Disclosure to Participants

Notice of Requirements For Successful Completion
Please refer to learning goals and objectives
Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours

Conflict of Interest (COI) and Financial Relationship Disclosures:
Presenter: Mary Jean Christian, MA, MBA, RD, CDE – No COI/Financial Relationship to disclose

Non-Endorsement of Products:
Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity

Off-Label Use:
Participants will be notified by speakers to any product used for a purpose other than for which it was approved

The Research
- Bench to Bedside
  - http://www.medicine.uci.edu/r2d2c2/team.asp

Much more than a patient
A chronic disease "patient" is a patient for an average of four 15-minute doctor visits a year...

...and a person living with chronic disease for the other 8,759 hours of the year

Improving Patient Engagement with Coached Care

The Research
- Bench to Bedside
  - http://www.medicine.uci.edu/r2d2c2/team.asp
Addressing “Real Life” in the medical visit helps!

Most patients don’t discuss “real life” problems with their doctor

Coaching helps patients and doctors discuss real life

Coaches help patients see better outcomes

What is Coached Care?

- Work with patients
  - In person in the waiting room
  - Over the telephone
  - Before and after the medical visit
- Make the most of the medical visit
  - Set & understand "targets"
  - Know their “status”
  - Identify & prioritize barriers
  - Bring “good” questions for the doctor into the medical visit
- Develop self-management skills for their chronic disease
  - Turn the answers to those questions into specific concrete goals
  - Follow through to accomplish those concrete goals

Objectives of Coached Care

- Improve patients’ understanding of the logic of the medical process.
  - Where are we heading with my plan of care?
- Use the medical records to provide each patient with individualized information about their care.
  - How am I doing so far?
- Help patients to use the information gained to ask better, more focused questions of their physicians.
  - Where am I stuck? How can we adjust?
- Improve patient adherence to plan of care, by giving patients a sense of choice and participation in medical decisions.
  - I’ll go full speed ahead if I believe in what I am doing
Patient Selection
- Patients are eligible if:
  - have had at least 2 visits with diagnosis codes for diabetes and/or heart failure to UC Irvine Health (Inpatient, Observation, ED or Outpatient) in 12 months.
- Chronic Disease Registries for
  - Diabetes (3/2016 N=5950)
  - Heart Failure (3/2016 N=1431)
- 2017: Obesity, Hypertension, CKD and Down’s Syndrome

Patient Selection: Criteria
- Diabetes:
  - Hemoglobin A1c ≥ 9%
  - LDL Cholesterol ≥ 100mg/dL
  - Microalbumin/Creatinine ratio <30
- Heart Failure: At least one
  - High blood pressure
  - LACE score >11
  - ST2 >35
  - Ejection Fraction ≤ 35
  - ≥ 1 non-elective inpatient visit with HF as primary Dx or acute HF as secondary Dx

The Coaching Visit
- We will see most patients roughly 4 times in person.
- At each visit, we want them to get closer and closer to:
  - Knowing their targets for chronic disease management
  - Understanding their status (how are they progressing toward their targets)
  - Recognizing the barriers that keep them from reaching their targets
  - Coming prepared to ask good questions of the doctor to help overcome those barriers
  - Taking the doctor’s answers to their questions to form concrete goals
  - Following through on the concrete goals they set
- Use “My Health Tracker” to help focus each session on where the patient currently is

Coached Care Contract
- Patient Responsibilities:
  1. I want to make lifestyle changes to improve my health.
  2. I am willing to set goals and work to achieve the goals I developed with my health coach.
  3. I will follow through on my goals, including watching health videos, attending health classes.
  4. I will answer and accept scheduled phone calls from my health coach.
  5. I will let my health coach know of any problems or concerns I have with the coached care program.
Coached Care Contract

- Coach Responsibilities:
  1. I will meet with you right before and after doctor visits to assist with your questions for the doctor using “Today’s Plan” tool.
  2. I will assist you with goal setting and record your goals on your “My Health Tracker” tool.
  3. I will document your progress towards your goals on your “My Health Tracker” tool.
  4. I will talk with your health care team using the UC Irvine Health electronic medical record.
  5. I will schedule phone calls to check in with you between doctor visits on a regular basis.
  6. I will provide tools for you to learn about your health through videos, handouts, signing up for health classes, etc.

Using the Coaches’ Tools

- My Health Tracker
- Today’s Plan

Today’s Plan

- #1 tool to guide discussion of
  - Barriers,
  - Questions for the Doctor
  - Concrete Goals
- Only fill out the parts you use!
  - Pre-Visit: Just fill in Questions
  - Post-Visit: Fill in Answers, and Concrete Goals

Working through “My Health Tracker”

- #1 tool to guide discussion of
  - Barriers,
  - Questions for the Doctor
  - Concrete Goals
- Only fill out the parts you use!
  - Pre-Visit: Just fill in Questions
  - Post-Visit: Fill in Answers, and Concrete Goals

IDENTIFYING BARRIERS

Asking about reasons is better than asking “Do you take your meds as prescribed?”

Source: Reducing Racial Disparities in Diabetes Coached Care Study (R2D2C2) Survey Data

Reveals more nonadherence

Better predictor of outcomes

Do you take your medications as prescribed?
Where am I stuck?

- Once we know a patient’s Targets and Status, we can see where they are “stuck”
  - Values of A1c, weight, LDL, blood pressure that are above target
  - HF patients not taking their water pill or weighing self enough
  - Recent hospitalization, ER visits

Now, we start to talk about “Why?”

“Nondirective support”

- Some tips
  - Let the patient direct the conversation.
  - Cooperate with the patient without taking over responsibility or control.
  - Help the patient come up with questions for the doctor (but try not to provide too many answers).
  - Remember, we want the patient to “graduate” and not need a coach to get all the answers!

Why ask questions?

- It alerts the doctor that the patient is asking for his/her attention and specifically information.
- It shows interest on the part of the patient. We all like others to be interested in what we do. Physicians deliver medical care. Asking questions reveals interest by the patient in his/her job.
- It is a way of taking an active part in care. Questions are a way of exerting control in conversation. They require a response from the other person. They ensure that for some period of time the discussion will be about something on the patient’s mind or that they care about.

Why don’t we ask questions?

- Forgetting.
  - A great deal happens during the average visit to the physician and it is the physician who directs the visit. Patients are often undressed, nervous and uncomfortable. It is easy to forget under the circumstances. Most people do, and the patient should be reassured that this is normal.
- Bad “Vibe” from the physician
  - Although physicians do not intentionally withhold information from patients, in the rush of trying to see many patients, they may give the impression that they don’t have the time for patients questions. Physicians sometimes give off these signals by:
    - looking at their watch
    - giving the patients a sense that they are “rushed”
    - acting annoyed by the question
    - using medical jargon
    - making the patient feel foolish for asking
    - not providing any opening: dominating the conversation
- Personal intimidation. Many patients:
  - are embarrassed
  - don’t want to look foolish in front of the doctor
  - may be slightly afraid of the answer to the question
  - think they can’t/don’t understand medicine well enough to question it
  - don’t want the physician to think that they don’t value/respect his/her judgment.
What is a good question?

- **RELEVANT** (or "TIMELY"): Addresses a high-priority area of need
- **SPECIFIC** (or "CLOSED-ENDED"): Can be answered with a Yes or No, or an Option A vs. Option B
- **ACTION-ORIENTED**: Invites discussion of a course of action

### SET concrete goals

- Based on responses of doctor and the patient’s motivations, decide on ONE specific thing they should accomplish **by the next visit**:
  - Seeing how a new medication makes me feel
  - Starting an exercise program
  - Bringing a healthy lunch to work
- Then, set a smaller goal to get them started on the path in the next two weeks:
  - I will fill the prescription
  - I will ask my daughter to walk
  - I will sign up for a cooking class

Review these goals in 6 months.

---

**THE POST-VISIT SESSION**

- **REVIEW responses from doctor**
  - Discuss each question that was written down:
    - Was it asked?
      - If not, why not?
    - Was it answered in a helpful way?
      - If not, why was the answer not given or not helpful?
    - Is there any pressing thing we should go back to ask now?

**Good Goal-setting is SMART**

- Specific
- Measurable
- Action-oriented (and Positive)
- Realistic and Relative
- Time-based

---

**Coach Contact after Medical Visit**

- If no medical visit scheduled in the next 6 months phone contact occurs:
  - every 2 weeks x 2
  - then in one month
  - then every 2 months x 2
- A medical visit with a face-to-face visit restarts the follow up phone schedule.
- At 6 months patient is assessed for graduation from the program.
SELECTING COACHES

Coaches have...
- a personal association with a chronic disease
- caring qualities and a passion for health improvement

Coaches are...
- Expected to develop and manage a panel of 100 patients with a chronic disease (diabetes and/or heart failure)
- Integrated into CMS projects to improve chronic disease management for underserved populations, i.e. DSRIP, PRIME, The Million Hearts™, etc.
- Utilized in population health program expansions, i.e. nonface-to-face time, obesity, hypertension, etc.

Program Outcomes: FY14
Patients with diabetes prior to coached care and one year after coached care.

Program Outcome: FY 15
- Coached patients improved clinical outcomes
  - Average A1c reduction of 3%
  - 31% reduction in worsening blood pressure

Patient Engagement Survey
Medication Adherence
Financial Impact: FY14

- 52% reduction in inpatient visits
- 60% reduction in Emergency Dept/Observation visits

UC Irvine Health Coached Care Team
- John Billimek, PhD
- Mary Jean Christian, MA, MBA, RD, CDE
- Nathalie De Michelis, BSN, RN
- Joan Hoppe, MS, RD, CDE

Our Coaches: Sara and Jose

Financial Impact: FY15

- Coached patients
- 94% reduction in Emergency Dept/Observation visits
- 90% decrease in missed appointments
- 85% reduction in inpatient visits