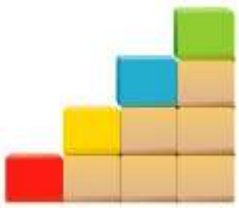

The 10 Building Blocks of Primary Care

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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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

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. _____,

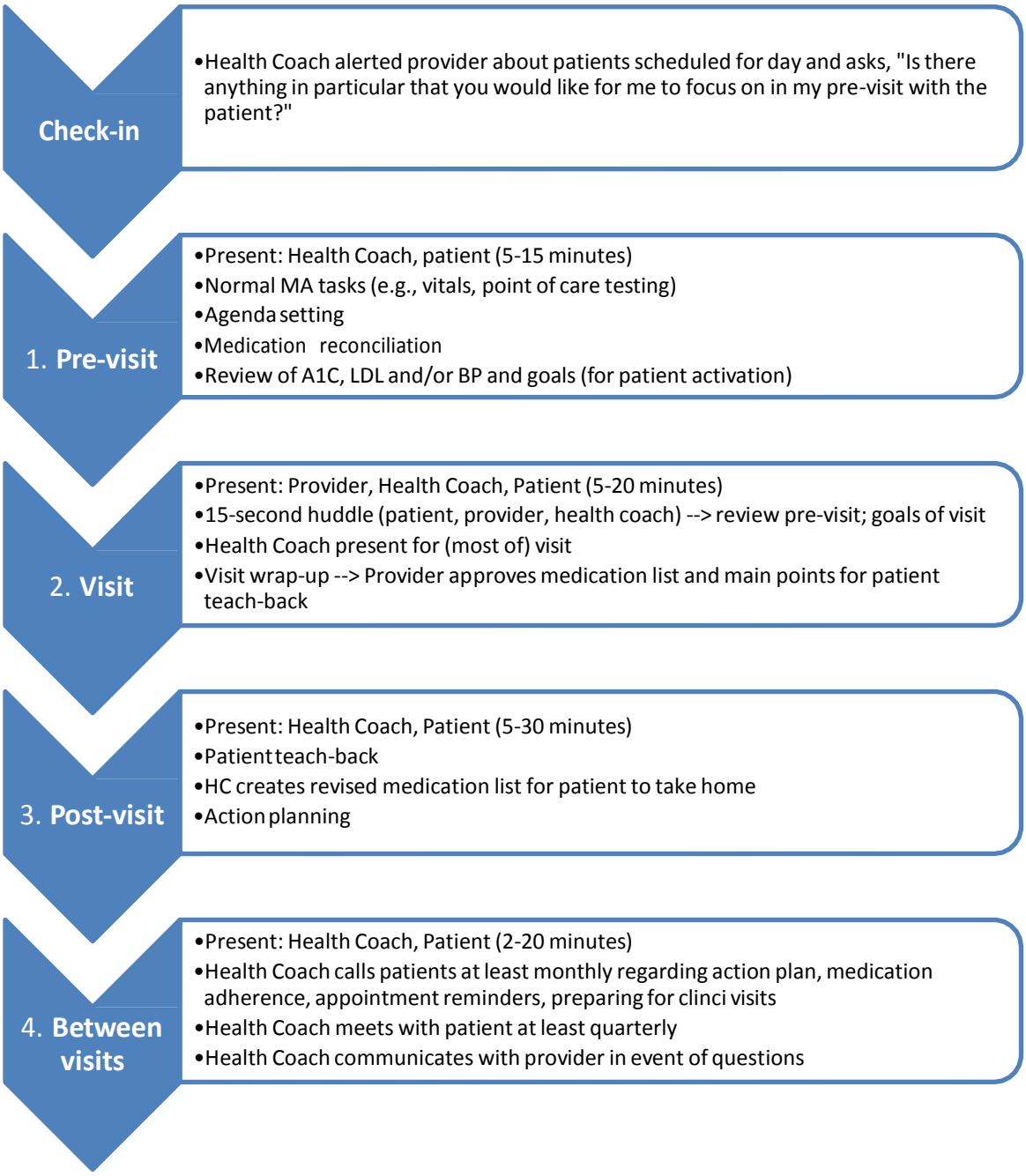
I wanted to let you know that I will be working with your patient, _____ [Name of patient]. Her next appointment is on _____ [date]. In the meantime, we will be meeting next week to discuss her goals for her diabetes care.

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

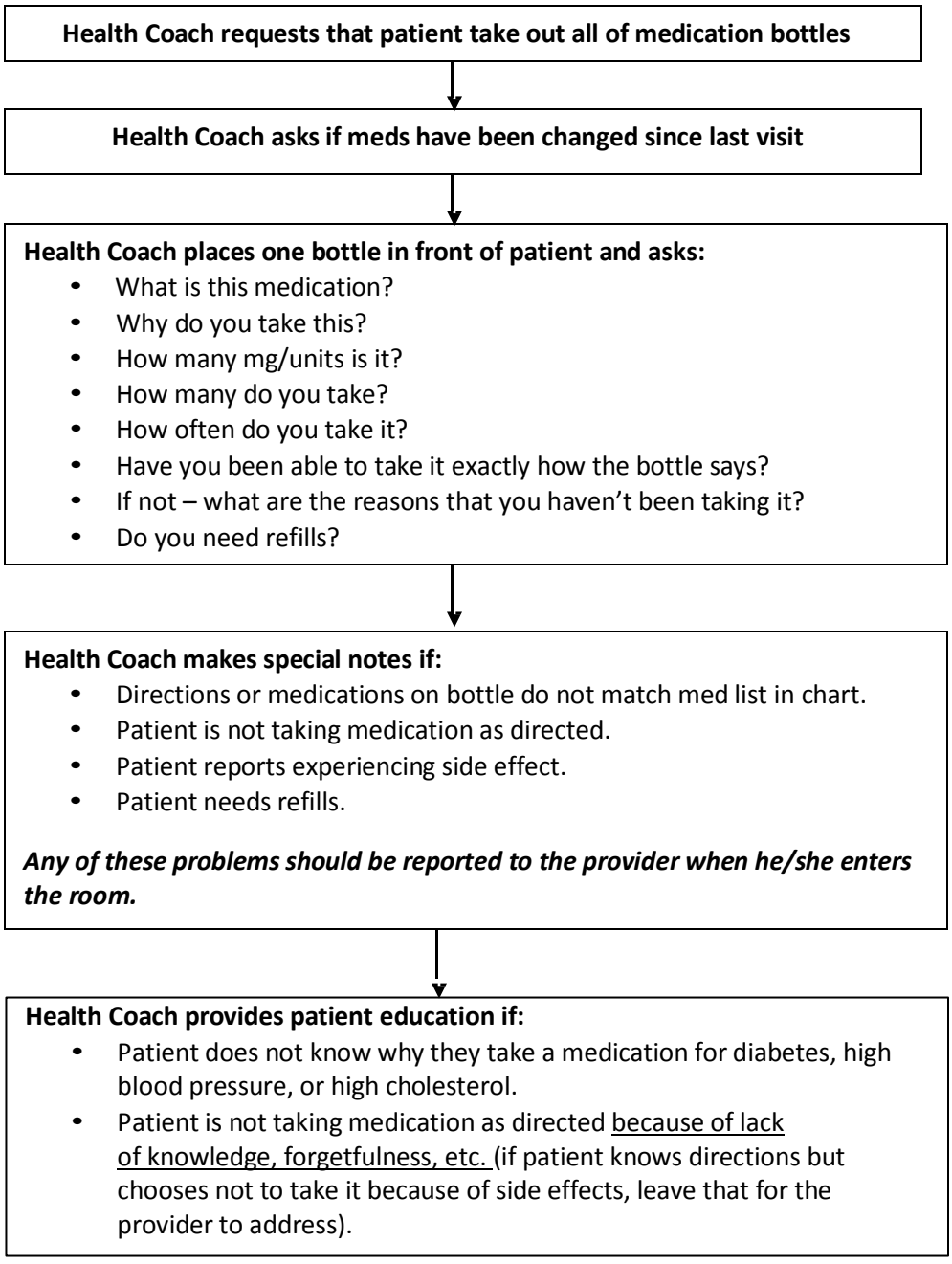


Check in

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

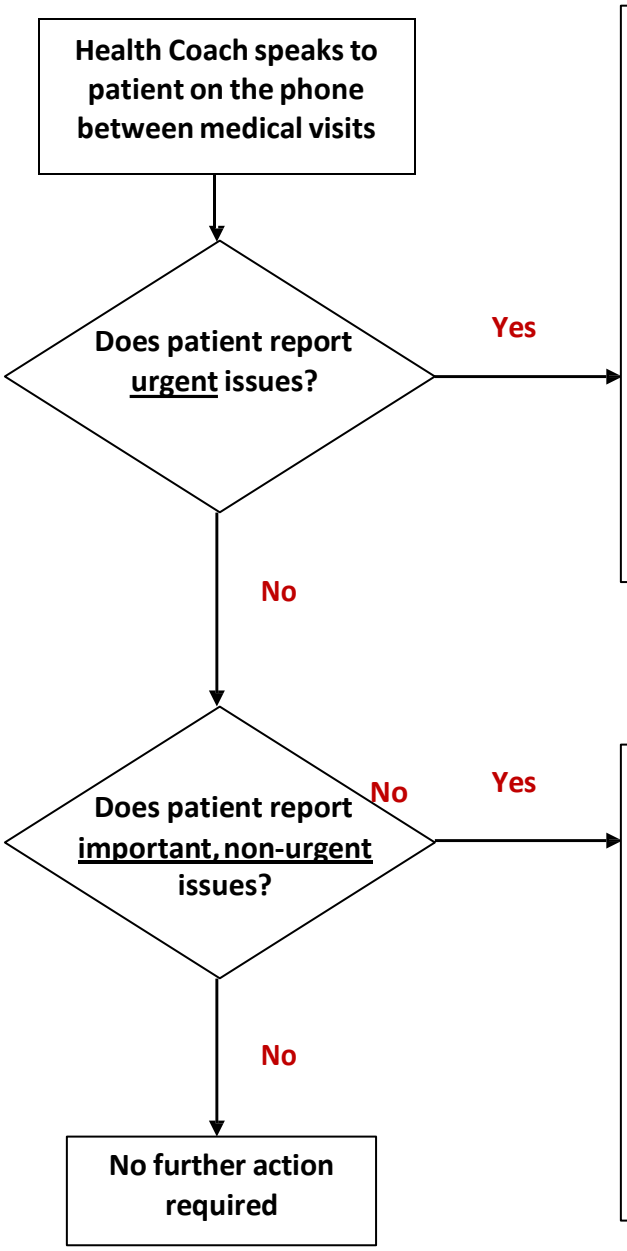
Follow up calls: HC will call patient one week after PCP visit to check in on medication changes, appointments, and behavioral change action plans. If needed, the HC may use these calls to help the patient create a new action plan.

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?*



The Health Coach will…

1. Ask patient, "How do you feel right now?"
2. Say to patient: "That is something that concerns me. I am going to look for your doctor or the triage nurse. If she is also concerned, would you be willing to talk with her or come into the clinic? In the meantime, if you feel badly now, you do not need to wait for me to call back. You can go to the emergency room or call 911."
3. Alert the PCP (if on unit) or triage nurse immediately.
4. Request the patient chart. Write note in medical chart indicating urgent symptoms and action (e.g., "Patient reported feeling sweaty and shaky this morning. Alerted triage nurse.")

The Health Coach will…

1. Say to patient, "That could be important for your provider to know. I can send him/her an email. In the meantime, if you feel badly, you do not need to wait for me to call you back. You can call (415) 552-3870 to ask about coming in for a walk-in appointment or to speak with the triage nurse."
2. Complete a "notification form"
3. Share the information with the provider via email. Include last and next appointment dates. The provider may request chart or HC assistance with follow up (e.g., medication titration) if desired.

Urgent issues include:

- Home blood glucose ≤80 or ≥ 400
- Home BP ≤ 90/50 or ≥ 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

Important, non-urgent issues include:

- 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

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 *(RA fills out as much as known)* Referral date: _____

Name: _____
DOB: _____
MRN: _____

Clinical values	Value	Date
HgA1c		
BP		
LDL		

Contact information

Phone number *(in order of preference)*	Type	Best day and time to reach
	□Home □Cell □Work □Other:	
	□Home □Cell □Work □Other:	
	□Home □Cell □Work □Other:	

Emergency contact information – if your phone doesn't work, who can we call to find you?

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 so 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

Visit Summary Notes

Patient information Visit date: _____

Name: _____

DOB: _____

MRN: _____

Appointments/labwork/referrals	Provider advice
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____
❑ _____	❑ _____
Medication	❑ _____
REFILL	❑ _____
	❑ _____
ADD	Health Coach Follow Up Tasks
	❑ _____
	❑ _____
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

☐ Home blood glucose of ≤80 or ≥ 400 ☐ Home BP of ≤ 90/50 or ≥ 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	**Alerted triage nurse. Date:_____Initials: _____** Other notes:

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

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

PCP Action

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

Provider signature: _____

Medication Reconciliation form

Patient:_____ **Date of visit:** _____

Provider:_____ **Health Coach:** _____

Medication	Strength	Instructions	What is it for?	Taken as prescribed? If not, why not?	Needs Refill

Notes:

If you have questions about your medicines, please call your health coach at (415) 552-1013 x 322.
Si tiene preguntas relacionadas con sus medicinas, por favor llame a su promotora de salud a (415) 552-1013 x 322.

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Health Coach Interaction Form

Patient name:	MRN:

Date of interaction:_____/_____/2011

How did you talk?
(select only one)

- ☐1 Medical visit
- ☐2 Phone call
- ☐3 Individual meeting (not medical visit)
- ☐4 Group meeting

About how long did you see/talk to the patient?
(select only one)

- ☐1 Less than 15 minutes
- ☐2 15–30 minutes
- ☐3 More than 30 minutes

Complete for medical visits

What parts of the medical visit were conducted? (select all that apply)

- ☐1 Pre-visit
- ☐2 Visit (health coach present)
- ☐3 Post-visit

What tasks did you conduct? (select all that apply)

- ☐1 Agenda setting
- ☐2 Medication reconciliation
- ☐3 Review labs ("know your numbers")
- ☐4 Teach back (closing the loop)
- ☐5 Create an action plans
- ☐6 Follow up on action plan
- ☐7 Provide navigational support
- ☐8 Other:

Complete for follow up calls

What tasks did you conduct?
(select a | that apply)

- ☐1 Discuss medication adherence
- ☐2 Follow up on action plan
- ☐3 Create a new action plan
- ☐4 Review labs ("know your numbers")
- ☐5 Deliver medication titration instructions
- ☐6 Deliver other message to patient from PCP
- ☐7 Provide navigational support
- ☐8

Complete for all interactions

What topics did you discuss? (select all that apply)

- ☐1 Medications
- ☐2 Food
- ☐3 Exercise
- ☐4 Stress
- ☐5 Hemoglobin A1c
- ☐6 Blood Pressure
- ☐7 LDL Cholesterol
- ☐8 Weight
- ☐9 Working with the provider
- ☐10 Using the clinic/resources at the clinic
- ☐11 Other (This can be family, the clinic, etc.):

Notes for follow up:

Description of action plan (if relevant):

☐ **Scheduled i2i prompt – next call**

Health Coach Observation Form

Health Coach:_____ **Date:** _____

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

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

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Comments:	
Coach/Patient Interaction	
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	
□	Coach warmly greets patient
□	Coach makes eye contact
□	Coach smiles
□	Coach is relaxed
□	Coach speaks slowly and clearly
In your own words describe the coach/patient interaction:	
Feedback for the health coach:	