The Win-Win-Win Health Coach Model:

Improving patient engagement, clinical outcomes, and career advancement through the integration of an emerging occupation in New York City primary care settings

NYC Healthcare Industry Brief
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NYACH

COMMUNITY CARE OF BROOKLYN

Introduction

Primary Care Providers (PCP), including doctors, physician assistants, and nurse practitioners, are under tremendous financial pressure to maintain two competing priorities at once 1) increase the number of patients they can see with limited time, and 2) provide "value," which requires extra time and staff to help patients through their health challenges, particularly those requiring more demanding levels of care. As much as PCPs would like to spend extra time with these patients, there is simply no viable way in the current healthcare delivery and financing model for them to do so at the kind of scale needed for NYC's community members.

It was in this context that the New York Alliance for Careers in Healthcare (NYACH), the healthcare industry partnership at the NYC Department of Small Business Services, and Community Care of Brooklyn (CCB), the Maimonides Medical Center-led regional network of providers formed under the New York State Delivery System Reform Incentive Payment program (DSRIP), began to look for creative workforce solutions to this primary care delivery challenge. To do this, NYACH and CCB looked at primary care staffing in the CCB network and determined that Medical Assistant staff would be best positioned to take on the extra requisite relationship-building, engagement, and follow-up for patients with chronic medical conditions if provided with appropriate skill development and commensurate compensation. This collaboration between NYACH and CCB led to the implementation of a customized Health Coach Model, an evidence-based approach in primary care to improve the experience, quality, and cost of care for patients most in need of extra support.[1,2,3,4,5,6]

The Health Coach model is an effective operationalization of person-centered, team-based care. It introduces a new role—the Health Coach—into the primary care team and changes how care team members work with each other and with targeted patients.

Outcomes Summary

The creation and implementation of the Health Coach program largely achieved many of the program design's key goals, delivering improved engagement and self-management of chronic medical conditions for patients, empowering them and giving them the tools they need to change their own behavior. The program also improved value-based, population health measures such as increasing medication adherence, improving key clinical measures such as HbA1C, blood pressure, body mass index, and LDL cholesterol, and reducing avoidable hospital use.

PROVIDER

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"There's a kind of a follow-up in the care, the attention seems to personalize the care and make them feel that they are getting something a little bit extra. It's going to really bring their health forward. They see the importance of [the health coach] and they don't feel like they're being necessarily pushed and commanded, but they feel like they're being embraced. So they have a chance to actually participate and even make a suggestion."

- Dr. Cave

Furthermore, the model succeeded as a workforce innovation, strengthening primary care services for patients with chronic medical conditions, expanding the resources and skill sets of primary care teams– enabling all members to work at the top of their licenses, access a college credit-bearing training program, and creating a career ladder for Medical Assistants and equivalent level staff.

Since January 2016:

- **260 individuals representing over 100 practice sites**, have completed the program
- **16 Health Coach cohorts** trained
- Health Coaches have engaged over **40,000 Medicaid patients** since March 2016
- **More than half of surveyed patients indicated satisfaction working with Health Coaches** to set and achieve health goals, understand health conditions, and better manage their health
- Engaged patients experienced **significant reductions in their levels of blood pressure/hypertension and cholesterol**
- Surveys showed **more than half of patients ate healthier food, consumed less sugar, exercised more, took medications more consistently, and lost weight due to their Health Coach engagement**

PATIENT

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[My health coach] will call me maybe once a week. I talk to her about the issues that I have, and it's very helpful, somebody to hear you like that and comfort you. Now I take my blood pressure in the house, I write it down, I let her know, and I call her or I text her. And whenever I need anything, I just text her and ask her questions and she'll text me back or she'll call me... Before the health coach we made appointments and that was it. But this is better because I've been having stable blood sugar, thank God.

- Maria

There are many patient engagement and care management-type models that have been documented over the past handful of years. A guiding light of these reform efforts has been to center the patient in system redesign. What sets the Health Coach model apart is that while the patient is central to the provision of care, workforce transformation is central to the implementation strategy. This includes comprehensive training for the Health Coaches themselves, support and incentives for broad adoption of the model, rigorous change management practice and follow though, and enabling technology infrastructure. This industry brief discusses each of these key enabling components, how the program responded to the COVID-19 pandemic, program outcomes, and adoption lessons learned and recommendations.

Key Enabling Factors

Comprehensive workforce development and training for the Health Coaches

Job Design
The Health Coach role in this model was imagined as an upgrade position from a Medical Assistant or similar level staff. As such, the job was designed with some similar experience and educational requirements to a Medical Assistant, the addition of a newly created training program (discussed below), and a wage increase creating this position as a 'next step' on a career ladder.

Eligibility Requirements:

- Community members who are certified Medical Assistants or equivalent-level staff (e.g. PCT/SWA)
- Employed by an organization that participates in CCB
- Minimum education of high school diploma or equivalent
- Strong interpersonal and customer service skills
- Experience working with patients/ consumers
- Demonstrated critical thinking skills

Job Responsibilities:
Fundamentally, the Health Coach is a different job from a Physician, Nurse, Medical Assistant, and other more traditional roles on a care team. Specifically, the Health Coach:

- Reinforces education provided by the primary care provider or nurse
- Works directly with patients to develop actionable patient-driven self-management goals and educates on the use of self-management tools
- Connects patients to community resources, including Medicaid Health Home, social services, mental health specialists, and others
- Works with the patient to mitigate impacts of social factors on health and functional status, e.g. by arranging transportation
- Coordinates care for a defined panel of patients and acts as a key point of contact for the extended care team during care transitions
- Uses registries to identify patients with newly diagnosed, undiagnosed, or poorly controlled chronic conditions and schedules follow-up appointments
- Outreaches to patients with overdue screenings or gaps in care
- Follows up with patients between visits to support engagement and keeping up with their care plan, including following up on test results and conducting between-visit monitoring and outreach
- Participates and assists in huddles and other internal team meetings

Recruitment
CCB and NYACH concluded that the care team members with the best head start to take on the Health Coach role were Medical Assistants already working within the CCB primary care network. To find the right person-fit, practice managers were asked to identify their Medical Assistants who were naturally proactive, engaging, and empathetic with patients. We were looking for the people who naturally wanted to get more involved in helping patients, could advocate for this new role, and who weren't afraid of speaking up in care team meetings with physicians and other more credentialed health professionals. In execution, this meant outreach to practice managers to talk them through the desired candidate qualifications/profile.

HEALTH COACH

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The difference to me is that a lot of things patients were not discussing with the providers—whether it's because they don't feel comfortable enough with them, or because they don't feel like there's enough time for them to get into a lot of detail, or they're not that close in a personal relationship with the providers. That's where the health coaches come in and they serve a bigger purpose.

- Prentice

Training

The curriculum for this initiative was the product of a multi-stakeholder collaboration. The curriculum itself was created by Kingsborough Community College (KCC), which is part of the City University of New York (CUNY) system, and Audrey Lum, a clinical leader and expert from Union Health Center. In addition, CCB provided ongoing feedback from an employer/on-the-ground health system perspective, NYC SBS provided feedback as a government workforce development agency, and NYACH provided feedback related to NYC's macro-level healthcare environment and system transformation goals. The resulting curriculum was dynamic in its approach to adult learning and specific to what the Health Coaches do on the ground from day one.

The comprehensive training is facilitated by KCC and is comprised of two 45-hour modules and a practicum. Participants were given protected time to participate in all training requirements. The training focuses on new models of care, communication and patient engagement techniques, cultural competency, stages of behavior change, patient education, in addition to chronic disease, wellness, and prevention. The practicum involves direct participation from CCB supervisors, who join the class and conduct observations and provide participants with feedback on role play activities. Upon completion of the training, participants receive a certificate in Health Coaching and six CUNY undergraduate credits.

Training Program Components

The Health Coach training program is facilitated by Kingsborough Community College and includes two 45-hour modules and a practicum experience. Program components include:

Introduction to Health Coaching: The 45-hour course provided students the opportunity to learn and practice techniques in self-management support (SMS) and motivational interviewing (MI) strategies to facilitate behavior change in patients with chronic conditions. Students gained an understanding of chronic disease management, wellness and disease prevention, and basic skills used in Health Coaching. At course completion, students acquired the knowledge and skills to educate, engage, and support individual patients to improve the patient's health outcome and lifestyle.

Chronic Diseases: The 45-hour course was designed to enhance medical assistants' understanding of chronic disease management, as well as wellness and disease prevention within the context of patient engagement and health education within Health Coaching sessions. Students gained an understanding of leading chronic conditions including diabetes, cancers, mental illness, cognitive impairment/dementia, HIV/AIDS, substance use disorders, and cardiovascular disease.

Practicum component: Using role play scenarios, students will practice communication and patient engagement techniques integrated with newly gained or enhanced knowledge in the prevention, treatment, and management of substance use/addiction and HIV/AIDS.

Example of a practicum role-play scenario:

> Mr. Lee is a 50-year old laundry worker. He complains of knee and lower back pain. Mr. Lee says to you at his first visit, I know my provider wants me to lose a couple of pounds, and I know that this is important, but it's just so hard. Mr. Lee's BMI is 32. How do we start? What are next steps?

College Credit: By participating in the 90-hour course, Health Coaches receive a certificate and 6 credits towards an undergraduate degree at CUNY. The program was also part of a longer-term KCC strategy to create stackable credit bearing models for medical assistants to receive their Associate of Science degree in Community Health and advance their career. This 60-hour certificate program took an existing 3 credit course that is part of the AS Degree in Community Health and updated and contextualized it for the Health Coach role. It was then paired with a newly created course around important emerging skills needed for today's healthcare workforce called Patient Engagement and Health Coaching Techniques. This second course was later approved at KCC for 3 credits and was included in the academic course catalog beginning in 2017. Paired together in this continuing education certificate program, students now take the course as non-matriculated students for a total of 6 credits that are transferable and appear on a transcript.

Professional Development
Once on the job, CCB coordinates a number of ongoing learning and professional development opportunities for Health Coaches. A few highlights include: monthly webinars with program updates and case conferences, a biannual collaborative, and targeted training and in-service activities in partnership with the 1199SEIU Training and Employment Funds.

Financial incentives for broad adoption of the model

By creating and funding this centralized and customized training, NYACH and CCB dramatically lowered the start-up costs a partner organization would have in putting the Health Coach model into practice for the first time.

CCB also created several additional financial supports and incentives to encourage partner adoption and participation over the demonstration years of DSRIP.

Wage subsidies
Early on in the program, CCB provided 75 partner organizations with direct wage subsidies for Health Coaches, with funded staff (on a full-time equivalent basis) determined by partner Medicaid attribution and expected performance. Partner organizations were also provided a wage subsidy for nurse supervision at a ratio of one supervisor for every 10 Health Coaches. These subsidies encouraged pilot partners to try the model by reducing the financial barrier to entry.

Process and performance payments
CCB began its implementation with funding for basic process measures such as a minimum number of Health Coach patient encounters, participation in team huddles, or the creation of care plans. Over time, CCB increased these demands of the process measures until the organization was performing at full expected productivity.

CCB also provided funds for the successful completion of periodic reviews CCB conducted of care plan quality and the degree to which Health Coaches were integrated into the care team. These reviews provided partners with additional funds and, importantly, created as space for them to reflect on the program and get support from CCB in adjusting the local implementation. In addition, and in the spirit of value-based care reform, CCB also encouraged the use of Health Coaches through helping participating partners understand how Health Coaches can impact a provider's ability to earn funds from quality incentives, improved patient experience scores, and higher reimbursement rates through NCQA Patient-Centered Meidcal Home (PCMH) recognition. Interestingly, while partners interviewed for this report discussed how they would never have started without direct funding, many also indicated that, going forward, they intend to keep the program even if CCB reduces its investment because of the way it impacts their value-based revenue and reimbursement rates.

Enabling technology infrastructure

While implementation was not contingent on best-in-class technology, it is also without question that partners that had stronger systems in place to support care planning and analytics had faster and more pronounced positive outcomes. In this way, technology served as a catalyst for the success of the Health Coach program, and CCB used the mechanisms it had available to support and encourage enabling technology.

Technologically-enabled care planning

As Health Coaches work with patients with multiple health needs, those patients also interact with many other health professionals and have multiple care logistics that need to be organized and facilitated. A streamlined and centralized care planning technology can play an enormously helpful role with Health Coach work. While CCB was a network of multiple organizations, and therefore was unable to create fully centralized care planning technology, CCB was able to encourage the adoption of standard templates and to help partner organizations think through and build Health Coach workflows into locally used platforms. In CCB's experience, the more an organization was able to build Health Coach workflows and templates into care management technology infrastructure, the more impact the Health Coaches could have on the patients they worked with.

Having care planning technology, however, does not in itself guarantee the technology will be used effectively. Health Coaches, most of whom were Medical Assistants before entering the role, were largely new to the heavy documentation requirements and the ways health professionals interact with each other about a common patient through a care plan. CCB, with the help of Health Coach supervisors, repeatedly reinforced the need for regular, detailed, and effective documentation of Health Coach activity. A few best practices CCB identified were:

- Documenting Health Coach patient activities while they are fresh in mind rather than employ a batch process, waiting until later in the week when they have many things to document.
- Encouraging Health Coaches and supervisors to allot time for documentation directly into their daily schedules, and to account for this when considering Health Coach caseloads.
- Using structured care plan templates as if they are checklists, reminding and reinforcing certain follow up and patient care protocols for the Health Coach with each use.

Analytics

While care planning is a foundational element of Health Coach workflows, it is also important that Health Coaches know which patients to

work with and that organizations are aware of their performance against key indicators. Given the distributed nature of the CCB network, CCB used the opportunity to support their partner's internal capacity to conduct population health analytics. This included:

- Equipping partners with an understanding of how value-based financial incentives work and how analytics can support performance
- Providing standard criteria for patient inclusion in population-based registries
- Working with partners to build in-house analytics infrastructure to pull registries
- Coordinating with insurance provider partners with "gaps in care" reports, and helping partners understand their performance
- Equipping supervisors with the skills they need to help Health Coaches develop and follow up on chase lists
- Providing pre-visit planning templates and best-practices

Rigorous change management practice and follow through

CCB, with NYACH's consulting support, also applied rigorous evidence-based change management practices throughout program implementation.[7]

Creating a guiding coalition

The CCB network is comprised of over 1,000 participating organizations, seven hospitals, 10 Federally Qualified Health Centers, more than 4,600 clinical providers, social service agencies, and community-based organizations. To enable and optimize broad Medicaid redesign success, CCB's governance and advisory structure pulled in executive leadership, subject matter experts, and change champions from across its partner network to be part of the change and decision-making process. As part of the DSRIP Program requirements, CCB established various governance committees and sub-groups, and it was through this governance structure that CCB was able to foster buy-in and enthusiasm for the Health Coach initiative.

Empowering executive sponsors and on-the-ground advocates

In the early days of the program, CCB spent a lot of time identifying and nurturing relationships with key local leaders at partner organizations. Just as with financial incentives, CCB began by targeting leaders at high Medicaid attribution partners, focusing first on finding at least one clinical and one administrative lead per organization. Over time, CCB often found that the most impactful change champions were "forward-thinking" Medical Directors who were able to imagine the future impact of employing Health Coaches and advocate with other leaders in their practices. As highly respected leaders at their respective organizations, the advocacy of these Medical Directors significantly enhanced initial buy-in for this initiative. In addition, because Health Coaches were selected from existing Medical Assistants, they were able to come in with pre-existing trusting relationships with patients and other members of the care team. This foundational trust helped reduce hesitancy in adopting the new model.

Having great supervisors and great supervision

A great Health Coach supervisor provides direction, coaching, and an escalation point for Health Coaches and is the core local advocate for the program with the care team and for the Health Coach to have protected time to do their responsibilities. It is no understatement to say that the program would not have succeeded without great supervisors. To ensure sufficient clinical oversight, CCB required supervisors to have a minimum clinical qualification of a Registered Nurse. In smaller practices, Health Coaches were often supervised directly by the primary care provider. CCB later expanded to allow some Social Workers to serve as Health Coach supervisors, but strongly recommends

the supervisor have medical-related content knowledge and experience.

Great supervisors were also brought into the CCB governance model – invited to provide their experiences and input into network-wide policy and programmatic decisions. This not only served as a mechanism to bring important information from the field into leadership decisions, but it was also motivating for supervisors across the network. By inviting great supervisors into more influence, CCB motivated all of the Health Coach supervisors to increased engagement, performance, and pride in their work.

Celebrating small wins

Initially designed as opportunities for shared learning, CCB created many opportunities to notice, highlight, and celebrate small wins for the Health Coach program. Among others, these opportunities included:

- Monthly structured case conference calls with Health Coaches. These calls created an opportunity for Health Coaches to share stories with one another, talk through complex clients, and celebrate when a peer had a breakthrough with a challenging client or colleague.
- Monthly calls with Health Coach supervisors. These calls discussed workforce challenges and needed changes to workflows. These calls also allowed supervisors to get support from peers from across the CCB network, to share strategies for engaging reluctant members of the care team in Health Coach related work, and to celebrate each other for incremental progress.
- Larger network-wide collaborative events 1-2 times per year (pre-COVID-19 pandemic) for Health Coaches to get excited about the progress made, practice new skills, and hear from guest speakers and subject matter experts in the field
- Highlights of the Health Coach program in network newsletters and other communications efforts, especially when the program had a patient success story or when the program was recognized in outside industry conferences or publications
- Support from a CCB Health Coach Coordinator, themselves a veteran Health Coach of over 10 years, who was hired to the central CCB team to further enhance the program

Celebrating small wins in these ways played a critical role in sustaining momentum and excitement around the program through the years of implementation. Importantly, this approach also helped snow-ball the change throughout the network. For example, one executive shared that they learned a successful strategy at one of the monthly calls. The strategy they tried was that when faced with a particularly vocal and reluctant doctor, you can pair a super-star Health Coach with “the doctor next door.” Once the positive effect of the Health Coach becomes obvious for the next door doctor’s patients, the reluctant doctor may have a change of heart and want the program for their own patients. The executive shared that “it was almost like magic!”

Embedding the change into work culture and standard practices

CCB worked with its network to establish recommended workflows and protocols for Health Coaches. These include what information should be reviewed during each patient visit, the appropriate timeframe for follow-up, and key progress indicators. Protocols also include additional tools for Health Coaches including community partner information, referral forms, Morisky Medication Adherence Scale-8 (MMAS-8) screener for medication adherence, social determinants screener, and patient education materials in nine languages. CCB has made these materials available in its Resource Portal so that partners can access easily.

In particular, Health Coaches were provided protocols for each of the following chronic conditions and risk factor:

- Newly diagnosed diabetes (type II)
- Uncontrolled diabetes (type II)
- Uncontrolled hypertension
- Uncontrolled asthma
- Hyperlipidemia
- Obesity
- Tobacco cessation (risk factor)

Once patients reach the key progress indicators for their condition, patients are "graduated" from the Health Coach's active panel. Health Coach engagement for most patients is 3-6 months.

Health Coaches participating in an activity during the CCB Health Coach Collaborative.

New Diabetes Health Coach Action Plan

(Figure, Sample of care plan featuring individualized, actionable steps for health coaches working with patients with diabetes.)

VISIT 1 – WEEK 1 • 30 MINUTES

1. Soothe patients' fears and worries
2. Review management goals set by provider
3. Re-enforce the importance of lifestyle changes
4. Introduce 3 session plan for HC to work with patient/caregiver
5. Discuss smoking cessation, if applicable
6. Demonstrate finger stick, if needed
7. Provide ABCs and MyPlate handout for patient to review post-visit
8. Warm handoff with internal behavioral health specialist, if available, or ensure a PHQ-2 is completed post-diagnosis
9. Schedule in person follow up in 2-3 weeks
10. Schedule follow-up within 1 week
11. Report back to PCP at huddle, if needed

CALL 1 – WEEK 2 • 5-10 MINUTES

1. Gather information on medication activities
2. Gather information on glucose readings to share with PCP
3. Gather questions / concerns to share with PCP
4. Confirm upcoming visit 2
5. Report back to PCP at huddle if needed

VISIT 2 – WEEK 3 • 45-60 MINUTES

1. Review ABC's handout: A1C, BP, Cholesterol, Smoking (if a smoker, refer to NYS Quitline or internal resource)
2. Review My Plate handout
3. Reinforce the importance of lifestyle changes
4. Complete MMAS-8 with patient
5. Help patient to set a goal-areas may include: make dietary change/reduce sugar intake, increase physical activity, take medications, check sugars regularly, reduce cigarettes
6. Schedule in-person follow up in 2-3 weeks
7. Schedule check in call within 1 week
8. Huddle or case conference with provider to prioritize focus areas for the patient

CALL 2 – WEEK 4 • 5-10 MINUTES

1. Check in on progress toward achieving self-management goal: a) reinforce success and build on that success; b) if there is no progress toward goal, reassure patient: i) assess readiness to change ii) assess barriers iii) re-assess goal iv) set new goal v) follow up on goal in 1 week
2. Gather information on clucose reading and medication activities to share with PCP
3. Gather questions to share with PCP
4. Confirm upcoming visit 3
5. Report back to PCP at huddle if needed

VISIT 3 – WEEK 5 • 45-60 MINUTES

1. Follow up on goal(s)
2. Gather information on glucose readings in past week to share information with PCP
3. Follow up on provider's care plan (eye exam, foot exam, referrals, etc.) and provide assistance as needed
4. Establish an additional goal
5. Complete MMAS-8 with patient, and discuss any identified adherence barriers
6. Schedule check-in call after 10 days
7. Review ABC's handout as needed
8. Report back to PCP at huddle if needed

ONGOING CALLS & GRADUATION – 3-6 months following initial visit

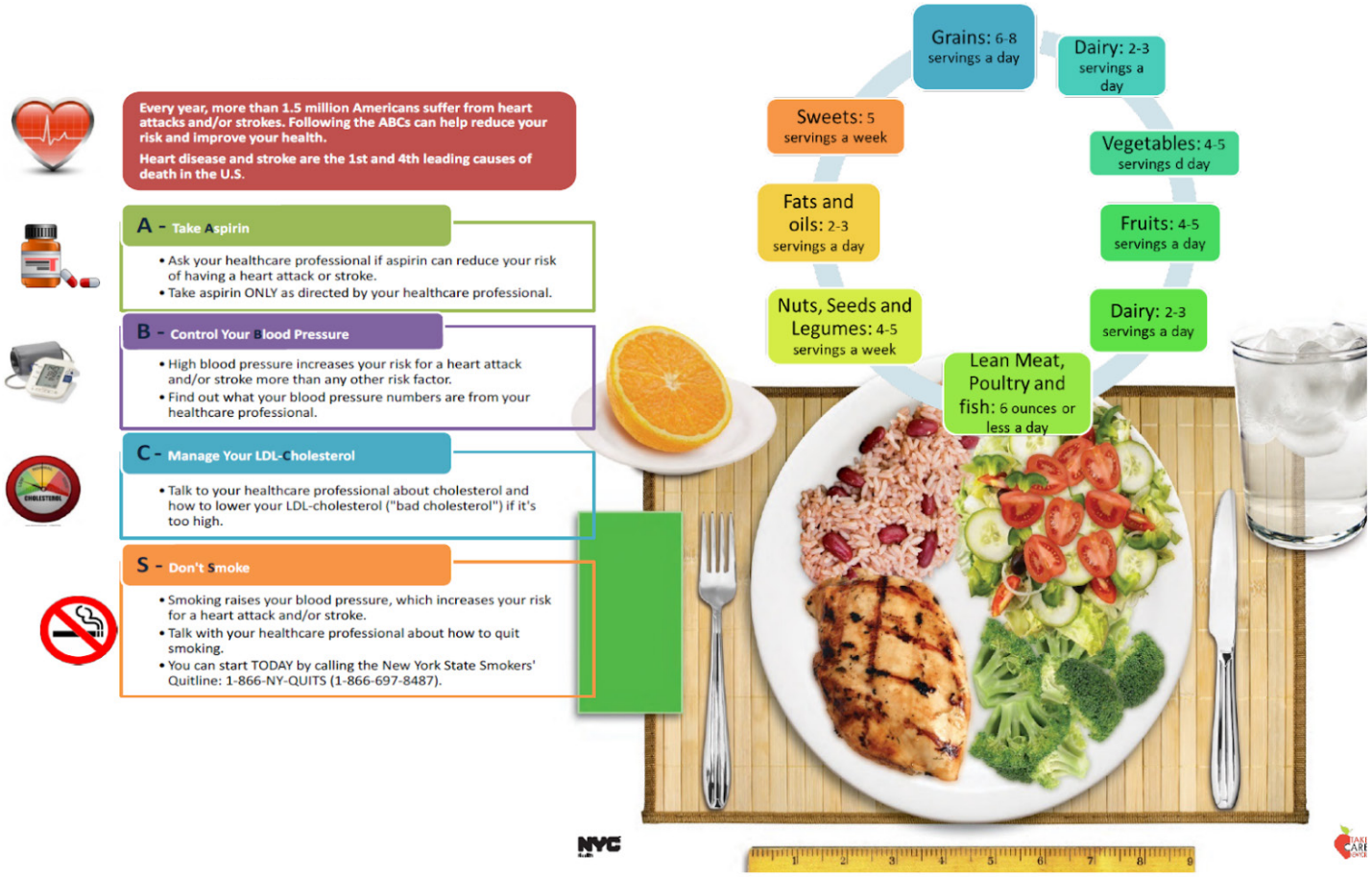
Ongoing Calls:

1. Continue to support self-management goal until patient is stable and has established a routine

Key Progress Indicators for graduation:

1. Medication Adherence for 30 days
2. Patient reaches A1C, BP, LDL goals set by patient and provider
3. Success with goal setting

Heart Health: Patient Information Guide to Reduce the Risk of Heart Attack or Stroke



(From NYC Department of Health Take Care New York (TCNY))

Planning for Sustainability

Since launching this initiative, CCB and NYACH have promoted the benefits of Health Coaching and advocated for the development and implementation of various sustainability models, to ensure these activities can be funded sufficiently and consistently. The Health Coach role has continued to gain momentum since the CCB and NYACH initiative started, and was recently highlight in a June, 2021 New York Times article, *We Could All Use a Health Coach*[8]:

> **'If and when the Biden administration tackles the astronomical costs of American health care, it would do well to find ways to make health coaches accessible to more people. Their still limited inclusion in modern medical care is a telling example of the penny-wise, pound-foolish structure of American medicine.**
>
> **As leading causes of disability and premature death, chronic disorders are responsible for the majority of the trillions of dollars now spent on health care. With the current surge in the number of Americans seeking insurance under the Affordable Care Act, insurers would be wise to include health coaching among the services offered.'**

Quality Incentive Payments Through Closing Care Gaps

With the shift toward value-based payment (VBP) structures, and existing quality bonus programs from insurance plans, healthcare organizations have increased incentive to perform well on quality measures. Part of the Health Coach role is to help close gaps in care for patients they are working with, and sometimes assist with more general gap in care outreach in coordination with the care team. Examples of relevant quality measures which Health Coaches commonly help to improve performance include Hba1c testing, Hba1c control, retinal eye exams and foot exams for patients with diabetes, and BP control. Organizations who consistently perform well on quality measures included in these VBP arrangements or quality bonus programs can use the funding earned to sustain the Health Coach role within the organization.

Medicare Chronic Care Management (CCM)[9]

Since 2015, CMS has offered payment opportunities for care management activities for Medicare fee-for-service patients with two or more chronic conditions. Practices billing for CCM can earn $42 per patient per month for 20-39 minutes of CCM services, up to $118 per patient per month for 60 or more minutes of CCM services.

Many of the CCM program requirements align with Health Coach priority activities, such as:

- Ensuring timely receipt of all recommended preventive care services
- Reviewing medication adherence and oversight of patient self-management of medications
- Management of care transitions between and among health care providers/settings
- Creation, revision, and/or monitoring of an electronic person-centered care plan

Currently, the only health professionals eligible to bill for these services are licensed providers (physicians, certified nurse midwives, certified nurse specialists, nurse practitioners, and physician assistants) and those practicing under the *direct supervision of a provider*.[10] It is this last option that is the most promising for Health Coach staffing models, and multiple CCB partners have implemented workflows that allow Health

Coaches to take on some billable CCM activities under the supervision of the provider.

Additional advocacy

The National Board of Health and Wellness Coaching (NBHWC) was formed in 2012 and "is overseen by a board of directors, and supported by committees composed of volunteers and staff members who seek to advance the profession of health & wellness coaching." NBHWC is working with the American Medical Association to create and implement billable codes for Health Coaching services. CCB is working with NBHWC to provide feedback on this progress and ensure partners can successfully bill for these services once approved.

Outcomes & Discussion

Goals/objectives of the program

Creating and implementing a Health Coach program had a number of key goals in design, and that were largely achieved.

First and foremost, this was a program designed to improve the health of targeted patients. Foundationally, the Health Coaches encourage patients to engage more closely with self-management of chronic medical conditions, empowering them and giving them the tools they need to change their own behavior. The program also looked to improve value-based, population health, measures such as increasing medication adherence, improving key clinical measures such as HbA1C, blood pressure, body mass index, and LDL cholesterol, and significant reduction in hospital use.

The program was also designed as a workforce innovation. This included strengthening primary care services for patients with chronic medical conditions, expanding the resources and skillsets of primary care teams–enabling all members to work at the top of their licenses, and creating a career ladder for Medical Assistants and equivalent level staff.

Health Coach in action at a primary care site

What kind of patients should Health Coaches work with?

If you imagine your patients on a spectrum of high risk and high utilization to easy and self-directed, the Health Coach works best when assigned to work with patients in the middle. These are patients who might seem to be stable on paper but in actuality are just one life challenge away from a bad health outcome. These types of patients are also sometimes the most willing and capable of behavior change when given the right support, and are exactly the patients that primary care providers wish they could spend more time with but can't.

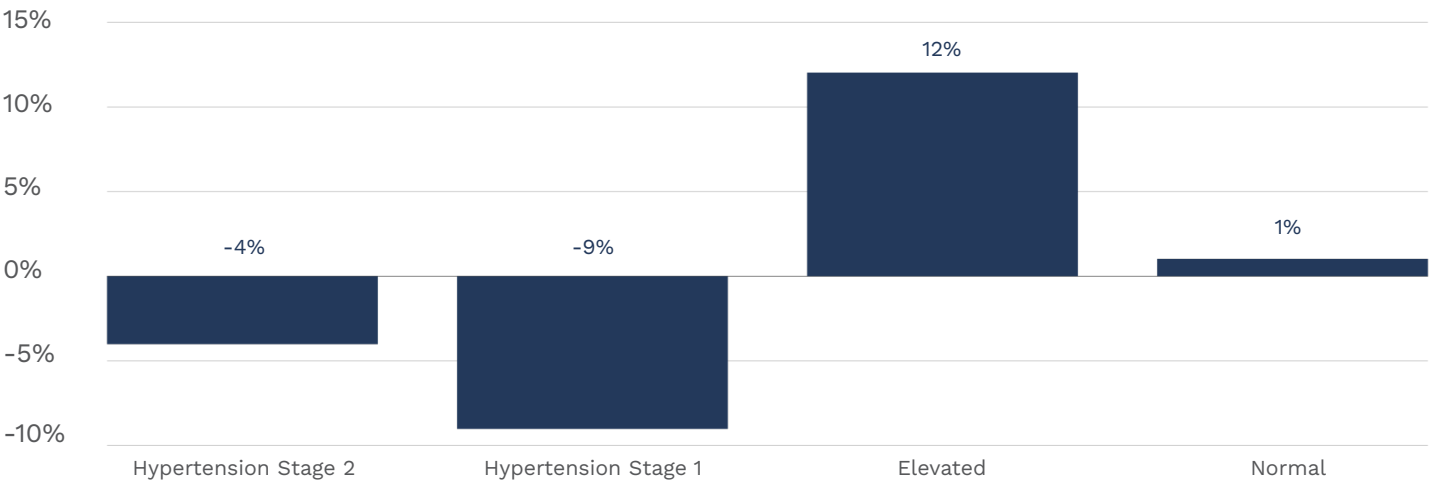
Clinical outcomes

CCB began tracking clinical data aligned with chronic conditions for patients engaged by a Health Coach in July 2018. The clinical data indicators tracked through this process include blood pressure, body mass index, Hemoglobin a1c and LDL cholesterol. The results below include data from July 2018 through December 2020. The preliminary analysis includes metrics to assess change in clinical indicators over time (increase/decrease, uncontrolled/controlled), and compares the first reported indicator value to the last.

Of patients with 6 or more total months of Health Coach encounters, with a gap of 1 month or less between each encounter:

- More than 50% of patients' systolic and diastolic measurements showed improvement
- 64% of patients had a decrease in LDL cholesterol
- 4% reduction in number of patients with HTN Stage 2 and 9% reduction in number of patients with HTN Stage 1 (as shown in chart below)

% Change in Hypertension/Blood Pressure Categories



(Chart, demonstrating total changes in percentage of hypertension and blood pressure readings between earliest and latest readings of 6334 patients in 4 CCB health coach cohorts.)

A survey of patients engaged by Health Coaches was conducted to assess patients' experiences working with Health Coaches and the subjective impact of Health Coaches in helping patients to improve their ability to self-manage their health conditions. 254 patients across 21 partner sites responded to the survey.

- Surveys were completed in English (76%), Chinese (12%), Arabic (4%), Creole (4%), and Spanish (4%).
- The majority of survey responses indicated satisfaction with working with Health Coaches to set and achieve self-management goals, understand health conditions, and better manage health.
- Survey respondents also indicated behavior changes associated with their Health Coach engagement:

PATIENT

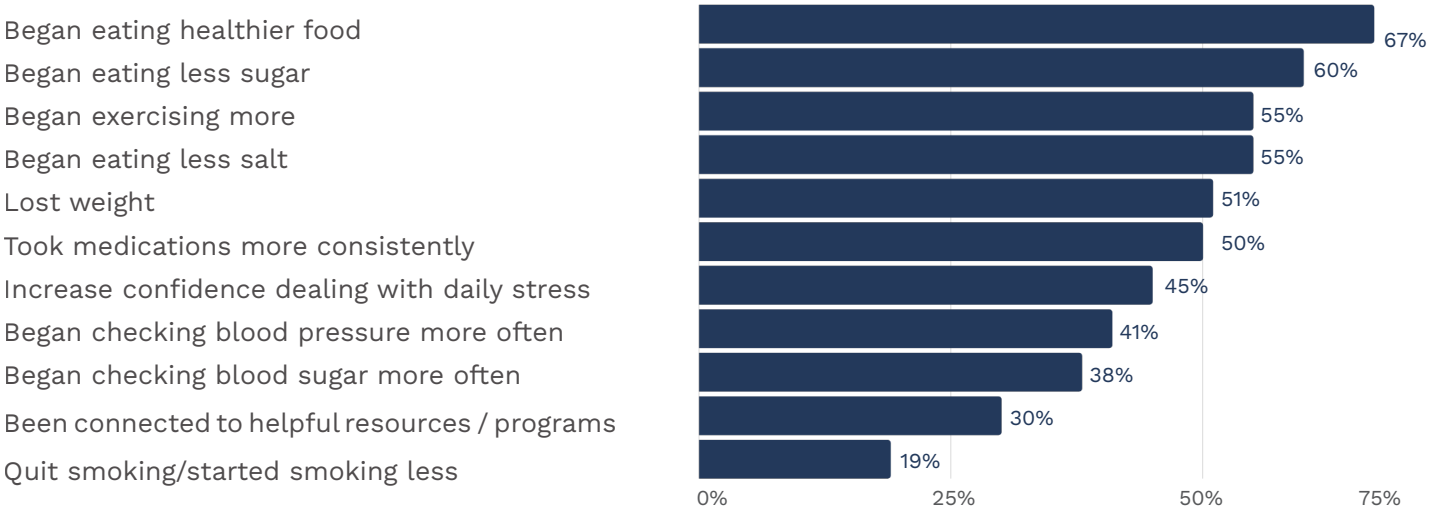
"

I'm monitoring my health more, especially the sugars. A year ago my blood pressure was around 200. Now it's low, low, way lower – sometimes 120, 130. I wouldn't change her for the world.

- Ada

Health Coach in action at a primary care site.

% Survey Respondents' Associating Behavior Changes to Health Coach Engagement



(Chart, demonstrating responses from 254 survey respondents (completed in 5 languages at 21 practice sites) indicating patient satisfaction with working with health coaches to set and achieve health goals, understand health conditions, and better manage health.)

Workforce outcomes

Today, Health Coaches within the CCB network are embraced as critical members of the care team. Staffing models have changed to bring the new role in, and care team members are excited to work with Health Coaches in caring for their patients. The Health Coach program also served as the launching pad for CCB, NYACH, and CUNY to create a brand new comprehensive training program for Medical Assistants to grow their careers. The training helped individuals to develop skills and earn college credits at the same time. While these enhanced skills are important for doing Health Coach work, patient engagement and care management skills are also important across a wide range of healthcare occupations, especially as value-based work continues to propel healthcare reform. In these ways, participating in the Health Coach program gives workers not just a wage increase above the job of Medical Assistant, but also a leg up should they want to grow their careers further in healthcare, through education or otherwise.

HEALTH COACH

“

[As a health coach], there’s more one-on-one. Now I get to help patients set goals for themselves and how to take control of their diabetes that helps them to control their hypertension. And it makes me feelgood that I’m doing my job.

- Margaret

Conclusion

Healthcare is filled with many passionate, smart, creative people who want the best for patients and community members and who want a better healthcare system to deliver that care. The system itself, however, is enormous, complex, interconnected, and slow to change. Oftentimes, new models of care are discussed as if a change in clinical outcomes is the only important measure of success – and that the model is a failure if it cannot demonstrate changed clinical outcomes in a perfectly controlled setting.

Behavior change is hard, however, and no healthcare network is a perfectly controlled setting. If new models of care are going to be successful and stick after implementation, they can't just force clinical outcomes they must also bring the people who deliver that care along for the journey. Yes, the Health Coach model has positive clinical and workforce outcomes, but what makes the Health Coach model special is that it changes the behavior of everyone involved. The care team that worked together on the Health Coach model becomes more open to future staff collaboration and care innovation.

ADMINISTRATOR

"

Hypertension, obesity, those are key indicators for us, when we look at our data by site, you can kind of almost see, without even knowing who, where there are health coaches. Because you will see a huge disparity, in terms of the outcomes at a site with health coaches, versus without.

- Alison

PROVIDER

"

If an institution adopts a health coach model they can expect Lower A1Cs and weight loss. But it also can offer a sense of humanity to your institution, to your organization, which people do respond to. And I think that it's an opportunity.

- Dr. Cave

This collaboration is also a great example of how effective inter-organizational partnerships can work. NYACH was able to convene experts and participants from both employers and adult education, secured funding for the curriculum development and initial pilot, and then the CCB and CUNY partners continued the program after the initial pilot because of what they had experienced they could accomplish together. The program's success is also a testament to the active and ongoing attention and investment by CCB. The work of the Health Coach model was not simply to create a good curriculum and then to hire workers from an occupational training. The work of the Health Coach model was also about facilitating and following through with the change process – bringing in a new title and working with leaders and care team members to "change the way things are done around here."

Endnotes

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8 Brody, J. E. (2021, June 7). We Could All Use a Health Coach. *The New York Times*.

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10 The relevant guidance states: "when the service is not personally performed by the billing practitioner, it can be performed under his or her overall direction and control although his or her physical presence is not required."

NYACH

The New York Alliance for Careers in Healthcare (NYACH) is a public-private industry partnership formed to address system-level challenges facing the local healthcare economy. Formed in 2011 as a collaboration between the NYC Workforce Funders and the NYC Department of Small Business Services, NYACH works with employers and other stakeholders in the healthcare industry to understand the future of the sector, translates that understanding for the workforce development ecosystem, and galvanizes coordinated action to prepare New York City for the healthcare economy of tomorrow.

http://nyachnyc.org/

Community Care of Brooklyn

Community Care of Brooklyn (CCB) is a network of over 1,000 health and social service organizations working together to improve the health and well-being of over 600,000 Medicaid beneficiaries in Brooklyn through New York State's Delivery System Reform Incentive Payment program. Managed through the Maimonides Department of Population Health, the CCB network continues beyond DSRIP to connect partners and better serve the health care needs of Brooklyn communities.

https://ccbrooklyn.org/