Million Hearts™

Language Concordant Health Coaches Fishbowl

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Scaling and Spreading Innovation
Strategies to Improve Cardiovascular Health
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CDC Centers for Disease Control and Prevention
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San Francisco General Hospital Family Health Center

- Hospital-based full scope family medicine clinic
- Part of the San Francisco Department of Public Health's primary care network
- Participating in access and quality improvement initiatives as part of the 1115 California Medicaid Waiver (CMS Incentive Program), which ties federal funding to milestones, including PCMH standards (team-based care, clinical outcomes)
- 10,700 patients served; 1500+ adults with diabetes
- 50,000+ patient visits per year
- Teaching clinic: 41 family practice residents and many medical and nursing students
- Diverse patient population
  - 42% Latino, 26% Asian, 14% Caucasian,

    12% African American
  - 51% Medicaid, 33% uninsured (almost all enrolled in Healthy San Francisco), 15% Medicare
  - 31 different languages spoken
    - 48% English, 30% Spanish, 9% Cantonese/ Mandarin

Description of health coaching at the SFGH Family Health Center

Health Coaches are members of the health care team who provide self-management support to a stable panel of patients with chronic illness (in our setting, primarily diabetes).

Health Coaches:

- are language-concordant with all their patients
- are trained in motivational interviewing, panel management, diabetes basics, and medication adherence
- work collaboratively with a patient's Primary Care Provider, unlike *promotoras* or community health workers in other settings
- are primarily in the job classification "Health Worker," but may also be Medical Assistants, pre-medical students, trained peers.

Description of health coaching at the SFGH Family Health Center

The Health Coach role includes:

Self management support

supporting their patients to have the knowledge, skills, and confidence to become active participants in their care

Bridge

clarifying information provided by the provider, pharmacy, or insurance company

bridging cultural/ linguistic gaps

Clinical continuity

following patients who are in their continuity panel, with a goal to maximize continuity between patient and health coach

Emotional support

language- and often cultural-concordance enhances trust and engagement in learning how to self-manage the chronic illness

Clinical Navigation

Health Coaches may be more accessible because they are in clinic every day and can be the primary clinic contact person for patients throughout the week

help with making and keeping appointments, accessing pharmacy and other services

Health outcome measures for a population of patients working with Health Coaches

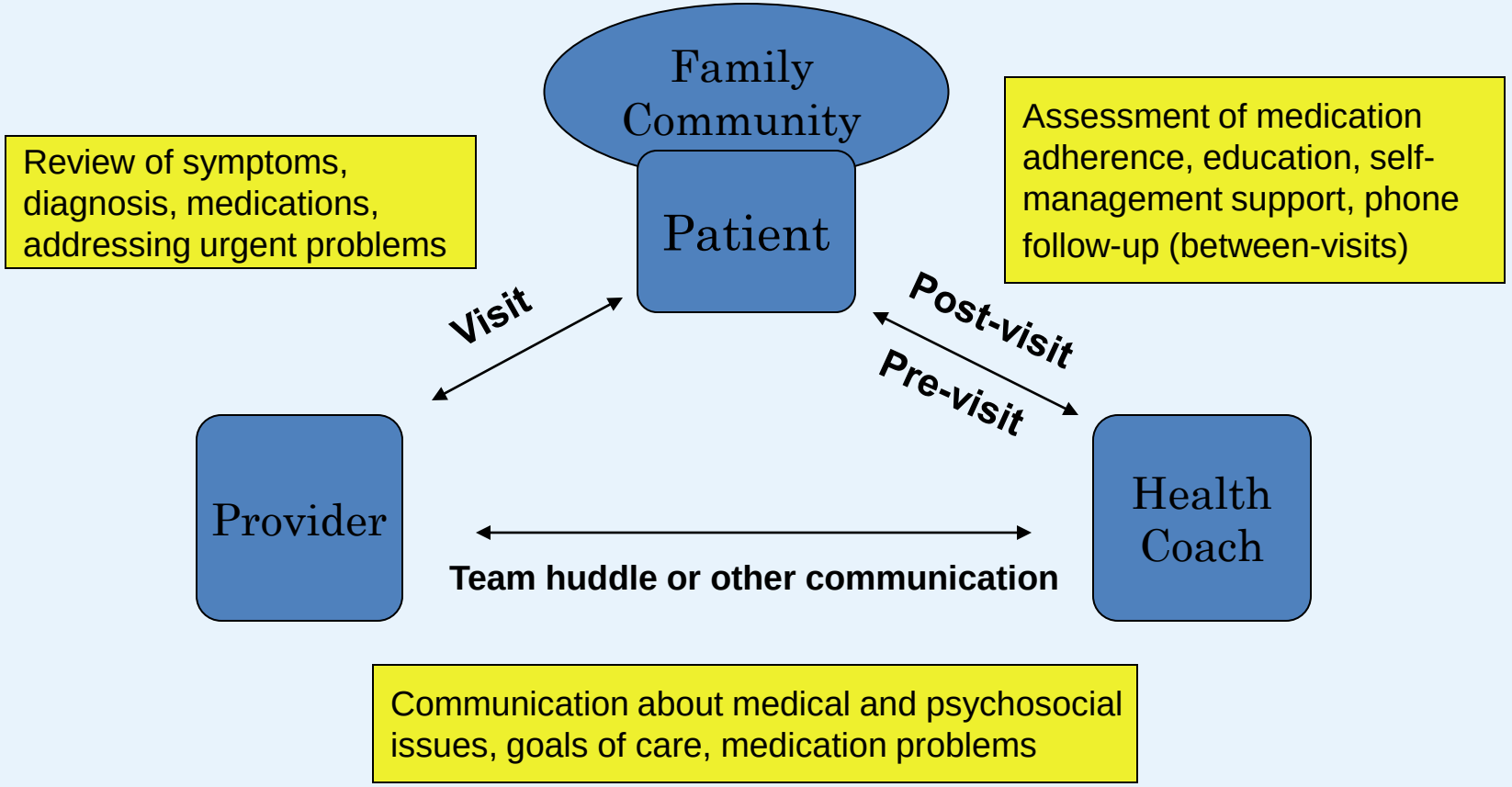
Measures	Baseline Dec. 2009 (n=281)	June 2010 (n=268)	Jun. 2011 (n=265)	Dec. 2011 (n=261)
HbA1c at goal (<8)	43%	43%	40%	50%
HbA1c up to date (2 in last year— > 90 days apart)	36%	73%	77%	66%
LDL cholesterol at goal (<100)	51%	51%	64%	63%
LDL up to date	91%	83%	81%	80%
Self-management goal documented	3%	21%	50%	no recent data

Costs associated with health coaching

- Health Coach program cost considerations
  - Salary ($58,000 per year in our setting, which is 44% of an RN)
  - A full time Health Coach can manage a patient panel of 200 patients
  - Physician or Nurse Practitioner supervision (approximately 5% time)
  - Training costs (6-8 sessions)
  - Must consider how Health Coaches are assigned and interface with other members of the care team (i.e. case managers, social workers)?

Factors to consider in the business case for health coaching

Who provides self-management support and education in a traditional primary care visit? What is the most cost-effective and efficient way to provide this important component of chronic illness care? Health coaching may be the answer.



Factors to consider in the business case for health coaching

The business case for Health Coaching relies on showing that it decreases long-term complications, hospitalizations, and emergency department use.

Self-management support *does* improve health outcomes in patients with chronic illness.

So, the question for health care organizations is: who should provide the self-management support?

The answer is based on the payer mix for the organization, as well as staffing costs.

In our organization, Health Coach salaries are approximately 36% of physicians and 44% of registered nurses.

Health coaching can be done effectively by a non-licensed, trained member of the staff under appropriate supervision.

Lessons learned in scaling and spreading

- Health coach resources should be allocated to patients at highest risk of poor outcomes if they are not able to self-manage their chronic illness. In our setting, we targeted diabetic patients with hgbA1c $\geq$ 8.
- Highest risk patients may also be most in need of emotional support: Health Coaches must be trained to place limits on patients so that coaching is possible.
- Communication, a patient's perception of access, and self-management education are best provided by trained staff who speak the patient's language.
- Other health coaching models which use RNs include the added roles of medication adjustment by protocol and symptom assessment; we prioritize self-management support and medication adherence education, which can be provided by an unlicensed coach.

Plans for scaling and spreading

Capitation (instead of fee-for-service reimbursement) allows providers to prioritize outcomes and satisfaction. As reimbursement is increasingly tied to improved patient outcomes, team-based approaches to chronic illness care will be feasible for more organizations.

Primary care workforce issues have also shed light on the increasing pressures and low job satisfaction among a decreasing pool of primary care providers. Engaging other members of the team to take on time-consuming, non-medical tasks, such as self-management support, may improve satisfaction and make primary care more sustainable.

With funding incentives through the CMS Incentive Program / Medicaid Waiver, we will be able to expand health coaching if we continue to show improvement in patient care and access.

Disclaimer

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