're also an advocate for the patient. So they're on the patient side so that we protect them. They don't do the labs themselves. It's not one of the health techs or the medical assistant or an aide. This is something that they are dedicated to diabetes health coaching. This is what they do and so they're even given admin time so that they can follow up with the patient by phone later on.

Miranda Williams:

In continuing to develop, your health coaches has been something that's very important to their development of their skills and doing that mentoring and monthly forums for case discussions and reviewing successes and challenges. So there are all sorts of patients that come in with all walks of life and having that peer support, and making sure that they're getting the education they need to be able to help patients has been proven to be a very important part of the services that we provide to patients. And so I'll let Krista kind of talk.

Krista Haven:

I'll just give an example of the health coaches and the weekly forums for case discussions. I know that when I first started in 2012 and the health coaches were new at what they were doing, they had a lot of questions and they would run into situations where they weren't sure how to proceed because the

patient was not ready for change. And so what we did is we had a psychologist that worked at our center come in and he came to our sessions and he just taught us how to deal with a patient that wasn't ready for change in diabetes and basic discussions like, do they want to change anything about their life? Do they want to feed their cat at a different time? I mean literally, the most basic things based on that patient. And then it was less discouraging for the patient or for the health coach and so they were able to feel successful and then also feel like if there were challenges, they could get help. They weren't just left in the room by themselves. We all talked about the patients in our own forum just with the team and we had our clinical care provider who's a medical doctor there and then we had a psychologist and myself and we would bring other people like Office of Native medicine and say, "How do we do this? How do we maybe become even more culturally appropriate with the patients?" And so those are the things that we did that helps with the continuing development.

I know we have lots of questions, so I think Miranda and I can just kind of go through them. Is that what you want us to do Jan?

Jan Frederick:

That would be great, yes. You've definitely gotten lots of people interested and they have some specific questions. So if you want, you can go ahead and read those. We've got them outlined for you.

Krista Haven:

Okay, so we'll just start with number one. Do your patients always see a provider with clinic visits or do they sometimes schedule visits with the health coaches for follow-up between provider visits? And so I'm going to answer that along with the question that I saw, "Can we bill for the health coaches?" And so at this point, we don't bill for the health coaches and they do see patients between provider visits but not very often. What they do see as a visit is actually a phone call. So for example, if the patient made a goal, an exercise goal or maybe they were supposed to titrate medication and we wanted to double check to make sure they actually did what the physician said, we would go ahead and call that patient and just say, "How did you do with your goal? Tell me how. Tell me what you did." And then they would go ahead and call and make another goal based on whatever the provider had made an order for. So, yes, we see patients between visits and we have many drop-in visits for a battery for their glucometer or they have a question or they forgot how to use their insulin pens. There are many times where they'll call and just say, "My blood sugars have been in a 200's and I don't feel good. What should I do?" And we refer them to the clinic.

Miranda Williams:

I just want to add to what Krista said, yes the health coaches are not billable, but one of the things that we've tried to do from the beginning is making sure that patients are seen during the time they're here, seeing a provider. So they don't have to come in a second time because it's a very remote and a rural area out here in Chinle and it can be difficult getting into clinic, so we really try to schedule them while they're already here being seen by a provider.

Krista Haven:

And when we did a test of change, just this is an FYI, about the money part is that we did a test of change on really dealing with our high risk patients that were very costly and were seen in the ER or the in-patient and we started making more contact with those patients and we were able to bring them in to the primary care on a more regular basis and we thought that by bringing them into primary care and the increase there, there was a decrease on the other side but we actually made more money by bringing the patients in, not that that was our goal but it did suffice that.

The next question was, what program did you use to certify your health coaches? They're not certified except for in brief action planning. They've had training and motivational interviewing. They've been to classes with Virginia Valentine and they suffice the basics ADA standard for a health professional, health educator. So we use that. In the future, we have looked into programs to have them certified so that if they wanted to move on and get a job somewhere else, they would easily be able to do that.

So how long are your patient visit times when they're seeing a primary care? So our patient times are 20 minutes. Some of our outlying -- I know that Tsale and Pinon have 30-minute visits but we actually -- the provider will see the patient and then we see the patient and the longest we can have a room is about 10 minutes. And so if we're taking longer than 10 minutes, which many times we do, we will move to an empty room even if that's the treatment room where nobody is working at that time.

Miranda Williams:

The longer appointments tend to be used for the patients that are newly diagnosed, who are new insulin starts who have some other pretty advanced barriers to managing their diabetes.

Do you want to mention about the grant?

Krista Haven:

Is this program primarily funded through grants or is there a way to bill for health coaches? And I think we already answered the bill for health coaches' part and yes, our program is primarily funded through the SDPI community-directed grant. We also have the Healthy Heart grant, which we are going to -- which this is our last year of grant funding.

Do you address with the clients you see, the need for people with diabetes have vaccinations: flu, pneumo, Tdap, Hep B. So we have great immunization records and the reason we do is because our public health departments works with us along with the clinic and so we do address these things with our clients. The health coaches don't have to do it as much as the actual clinic staff. We have reminders that come on, so they have clock and so when the patient comes in, the health tech that's part of the multidisciplinary team asks those question.

And so the next question was, does this program rely primarily on in-clinic and phone encounters or do you utilize your health coaches within the home environment as well? So it's a really good question. We actually and I'll tell a quick story -- we actually did try to go to the home. We are very remote. So let me give you an example. I am not Navajo but I have a lot of Navajo family as I married a Navajo man and I decided to go, I wanted to see the community and see where I'm at and I'm a public health nurse so I wanted to go. And so one day, I took the time to go to a patient's home in Nazlini, which is about a 45-minute drive and we had an all-terrain truck vehicle to go. I went through three washes to get to the patient's home and took four hours to get out there because of the weather and when I got to the patient's house, the patient was not there and so we decided after a couple of more times of The similar things happening and actually that patient was in the clinic. When I got to her house and got back, I found out she was in Urgent Care. But we found that we actually can see more patients and do more work in our program in the clinic and then if we need assistance out in the public, we ask a community health representative and the public health nurses to provide us with the service and they will take referrals out to the patient's home if needed.

So the next question is, would community health representatives be able to join your facility for training? So, absolutely and they do -- I do probably six trainings a year for the CHR's and we invite them to our paraprofessional training. We also provide resources for their monthly training through the Chinle Service Unit so we address their women's health, a lot of other issues through our system that Chinle actually provides those services for them.

Miranda Williams:

I just wanted to add to that. Along with the community health representatives, we are joining efforts to integrate them as part of the clinical care team. So some of the groundwork we've done is we provided training on how to use EHR. We set up templates. We've kind of provided that ongoing support and using EHR on patient encounters, documenting patient encounters. We're still continuing to provide support in that effort. But we are working with our CHRs particularly with the patients that are kind of more of the high-risk population.

Krista Haven:

And the health coaches do chart. The health coaches have to co-sign their note to the primary care physician and the CDE, which is myself. I don't want to see every single note but I look at about six notes a week per health coach so that I can know that they're competent in what they're doing. But every time they do a note, even a phone visit, they co-sign the providers so that providers are aware especially if there were any problems with that phone call.

Is a curriculum-training plan for the health coaches available for sharing? Absolutely we'll share whatever we have. I go by the competency grid that I showed you and we just go through those things and if -- we also do -- quarterly, we ask the health coaches themselves, "What would you like to learn?" And they give us ideas. So for example, if they feel like maybe they need a review on something, we'll go ahead and do motivational interviewing. We already have our annual trainings that we do, brief action planning, motivational interviewing. We'll go over nutrition and there are several others that we go over on a regular basis and annually so that it doesn't get forgotten.

Miranda Williams:

I just want to add to that. So Krista, even though she has her set schedules for her trainings, she also goes by what's needed by each one of the health coaches too. So we've had over this past year three new health coaches that have joined our team and so she's had to evaluate them differently based on kind of what are our other more experienced health coaches have, but they're all getting the same sort of trainings. It's just she's having to kind of evaluate them at the level that they're at.

Krista Haven:

And they self-evaluate so if they feel uncomfortable with a subject or they're in a room and they feel stuck, they can come and get me or another health coach or the physician, the provider and they have the support there. The providers love the health coaches and so they're very willing to help if they're stuck on something.

Have you since created a template for EHR documentation? When collecting data, did you use a monthly spreadsheet in addition to the checklist provided in the earlier slide? So absolutely, we had to create several templates for the EHR documentation. So when we created it, we have the new insulin start, we have many, many different documentations; the phone, the chart review, everything. We definitely follow a plan and a path so we're not forgetting something because our medical records department is part of that as well as billing.

And then when collecting data did you use a monthly spreadsheet? Yes, we do. We have a list of data that we do monthly, quarterly, and annually. We actually do our audit quarterly so that we don't submit it every quarter but we actually look at our audit quarterly and then all of our stakeholders are made aware and we have a monthly meeting. It's our diabetes improvement team meeting where we have all of our stakeholders call in or come to our meeting so that we can review and do more improvement based on what our data says.

What is the ratio for patient to coach? It really just depends. When you saw the slide where it says, there were six different types of health coaching that we provide six different types of case management, so each day is different. They do have specific patients that they see but like they wait for the patients to come into clinic and then they have a system of calling those patients afterwards so the admin time they get is two to three sessions per week where they can actually follow up on the phone calls and then during the day, they're seeing the patients as they actually come in so the case management is a little bit different. Then we have just a different level of case management for the high-risk patients and that's where they may have 10 or they may have 20 patients or they're at the most 30 patients on top of what they're already doing to contact and get them into clinic. Because that's our goal, is bring them into clinics so that the whole multidisciplinary team can see the patient.

And then are you a certified diabetes education program via AADE or ADA? So I have a CDE. We do not have the AADE certification for our whole service unit. I know that I think Tsaille, the pharmacists were working on something like that. But if there's a lot of work to go into that and it is a goal for us.

So I am a certified diabetes educator and we have some pharmacists that are. We have some PHNs that have their CDE and we also have some dietitians and so the way they fit into the model is for myself, I am the lead in the clinic. So I take what the health coaches are doing and I let them do the health coaching while I do almost like the supervision in clinic. I made sure that it's safe care, that it's legal care, that we're doing the right thing and that the health coaches are safe, the patients are safe and the providers are happy. So it's my job to kind of also be doing the improvement work. So I look back and see, are we focused on the right thing? And that's how I fit into it but the physicians that have their CDEs, the pharmacy and the nutrition, we pull nutrition, they're part of our multidisciplinary team in the clinic so they see patients and then our pharmacy depending on the clinic. They also see patients and have a chronic disease management program on their own that we refer patients to if we feel like they need more medical or medicine management.

What is your staffing for primary care number of providers; number of RNs, number of -- that's a whole other question? I think I'll come back to that one because that's not based on the --

Miranda Williams:

I think they're wanting to know kind of what as part of the care team like how many providers, how many RNs?

Krista Haven:

So we have 17 providers, we have three to five providers per clinic, we have two RNs per clinic, and then they have another flu shot RN, they have I believe for every provider they have a health tech --

Miranda Williams:

Which is a certified medical assistant.

Krista Haven:

Which is a certified medical assistant and then they have two on each clinic, they have two medical assistants that actually answer phone calls and talk to patients and take messages. So I hope that answers your question. And then for each side of the clinic, there are three health coaches but they're not all scheduled every single session.

Miranda Williams:

So we have at least two.

Krista Haven:

Yeah, so we try to staff at least two. I hope that answers your question. And then are there clients coming to the clinic for diabetes visit or they're going -- okay, so this is a great question. Are they going for another type of visit like they have a cold or they're catching them when they come in? Okay. So, this is a great question because when we first started this, we were only taking the patients that were coming in with diabetes and for a diabetes-related visit and now we see any patients that are diabetic. So when we do our preplanning in our i-care panel that comes up each day, we take any patient that is a diabetic, whether they come in for a follow-up of diabetes and we do an A1C on them and we go ahead and see them for diabetes as well and look at their meds. Do they need to be renewed? How is the patient doing? Is their blood sugar too high, too low? And then this is what we encourage the providers to let us do so that the patient is addressed, but we don't force it. So we know that if you're really sick and you have a cold or some other issue, they're not going to want to see a diabetes health coach but we do just kind of wave our hand and say, "Hey, we're here" if you would like us.

Did you have a system that allowed you to view diabetes education and hospital admissions to contact these patients for a follow-up visit within a reasonable amount of time based on Medicare guidelines? Okay. So that's kind of a dual question for us. We see the patient while they are in the hospital. We get them an appointment in primary care while they're in the hospital especially patients that are more high risk and then we try to contact these patients if they don't follow up with their visit and I hope that answers your question. We have seen a decrease in our hospital admissions. It's been for a couple of years, our observations are increasing a little bit but our overall readmission is going down and we do diabetes education with those patients.

Miranda Williams:

I just want to add, so the health coaches do a daily list for patients that are admitted and they do attend the multidisciplinary in-patient team and so just to kind of listen in on what's going on with these different patients and then they do, like Krista said, do the follow-up.