Critical Access Hospital
"Quest for Excellence" Award Application

Topic: The Use of Health Coaches in the Management of Chronic Health Conditions in a Critical Access Hospital and Family Practice Clinic

Category of Criteria: **Patient and/or Community Focus**

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The Use of Health Coaches in the Management of Chronic Health Conditions in a Critical Access Hospital and Family Practice Clinic

Introduction:

The New England Journal of Medicine published in 2003 reported that evidence-based care is provided to patients only 55% of the time. Blood sugar is controlled in only 37% of patients with diabetes and blood pressure is properly controlled only 35% of the time in hypertensive patients. Donald Berwick, newly appointed head of the Centers for Medicare and Medicaid Services (CMS), says that "Every system is perfectly designed to get the results it gets." Results that patients receive depend on physician memory and the individual effort of those physicians. In the future the quality of care that our patients receive will depend more on the system the practitioners work in and less on the physician's individual effort.

The majority of patients seen at Dinklage Medical Clinic (DMC) and St. Francis Memorial Hospital (SFMH) have chronic conditions. At a hospital convention our CEO, Ron Briggs, and Carol Kampschneider, Vice President of Clinical and Regulatory Services, were approached by CIMRO of Nebraska, QIO, to participate in a quality improvement project for diabetic patients. This challenged our organization to evaluate our practice on how well we implement evidence-based medicine on a day to day basis. SECAT was the electronic registry CIMRO offered to assist us. Baseline SECAT data showed that patients were not consistently receiving evidence-based medical care. (Refer to Table 1 within Supporting Documentation)

After 5 years of monitoring patient data, listening to our patients, and input from physicians from Clarkson Family Practice Residency program, it was identified that "something" more was needed because care was fractured. Patients were routed between specialists, their family doctor, the diabetes educators, the Coumadin clinic, physical therapy, etc. and their care needs still not always met. Office visits alone did not allow the time for the physicians and clinic nurses to

satisfy the needs and expectations of our patients. The concept of "health coaching" was the answer. Coaches are by definition people who give instruction, advice, tutor, and/or mentor. We most generally associate coaching with sports. Our society has bought into the concept, so that we now have coaches for executives, companies, parents, couples, careers and relationship building. Healthcare is now catching on to this idea and "health coaching" is the result.

The Health Coach:

Our health coaches focus on implementing an evidence-based chronic care model (see Attachment 1 under Supporting Documentation) assisting individual patients to improve self-management skills and evaluating the overall effectiveness of chronic care management.

Lifestyle behaviors are a major contributor to chronic disease and the costs of treating these conditions is becoming prohibitive. A Johns Hopkins University study in 2007 found that 85 % of healthcare dollars are spent on the treatment of chronic health conditions. Intervention with these patients to encourage them to be accountable for their health and to make behavioral changes is critical to lowering those costs and having a healthier community and society. "Health coaching" involves a healthcare professional utilizing evidence-based medicine to affect the behavioral lifestyles of individuals.

In a study released September 2010 by the Agency for Healthcare Research and Quality (AHRQ) one in five hospitalizations involved patients with diabetes. Patient education is critical, but patients don't always follow through on recommendations. The health coach realizes the patient is ultimately responsible for his or her choices, but seeks to find the patient's personal motivation that's needed to initiate and maintain healthy changes. Health coaches are change agents—helping to bridge the gap between physicians and patients. They are patient advocates.

The Dinklage Medical Clinic health coaches are registered nurses. DeLaney Brudigam and Stacie Petersen have completed Certificates of Competency in Health Coaching through the Mercy Health System in Des Moines, Iowa. Phyllis Heimann and Stacie Petersen are Certified Diabetes Educators.

The health coaches:

1) Oversee the disease registry (Care Measures, previously SECAT/CIMRO).
    - Keeping the database up to date (A transcriptionist assists in data entry.)
    - Identifying patients overdue for physician visits and/or laboratory tests
    - Making referrals and arranging for follow up services as needed
2) Conduct pre-visit chart review using an "Appointment Worksheet" (see Attachment 2) to identify all needed preventive health maintenance and chronic disease interventions. Depending on patient age and diagnosis this includes:
    - Checking previous lab results/progress notes/consultations/x-rays
    - Reviewing medication list and Immunizations

    When standing orders allow, the interventions are ordered and/or completed before the patient sees the provider. This helps make the visit more productive for both the patient and the provider. Pre-visit chart review pays for the health coaches. Mercy Health System in Des Moines, Iowa estimates for every dollar invested in the health coach they get a $4 return.
3) Work with the patient and their families by setting short and long term goals for self management of their conditions. They address:
    - Medication adherence
    - Lifestyle change compliance
    - Treatment compliance
    - Keeping follow-up appointments with all healthcare providers

4) Coordinate care and communication across the continuum by acting as a liaison between patients and their families and the following:

   - Health care providers and clinic staff
   - Specialists and their clinics
   - Community resources

   If hospitalized, following up by phone shortly after discharge, patients only remember 20% of what they hear upon discharge and 50% of this they recall incorrectly. (January 2007 Pfizer Clear Heath Communication Initiative)

5) Proactively act as patient advocates, working to resolve patient concerns.

How did we get to this point?

Providing quality patient care in a clinic setting requires a team effort. It takes continuous planning and evolving of quality initiatives, and starts by involving the entire staff: front office, nursing and medical staff. As a result of this shared mental model not only do we meet patients' expectations, but we exceed them. Our team effort is demonstrated in the following timeline.

Summer 2003

A "diabetes case manager" was hired through a grant which provided funding for 3 years. This was a collaborative effort with the Elkhorn Logan Valley Public Health Department, Goldenrod Hills, and the University of Nebraska Lincoln Extension. The focus was on diabetes prevention, screening, and case management.

Fall 2003

SECAT disease registry was installed in our clinic as part of a "CIMRO of Nebraska" diabetes project. Diabetics were identified through a query of patients who had an A1c, a commonly used diabetic indicator. Available office staff and nursing staff manually entered all

demographic information on the identified diabetics to set up the registry. Clinic charts were labeled with a pink tab on the binder and diabetic flow sheets were inserted.

Spring 2004

Clinic nurses filled out the diabetic flow sheet at every diabetic visit, and a trained transcriptionist reviewed the provider's office note and manually entered pre-determined indicator data. We used evidence-based medicine for monitoring and tracking the diabetic indicators and providing feedback to providers and staff.

We collaborated with the Lions Club on a grant for health screening and education.

Spring 2005

The QI project on foot care was added to our CIMRO Diabetes Prevention and Control Program. Foot care flow sheets were added to each chart with specific foot assessments that the nurse filled out. Education materials were given to all diabetic patients.

Quarterly query of the registry identified patients who had not had an A1c done annually and reminder letters signed by the practitioners were sent.

A presentation by the "diabetes case manager" and a clinic RN entitled "Focus on Health: Nebraska's Community Diabetes Benchmark" was given at the annual CIMRO Quality Forum.

In the winter of '05, Dr. Timothy Wahl, Endocrinologist, gave a presentation to the medical and clinic nursing staff, and together the staff worked to established goals for consistent management guidelines for diabetics.

2006

Our grant ended but the "diabetes case manager" working on the diabetic project grant was hired by the hospital. She also successfully completed the practice requirements and written exam to become a Certified Diabetes Educator.

The clinic staff continued tracking patients using SECAT registry and sending reminder letters.

The program was expanded beyond diabetes to include osteoporosis. Patients were identified through a query of the hospital radiology department of patients who received a CT Bone Mineral Density study. Patients were added to a registry using Excel by a second transcriptionist since the osteoporosis module was unavailable through SECAT. Charts were again labeled and a separate osteoporosis flow sheet was developed and utilized by the clinic nurses at annual visits.

Fall 2006

The Certified Diabetes Educators started reviewing clinic patients' charts, for patients scheduled for diabetes visits with their family physician.

2007

Our Certified Diabetes Educators began working as Care Managers in the clinic for three mornings per week, using the evidence-based chronic care model for chart review. Working together, the clinic nurses also reviewed the charts before sending the charts to the providers for refills and called patients to schedule labs, x-rays and physicals, resulting in an immediate increase in clinic visits and referrals to other departments.

The Care Managers researched registry tools and possible clinic EMR's since SECAT was no longer meeting the expanded needs of the chronic care projects. CIMRO was also going to cease support of this software.

The clinic nurses started tracking patients with hypertension, by initiating a separate hypertension flow sheet and labeling the outside of the chart. Soon the diabetes and hypertension flow sheets were combined into one. The office staff continued with data entry.

2008

Preventative disease monitoring for cancer prevention (tracking of abnormal Pap smears and all colonoscopies in our patient population) was put into an Excel file to create a colonoscopy registry and abnormal Pap smear registry. Letters were being sent as needed for follow-ups. Several nurses visited Des Moines, Iowa to learn about the "health coaching" concept. Care managers became available in the clinic five days per week.

2009

Research of disease managment registries was completed. Care Measures was chosen and software training was completed. Data from SECAT was transferred to Care Measures. The two chronic conditions that could be immediately tracked were diabetes and hypertension.

In fall of 2009, another nurse began reviewing charts. Two of the nurses, Stacie and DeLaney, received a "Certificate of Competency as a Health Coach" through a program in Des Moines, Iowa.

DMC also became a beta site for Version 2 of Care Measures. Any available staff assisted in manually entering data to Care Measures.

Franciscan Care Services (FCS) implemented TeamSTEPPS (Team Strategies and Tools to Enhance Performance & Patient Safety). It is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals. Over the next 12 months, all FCS employees, including medical staff, received TeamSTEPPS training.

2010

We collaborated with Elkhorn/Logan Valley Health Department in sending letters to our patients, ages 50-65, encouraging them to have a screening colonoscopy for cancer prevention. 1010 letters have been sent out in the past year to this age group. We are going to continue sending letters to those in our clinic patient population turning 50 years of age.

We now track lab results for our chronic disease patients and have the ability to query the patients with chronic conditions via Care Measures.

We will become part of the Blue Cross Blue Shield Medical Home Pilot Program that begins October 1, 2010.

The Health Coach nurses will be presenting a Webinar on health coaching for the Nebraska Hospital Association in October, 2010.

Quality Initiatives Led by Our Health Coaches:

1) The Care Measures Warehouse combines data from over 2000 physician clinics nation-wide, providing the benchmark for our Quality Measures Report. Our clinic registry is tracking over 500 diabetic patients. On all diabetic parameters in the database, our clinic is well above the benchmark. (See Table 1) The same is true of our 1500+ hypertensive patients. (See Table 2)
2) The last colonoscopy date is noted in the chart review and documented on the physical "appointment worksheet". To date, 1686 patients are in the colonoscopy registry and follow up reminder letters are being sent quarterly in addition to chart reviews.
3) We are tracking 457 osteoporosis patients in an Excel registry since 2005. These patients are called or sent a reminder letter when they are due for a two year follow-up. (Care Measures has not developed the osteoporosis component.)
4) Health coaches set up senior patients for assessments through our Geriatric Assessment Program. They conduct pre-visit planning, coordinate testing, reconcile medications, refer to social services (if needed), and develop a plan for the follow-up consultation.
5) The coaches schedule patients coming in for their "Welcome to Medicare" physical.

6) The coaches work with patients to assist them with getting low cost medications as part of the Part D formulary and in using generic medications. They also work with patients with diabetes to find the most affordable insulin that will work for the patient.
7) An audit was performed on specialty clinic patients, mainly pulmonary and cardiology. The health coaches discovered the patients were not consistently receiving their test results. The coaches worked with both the specialty clinics and the family physicians to ensure all patients receive their results. A similar situation was discovered with Sleep Study results and this too was resolved.
8) For several years, our Certified Diabetes Educators and dietitian have presented televised programs on diabetes care at area high schools' distance learning sites and NET2, reaching patients throughout the state.
9) A Health Coach was one of four facilitators for TeamSTEPPS. Since communication is the lifeline of a well-functioning team, TeamSTEPPS provided strategies to improve effective communication. One of the strategies taught in TeamSTEPPS is the SBAR (a communication model). The Health Coaches assisted area nursing homes in utilizing the SBAR format to communicate resident needs to our clinic staff.

Future:

The Health Coaches plan to start having small group appointments for patients with diabetes. They are also planning to track Chronic Obstructive Pulmonary Disease (COPD) to improve the long term prognosis for these patients.

Initially, one statement made by our Board of Directors, as well as our system board, was "Right now we only get paid when people are sick. Aren't we going to lose money by keeping them out of the hospital?" They have come to feel that by helping our patients manage their

chronic conditions we are "doing the right thing" and preparing our system for a time (maybe soon) when we are paid for keeping our population healthy. Our Board is very supportive of this effort and what it means to the people who receive care here.

By utilizing health coaches in our facility we hope to further our goal of becoming the center of excellence for our area and a true medical home for our patients. We seek to promote wellness and assist patients in the management of their chronic conditions—hence, our vision statement becomes a reality. **"We will be recognized as a center of excellence. We will promote wellness and be your medical home."**

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