

Office-Based Health Coaches: Creating Healthier Communities

BY DAVID SWIESKOWSKI, M.D., M.B.A.



Health coaches, usually working from call centers, are commonly used by disease management companies to address gaps in the current ambulatory care delivery system. This telemarketing approach has failed to engage physicians, who are often resentful that insurers will pay outsiders to provide self-management support but not them. Embedding the health coaching services in the physician's office can lead to much greater acceptance by patients and physicians; can achieve outcomes beyond those of disease management companies; and because it piggybacks on the existing office infrastructure, can be done at far less cost. This article will

discuss how a clinic system successfully embedded health coaches into fee-for-service physician offices.

This article will discuss how a clinic system successfully embedded health coaches into fee-for-service physician offices.

Mercy Clinics is a 150-physician multispecialty clinic in Des Moines, Iowa whose mission is "the creation of healthier communities." In the last year, we served 226,000 patients

with 877,000 patient visits. We have enrolled 8,600 patients with diabetes and 10,500 with hypertension in our disease registry. The clinic is owned by Mercy Hospital Medical Center and is structured so that each clinic site is managed by its physicians as its own cost center, with the difference between revenue and expenses at each site distributed as salary to the site's physicians. Since physicians take all the financial risk, it allows them freedom to try new approaches in care delivery processes and services.

In 2003 the *New England Journal of Medicine* published a Rand Corporation study finding that only 55 percent of evidence-based recommended care is provided to patients nationwide.¹ We recognized that this was the case in our practice and felt that the reason was primarily the care delivery system, which was designed for acute episodic care rather than chronic and preventive care. This gave the impetus for two sites to volunteer as pilots for a care delivery redesign project that evolved into disease registries and health coaches. The pilot sites were so successful that the physicians at the other primary care sites voluntarily introduced health coaches in their clinics.

Each clinic did this differently, but always started with the coaches getting the registry up and then migrating to other duties as the physicians in the clinic became comfortable and saw value in them. Physicians were initially reluctant to give up traditional duties such as

ordering labs for diabetes patients, but this reluctance was overcome as physicians who embraced coaches performed better with less effort. After the first four clinics introduced coaches, our largest payor began a pay-for-performance program, which was a major motivator for the rest of our physicians to get involved.

Mercy Clinics currently employs 15 full-time RN Health Coaches located at 12 clinic sites. In addition to improving patient outcomes, the coaches have more than covered the cost of their salaries by relieving physicians of clerical and nursing work, increasing the number of office visits, allowing us to bill higher levels of service, increasing testing revenue, and supporting P4P initiatives.

The Health Coach

The health coach position evolved and adapted to exploit the opportunities in our system. The coaches' greatest motivation is to help patients and improve quality, but they also must provide services which the physicians value and will utilize. Because of the different needs and stages of readiness in each clinic, we now have three coach job descriptions—one for CMAs and two for RNs—to meet the needs of our different clinics. Over time, the clinics migrate to the RN II position, which lists five essential functions:

1. Oversee the **disease registry** database.
2. Conduct **pre-visit chart review**.
3. Work with patients and families on **self-management support**.
4. **Coordination of care** across the care continuum.
5. Involvement in **QI activities**.

Disease Registry

Health coaches oversee the disease registry by making sure that data entry is complete and accurate. Registry data entry is done manually, and once the process at a site is mature, this takes less than three

FIGURE 1
Physician Level Performance Report

ALL Diabetes Data: 9/1/06-8/31/07							
Provider	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E	Dr. F	Goal
Total Patients	48	173	38	124	154	242	
Process goals:							
HgA1c last 12 mo.	92%	94%	92%	93%	90%	95%	94%
LDL last 12 mo.	85%	94%	79%	89%	87%	91%	94%
Microalb last 12 mo.	79%	93%	55%	73%	73%	70%	90%
Out come goals							
% HgA1c < 8.0	79%	92%	79%	82%	76%	87%	75%
% HgA1c < 7.0	63%	85%	61%	66%	60%	66%	50%
% LDL < 100	52%	63%	40%	46%	58%	74%	65%
% BP < 140/80	60%	68%	71%	55%	60%	67%	70%

FIGURE 2
Results Compared to Quality Measures

NQF Diabetes Measures	Measure Description	MCI Dec 06-Nov 07	HEDIS 2006
		% at goal	90th Percentile
#1	HbA1c	93.7%	92.7%
#2	HgA1c > 9.0	14.1%*	20.4%*
(*low is better)	or not done		
#3	LDL in last year	89.6%	95.4%
#4	LDL < 130	77.1%	76.6%
#5	LDL < 100	59.3%	52.9%
#6	Urine Protein		
	Screening	80.3%	68.9%
#7	Eye Exam	51.2%	69.3%
#8	Foot Exam	15.0%	
#9	BP <140/80	60.9%	
#14	HbA1c < 9.1	91.7%	
#14	HbA1c < 8.1	77.3%	
#14	HbA1c < 7.1	55.4%	
Ambulatory Measure #13	HTN patients with BP < 140/90	77.2%	76.3%

minutes per visit. At first coaches did the data entry themselves, but usually lower level clerical staff take over this role. The registry data is used to create physician-level performance reports, which contain population-based quality measures, such as percent with BP controlled or percent meeting certain measures

for diabetes (see Figure 1). These un-blinded reports are distributed monthly throughout our organization. The coaches use the data behind each performance measure to contact patients overdue for care or not meeting outcome goals. We find that 90 percent of patients contacted will come in for follow-up and most did

not understand that they were due to come in. Finally we use the registry to create individual patient summaries that list vital signs, procedures, lab results, and tests that are due or overdue. These reports are placed on each chart before a patient visit.

Many practices delay introducing a disease registry because they think that an EHR will be the solution. The danger is that the EHR does not make process change easier and may not function well as a registry. Unless you implement changes before introducing the EHR, you risk electronically encoding the old care system, making future change even more difficult. A disease registry is a low-cost, low-risk, and high-return way to enter the electronic world. Once your processes are adapted to the registry, you will be in a better position to choose and implement an EHR. We do not currently have an EHR, but are planning implementation at our first site later this year.

Pre-visit Chart Review

Coaches review the charts of patients prior to the physician visit. They use checklists to identify all needed lab tests, referrals, and preventive care needs, which are then completed based on standing orders. This planned visit process not only saves physician time for chart review and completing order forms but is also much more effective in helping to ensure patients receive all needed care. The income from the increase in medically necessary lab tests and procedures could easily cover the entire health coach salary.

Self-Management Support

Health coaches offer self-management support (SMS) to patients who are not meeting outcome goals. This is usually structured as a face-to-face visit with a follow-up by phone in one to two weeks. Health coaches have their own schedule for patient visits, but since they spend much of their time on clerical tasks, they

often are immediately available if a physician identifies a patient with a need for SMS. The coaches' key SMS skill is health behavior change. They use a "5As" format where they:

1. **Agree** on a goal that is patient-directed.
2. **Assess** the patient's readiness to change, importance of change in relationship to other values, and confidence of success.
3. **Advise** patients after carefully eliciting what the patient would like advice about.
4. **Assist** the patient in developing a personal action plan.
5. **Arrange** follow-up contact with the patient, usually in one or two weeks, to assess how the patient is doing on the plan and to modify it if needed.

A Self-Management-Support 5As form is used to prompt and document these encounters.

The biggest payoff is the creation of healthier communities.

Since this is health behavior change and not disease-specific education, it is possible for coaches to work with any disease or preventive health care. All health coaches go through at least one, four-hour health behavior change training session and then have this training reinforced at their biweekly meetings. Coaches also complete a four-day diabetes education program and receive education on other disease-related topics at their regular meetings. Coaches access community resources to meet patients educational needs or other services which they cannot personally provide.

Physicians are not trained to do SMS, and they do not have adequate time to be effective. Using coaches

to do SMS gets better results and frees up physicians' time to see more patients. We have negotiated payment for health coach services with one enlightened insurer.

Coordination of Care

Coaches coordinate the care team to improve communication and connect patients to needed office and community resources. Patients can contact them easily, and their close relationship with providers makes them a trusted point of access. Coaches try to anticipate needs and prevent incoming phone calls by contacting patients before they call the office—for example, with lab results—or phoning patients the day after hospital discharge. The coordination activity reduces expensive incoming phone calls, frees physician and staff time, and improves patient satisfaction—patients love their coaches.

Involvement in QI Activities

Most activity in medical clinics is reactive, going from one urgency to another, leaving very little time for proactive work. The coach's role is designed to be proactive, whether working with patients or taking time to plan office improvements. Part of their time is devoted to using PDSA cycles to initiate improvement projects in their clinics or to adopt changes they learned about in other clinics. The coach at one site worked on a project to return lab results to patients the morning after they were seen; 80 percent of results were returned by noon the next day and incoming phone calls for lab results fell from 442 to 124 per week. The regular coach meetings were an important vehicle to spread this innovation to all clinic sites in our system.

How to Start

If your group is interested in developing a program with health coaches, make a commitment to hire a full-time coach because if they

have other duties, reacting to the daily clinic urgencies will always pull them away from the important but not urgent coaching work. Pick one site with supportive physicians and start with the coach working on the registry and pre-visit chart review. Pre-visit review is easily learned, can be used for all patients regardless of diagnosis, and will generate a positive financial return immediately. The most difficult step is SMS and health behavior change. The book, *Health Behavior Change*, by Stephen Rollnick² and materials on the New Health Partnerships website³ provide excellent advice about implementing SMS. As coaches became busier with SMS, we trained clerical staff to relieve them of their registry duties.

Business Case and Summary

Overall we are bringing in at least \$4 in revenue for every dollar spent on health coach salary and benefits. Additional sources of revenue include:

1. Billing higher levels of service for diabetes visits. Because of the pre-work and after-work done by our coaches, our level 4 EM coding for diabetes visits went from 35 percent to 74 percent of visits.
2. Total diabetes visits went up 51 percent in one year.
3. Increase in lab revenue for HgA1c and microalbumin went up 95 percent in one year.
4. Referrals for DXA, cancer screening, and immunizations have increased.
5. Our largest insurer paid P4P bonuses to 85 of 86 providers.
6. We have negotiated a payment for health coaching services with our largest insurer.

The biggest payoff is the creation of healthier communities. Our quality measurements are hard to compare over time because of different measurement techniques

and specifications. We have recently adopted the NQF measures and find that we can easily achieve the 90th percentile on measures we have focused on (see Figure 2).

In summary, health coaches improve patient outcomes and are well accepted by patients. They foster a culture of data collection and continuous improvement, moving practices from reactive to proactive. Finally, they pay for themselves in a fee-for-service practice, even without pay-for-performance.

References

1. E.A. McGlynn, S.M. Asche, J. Adams, J. Keesey, J. Hicks, A. DeCristofaro, and E.A. Kerr. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*. 348(26): 2635-2645.
2. S. Rollnick, P. Mason, C. Butler, C. Butler. 1999. *Health Behavior Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone.
3. www.newhealthpartnerships.org

David Swieskowski, M.D., M.B.A., is vice president for quality at Mercy Clinics, Inc., Des Moines, Iowa.