Objectives

1. Practice using health coaching skills in patient-centered collaboration to manage chronic conditions
2. Describe the evidence showing health coaches can improve chronic illness outcomes
3. More practice using health coaching skills in patient-centered collaboration to manage chronic conditions
4. Discuss challenges and solutions to implementing health coaching
5. Begin to draft a plan to implement a health coaching program specific to their primary care practice or clinic

What is health coaching?
What is closing the loop?

- Repeat what I said
- Tell me what you heard
- Do what I told you

What happens if you don’t close the loop?

- Partner up (A&B)
- Partner A will read the script to Partner B
- Partner B will recall the directions
- Discussion – How well did Partner B recall?
How do you close the loop?

What have we learned about health coaching?

- Peers for Progress: Peer Coaching
- Moore Foundation: Health Coaching with MAs
Peer Coaching for Patients with Diabetes:
Lessons Learned from Research and Real Life

What did we want to explore?

Will low-income patients with diabetes, who are linked with other diabetic patients trained as peer coaches, have improved glycemic control compared with patients receiving usual care?

What did we want to explore?
What did we do?

- Two-armed randomized controlled trial - peer coaching vs usual care
- Multicenter approach – coaches and patients with diabetes from six San Francisco Department of Public Health clinics
- Intervention – face to face and phone encounters over 6 months

What is coaching?
This is NOT coaching.

Who were our Peer Coaches?

- HbA1c ≤ 8.5%
- Recommended by the clinic
- Successfully complete a 36 hour training and evaluation
- 23 peer coaches completed training, passed evaluation and coached patients
Coaching Skills:
• interact with clients using active listening and non-judgmental communication
• help with diabetes self-management skills,
• provide social and emotional support,
• assist with lifestyle change
• facilitate medication understanding and adherence

How did we train the Coaches?

• “I gave them tools they needed, and I’ve seen their enthusiasm…. It made me feel proud…. This is my passion, doing this! So it makes me very fulfilled.”
• “I have some pretty good clients. They help me, too, you know. I’m telling you, it works both ways. Whether they know it or not, they’re peer-coaching me, too.”
• “Being a peer coach, I think, is a great thing. I think some of the other diseases also need coaches - like people with high blood pressure …. If I’d had a coach from the very beginning, when I got the diabetes, I would have been able to control mine much better.”

What did the Coaches think?
Who received coaching?

- English and Spanish speaking patients with HbA1c ≥ 8% in the last 6 months
- Contact potential patients using letters, phone calls, flyers, diabetes education groups, clinic referrals
- 299 patients recruited
  - N=148 peer coaching
  - N=151 usual care

What were the two groups like?

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coaching (N=148)</th>
<th>Usual care (N=151)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean ± s.d.)</td>
<td>56.3 ± 10.3</td>
<td>54.1 ± 10.4</td>
<td>0.07</td>
</tr>
<tr>
<td>Female (%)</td>
<td>51.4</td>
<td>50.0</td>
<td>0.89</td>
</tr>
<tr>
<td>Primary language other than English (%)</td>
<td>45.6</td>
<td>49.0</td>
<td>0.31</td>
</tr>
<tr>
<td>Born outside of United States (%)</td>
<td>47.3</td>
<td>50.6</td>
<td>0.25</td>
</tr>
<tr>
<td>Married or married (%)</td>
<td>30.4</td>
<td>43.7</td>
<td>0.02</td>
</tr>
<tr>
<td>Working outside of home (%)</td>
<td>36.1</td>
<td>36.5</td>
<td>0.91</td>
</tr>
<tr>
<td>Less than high school education (%)</td>
<td>36.5</td>
<td>37.1</td>
<td>0.72</td>
</tr>
<tr>
<td>Never married (%)</td>
<td>25.0</td>
<td>23.0</td>
<td>0.26</td>
</tr>
<tr>
<td>White non Hispanic (%)</td>
<td>11.5</td>
<td>10.0</td>
<td>0.90</td>
</tr>
<tr>
<td>Latino or Hispanic (%)</td>
<td>44.6</td>
<td>46.7</td>
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</tr>
<tr>
<td>Black/African American (%)</td>
<td>31.8</td>
<td>30.7</td>
<td>0.73</td>
</tr>
<tr>
<td>Asian Pacific Islander (%)</td>
<td>7.4</td>
<td>7.3</td>
<td>0.27</td>
</tr>
<tr>
<td>Hypertension (%)</td>
<td>66.5</td>
<td>77.5</td>
<td>0.02</td>
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<tr>
<td>Hyperlipidemia (%)</td>
<td>60.0</td>
<td>62.2</td>
<td>0.78</td>
</tr>
<tr>
<td>Smoked in past 30 days (%)</td>
<td>35.7</td>
<td>26.5</td>
<td>0.27</td>
</tr>
<tr>
<td>Using insulin at baseline (%)</td>
<td>60.1</td>
<td>20.0</td>
<td>0.06</td>
</tr>
<tr>
<td>Years with diabetes (mean ± s.d.)</td>
<td>5.1 ± 8.91</td>
<td>8.7 ± 11.1</td>
<td>0.47</td>
</tr>
</tbody>
</table>

* *p*-value from t-test
Whose your coach?

Primary outcome is the difference in change in HbA1c at 6 months.
Secondary outcomes were proportion of patients with a drop in HbA1C of > 1.0% and proportion of patients with HbA1C <7.5% at 6 months.
Additional outcomes examined were changes in LDL, systolic blood pressure (SBP) and body mass index (BMI) calculated as kg/m².
Measurement: Surveys at baseline, 6 months and 12 months (peer coaches only); medical record review.

What did we track?
What was the primary outcome?

Change in HbA1c

What else did we find?

Drop in HbA1c > 1.0%
Peer health coaching is a low-cost strategy that can effectively help patients with diabetes.

What did we conclude?

Health Coaching: Nuts and Bolts
Lessons learned from research and practice
Who are we?

I. What did we do?
II. What did we learn?
III. Where the rubber meets the road: Making health coaching work in real-life health centers
IV. Where can you learn more?

What are we talking about?
What does health coaching mean to you?

What was special about our model?

- Medical assistants working in the clinic
- Stayed in the exam room during the medical visit
- Knew the patients – the same health coach and patient worked together for 12 months!

What did we do?

Research study (randomized controlled trial) in two primary care health centers using a specific model
Intervention Model

Check-in with PCP

1. Pre-visit

2. Visit

3. Post-visit

4. Between visits

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Intervention Model

1. Pre-visit
- Perform vitals, point of care testing
- Set agenda
- Do medication reconciliation
- Review labs and goals (patient activation)

2. Visit
- 15-second huddle
- Stay for visit
- Assist provider if asked
- Visit wrap-up
Intervention Model

3. Post-visit
- Close the loop
- Revise medication list for patient to take home
- Create action plan for behavior change

4. Between visits
- Call patients
- Communicate with provider in event of problems
- Assist with between visit care and navigation
What did we want to find out?

Do patients with a health coach have better health outcomes than patients without a health coach?

How do health coaches affect the patient experience?

How do health coaches affect the clinician experience?

What did we do?
What did we learn?

* Improved control for this analysis means: HbA1c<8%; Systolic blood pressure at goal (<130 for diabetics; < 140 for people without diabetes; and/or LDL at goal (<100 for diabetics; <130 for people without diabetes)

What did we learn?

* % patients at study goal* for blood sugar, blood pressure, or cholesterol at 12 months

<table>
<thead>
<tr>
<th>Health Coach</th>
<th>No health coach</th>
<th>p&lt;.05</th>
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<tbody>
<tr>
<td>46%</td>
<td>34%</td>
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% patients with A1c<8

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</table>
What did we learn?

* Study goal for this analysis means: LDL <100 for diabetics; <130 for people without diabetes

% patients at study goal for cholesterol (LDL)*

What did we learn?

% patients who would "definitely recommend" to friends or family

What did we learn?
What did we learn?

*p As measured by the Patient Assessment of Care for Chronic Conditions (PACIC)
What did we learn?

What our clinicians said...

“I think health coaches are really useful for very difficult patients. . . . They sort of provide like a VIP feeling for the patient, where they have like a special person who takes care of all their needs, makes sure all their refills are done, . . . just more of a personal connection and somebody who really celebrates their successes and just takes time with them, which I think is really challenging for providers to do.”

“I think that med rec is nice, ‘cause you don’t spend so much of your visit trying to just figure out what medicines they’re taking. So you can talk to them more just as a human. And then the agenda setting’s nice, ‘cause you get the sense of what’s really important to them, and you’re not in there with your 20 things that you have to control . . .”
What do you think?

Where the rubber meets the road:
Making health coaching work in real-life health centers
The clinicians at Clinic Do-It-Myself seldom refer patients for health coaching, and admit they are uncomfortable letting the Coaches talk to patients about certain topics. For example, they do not think Coaches should discuss medications with patients.

What would you recommend as a first step?

Challenge: Clinician buy-in

Your team comes back from the workshop today ready to roll! You want to start health coaching as soon as possible, but you really just have a 1 MA: 1 clinician ratio, with one extra MA for every five clinicians.

What would you recommend as a first step?

Challenge: Limited Staffing
Anna at Clinic Putting-Out-Fires is a MA trained as a health coach. The clinic is currently short-staffed, and when other MAs call in sick, Anna needs to cover for them. Although patients are referred to her for health coaching, she has no time to see them – she needs to be on the floor rooming patients.

**What would you recommend as a first step?**

**Challenge: Ebb and Flow**

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Clinic Tidal Wave is motivated to do Health Coaching, and they have staff trained as coaches. However, they don’t know where to start – after all, they have 7,000 patients!

**What would you recommend as a first step?**

**Challenge: Choosing Patients**
Take Home Points

- “The PDSA Certainty Principle”
- Change is difficult
- Be kind to yourselves

We love to share!
- Contact us if you’d like a copy of our protocol or forms
- A few resources in your packet
  - Health Coaching – the business case
  - MA scope of practice summary (from the Center for the Health Professions)

Contact us:
Center for Excellence in Primary Care
Ucsf Department of Family and Community Medicine
willardr@fcu.ucsf.edu

Visit our website:
http://familymedicine.medschool.ucsf.edu/cepc

Information and resources
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Why do we ask?
What happens if we only tell?

Ask-Tell-Ask
How do we make coaching work in the real world?