

The 10 Building Blocks of Primary Care

Health Coaching in Primary Care – Intervention Protocol

Background and Description

The Health Coaching in Primary Care Intervention Protocol is a detailed description of the health coaching model used in our randomized controlled trial (RCT) of health coaching conducted by medical assistants for patients with uncontrolled diabetes, hypertension, and hyperlipidemia. The protocol describes how to assign and introduce patients and primary care providers to the health coaches, and it provides detail on health coaching activities, including pre-visit, during visit, post-visit, and between visit tasks.

Instructions

These protocols and forms may be adapted and used by sites that are launching health coaching programs.

UCSF Center for Excellence in Primary Care

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care.

Acknowledgments

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Health Coaching in Primary Care – Intervention Protocol

Abbreviations

PCP – Primary Care

Provider HC – Health

Coach

RA – Research Associate

Assignment of patient to a Health Coach

When a patient is enrolled in the Health Coaching study and is randomized into the intervention arm, the Research Associate (RA) will assign the patient to one Health Coach (HC). The assignment will be based on which HC is on call to receive patients that day. HCs will coordinate so as to ensure that the number of patients in their caseload is roughly equal.

First interaction with Patient

Independent of medical visit. After a patient is enrolled in the study and assigned a HC, the RA will accompany the patient to the adult medicine department in order to make a “warm handoff,” introducing the patient to his or her coach. In cases when the RA is unable to introduce a patient in person, the HC will call the patient to set up an introductory meeting.

Within a week of enrollment, the HC will conduct a brief introductory session with the patient, with questions guided by the **Patient Intake Form**. The HC will also explain her role to the patient and will provide the patient with a language-specific **Health Coaching brochure** and a business card with the HC’s contact information at the clinic.

If the patient does not have visit scheduled within two months of his or her last PCP visit, the HC will confirm the patient’s PCP and help the patient to schedule an appointment. In the event that the medical visit is not scheduled within two weeks of the initial meeting between HC and patient, the HC will also set up an individual meeting to begin discussing clinical measures (A1c, LDL, blood pressure) and the patient’s goals for their health. If the patient is interested in creating an action plan, the HC may begin to work with the patient on these goals prior to their first appointment.

After enrollment, the HC will call the patient at least monthly to check in, help navigate healthcare, discuss action plans and help patients prepare for PCP visits- even if no PCP visit has yet occurred with the HC.

Same day of appointment. If the patient is enrolled directly before a PCP visit, the HC will inform the PCP of enrollment. The PCP will introduce the HC as part of the patient’s healthcare team for the next year. If there is time, the HC may perform pre-visit medication reconciliation and agenda setting. The HC will stay with the patient during the visit, confirm the medication list with the PCP and perform the post-visit and between visit follow-up. Behavioral change action plans are optional during the first HC visit.

Additional Health Coach duties when receiving a new patient include:

- Update i2i
 - Update tracking type (Health Coaching)
 - Add health coach (History > Other Profile Items)

- Update missing lab information and vital signs
- Set up follow up alerts
- Enter patient information in Health Coaching database in Access & fill out interaction report (in Access)
- Place green Health Coach sticker on chart
- Email provider – patient has been assigned a health coach, next appointments

Sample email to provider:

Dr. _____,

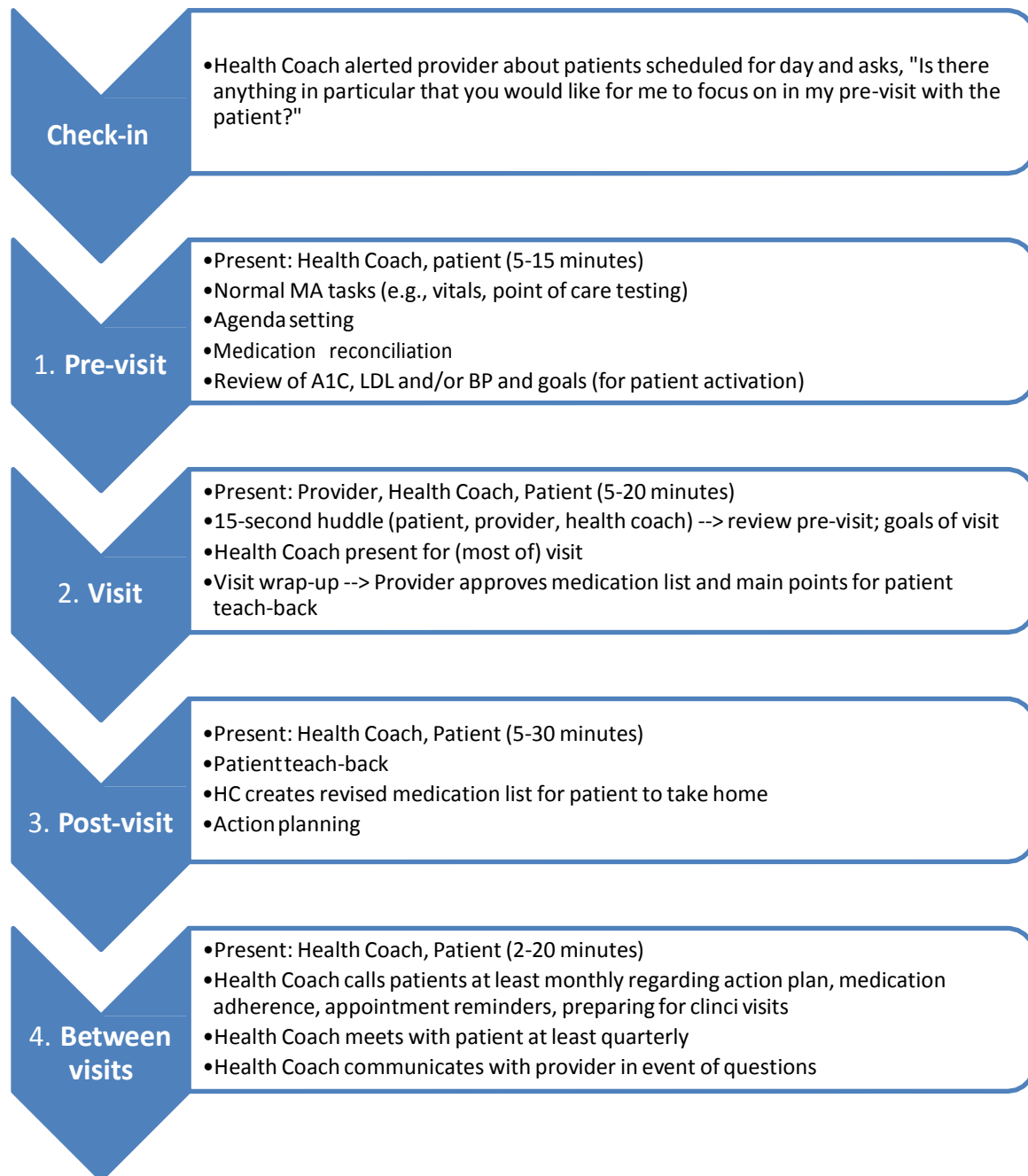
I wanted to let you know that I will be working with your patient, _____ [Name of patient]. Her next appointment is on _____ [date]. In the meantime, we will be meeting next week to discuss her goals for her diabetes care.

If there is anything in particular that you would like for us to think about during our visit, please let me know.

Thank you, and I look forward to working with you!

_____ [Your name]

Typical visit model

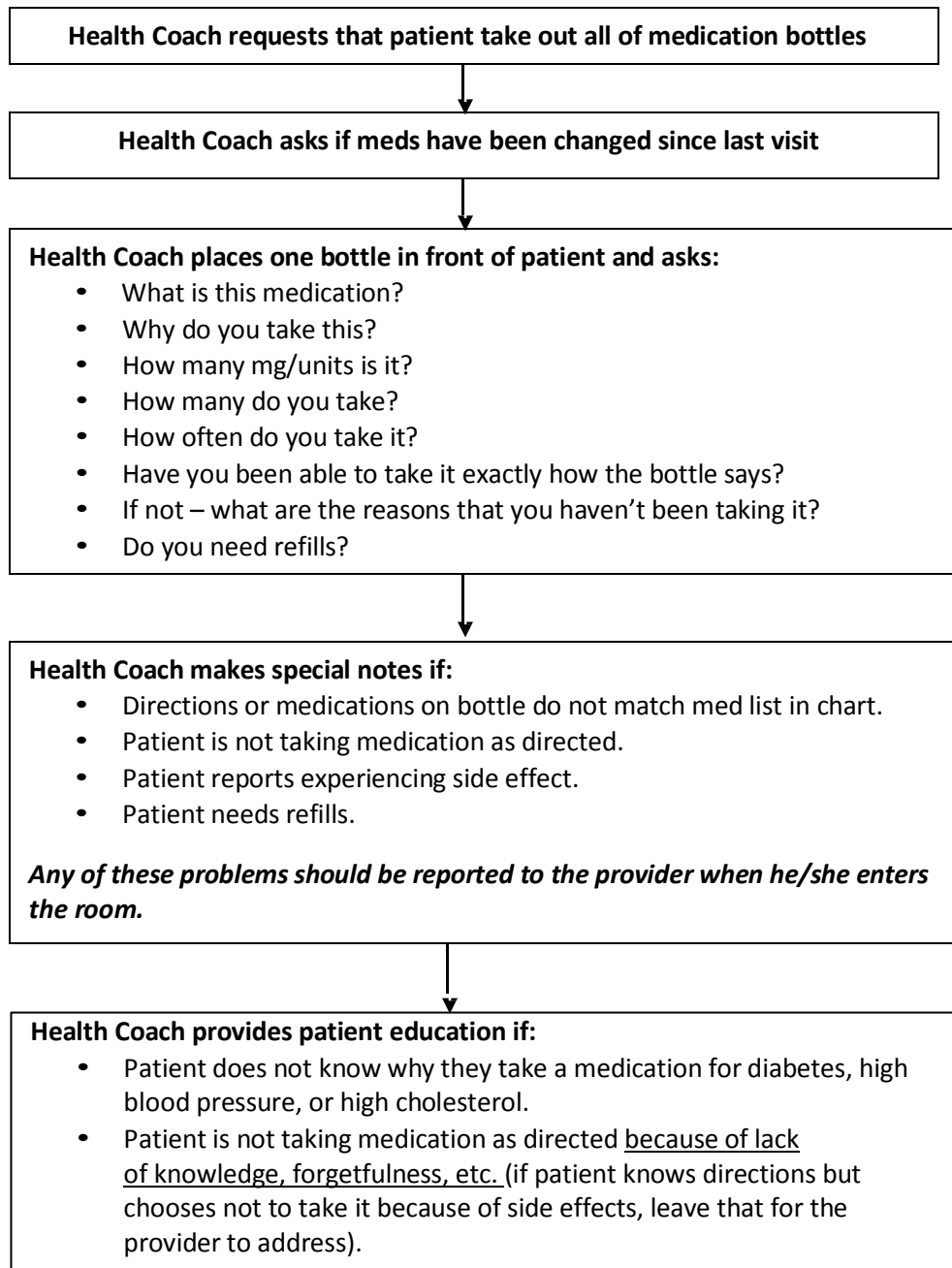


Check in

On the day that a patient with a HC is scheduled, the HC will approach the PCP and alert him or her of the appointment. The HC will ask, "Is there anything in particular that you would like me to focus on in my pre-visit with the patient?"

Step 1: Previsit

- *Intake.* The HC will take vital signs and ask standard intake questions (e.g., smoking status, drug allergies).
- *Point-of-care testing.* The HC will conduct blood glucose for each visit of a patient with diabetes and will conduct HgA1c testing every three months. Depending on clinic recommendations, the HC may also conduct urinalysis.
- *Medication reconciliation.* The HC will record what medications are prescribed to the patient and whether the patient reports taking each medication as prescribed using the **Medication Reconciliation form**. The HC will note if patient needs refills.



- *Agenda setting.* The HC will use the **Agenda Setting form** to assist the patient in listing what issues they would like to address during the PCP visit and to identify their top issue for the visit. The HC will explain that the PCP may not have time to address all concerns and that the list will assist the PCP to organize the visit in partnership with the patient.
- *Chronic condition lab review.* The HC will ask the patient about their current A1C, BP and/or LDL levels and discuss the recommended goals for these values. This discussion will be used to assess the education, behavioral change motivation, and psychosocial needs of the patient in relation to their chronic care.

Note: It may not be possible to address all of the points above during the pre-visit. As described below, HCs expect the PCP to enter the room when he or she is ready to begin the visit with the patient. Items that cannot be covered during the pre-visit may be addressed during the post-visit.

Step 2: Visit

- *Huddle.* It is anticipated that the HC will usually NOT be able to complete all pre-visit discussions prior to the visit. HCs expect the PCP to enter the room when he or she is ready to begin the visit. The PCP may greet the patient and then say something like, “I know that you two have been discussing your concerns and your medications. I’m going to ask your HC to bring me up to date on what you have been talking about.” The HC will then update the PCP about the pre-visit in front of the patient in the exam room. In most cases, the HC will summarize in about 15 seconds the major events since the last visit, the patient’s top goals for the visit, and what the HC has learned in medication reconciliation (e.g., medications not being taken as prescribed).
- *Visit.* The HC will stay in the room during the visit unless the patient prefers that the HC leave. During the visit, if necessary, the HC will remind the patient to communicate directly with the PCP. The HC may help fill out lab request forms and order forms for preventive care (e.g., vaccinations, cancer screening).
- *Documentation:* The HC will take notes on the **Visit Summary form** to list items for patient teach-back.
- *Medication review:* The PCP will confirm the medication list and changes to be made on **Medication Reconciliation form.**
- *Huddle:* The PCP and the HC will huddle briefly in front of the patient to review items for teach-back and possible areas for behavioral change using the **Visit Summary form.** The HC will prompt the PCP to identify goals for Hemoglobin A1c (if appropriate), LDL, and blood pressure.

Step 3: Post-visit

- HC will perform patient teach-back.
 - *Chronic condition lab review.* The HC will continue to talk with the patient about their current A1C, BP and/or LDL levels and the recommended goals for these values.
 - *Medication List:* The HC will review medications and provide the patient with a copy of current medications using a fresh **Medication Reconciliation Form.**
 - *Other:* The HC will close the loop on other items identified by the PCP as subjects for teach back.

- *Action Plan:* The HC will guide the patient in creating a **Behavioral Change Action Plan** on a topic that the patient identifies.
- *Navigational Support:* HC will help patient navigate the system in order to get labs, secure medications, and schedule follow up appointments.
- *Education:* The HC will provide basic information on nutrition and exercise. Other areas of education include teaching patients to use glucometers and measure their blood pressures at home.

Step 4: Between-visits

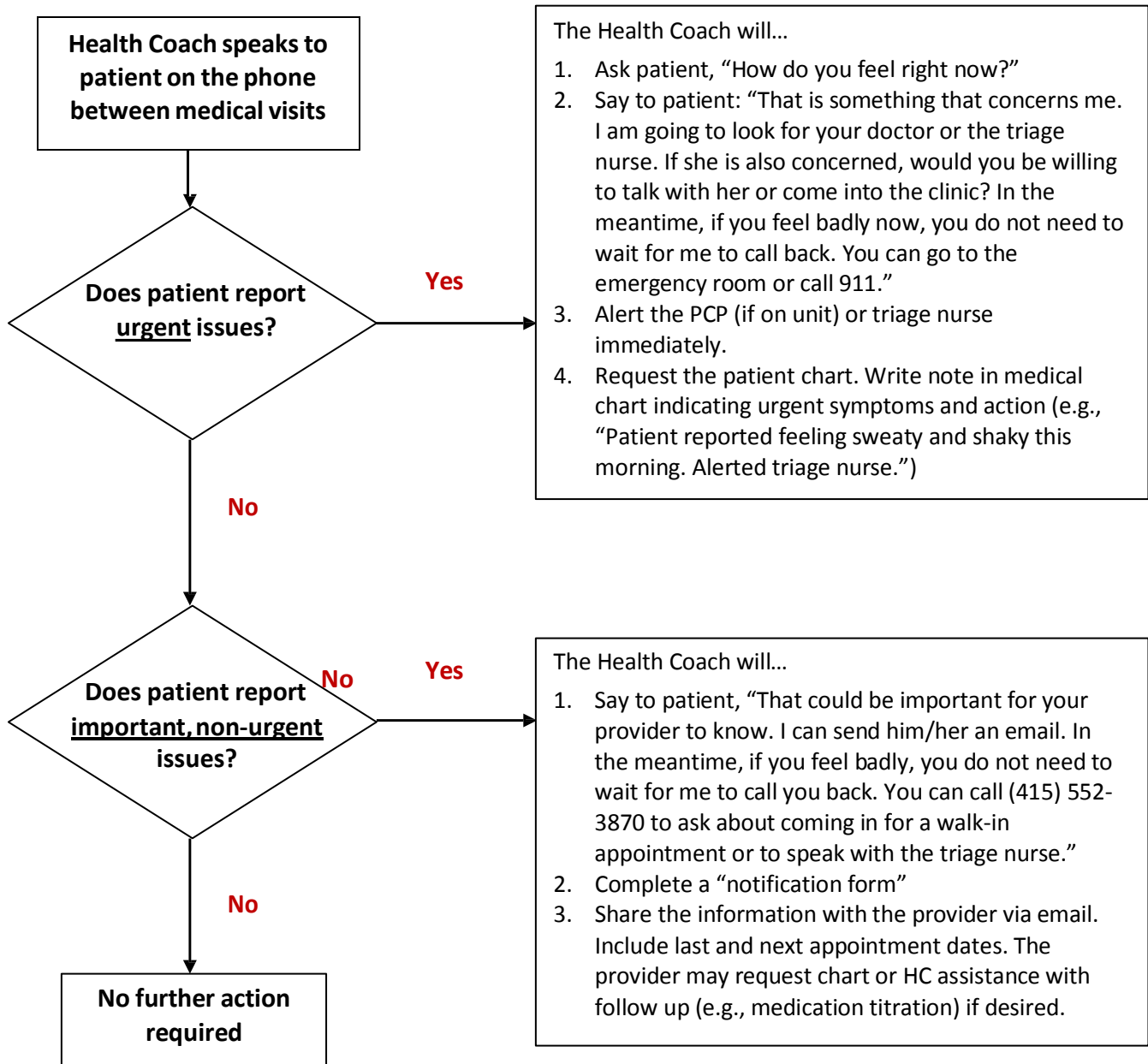
Follow up calls: HC will call patient one week after PCP visit to check in on medication changes, appointments, and behavioral change action plans. If needed, the HC may use these calls to help the patient create a new action plan.

Follow up meetings: HCs will meet with patients at least once every three months. Usually these visits will occur during regularly scheduled appointments with the PCP. However, if the regularly scheduled appointments are more than three months apart, patients may be encouraged to come in for a visit with their HC in between visits with the PCP. Additionally, if the patient could be better assisted by in-person meetings, the HC will meet with the patient in-clinic. For example, the patient may bring in medicine bottles for reconciliation if forgotten during the PCP visit. Similarly, glucometer or home BP measurement instruction may be better provided in person.

- *Navigational support:* HC will help patient navigate the health care system. For example, they might provide instructions on how and when to refill medications or how to get an appointment at the lab. HC may assist patient with navigating services such as laboratory tests, pharmacy refills, nutritional counseling, social work or mental health appointments, specialty care referrals, community resources access, or enrollment in programs such as Healthy San Francisco.
- *Communication with PCPs and medication titration:* The HC will communicate new developments in the patient's management of their diabetes, hypertension, or hyperlipidemia to their PCP, including new clinical values (e.g., A1c, blood glucose, LDL, or home SBP). The HC will ask PCP if they can assist in medication titration for diabetes, hypertension or hyperlipidemia before the next visit.
- *Appointment reminders.* HC will track PCP follow up appointments and call patients one week prior to visit to remind patient of appointment. The HC will encourage patients to arrive early and allow additional time after the appointment to conduct the post-visit. The HC will also remind the patient to bring medication bottles or a medication list to the appointment.

Panel management. The HC will review patient panel every week to identify labs that are out of date. He or she will fill out a lab slip and check with PCPs if they would like other labs to be drawn at the same time.

Communication with providers: What if the Health Coach learns something important in a phone call?



<p><u>Urgent</u> issues include:</p> <ul style="list-style-type: none"> • Home blood glucose ≤ 80 or ≥ 400 • Home BP $\leq 90/50$ or $\geq 200/120$ • Symptoms of hypoglycemia without BS measure: sweaty, shaky, dizzy, etc. • Other symptoms: chest pain, loss of consciousness, sudden shortness of breath, weakness on one side of body, sudden vision loss, new severe pain 	<p><u>Important, non-urgent</u> issues include:</p> <ul style="list-style-type: none"> • Patient not taking medications as prescribed • Problems getting prescription filled • Serious side effect of medication • ED visit or hospitalization • FBS ≥ 160 or post-prandial BS ≥ 250 for multiple days while still on meds • Hemoglobin A1c ≥ 12 • SBP ≥ 150 for multiple days • LDL ≥ 130
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Communication with PCP

Because they are making calls to patients between medical visits, Health Coaches may become aware of symptoms or home monitoring readings that should be communicated to the PCP or other clinic staff. The Urgent Issues protocol defines patient reported issues that should be communicated immediately to a PCP (if on the unit) or the triage nurse). In addition, the HC should communicate certain information about the patient to the PCP via email or in weekly huddles.

In addition to the description of the situation and patient identifiers, HCs will share the **Patient Medication List** that was produced for the patient during the last visit. In the event that the PCP wishes to titrate a medication for diabetes, hypertension, or hyperlipidemia, he or she will write a brief chart note and prescription. The HC may then call the patient to relay the information. Alternatively, the PCP could request that the HC make an appointment to follow up earlier with the patient.

Coach-Patient Interactions

HCs will record their interactions with the patients using the **HC Interaction Form**. Information from this form will be entered in the Health Coaching Database.

Documentation

HCs will need to document different information for the medical record, patient registry, the HC files, and the research study.

The following information should be included in the Medical Record:

- Behavior Action Plan (yellow copy)

The following information should be included in the i2i Patient Registry:

- Hemoglobin A1c values
- Blood pressure
- LDL and other labs

The following information should be included in the HC records and entered into the study database as required:

- Patient intake form
- Patient Medication List
- Visit summary forms
- Interaction forms

Glucometer teaching and log

Home BP measurement teaching and log

Blood draws

If certified for phlebotomy, the HCs will draw blood for the study patients to obtain fasting lipid testing at baseline and at 12 months.

Other Clinical Tasks

HCs are encouraged to be helpful to other members of the clinical team, insofar as that does not interfere with their HCing duties or the research study protocol.

1. HCs conduct all MA tasks for their assigned patients, in addition to carrying out HCing activities.
2. HCs may sub in for typical MA roles (e.g., intake, vitals, rooming patients) when the clinic is short staffed, provided these do not interfere with their HCing responsibilities. For non-study patients, the HCs will not provide additional HCing support.
3. HCs may help with non-patient intensive clinic projects, particularly those that are flexible in time (and can be done around patient appointments).
4. **Tasks to avoid: Providing help with clinic navigation, behavior change and action planning, or medication reconciliation to non-study patients**

Training

Coach mentoring and observation

After skills-based training and role-plays, HCs will shadow experienced HCs and discuss their observations in team debriefing meetings.

HCs will be observed working with at least two patients. The observer will use the **HC observation form** to provide feedback to the HC. The observer for the original observation sessions will be supervising study personnel. However, for subsequent observations, one coach may observe another coach and provide feedback.

HCs will debrief with the study team during meetings, to occur at least every other month. These meetings will include discussions of particular cases.

Intake form

Patient information <i>(RA fills out as much as known)</i>	Referral date: _____												
Name: _____ DOB: _____ MRN: _____	<table border="1" style="margin: auto; border-collapse: collapse;"> <thead> <tr> <th style="padding: 5px;">Clinical values</th> <th style="padding: 5px;">Value</th> <th style="padding: 5px;">Date</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">HgA1c</td> <td style="width: 100px;"></td> <td></td> </tr> <tr> <td style="padding: 5px;">BP</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">LDL</td> <td></td> <td></td> </tr> </tbody> </table>	Clinical values	Value	Date	HgA1c			BP			LDL		
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HgA1c													
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Contact information													
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Emergency contact information – if your phone doesn't work, who can we call to find you?													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="padding: 5px;">Name</th> <th style="padding: 5px;">Relationship</th> <th style="padding: 5px;">Phone number</th> <th style="padding: 5px;">Other information</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name	Relationship	Phone number	Other information									
Name	Relationship	Phone number	Other information										

Health coach use

Preferred name: _____

Preferred language- Speaking: English Spanish
 Reading/writing: English Spanish

Health literacy (how often needs help reading instructions, pamphlets, or other written material from your doctor or pharmacy): Never Rarely Sometimes Often Always

Have you been diagnosed with...

Diabetes -----> Use glucometer at home? Keep a log? _____

High cholesterol _____

High blood pressure----->Use blood pressure monitor at home? Keep a log? _____

Patient has paperwork that he/she needs help in completing

Possible questions for conversation:

- Just to get to know each other a little bit more, what do you like to do for fun?
- Tell me about the **things that are most important in your life**. How does having diabetes/high blood pressure/high cholesterol affect those things?
- Tell me about **how you take care of your health**. Who or what helps you take care of your health?
- Tell me about the **things that make it hard to take care of your health**.
- What are **your goals** for your health?

Introduce health coaching using brochure.

- In what ways do you think that I can help you to take care of your health? *(If patient has specific ideas of how to improve their health, you can ask if they would like to make an action plan.)*

Notes

Confirm PCP: _____ (I see that _____ is your primary care provider here at MNHC. Is that correct?)

Confirmed or set up appointment with PCP within 2 months of last appointment

If PCP appointment is more than 2 weeks away, set up time to meet to discuss goals, #s

Post visit

- In i2i
 - Update tracking type (Health Coaching)
 - Add health coach (History > Other Profile Items)
 - Update missing lab information and vital signs
 - Set up follow up alerts
- Enter patient information in Health Coaching database in Access
- Fill out Health Coach Interaction form
- Put green sticker on chart
- Email provider – patient has been assigned a health coach, next appointments

Patient agenda for next visit

Questions for my next visit

What are the most important things I would like to talk about in my next medical visit?

1. _____

2. _____

3. _____

Remember to bring:

- Bottles of all the medications you are taking
- A log of your glucometer or blood pressure readings if you take them at home

Preguntas para mi próxima visita

¿Cuáles son las cosas más importantes de que yo quiero hablar en mi próxima visita médica?

1. _____

2. _____

3. _____

No se olvide de traer:

- Botellas de todos los medicamentos que está tomando
- Una lista escrita de sus números de azúcar por su glucometer o su presión si lo toma en casa

Agenda setting form
(form developed by MNHC)



1. What are the 2 or 3 most important topics that the patient wants to discuss in their visit today:

- a. _____
- b. _____
- c. _____

2. Does the patient need med refills? Yes No

- a. For what medications?

3. Since last visit, has the patient had any of the following exams performed at another clinic?

- a. Lab Test: _____
- b. X-Rays: _____
- c. Other Tests: _____

4. Since last visit, has the patient had any other tests performed? Which tests?

5. Since last visit, has the patient been to the hospital recently? Yes No

6. Since last visit, has the patient been to the emergency room recently? Yes No

7. Since last visit, has the patient had any specialty services in the last month? Yes No

8. Did you bring any papers/forms/letters that you need the provider to fill out or sign for you? Yes No



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Visit Summary Notes

Patient information	Visit date: _____
Name: _____	
DOB: _____	
MRN: _____	

Appointments/labwork/referrals <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Provider advice <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Medication	
REFILL	
ADD	Health Coach Follow Up Tasks <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
CHANGE	
STOP	
Notes:	



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Notification form from Health Coaches

Patient name: _____ MRN: _____
Date of call: _____ Health coach: _____ Provider: _____
Date of patient's last visit: _____ Phone number at which patient can be reached now: _____

URGENT issue reported by patient – alert triage nurse

<input type="checkbox"/> Home blood glucose of ≤ 80 or ≥ 400	Alerted triage nurse. Date: _____ Initials: _____ Other notes:
<input type="checkbox"/> Home BP of $\leq 90/50$ or $\geq 200/120$	
<input type="checkbox"/> Symptoms of hypoglycemia without BS measure: sweaty, shaky, dizzy, etc.	
<input type="checkbox"/> Other symptoms: chest pain, loss of consciousness, sudden shortness of breath, weakness on one side of body, sudden vision loss, new severe pain	

IMPORTANT, NON-URGENT issue reported by patient – advise provider via email

<input type="checkbox"/> Patient not taking medications as prescribed Which medication? _____ What is the change? _____ Why the change? _____	Advised provider via email. Date: _____ / Initials: _____ Other notes:
<input type="checkbox"/> Problems with getting prescription filled or refills <i>Describe in "other notes"</i>	
<input type="checkbox"/> Patient reports serious side effect of medication	
<input type="checkbox"/> ED visit or hospitalization	
<input type="checkbox"/> Patient reports FBS ≥ 160 for multiple days	
<input type="checkbox"/> Patient reports routine post-prandial BS ≥ 250 even with diet modification and medication adherence	
<input type="checkbox"/> Patient reports routine SBP ≥ 150 even with diet modification and medication adherence	
<input type="checkbox"/> LDL ≥ 130	

PCP Action

<input type="checkbox"/> Noted – no changes at this time	<input type="checkbox"/> Titrate medication Medication to change: _____ New dosage/instructions: _____ <hr/> <input type="checkbox"/> Noted in chart <input type="checkbox"/> New prescription to pick up
<input type="checkbox"/> Patient should return for routine appointment	
<input type="checkbox"/> Patient should return for expedited appointment	
<input type="checkbox"/> Ask patient to call back if symptoms get worse	
<input type="checkbox"/> Patient should call 911	
<input type="checkbox"/> Other:	

Provider signature: _____

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Health Coach Interaction Form

Patient name:	MRN:
---------------	------

Date of interaction: _____/_____/2011			
<p style="text-align: center;">How did you talk? (select only one)</p> <p><input type="checkbox"/>₁ Medical visit</p> <p><input type="checkbox"/>₂ Phone call</p> <p><input type="checkbox"/>₃ Individual meeting (not medical visit)</p> <p><input type="checkbox"/>₄ Group meeting</p>	<p style="text-align: center;">About how long did you see/talk to the patient? (select only one)</p> <p><input type="checkbox"/>₁ Less than 15 minutes</p> <p><input type="checkbox"/>₂ 15–30 minutes</p> <p><input type="checkbox"/>₃ More than 30 minutes</p>		
<p style="text-align: center;">Complete for medical visits</p> <p>What parts of the medical visit were conducted? (select all that apply)</p> <p><input type="checkbox"/>₁ Pre-visit</p> <p><input type="checkbox"/>₂ Visit (health coach present)</p> <p><input type="checkbox"/>₃ Post-visit</p>	<p style="text-align: center;">Complete for follow up calls</p> <p>What tasks did you conduct? (select all that apply)</p> <p><input type="checkbox"/>₁ Discuss medication adherence</p> <p><input type="checkbox"/>₂ Follow up on action plan</p> <p><input type="checkbox"/>₃ Create a new action plan</p> <p><input type="checkbox"/>₄ Review labs (“know your numbers”)</p> <p><input type="checkbox"/>₅ Deliver medication titration instructions</p> <p><input type="checkbox"/>₆ Deliver other message to patient from PCP</p> <p><input type="checkbox"/>₇ Provide navigational support</p> <p><input type="checkbox"/>₈</p>		
<p>What tasks did you conduct? (select all that apply)</p> <p><input type="checkbox"/>₁ Agenda setting</p> <p><input type="checkbox"/>₂ Medication reconciliation</p> <p><input type="checkbox"/>₃ Review labs (“know your numbers”)</p> <p><input type="checkbox"/>₄ Teach back (closing the loop)</p> <p><input type="checkbox"/>₅ Create an action plans</p> <p><input type="checkbox"/>₆ Follow up on action plan</p> <p><input type="checkbox"/>₇ Provide navigational support</p> <p><input type="checkbox"/>₈ Other:</p>			
Complete for all interactions			
<p style="text-align: center;">What topics did you discuss? (select all that apply)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/>₁ Medications</p> <p><input type="checkbox"/>₂ Food</p> <p><input type="checkbox"/>₃ Exercise</p> <p><input type="checkbox"/>₄ Stress</p> <p><input type="checkbox"/>₅ Hemoglobin A1c</p> <p><input type="checkbox"/>₆ Blood Pressure</p> </td> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/>₇ LDL Cholesterol</p> <p><input type="checkbox"/>₈ Weight</p> <p><input type="checkbox"/>₉ Working with the provider</p> <p><input type="checkbox"/>₁₀ Using the clinic/resources at the clinic</p> <p><input type="checkbox"/>₁₁ Other (This can be family, the clinic, etc.):</p> </td> </tr> </table>		<p><input type="checkbox"/>₁ Medications</p> <p><input type="checkbox"/>₂ Food</p> <p><input type="checkbox"/>₃ Exercise</p> <p><input type="checkbox"/>₄ Stress</p> <p><input type="checkbox"/>₅ Hemoglobin A1c</p> <p><input type="checkbox"/>₆ Blood Pressure</p>	<p><input type="checkbox"/>₇ LDL Cholesterol</p> <p><input type="checkbox"/>₈ Weight</p> <p><input type="checkbox"/>₉ Working with the provider</p> <p><input type="checkbox"/>₁₀ Using the clinic/resources at the clinic</p> <p><input type="checkbox"/>₁₁ Other (This can be family, the clinic, etc.):</p>
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Notes for follow up:			
	Description of action plan (if relevant):		
	<input type="checkbox"/> Scheduled i2i prompt – next call		

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Health Coach Observation Form

Health Coach: _____

Date: _____

Greeting	
<input type="checkbox"/>	Coach is friendly and greets patient.
<input type="checkbox"/>	Coach introduces herself and states that she is working with provider today
Comments:	
Setting the Agenda	
<input type="checkbox"/>	Coach asks patient what they want to talk about (setting the agenda).
<input type="checkbox"/>	Coach restates what he/she heard patient say
<input type="checkbox"/>	Coach asks patient if it OK to talk about things coach wants to talk about (setting the agenda).
<input type="checkbox"/>	Coach and patient set the agenda for the visit using both patient and coach items
Comments:	
Ask-Tell-Ask	
<input type="checkbox"/>	Coach listens without interrupting
<input type="checkbox"/>	Coach’s comments, tone, and facial expressions are friendly and not judgmental
<input type="checkbox"/>	Coach engages in reflective listening – uses patient’s words as cue for the next sentence
<input type="checkbox"/>	Coach asks patient questions relevant to the topic at hand.
<input type="checkbox"/>	Coach provides information ONLY when patient asks or patient doesn’t know.
<input type="checkbox"/>	Coach provides accurate information.
<input type="checkbox"/>	Coach did not know the information and said, “I don’t know but I will find out and get back to you”.
Comments:	
Medication Reconciliation (med-rec)	
<input type="checkbox"/>	Coach reviews one medication at a time
<input type="checkbox"/>	Asks name
<input type="checkbox"/>	Asks dose;
<input type="checkbox"/>	Asks what med is for;
<input type="checkbox"/>	Asks how often to take it;
<input type="checkbox"/>	Asks if they take it as prescribed;
<input type="checkbox"/>	Discusses reasons not taking as prescribed;

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<input type="checkbox"/>	Asks if patient needs refills
<input type="checkbox"/>	Coach repeats process for each medication
<input type="checkbox"/>	If patient needs help with and is interested in improving medication adherence, asks if patient wants to make an action plan.
Comments:	
Action Plan	
<input type="checkbox"/>	Coach asks the patient what they want to work on.
Coach helps patient plan...	
<input type="checkbox"/>	What
<input type="checkbox"/>	How
<input type="checkbox"/>	Which days
<input type="checkbox"/>	Where
<input type="checkbox"/>	With whom
<input type="checkbox"/>	Coach asks when the patient wants to start.
<input type="checkbox"/>	Coach asks the patient about their confidence on a scale of 1–10 (7 or higher means patient is feeling confident).
<input type="checkbox"/>	Coach sets date/time to follow up.
<input type="checkbox"/>	Coach helps patient troubleshoot barriers.
Comments:	
Closing the Loop	
<input type="checkbox"/>	Coach asks patient to retell the information, in a respectful manner.
Coach asks patient close the loop about...	
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Action plans
<input type="checkbox"/>	Health education
<input type="checkbox"/>	Care plan
<input type="checkbox"/>	Appointments
<input type="checkbox"/>	Coach closes the loop around patient's agenda
<input type="checkbox"/>	Coach closes the loop when uncertain about what the patient said

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Comments:	
Coach/Patient Interaction	
<i>Note to observer: Check off the following based on your observations of the interaction between coach and patient. Points of observation include eye contact, facial expressions, body language, tone of voice, ease of conversation, and topics discussed</i>	
<input type="checkbox"/>	Coach warmly greets patient
<input type="checkbox"/>	Coach makes eye contact
<input type="checkbox"/>	Coach smiles
<input type="checkbox"/>	Coach is relaxed
<input type="checkbox"/>	Coach speaks slowly and clearly
In your own words describe the coach/patient interaction:	
Feedback for the health coach:	