Health Coaching in Team-Based Care

Recipes for Success

Great Lakes PTN

Today's Presenters

Iowa Chronic Care Consortium/Clinical Health Coach®

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Siouxland Community Health Centers

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The Iowa Clinic

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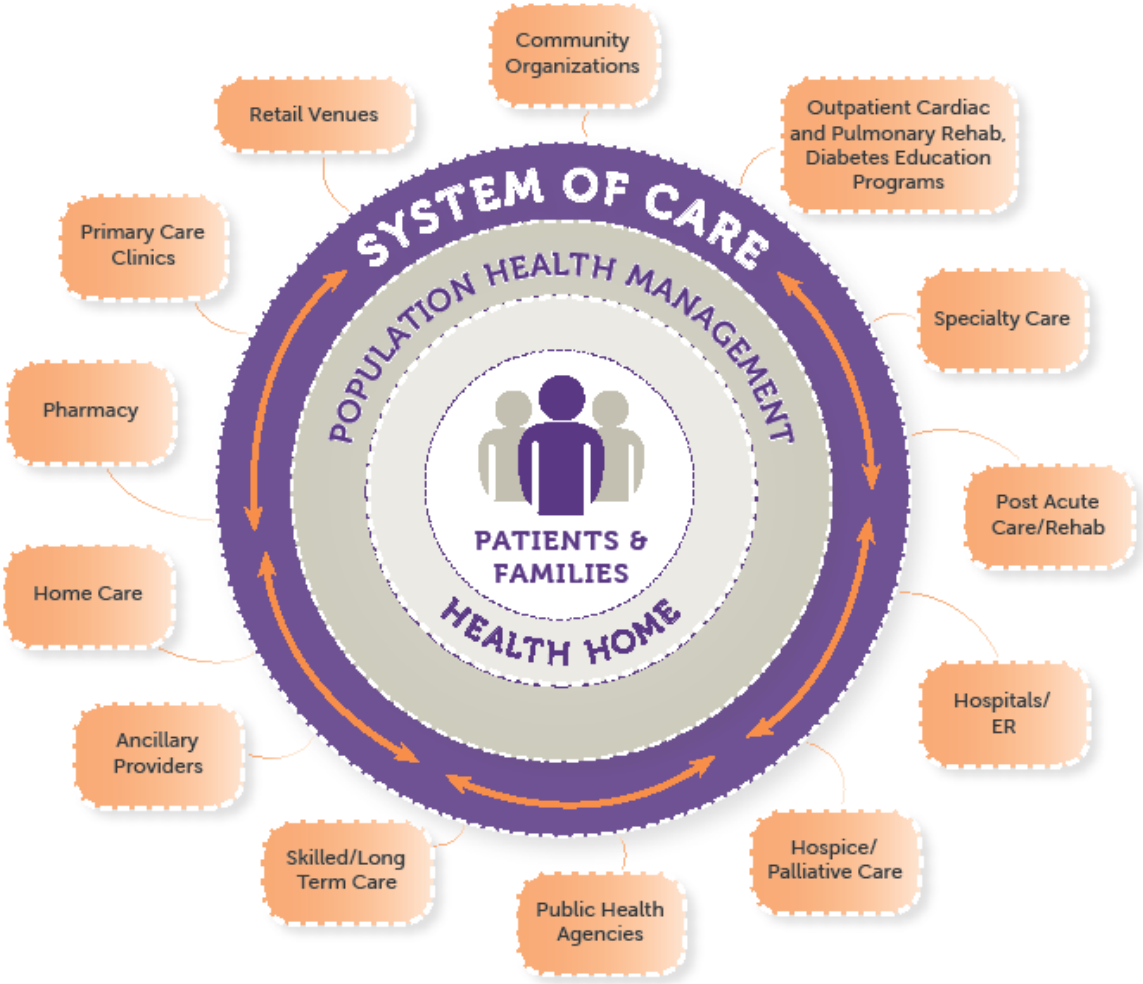
Director, Care Management & Quality

Teams Matter

Why Teams?

- Knowledge Explosion: Currently 2,000 Clinical Practice Guidelines (U.S. National Guidelines Clearinghouse)
- Primary Care: Responsible for Population Health Management and Coordinating Care: Medical Home
- Chronic Disease Management: Typical Medicare beneficiary visits 2 primary care clinicians and 5 specialists per year (increases with multiple chronic conditions)
- Potentially harmful outcomes/errors when patients are being seen by many providers and information is not shared
- Interprofessional Care: High value care with diverse healthcare teams

Teams: Help Navigate Systems of Care



Team-Based Care is Still Evolving!

Many innovative models and programs:

- Patient-Centered Medical Home
- Integrated Health Homes
- Care Transitions Teams
- Accountable Care Organizations
- Community-Based Care Teams

Goal of Team-Based Care: The Triple Aim +

- Improving the patient experience of care (quality and satisfaction);
- Improving the health of populations; and,
- Reducing the per capita cost of health care.

http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx

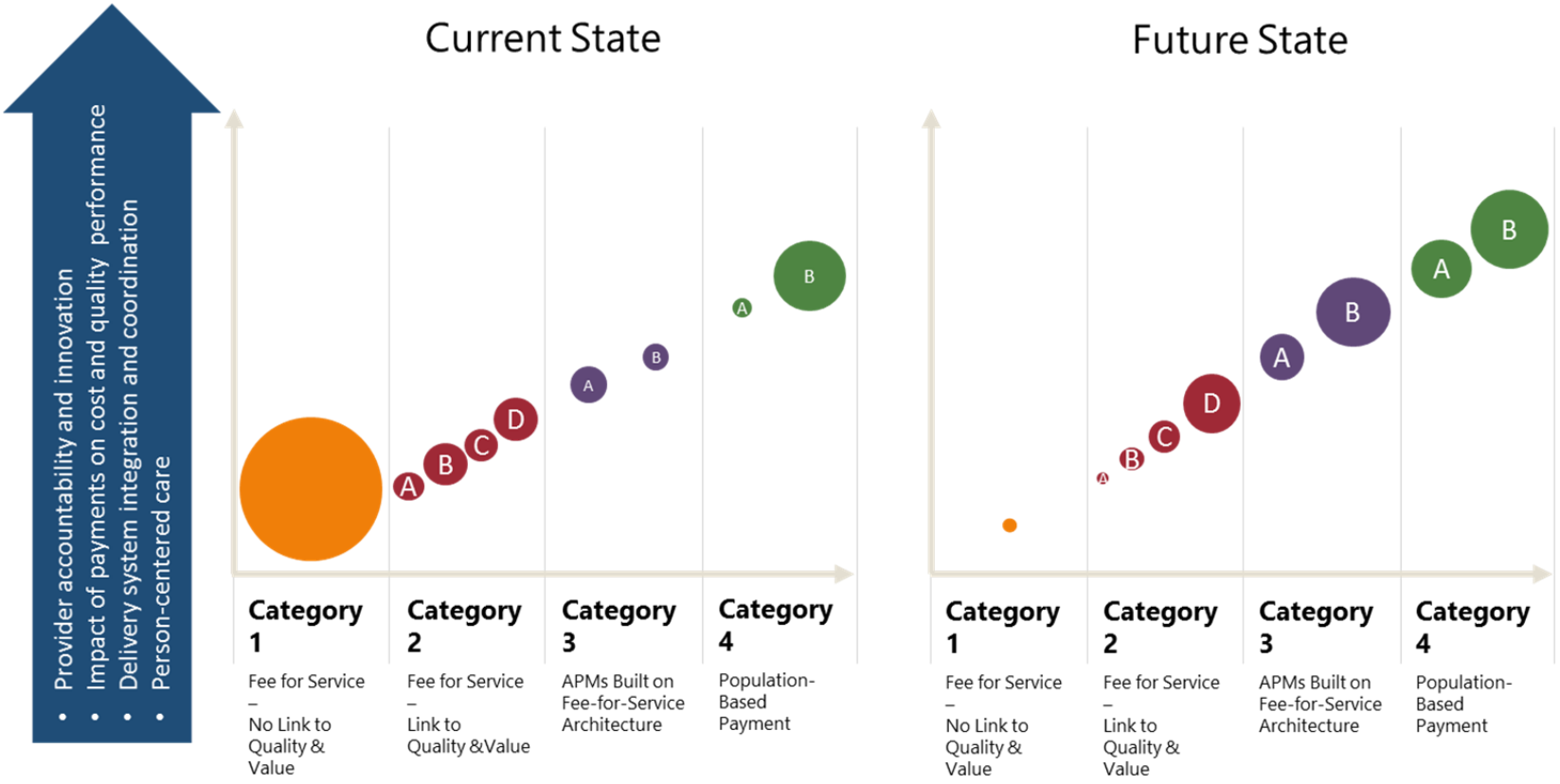
- And….reducing provider and healthcare team burnout

MACRA

Medicare Access and CHIP Reauthorization Act of 2015

- Repeals the Sustainable Growth Rate formula
- Changes the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
- Gives bonus payments for participation in eligible alternative payment models (APMs)

CMS Goals for Payment Reform



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Ingredients to HealthCare Delivery Under MACRA

1. Electronic Data System
2. Population Health Management
3. Robust Quality Improvement Program
4. Care Coordination
5. **Patient Engagement**

Why Engagement is so Important

- Population health focuses on entire panel of patients
- Value-based healthcare means “owning and managing” patients to improve health and reduce risk
- Engagement measures are included within many quality improvement initiatives and quality payment programs
- Maximize encounters for prevention and chronic condition management
- To reduce “no shows” appointments
- And…

Engagement Sparks Accountability

"A growing body of evidence demonstrates that patients who are more actively involved in their own healthcare experience better outcomes and lower cost."

Health Affairs Robert Wood Johnson Foundation, 2013

Greatest Underutilized Resource

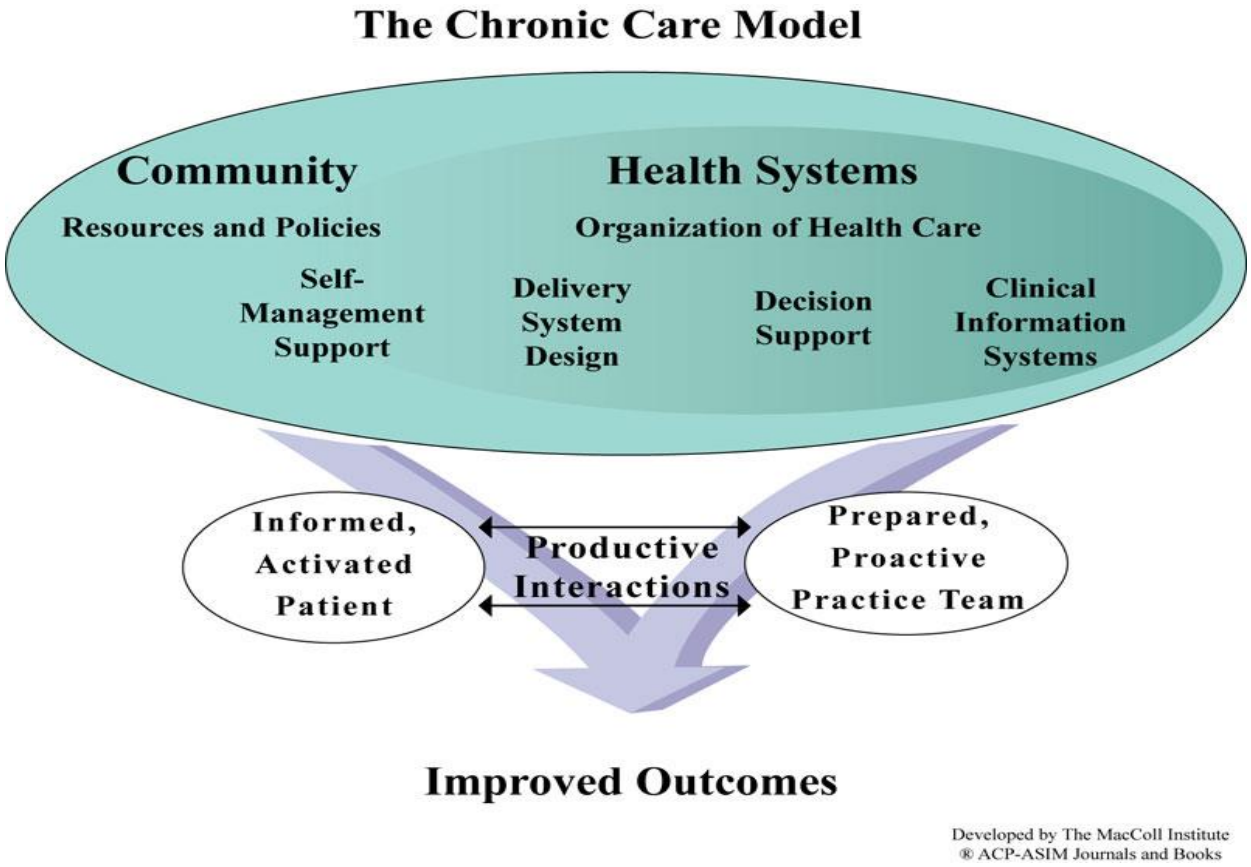
"We are in an era looking at all of the underutilized resources in healthcare. And, ***the greatest underutilized resource is the patient*** *and their family."*

Dr. Farsad Mostashari

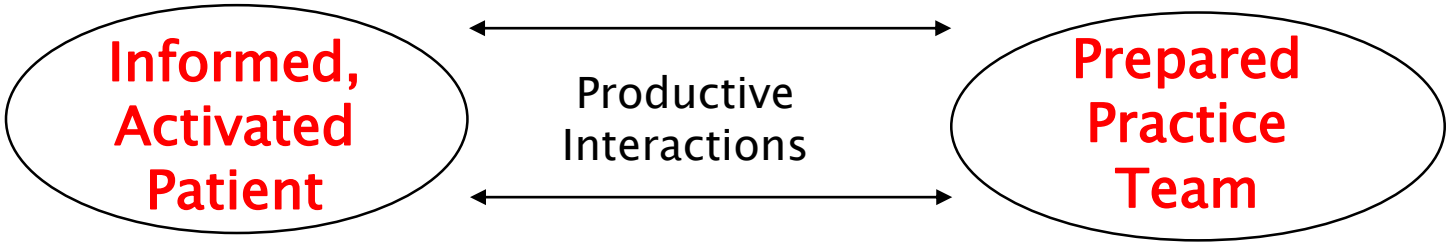
Patient as True Resource

- 95-98% of healthcare takes place outside provider office
- 96% of diabetes care is self-care
- 70% of total healthcare costs are driven by behaviors
- Patients act on their own ideas and plans
- Value in seeing the patient as capable

Guiding Model for Chronic Care Management



Essential Elements of Effective Chronic Illness Care



What is a productive interaction?

Patient needs are met!

Health Coaching in Clinical Setting

- Emerging Field focusing upon Chronic Illness; Quality Improvement; Care and Care Management; Prevention; Maintenance; and, Social Determinants of Health
- Built upon a solid and evidence based foundation.
- Health coaches use very particular skills and processes to help clients and patients manage health risks and medical conditions, often combining education and mentoring process with coaching.

Coaching

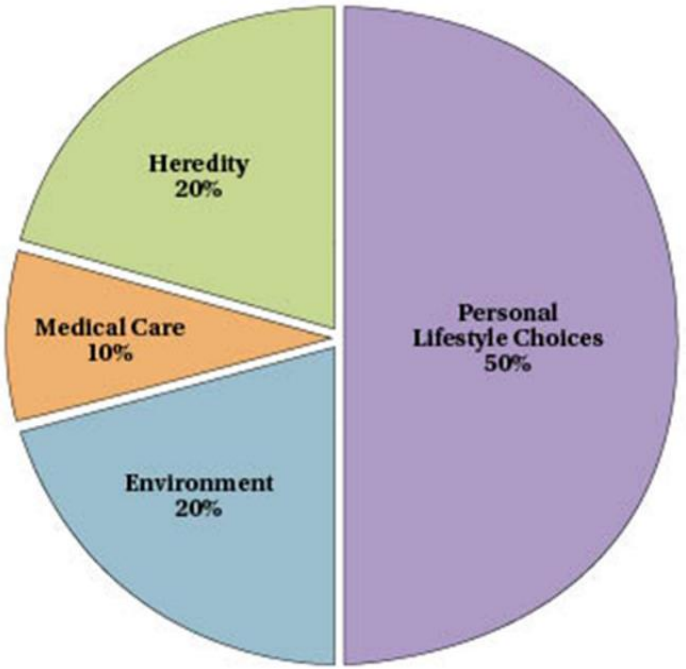
A partner relationship with a patient, providing the structure, accountability, expertise, and guidance to empower an individual to learn, grow and develop beyond what s/he can do alone.

Unique Responsibilities

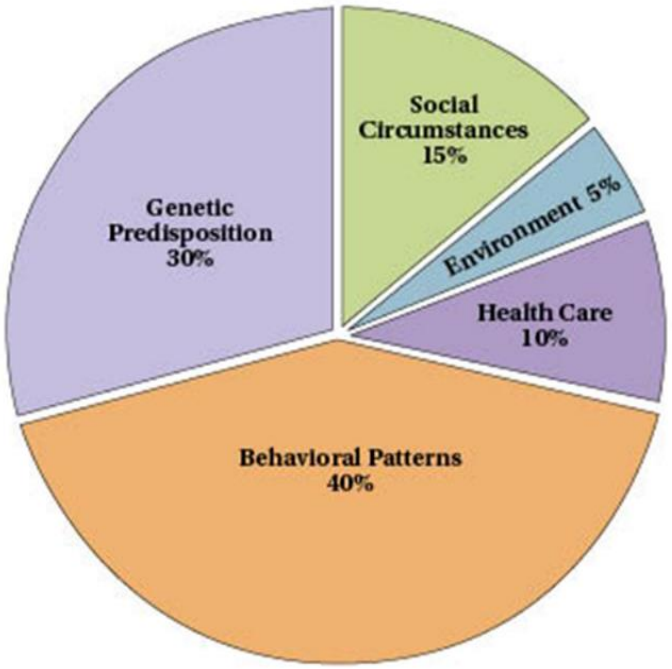
- Partner
- Collaborate
- Facilitate
- Explore and Provide Resources
- Support Self-Empowerment
- Guide Population Health Processes

Determinants of Health

Factors Contributing to Health
(CDC 2009)



Proportional Contribution to
Premature Death *(S. Schroeder NEJM 2007)*



Social Determinants of Health

Siouxland Community Health Center

Health Coaches-

The glue that holds the healthcare team together

Siouxland Community Health

an iowahealth center

Great Lakes PTN

SCHC- Services Offered

- 18 Empaneled Medical Providers- 5 MDs, 5 PAs, 8 NPs
- Urgent Care
- Prenatal- Partner with family practice residency program
- Dental
- In-house pharmacy
- Moderately complex lab
- Radiology/Dexa Scan
- Clinical pharmacist
- HIV Care- 3 certified providers
- Behavioral Health- NP, BH therapists, BH case managers
- Medication-assisted treatment (MAT)

Care Management History at SCHC

Prior to 2007

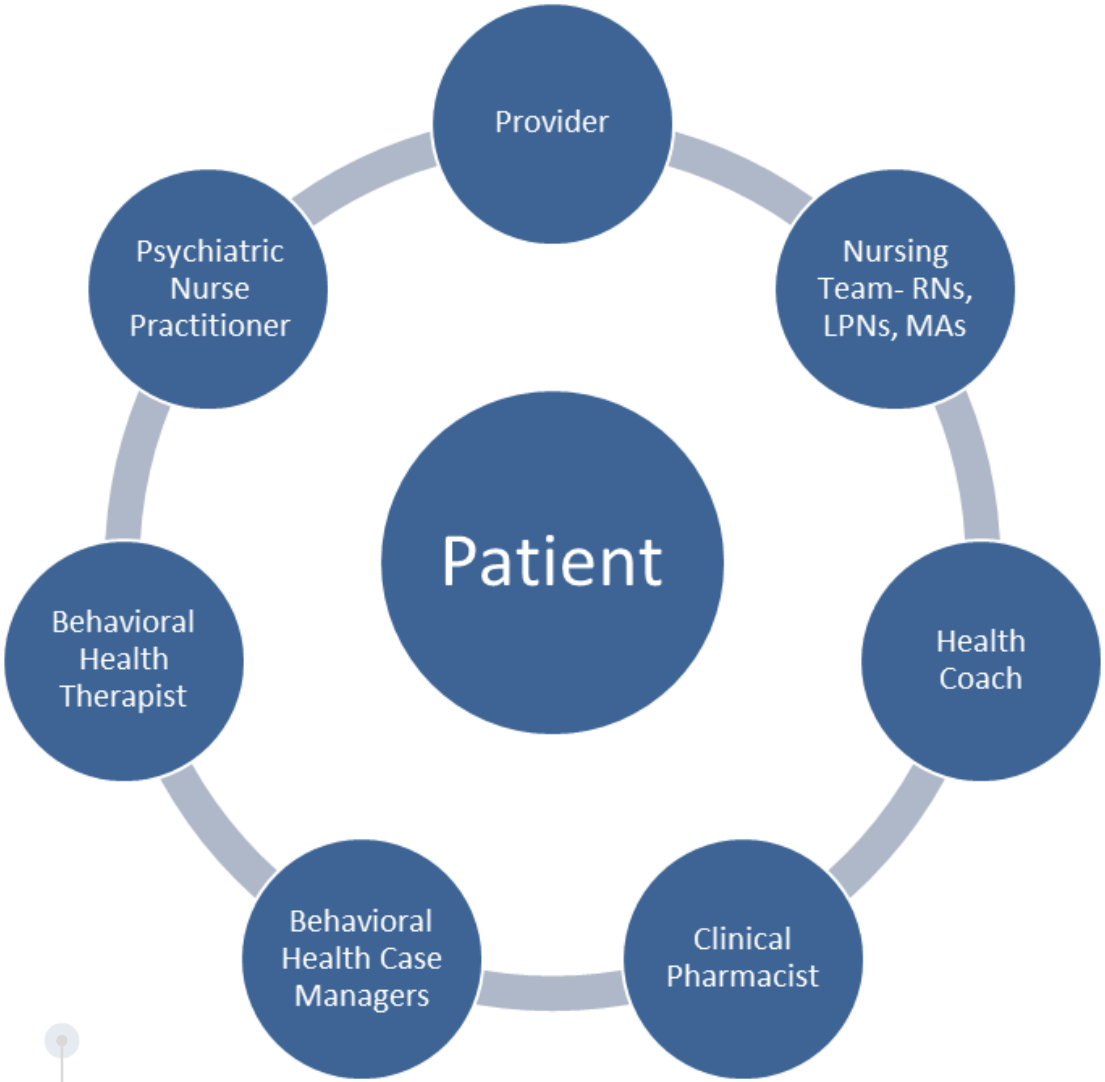
- Patients empaneled starting in 1996
- HRSA's Health Disparities Collaborative/PECS Registry- case managers
- I2i- Population Health tool
- Quality manager and case managers- minimal guidance or from clinical team
- IT and clinical team- minimal interaction
- No regular feedback to provider teams regarding quality measures or expectations
- Frequent turnover in quality manager and IT personnel

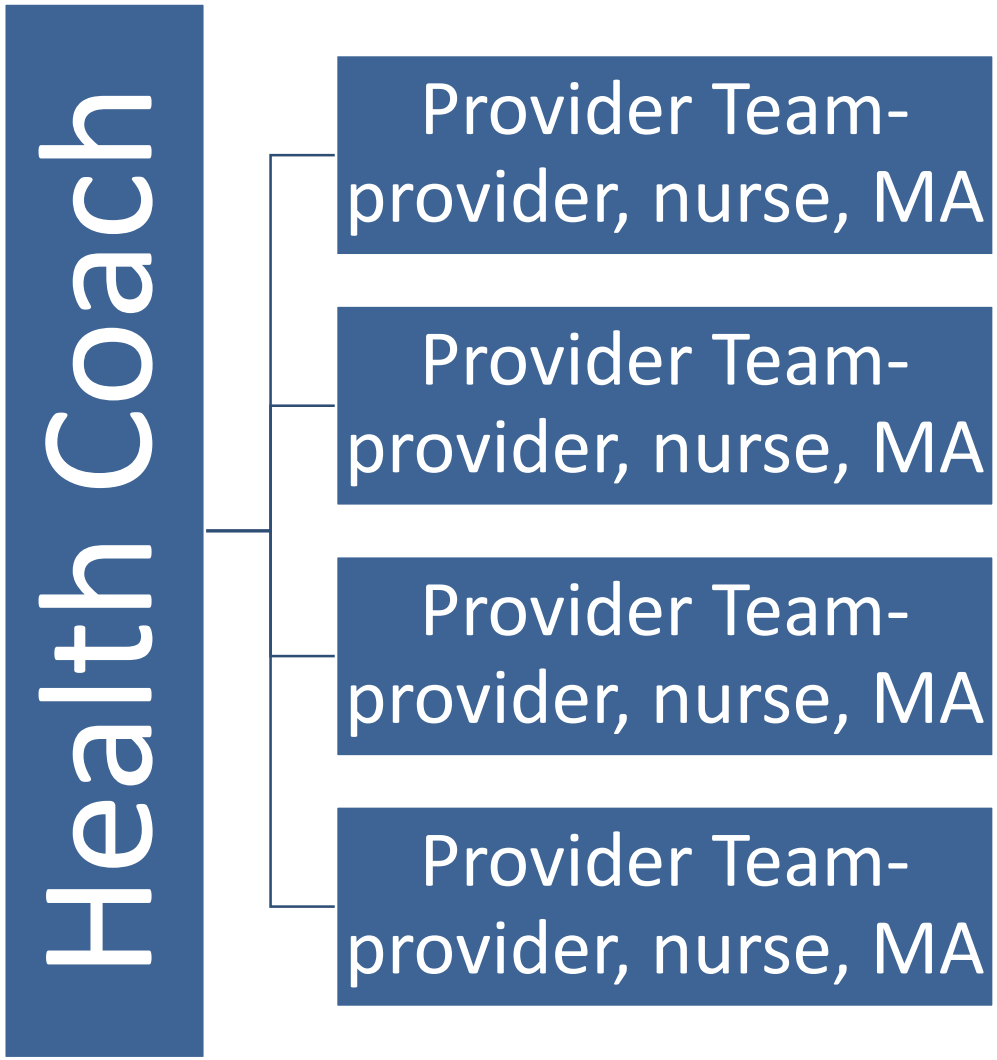
Care Management History at SCHC

2011 to Present

- EMR
- Organizational chart structure changes- provider oversight
- PCMH- risk adjusting patients, daily huddles
- Quality boards- benchmarking/trending
- Provider team quality huddles- every 6 weeks
- Increased usage of i2i and iTi (population health/case management tools)
- Clear expectations- policies and procedures
- Transition from case managers to health coaches

Care Team


Provider
Nursing Team- RNs, LPNs, MAs
Health Coach
Clinical Pharmacist
Behavioral Health Case Managers
Behavioral Health Therapist
Psychiatric Nurse Practitioner
Patient


Health Coach
Provider Team- provider, nurse, MA
Provider Team- provider, nurse, MA
Provider Team- provider, nurse, MA
Provider Team- provider, nurse, MA

Health Coach Role Evolution

- Case Managers -- Health Coach and Motivational Interviewing Training

  Clinical Health Coach(R) Fusion Training
- Understanding the need to change behavior to achieve quality goals
- Continued need to perform other case manager duties -- health education - mainly DM, ER/Hospital follow up, procedure follow up, etc.
- Production Expectations -- Monthly scorecard
- Support and Development -- 2 trainings a year, bi-weekly meeting
- Title Change -- Medical RN Case Manager-->Health Coach
- Formality to program -- Enhanced Care Coordination (care flow process)
- Current focus -- Medicaid SPA and A1c>9%
- Future -- Chronic Care Management (Medicare), Value-based payment

PRAPARE -- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

- National effort to help health centers collect social determinants of health (SDH) data
- SCHC considered a "PRAPARE pioneer"
- Started in 2013
- Total patients ever screened- around 11,000
- Goal is to screen all patients annually -- currently at 36.4%
- Screening for SDH helps at the patient level and at a community level
- Health Coaches play a major role in addressing determinants identified

Health Coach -- Patient Interactions

- Face to Face
  - Office visits with medical provider
  - Scheduled visits with health coach
  - Shared medical appointments
- Telephone/Text/Portal
  - Schedules calls
  - Impromptu calls
  - CareMessaging texting program -- trialed
  - Patient Portal- limited

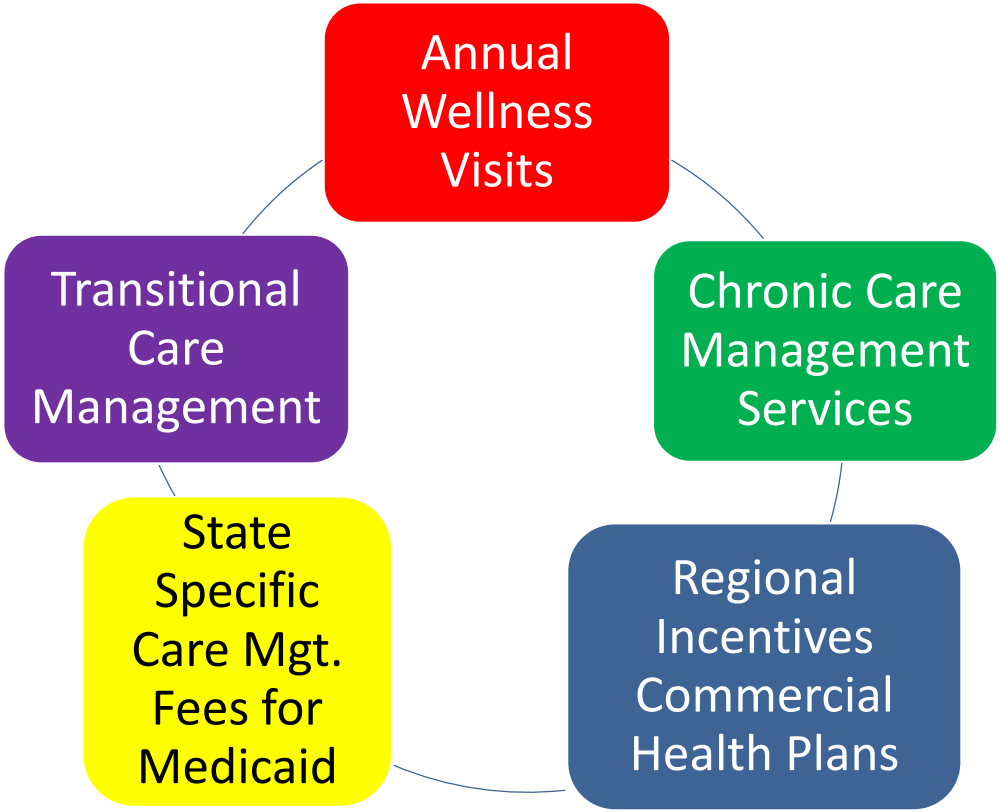
Health Coaches and Population Health

- Crucial part of the care team --- daily huddles, quality team huddles
- Monthly scorecards
- Quality Incentives
- Lists of patients not at goal for UDS measures- i2i
- Payment opportunities
  - Chronic Condition Health Home -- State Plan Amendment (was $40K/mo)
  - Medicaid ACO with United Healthcare -- IowaHealth+ quality payments
  - Iowa Dept. of Public Health Grants -- hypertension
  - Million Hearts

Lessons Learned and Success Stories

- Maximizing health coach/patient interactions
  - -- co-locating provider teams and health coaches
  - -- impromptu health coaching opportunities
- Need for tracking, accountability, and expectations -- SPA patients
- Provider involvement in structuring program
- Being realistic in capacity
- PDSAs
- Developing trust between provider teams and health coaches
- Getting the right people on the bus
- Job satisfaction
  - -- part of the team
  - -- meaningful relationships
  - -- changing lives

Optimize Billable Care Management and Coordination Opportunities



The Iowa Clinic

Health Coaching in Population Health

Agenda

- Introduction and About Us -- The Iowa Clinic
- Population Health/Care Management
- Health Coach Training
- Population Health Management
- Process Flow
- Outcomes
- Success Story

The Iowa Clinic

- Founded in 1994
- 250+ physicians and providers in more than 40 Specialties
- Main Campus: West Des Moines
- 7 additional clinic sites throughout the Des Moines Metropolitan
  - Altoona
  - Ankeny
  - Des Moines
  - Indianola
  - Johnston
  - Urbandale
  - Waukee

The Iowa Clinic

- Population Base: 1.1 million
- 450,000 average visits/year
- Primary Care
  - Family Medicine
  - Internal Medicine
  - Pediatrics
- Patient Centered Medical Home (PCMH)
- Population Health/Care Management

Introduction

- Melissa Linder, MHA, CPHQ, CHC, CMA (AAMA)
- Director of Care Management and Quality
  - 5 years
- 25 years in Healthcare
  - Clinical
  - Care Management, Utilization Review
  - Quality, Compliance, Accreditation
  - Insurance/Medicaid

Implementation of Population Health

- Pilot program: 2014
- Fully integrated: 2015
- 2018
  - 8 Care Managers
    - RNs and CMAs
  - 10 Primary Care Locations
  - 83,400 total patients
  - 10,430 patients/CM
  - 45 High Risk patients/CM

Health Coaching

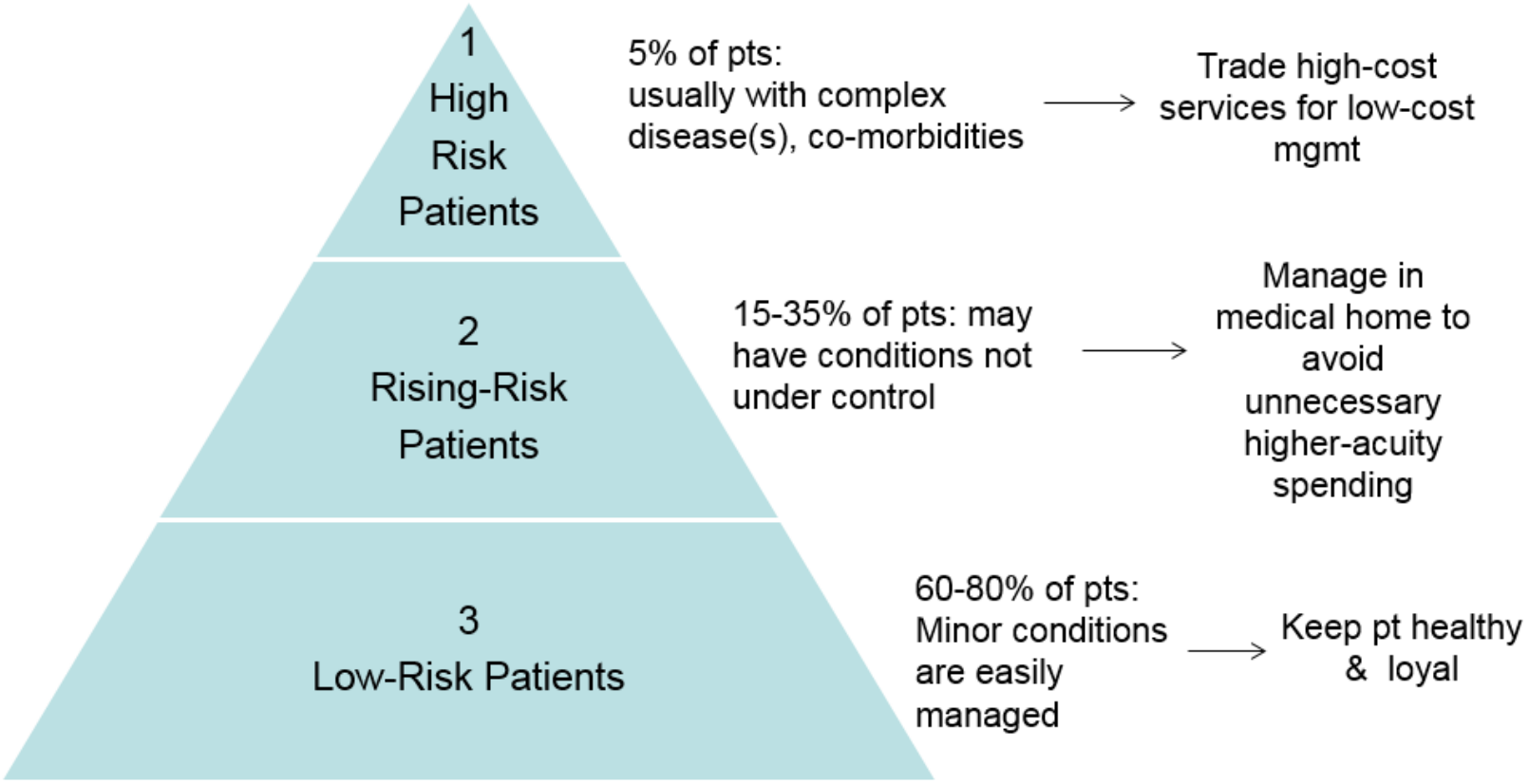
- Taking it to the next level
  - Clinical Health Coaching
  - 2 Day Intensive On Site Training
- Motivational Interviewing
- Assessing patients
- Identifying barriers
- Patient engagement

Care Management/Population Health

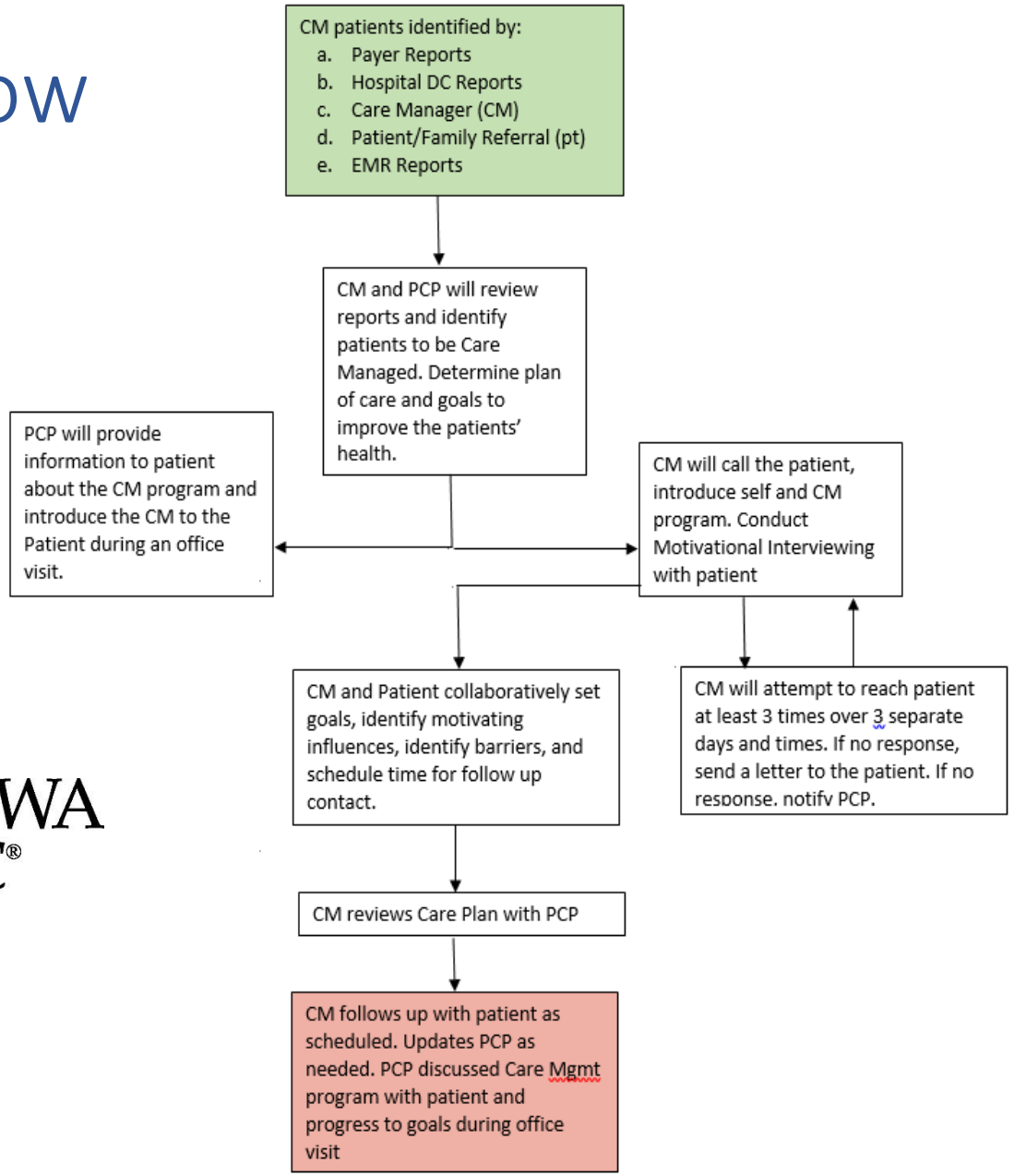
- Responsibilities of Care Manager
- Identification of Patients
  - Wellmark ACO
  - Medicare Advantage Plans
  - Medicare Shared Savings Program
  - High Risk Classification (2+ chronic conditions/comorbidities)
  - High Spend/Utilization
- Tying in Health Coaching

Care Management/Population Health

- Coaching, Care and Contact are Individualized:



Process Flow



THE IOWA CLINIC®

Outcomes

- Most Health Coaching is care gap focused
- Top 2 in State: Wellmark ACO
  - Quality: above the 90th percentile
  - Cost: Showing approx. $25 pmpm savings
- Medicare Advantage
  - Humana 4.26 Star Rating
  - UHC 4.63 Star Rating
- AMGA Adult Immunization Collaborative
  - Most improved: Pneumococcal
  - 77% completion: 65+

Outcomes

- UHC - MA

Quality Measure	Eligible Members	Compliant Members	Non-Compliant Members	% Compliant
C01-Breast Cancer Screening	43	32	11	74%
C02-Colorectal Cancer Screening	184	153	31	83%
C07-Adult BMI Assessment	164	153	11	93%
C12-Osteoporosis Management in Women who had a Fracture	-	-	-	-
C13-Diabetes Care - Eye Exam	73	55	18	75%
C14-Diabetes Care - Kidney Disease Monitoring	73	70	3	96%
C15-Diabetes Care - Blood Sugar Controlled	73	60	13	82%
C17-Rheumatoid Arthritis Management	3	3	0	100%
DMC24-Hospitalizations for Potentially Preventable Complications	-	-	-	43
D12-Medication Adherence for Diabetes Medications	35	33	2	94%
D13-Medication Adherence for Hypertension (RAS antagonists)	149	137	12	92%
D14-Medication Adherence for Cholesterol (Statins)	173	151	22	87%

Outcomes

Model Practice Performance Observations

Quarter 4 2017

Humana

- Model practice
  - Rewards paid in 2016= $35,000
  - Rewards paid in 2017= $44,000
- Model practice opportunities
  - Q4 potential $15,605.50. Received $14,812.00 reward
  - Met targets for breast cancer screening, diabetes care-nephropathy, colorectal cancer screening, medication adherence, chronic care management, patient experience rating, 30 day readmit rate and ER utilization/1000
  - Opportunities include diabetes care – A1c

Model Practice		
Measure	**Q4 Target Achievement**	**Target**
Breast Cancer Screening	80.00%	≥ 76.00%
Diabetes Care - HbA1c	73.00%	≥ 84.00%
Diabetes Care - Nephropathy	98.00%	≥ 98.00%
Colorectal Cancer Screening	82.00%	≥ 81.00%
Medication Adherence	83.00%	≥ 80.00%
Chronic Care Management	95.00%	≥ 82.00%
Patient Experience Rating	82.00%	≥ 80.00%
30 Day Readmit Rate	7.00%	≤ 10.00%
ER Utilization per 1,000	195	≤ 283.00

Great Lakes PTN

Outcomes

- AMGA
  - Together 2 Goal: Diabetes Program

We have more patients with positive change than any other group: we have the lowest % of patients with no change in 24 month period!

Today

- AMGA Obesity Collaborative
  - Applying a population-based approach to obesity care management in the primary care setting
  - 1 of 9 clinics nationwide
  - Identifying best practices
  - Care Managers/Health Coaches
    - Motivational Interviewing
    - Readiness Assessment (scale)
    - Care Management
    - Gaps in Care

AMGA™
Advancing High Performance Health

Great Lakes PTN

Today

- Track 1 MSSP
  - Focus on Quality and Cost Savings
  - No Downside Risk x 3 years
- Data Analytics
  - Claims Analysis
  - Cost Savings
  - ID Care Management Involvement

Honor the Practice of Teams

The Primary Care Team (Before)

- Physician and/or Advanced Practice Clinicians
- Certified Medical Assistant
- Receptionist
- Registered Nurse (maybe)
- Laboratory Technician (if you are lucky)

The Primary Care Team (Value-Based Care)

Primary Team

- Physician/AP Clinicians
- Certified Medical Assistant (Health Coach)
- Registered Nurse (Care Manager, Care Coordinator or RN Health Coach)
- Office IT/Population Health
- Reception Staff (Care Coordination)
- Laboratory Technician
- Care Coordinator

Additional Team Members

- Pharmacist
- Behavioral Health/LISW
- Registered Dietitian
- Certified Diabetes Educator
- Community Health Worker

Questions and Contacts

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