Health Coaches, Registries and Panel Managers, Oh My!

Matching chronic care redesign to educational development

Family Health Center
San Francisco General Hospital

UCSF/SFGH FAMILY AND COMMUNITY MEDICINE RESIDENCY PROGRAM
SFGH UCSF Residency Training

- Grounded in
  - Scientific model: biopsychosocial
  - Clinical framework: family systems/contextual
- Values cross cultural, interdisciplinary, collaborative care with underserved patients and families
- Movement towards team-based care and population management challenged by resources and mythology
[Images from the past]

Continues to influence the identity of developing physicians
Physician-centered Teams

MD  MA  PHN  RN  SW  Nutritionist

Patient

Family  Community
Context and Drivers

- Research
- Leadership
- Funding
- Field of Family Medicine
Context and Curriculum
Family Health Center

- On San Francisco General Hospital campus
- 10,000 patients served; 1250 diabetics
- 40,000+ visits per year
- Full scope family practice
- Teaching clinic: 41 family practice residents and many medical and nursing students
- Diverse patient population
  - 39% Latino, 27% Asian, 17% Caucasian, 13% African American
  - 46% Medi-Cal, 18% uninsured, 18% Medicare
  - 31 different languages spoken
    - 42% English, 25% Spanish, 8% Cantonese/ Mandarin
Residents and Staff

- **SFGH FCMRP Residents**
  - ~50% graduates went on to work in FQHCs or equivalents in last 4 years

- **Nursing Staff**
  - 14.8 FTE medical assistants, 4.0 FTE health workers, 5.1 FTE RNs
  - Extremely diverse. 10 languages spoken by staff.
OVERALL GOAL

- To create an *experiential* curriculum to prepare residents to provide planned evidence-based and team-based primary care to diverse, low income, low literacy patients with chronic illnesses.
  - Focus on self management support through team care
  - Focus on panel management using registry data

- 3 groups of learners:
  - Residents, faculty, and staff
Instructional Methods

- Didactic presentations with interactive components
  - Lectures
  - Cases
  - Role plays
  - Video review for discussion
  - Registry review
  - Interdisciplinary

- Redesigned chronic care clinics

- PGY1 clinical supervision
  - Intensive clinical precepting
  - Live supervision
  - Video review
  - Facilitation of team work

- PGY2
  - Facilitation of team work and registry review
Redesigned Planned Visits
Physician-centered Teams

MD

MA

PHN

RN

SW

Nutritionist

MD

Patient

Family

Community
Teamlet is a “mini-team” including the provider and a health coach [health worker or medical assistant]
Teamlet Model
Primary care visit

- Review of symptoms, diagnosis, medications, education, goal-setting
- Medication reconciliation, education, closing-the-loop, action plans, phone follow-up (between-visit)
- Communication about medical decision-making, goals of care, panel management

- Family Community
- Patient
- R MD
- Faculty
- Health Coach
- Shared Decision making
- Team huddle
Health coach role

- **Self management support**
  - supporting patient to have knowledge, skills and confidence to become active participants in their care

- **Bridge**
  - Clarifying information and updates
  - Cultural/linguistic gaps

- **Clinical Navigation**
  - Due to language concordance, health coaches can make follow-up phone calls or no-show phone calls between visits
  - Health coaches are in clinic every day and can become a primary contact person for patients throughout the week
Between Visits:
health coach as continuity and navigator

- **Clinical continuity**
  - Patients are part of continuity panel
  - Goal to maximize continuity between patient and health coach/resident.

- **Emotional support**
A resident’s perspective on health coaching: a teammate to help alleviate barriers to ideal patient care

Language

Adequate time with patient

Cultural beliefs

Behavior change

Learning a complicated new health care system

Physician member of a prepared, proactive, patient-centered team
### Year 1

<table>
<thead>
<tr>
<th>Teamlets in clinic</th>
<th>Patients and registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 2007-2008 PGY1 class</td>
<td>- 192 patients with DMII, HTN, hyperlipidemia, tobacco use or obesity:</td>
</tr>
<tr>
<td>- Continuity with faculty</td>
<td>- ~150 patients seen</td>
</tr>
<tr>
<td>- 16 chronic care clinics</td>
<td>- ~300 visits</td>
</tr>
<tr>
<td>- 12 health coaches</td>
<td>- 27% no show rate</td>
</tr>
<tr>
<td>- Health workers and medical assistants</td>
<td></td>
</tr>
<tr>
<td>- Goal of 1:1 stable teamlets with language grouping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- i2i registry</td>
</tr>
<tr>
<td></td>
<td>- Summary sheets at point of care</td>
</tr>
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<td></td>
<td>- Reports reviewed twice</td>
</tr>
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</table>
Outcomes

Signed patient permission obtained
### Year 1 Teamlet patient clinical measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>2/07 baseline</th>
<th>6/08 post</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP at goal</td>
<td>48.7%</td>
<td>56.5%</td>
<td>0.22</td>
</tr>
<tr>
<td>LDL at goal</td>
<td>49.1%</td>
<td>58.6%</td>
<td>0.07</td>
</tr>
<tr>
<td>HbA1c &lt;7</td>
<td>26.7%</td>
<td>36.7%</td>
<td>0.12</td>
</tr>
<tr>
<td>[total DMII n=99]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c&lt;8</td>
<td>58.9%</td>
<td>65.6%</td>
<td>0.28</td>
</tr>
<tr>
<td>Self-Management Goal Documented</td>
<td>19.9%</td>
<td>55.5%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
PGY1 productivity

Average number of encounters per intern

2006-2007 (total 143)  2007-2008 (total 146)

pediatric visits

adult visits

12%
13%

**Educational successes**

- 100% R1s with planned visits with Teamlet
- 100% reviewed their panel registry data with their health coach to plan follow up and future care
- 9 of 13 Teamlets were directly observed with video

**Reported successes**
- Residents recognized the value of health coaches in terms of cultural bridges, social support, continuity, and navigation.
- Experiences recognizing increased motivation and confidence of patients to manage own conditions.
Educational challenges

- Teaching “Team-ness”
  - Faculty learning to facilitate
  - Variation of teamlet experience
  - Developing communication time and pathways
- Defining primary relationships and sense of responsibility as primary care providers
- Giving quality improvement context within the development of first year residents
  - Overwhelming for PGY1s
  - CC clinics not a full spectrum FM experience
  - Perception of registry reports as report cards rather than tools
<table>
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<tr>
<th>Year 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Teamlets</strong></td>
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</table>

- 5 health workers trained both health coaches AND panel managers; work with panel 40-60% of time
- 2008-2009 PGY1s: referral system within regular continuity clinic. Started 10/08.
- PGY2s have protected huddles and appt slots within continuity clinic 6 months of year

- PGY1 patients: those with DMII and HgA1C>8 + referred patients
- PGY2: all pts with DMII.
Year 2 PGY2 clinical outcomes

<table>
<thead>
<tr>
<th>Measures</th>
<th>7/08</th>
<th>4/09</th>
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<tbody>
<tr>
<td>N= 176 with DMII</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP at goal</td>
<td>33.5%</td>
<td>32.5%</td>
</tr>
<tr>
<td>LDL at goal</td>
<td>38.1%</td>
<td>49.7%</td>
</tr>
<tr>
<td>HbA1c &lt;7</td>
<td>21.6%</td>
<td>24.3%</td>
</tr>
<tr>
<td>HbA1c&lt;8</td>
<td>37.5%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Self-Management Goal Documented</td>
<td>31.8%</td>
<td>50.3%</td>
</tr>
<tr>
<td>LDL up to date</td>
<td>71.6%</td>
<td>78.7%</td>
</tr>
<tr>
<td>HgA1C up to date</td>
<td>53.0%</td>
<td>77.5%</td>
</tr>
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Chronic care education outcomes

Improved enjoyment of caring for patients with chronic disease apparent mid-PGY2 year [3.9 vs 4.2 p=<.001]

Improved self-reported knowledge and ability to apply the Chronic Care Model

- PGY1 vs. “control PGY1”
  - Knowledge of chronic care model [2.6 vs. 3.9 p=<0.01]
  - Ability to set up care systems based on the CCM [2.5 vs. 3.1 p=0.04]

- PGY1 vs. PGY2
  - Ability to set up care systems based on the CCM [3.1 vs. 3.8 p=0.02]
Satisfaction

- Mid-PGY2 residents
  - Agreed more strongly that teamlet visits provide better care
  - Continued to strongly agree they would want to work with a health coach in the future
  - Agreed that teamlet visits decreased work for them, a change from the end of PGY1 year [2.3 vs. 3.3 p=0.05].
Educational outcomes

- PGY1s vs. “control” ranked staff as more appropriate
  - Help patients set behavioral change action plans
    - [Mas: 5.0 vs. 4.2 p=0.04] and [HWs: 5.0 vs 4.5 p=0.05]
  - Call patients between visits to check how they are doing
    - [HWs: 5.0 vs 4.1 p=0.03]

- Mid-PGY2 ranking for MAs to set action plans decreased [5.0 to 3.8 p=0.06].

- Mid-PGY2s continued to rank HWs highly [4.7- 4.9].
creating a medical home

IF WE BUILD IT [WITH THEM],

THEY WILL LEARN.
Matching redesign to educational development

Given postgraduate educational requirements,

- **PGY1 objectives**
  - Introduction to CCM, registry reports and health coaches
  - Provide clinical teamlet care with 3 patients with faculty live supervision, including case discussions as group
  - Emphasis on chronic care guidelines, biopsychosocial model, and interpersonal communication to partner with patients and team members
  - Review registry report 2 times during year
Matching redesign to educational development

- Additional PGY2- PGY3 objectives
  - Team leadership
  - Familiarity with system to start considering impact on patient care and team dynamics.
  - Familiarity to actively participate and see own role in quality improvement efforts
    - Testing change
    - Considering complexities of setting improvement goals

- Examples
  - Resident ideas for PDSA cycles brought up during huddle
  - PGY2 focus group themes
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  - Lisa Ward, Danielle Hessler, David Thom, La Phengrasamy, Stephanie Tache, Kelsey Laird, Laura Hill-Sackera, Paula Fleisher
Contact Information

- Ellen Chen, MD
  - elchen@fcm.ucsf.edu

- Hali Hammer, MD
  - hhammer@fcm.ucsf.edu

- George Saba, PhD
  - gsaba@fcm.ucsf.edu

- Andres Marin, MD
  - Andres.marin@fcm.ucsf.edu

- Suzannah Stout, MD
  - Stouts@fcm.ucsf.edu

- Center of Excellence in Primary Care
  - http://familymedicine.medschool.ucsf.edu/cepc/index.html