HealthCoaching

in a Safety Net Health System

Elizabeth Carter, MD

JPS Health Network

The $950 million tax-supported healthcare system serving residents of Fort Worth and surrounding communities in Tarrant County, Texas.

John Peter Smith Hospital

- 537 acute-care beds
- Tarrant County's only Level I Trauma Center
- 110,000+ emergency room visits annually

Trinity Springs Pavilion

- 96-bed psychiatric hospital
- Tarrant County's only psychiatric emergency center
- 20,000+ inpatients annually
- 24,000+ outpatient visits

Patient Care Pavilion at John Peter Smith Hospital

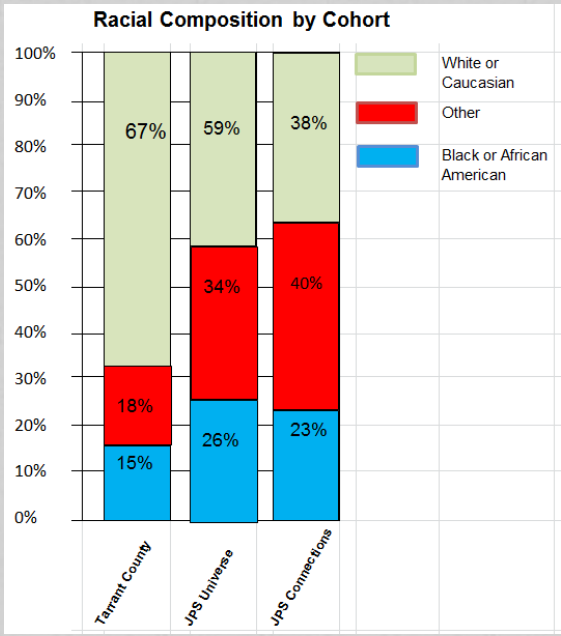
30 primary care and specialty clinics

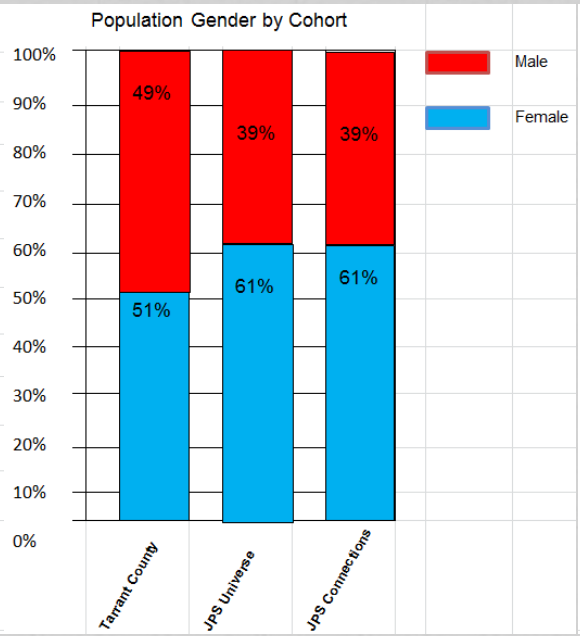
20 school-based health centers

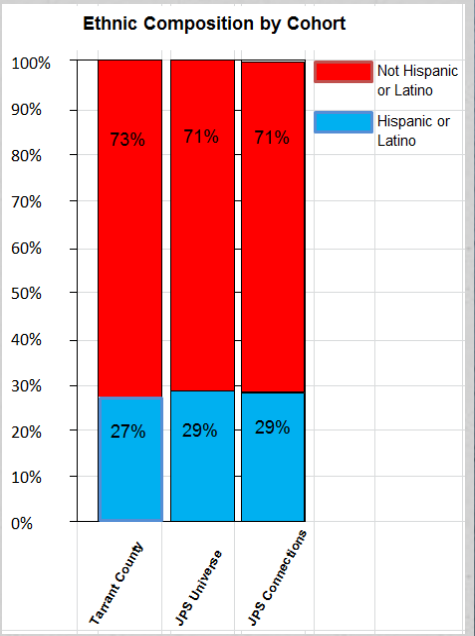
1.1 million patient encounters annually

Nine residency programs, including the nation's largest hospital-based family medicine residency

Tarrant County and JPS Health Demographics



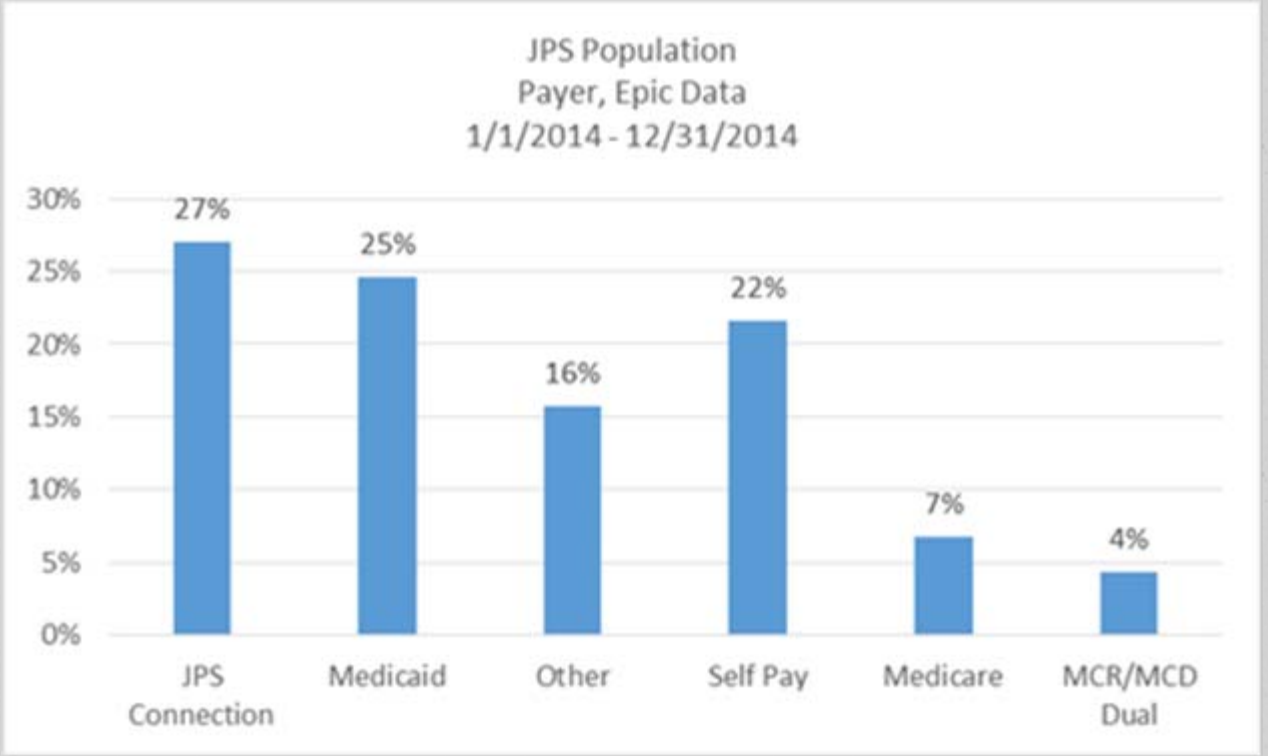




JPS Population: 140,864 Patients received care within the Network

- 101,049 Non-Connections
- 39,815 Connections

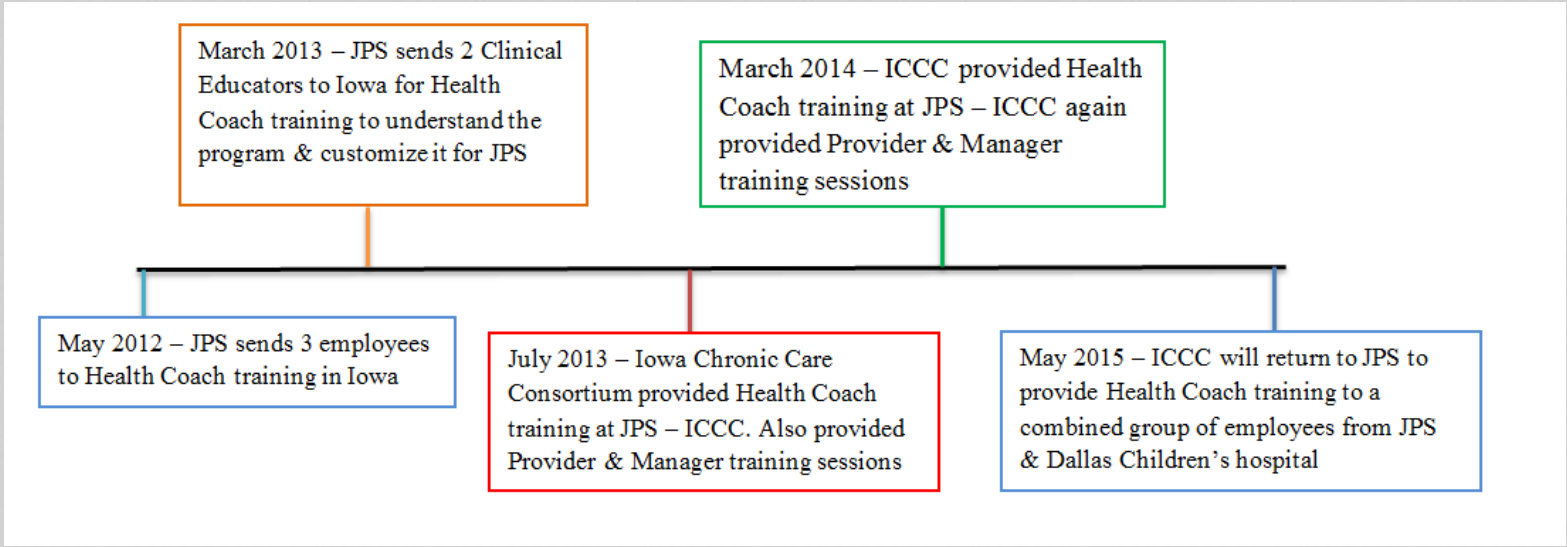
Payer Mix


JPS Population
Payer, Epic Data
1/1/2014 - 12/31/2014
30%
25%
20%
15%
10%
5%
0%
27%
25%
16%
22%
7%
4%
JPS Connection
Medicaid
Other
Self Pay
Medicare
MCR/MCD Dual

Challenges

- Shifting health care coverage of a vulnerable population
- JPS neighborhood clinics in transition to PCMH
- Patient barriers to care
  - Mobile patients- phones off and on
  - Community support- non-traditional partners
  - Socioeconomic challenges- money for meds, family support
  - Suspicion- outreach with mail, phone calls not always welcome

Timeline for Coaching Education & Training



Health coaching by the numbers

- Trained 101 employees- nurses, case managers, social workers, clinical pharmacists, and dieticians
  - 55 nurses
    - 19 left position or the network
    - 8 not coaching because of direct nursing demands
  - 28 nurses remaining
    - 3 full-time coaches
  - 25 nurses with varying dedicated time (21 in primary care)
    - average 15% time for coaching

A New Philosophy

- JPS took philosophical approach when choosing a model of patient empowerment
  - Some nursing staff would fulfill a patient-coach role in the medical home
  - Some staff would use a coaching approach in their day to day work with patients- social workers, case managers, clinical pharmacists

Diverse coaching sites

- Homeless
- OB
- Medical specialty
- Primary care

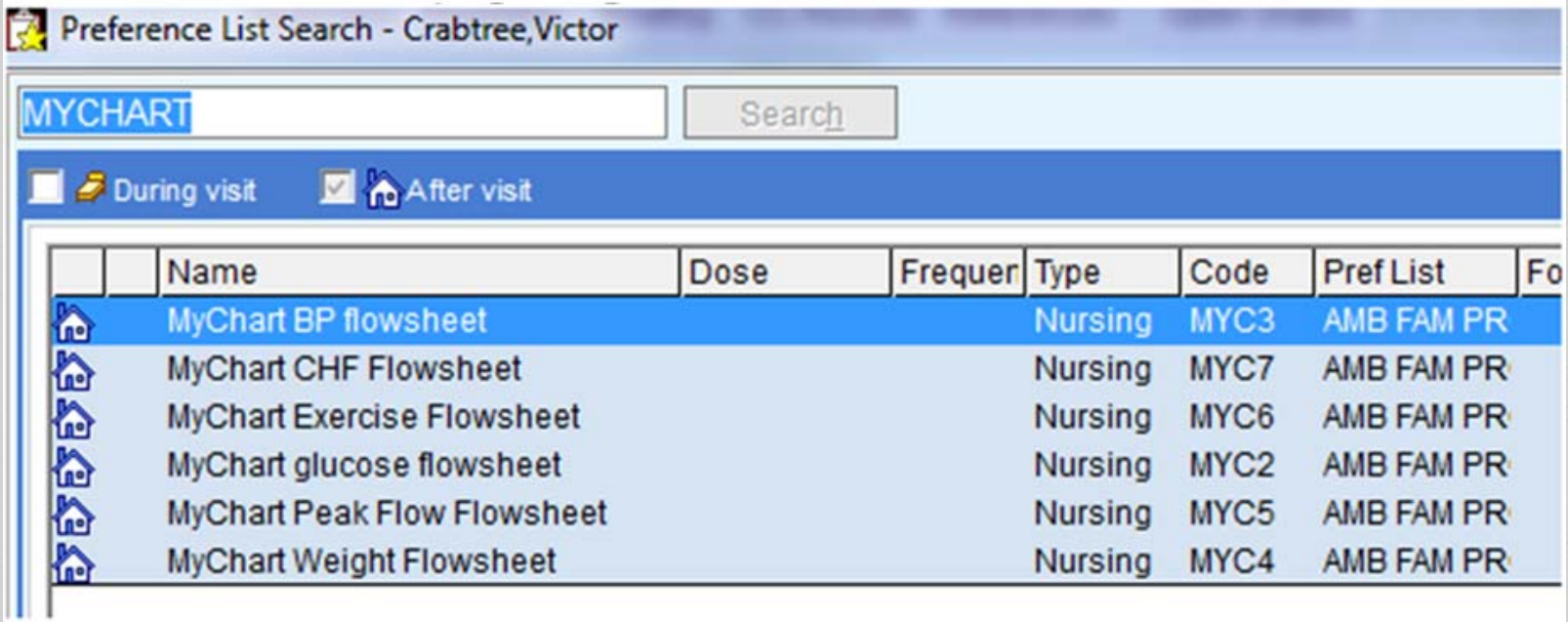
Our Coaching Work

- One on one encounter, telephone visit, and My Chart (Epic patient portal)
- Consistent patient/coach focus over time
  - Patient's desired outcome and readiness to change
- Motivational Score – each visit and at discharge from PCP visit by nurse
- Patient's plan documented in the coach visit, goal setting in Epic

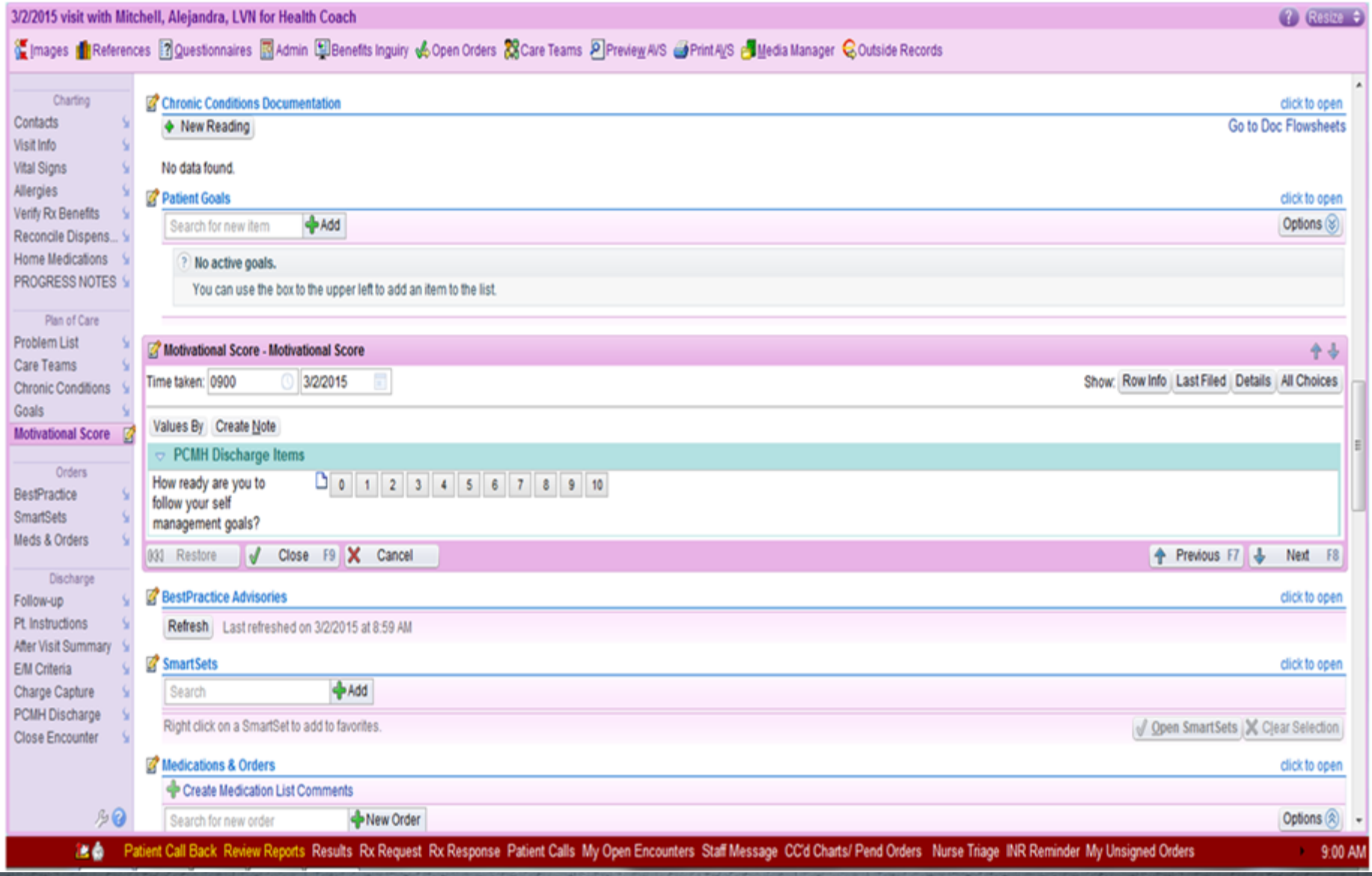
Tools

- Physician Approved Orders for prevention and chronic disease management
  - Diabetes management
  - Point of care INR
  - Mammogram
  - Hepatitis B vaccine
  - Hepatitis C screening
  - TDaP vaccine
  - Lipid screening
  - Screening
  - TSH
  - FOBT
- Flow sheets for tracking management of condition sent to patient through My Chart or given directly to the patient

MyChart Flowsheet



Documentation Template Used in Health Coaching



Health coach tasks

- Updating and documenting patient goals
- Referring to community resources
- Assisting with ongoing management of clinical conditions
- Providing patient with self-management tools and education
- Assessing self-management ability
- Communicating with PCP regarding patient needs
- Scheduling

Coaching Not a full-time job

- Other responsibilities may over-shadow coaching time
  - Clinical team leadership
  - Direct patient care duties

Some Traditional Coaching tasks managed by other staff

- Navigator
  - Follow-up on outstanding lab and referrals
  - Registry use and tracking
  - Pre-visit chart review
  - Coordination of care
  - Support of quality improvement activities
- Case management and Nursing team members
  - Coordination of care, quality improvement

The Patient Experience

METRIC: Positive Score

	FY2013	FY2014	FY2015
Overall Rating of Provider	74.0	75.3	77.1

HEDIS BUNDLE COMPARISON FY 2014/YTD FY 2015

Chronic Care / Diabetes HEDIS Measures:

CHRONIC CARE / DIABETES HEDIS BUNDLE	**A1C Poor Control (>9.0%) (Lower is better)			Blood Pressure Good Control (<140/90) (Higher is better)			Retinal Eye Exam (Higher is better)			*Foot Exam (Higher is better)		
	Results	Target	Score	Results	Target	Score	Results	Target	Score	Results	Target	Score
FY2014	36.13	43.00	1	66.80	56.00	1	37.08	54.00	0	27.80	11.00	1
YTD FY2015	35.31	35.00	0	65.55	67.50	0	57.56	58.00	0	60.60	58.00	1

Preventive HEDIS Measures:

PREVENTATIVE CARE HEDIS BUNDLE	Cervical Cancer Screening (Higher is better)			*Colorectal Cancer Screening (Higher is better)			Pneumonia Immunization Rate (Higher is better)		
	Results	Target	Score	Results	Target	Score	Results	Target	Score
FY2014	59.79	74.00	0	43.28	68.00	0	78.97	78.00	1
YTD FY2015	61.93	70.00	0	52.51	63.50	0	83.46	79.00	1

Lessons Learned

- Choose the right people to be coaches, not just a role
- Clearly define the coach role as distinct from case managers and navigators
- Implement coaching program with clear timelines for implementation and educate management and practitioners
- Consider strategic selection of coaches who can speak different languages

Sustainability

- Straight-forward revenue models don't work
  - No offset for more visits or lab income
  - No charge to patients
- Value to the organization and patient care delivery must be foremost
  - Shifting roles and expectations in a PCMH model will add some flexibility for incorporating essential processes

Next Steps

- Executive commitment to protect the coach function with the goal of one coach per clinic
- Collaborate with other health systems to bring coaching education to our region through cost-sharing
- Use a lean approach to flow and staff function for getting all potential coaching tasks completed

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