Health Coaching for Complex Patients with Diabetes
A report from the High Value Healthcare Collaborative (HVHC)

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Jönköping Sweden

Objectives

➢ Review the evidence base for our intervention

➢ Describe the macro, meso, and Microsystems of our coaching project

➢ Describe the components of our clinical intervention

➢ Present preliminary outcomes
The Chronic Care Model

Community

Resources and Policies

Self-Management Support

Health Systems

Organization of Health Care

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Early Evidence

1994

Improving Primary Care For Patients with Chronic Illness
Bodenheimer, Wagner & Grumbach
JAMA Oct 2002

Chronic Illness
Breakthrough Series at IHI 1998-1999

Later Evidence

2004

Medicare Coordinated Care Demonstration
April 2002-June 2005

2014

HVHC Complex Patient Project – Diabetes 2011-Present
Key Points

- A large scale quality improvement collaborative for chronic conditions such as diabetes is feasible
- Focus on the sickest patients
- Coaches need training in behavioral change
- Critical to engage with clinical team in-person
- Empower coaches to work autonomously
HVHC: 1,478
HVHC/Pioneer: 609
HVHC/Pioneer/20%: 79
Health Coach Note

Progress Notes Info

Encounter Date: 12/27/2014
Progress Notes Info

Author: Ray, Beinda B

Progress Notes:

Health Coach Progress Note

Provider Type: Health Coach
Clinical Area: Diabetes

Contact Type: Follow-up Contact Coaching and Survey:
Coaching and/or Care Coordination: Follow-up Planned. Will call next week to check in.
CMRI Survey: Pending Surveys

Encounter Duration: 90.60 minutes

Primary Reason for Contact: Goal Setting Follow-up
Secondary Reason for Contact: Admonition, Survey, Care Coordination and Other Health Coaching

Actions Completed: Care Coordination
Answer General Questions
Questionnaires (6 months)

Susan Test is a 64 year old female who presents for follow-up health coaching focusing on diabetes self-management.

Current issues discussed

• blood sugar testing issues
• diet concerns and goals
• exercise goals

Other concerns: financial, psychosocial and sleeping issues

Patient feels lonely, being away from family and friends, particularly with Christmas coming up.
She worries about being able to afford a trip to see friends but feels she knows how to save adequately if she starts now.
When she worries, she has a hard time sleeping. Also, not moving around makes it harder to sleep at night.

Assessment: Susan Test was doing well with taking her diabetes medication and eating low carb diet over the long Thanksgiving weekend. She also was able to get to the gym where she works and exercised for about 40 minutes on a recumbent bike, treadmill, and used strength training machines on upper body. Felt good afterwards and thinks it helped her sleep.
Pt wants to work on continuing to exercise, quitting smoking, and improving sleep. See action plan below.
Pt will have month long visit with friends in the south, starting in mid-December. Acknowledged that just staying home with no structured activity would be difficult for her over Christmas.

Follow Up Plan: Phone; pt to call once she has made apppt with her PCP, which she intends to do via myD-H message.
Pt filled out primary care questionnaire at visit and welcomes subsequent questionnaires being sent to her via a myD-H message.

Information about diabetes

To: Susan Test
From: SUSAN Z BERG, MS
Received: 12/2/2014 2:44 PM EST
Tasks: [ ] Q: PACIC
[ ] Q: HVHC Diabetes Survey

Dear Susan Test

Primary Care at Dartmouth-Hitchcock is sending an educational program to patients with type 2 diabetes. This program offers information about diabetes management that we think you may find helpful.

Living With Diabetes: Making Lifestyle Changes to Last a Lifetime.

Many find this program helpful in learning about diabetes and how to manage it. You may view this web based program as often as you like by keeping this message and clicking on the above link. If you would prefer a hardcopy contact us and we will mail it to you.

To help us learn whether this program is helpful to patients we would appreciate you completing the short questionnaires about your health and your understanding of diabetes that is attached to this message and again in 3 and 6 months.

We hope you find the information in the web program helpful. If you have any questions please contact me.

Internet | Protected Mode Off
Living with Diabetes

Introduction

Living with Diabetes
Test, Susan
Hemline Dr, South

From: Office of Rec. Services (PR 0000004046)
To: Susan Hemline

Date: 3/2/2015 3:33 AM
Subject: Questionnaire Submission

Re: Questionnaire Submission

You are invited to complete the Hemline Dr. Questionnaire. This questionnaire is designed to help us better understand your needs and preferences. Your feedback is important to us.

1. How satisfied are you with the services provided at Hemline Dr?
   - Very Satisfied
   - Satisfied
   - Neutral
   - Dissatisfied
   - Very Dissatisfied

2. How likely are you to recommend Hemline Dr to others?
   - Very Likely
   - Likely
   - Neutral
   - Unlikely
   - Very Unlikely

3. Please provide any additional comments or suggestions.

Thank you for your time and consideration. We appreciate your feedback.

Sincerely,
[Signature]

Hemline Dr. Staff
Determinants of health

- Clinical Care 20%
  - Access to care
  - Quality of care
- Health Behaviors 30%
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex
- Social Economic Factors 40%
  - Education
  - Employment
  - Income
  - Family & social support
  - Community safety
  - Environmental quality
  - Built environment
- Physical Environment 10%

Longitudinal relationship-centered care

Doctor
Dietician
Diabetes Educator
Care Coordinator
Endocrinology

Coaching

Nelson, Batalden, Godfrey, Lazar Value by Design. 2011
"Overall, I’m probably in the best health in a long time. I feel strongly that health coaching has had a significant effect.

"...you are actually participating in your health care"
Dialing engagement intensity

Low
Patients desiring minimal support to initiate goal setting or get back on track

Moderate
Patients wishing to create and use action plans to make life-style changes and who desire regular support to reach their goals

High
Patients with diminished capacity, low health literacy, psychiatric issues and/or negative history with medical institutions

Action Plan

Patient Name:  

I am doing well with:  

I want to do better with:  

The long term goal I have to improve my health is: 

Reduce Stress  Healthy Eating  Physical Activity  Taking my Medications

Today I met with:  

Decision Aid:  

Priority Concerns:  

Date:  

Outs:  

Provider Feedback
13/14 respondents want the service to continue

At least three patients have had HbA1c drops of >2. One with a HbA1c of 13 who declined all care for 10 years is now taking Lantus

A lot of the patients we refer are depressed. Having an extra person there helps give them a connection and also can act as a safety net.

We need this support, ideally integrated with the team and designed to minimize fragmentation of people involved.

Based on what we know nationally, health coaching should be standard of care for chronic conditions. This has been validated locally. We need to offer this standard of care

Enrollments

Figure 1: Cumulative Diabetes Patients receiving Decision Aid / Health Coaching

Patient count (n)

July Aug Sep Oct Nov Dec Jan Feb Mar Apr May June Jul Aug Sep Oct Nov Dec

Cumulative DA patients
Cumulative HC patients

N=672
N=207
Hemoglobin A1c

Lessons Learned

- Health coaching by non-clinical coaches is appreciated by patients and clinicians
- Establishing relationships within and between microsystem is essential for success
- Effective health coaching is time consuming
- Success is difficult to define and therefore measure
Blood Pressure

- Patient Enrolled
- PCP Declined
- Patient Declined
IHI Breakthrough Series 1998 - 1999

Collaborative quality improvement is possible

Community health centers with fewer resources and sicker patients showed the greatest improvements

Self management was effective

Health coaches and care coordinators felt they needed more training

Meta-analysis 1966-2006

<table>
<thead>
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<th>Quality Improvement Strategy</th>
<th>No. of Trials</th>
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<tr>
<td>Team Changes</td>
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<tr>
<td>Case Management</td>
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<td>Patient Reminders</td>
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<td>Patient Education</td>
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<td>Electronic Patient Registry</td>
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<td>Clinician Education</td>
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<td>Facilitated Relay of Clinical Information</td>
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<td>Self-Management</td>
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<td>Audit and Feedback</td>
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<td>Clinician Reminders</td>
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<td>Continuous Quality Improvement</td>
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<tr>
<td>All Interventions</td>
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Shojania, Ranji, McDonald et al. JAMA 2006
Medicare Coordinated Care Demonstration 2002-2012

- Focus on the highest risk population
- Care coordinator training in behavior change techniques
- Face to face contact with patients’ physician
- Evidence-based patient education
- Medication management program
- Care transition programs
HVHC members participating in diabetes pilots

Dartmouth-Hitchcock Primary Care

Lebanon
- 41k patients
- 3k diabetes patients
- 153 staff FTE

Keene
- 50k patients
- 4k diabetes patients
- 112 staff FTE

Concord
- 37k patients
- 2k diabetes patients
- 105 staff FTE

Manchester
- 55k patients
- 3k diabetes patients
- 148 staff FTE

Nashua
- 44k patients
- 3k diabetes patients
- 147 staff FTE

Source: D-H HR/IS
Health systems benefit

As health systems assume greater accountability for quality and costs, patient engagement is an important strategy to improve value.

- **5.3%** Lower overall medical costs and
- **12.5%** Fewer hospital admissions for patients receiving intensive coaching
  
  *Veroff D et al. Health Affairs 32; 2013*

- **21%** Increased medical costs
  
  Patients with the lowest activation scores – having the least skills and confidence to actively engage in their own health care – incurred costs up to 21% higher than patients with the highest activation levels. *Health Policy Brief Health Affairs/RWJ 2013*

Care teams need engaged patients

**It takes 21 hours/day for a primary care physician to meet all of the acute, preventive, and chronic disease management needs for a panel of 2500 patients.**

*Yarnall et al. Prev Chronic Dis 2009*

**Patients who are more activated are more likely to adhere to treatment regimens, get preventive care, and engage in health behaviors.**

*Hibbard JH et al Health Affairs 32 (2): 2013*

**Decision aid use results in greater patient knowledge of treatment options AND higher levels of satisfaction for both patients & their clinicians.**

Self-Care

Individual Provider

Mesosystem (comprised of microsystems)

Macrosystem

National Context

High Value Health Care Collaborative

Dartmouth Hitchcock Medical Center

Primary & Specialty Care

CSDM Health Coaches

Patient