Patient Engagement and Coaching Models

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Presenting with the 5 I’s

• Interactive
• Informal
• Imperfect
• Iterative
• Informative
Patient Centered Care

“...care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions”

PCC Components

1. Respect for patient’s values, preferences, & expressed needs
2. Coordination & integration of care
3. Information, communication, education
4. Physical comfort
5. Emotional support
6. Involvement of family and friends
7. Transition and continuity

Lucy’s ACL Surgery
Needs, Preferences, Information, Support

• Text message Tuesday: “We look forward to seeing Lucy Friday!”

• Friday: “Do you prefer text message, email, patient portal, or phone call?”

• Monday call: “How is Lucy?”
Do We Really Provide PCC?

• Resurgence of PCC nationwide
• In Mission, Vision, Values statements
• **Studies—Health professionals tend to overestimate provision of PCC**
• Rank care priorities differently than patients
• “Sometimes the CARE in healthcare is *NOT EVIDENT*”
Ideal Patient Approach

- PCC
- Patient Engagement
  - Self-Management
  - Shared Decision-Making
  - Coaching
Consider...

- Chronically ill patients make many daily health decisions
  - Diet, exercise, medication, when to seek medical care
- Sometimes make unwise decisions
- Don’t fully understand implications of particular health decision
- Lack support to make better choices
Why Patient Engagement?

• To assist “high-risk” patients who have been unsuccessful at managing their own care
• To engage patients in improving self-care
• To improve the relationship between providers and patients
Most Important Determinant

Shared relationship between patient and provider most important to advance healthy behaviors

Can We Be Engaged?

• 23% adopted new health behaviors (but unsure could maintain if stressed)
• Remaining 77%:
  -- Remain passive recipients (12%)
  -- Lack basic facts to follow treatment recommendations (29%)
  -- Have facts, but no skills, confidence (36%)

Education + Self-Management

- Information, technical skills
- Problems due to poor disease control
- Disease-specific knowledge, technical skills
- Goal is compliance with behavior to improve outcomes

- Skills to act on problems
- Patients identify problems in management
- Improving patient confidence in abilities to make changes
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Patient Self-Management

• Facilitating healthy behavior change
• Training problem-solving skills
• Assisting with emotional impact of a chronic condition
• Maintaining regular, sustained follow-up
• Encouraging active participation in disease management

Transcript Studies

• Providers tend to take control of communication, direct topics away from patient concerns, avoid offering empathy or validation
• Have strong desire to dive into first problem patients’ mention
• Reasons: Cited fear that patient verbalization will extend length of interaction; lacked awareness

Effective Communication

- Literature review (1949-2008): Communication positively correlated with patient adherence
- Decreases potential for errors; promotes patient engagement
- “Talk to me like you would to your friends”

Health Coaching

- Method to guide patients to address health, make needed behavior changes
- Involves goal setting, identifying obstacles, using support systems
- Relationship between coach and coachee is accountability partnership focused on health goals defined by both

Medication Adherence?

Take 3 tablets by mouth 2 times per day, with food for 14 days, then take 2 tablets 2 times per day with food for 14 days, then take 1 tablet every morning, 30 minutes before meal for 14 days, then take $\frac{1}{2}$ tablet every morning, 30 minutes before meal for 14 days.
Medication Adherence

• 40-80% medical information given forgotten immediately; half retained is incorrect[1]

• Physicians thought 89% of patients understood medication side effects, only 57% of patients understood[2]

How would you engage your patient to take this medication correctly?

Take 3 tablets by mouth 2 times per day, with food for 14 days, then take 2 tablets 2 times per day with food for 14 days, then take 1 tablet every morning, 30 minutes before meal for 14 days, then take ½ tablet every morning, 30 minutes before meal for 14 days.
Teach-Back Method

• Method to confirm patients understand what we tell them
  – “Tell me why you need this medication”
  – “Tell me how you would take this medication”

• Teach Back not a test of patient's knowledge

• Is a test of how well we explain something

Teach-Back Method

“View this DVD and be ready to show us you can do the ROM exercises for Lucy”
Motivational Interviewing

A collaborative, patient-centered form of guiding to elicit and strengthen motivation for change

Motivational Interviewing

• Non-judgmental, non-confrontational, non-adversarial
• Explore and resolve ambivalence
• Help patients envision a better future, and become increasingly motivated to achieve it

Why We Need MI

No matter what reasons we might offer to convince individuals of the need to change their behavior, or how much we want them to,

*or how much we want them to*,

lasting change is more likely to occur when they discover their own reasons and determination to change.
Four Principles of MI

1. Express empathy
   – See things through the client’s eyes

2. Develop discrepancy
   – Explore how they want their life and how it is now

3. Roll with resistance
   – Do not fight client resistance, but "roll" with it

4. Support of self-efficacy
   – Embrace client autonomy
OARS

• Open-ended questions
• Affirmations
• Reflections
• Summaries
Reality and Practicality

• It takes time to engage patients; you may have to adjust your workflow
• Promote planned care, and team-based care
• Don’t try to fix patients’ problems, help them fix their own
• It works—start with small changes
Engaging Patients Through Coaching: A Method to Consider

Larry Garrett, PhD(c), MPH, BSN
HealthInsight
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“Even people with chronic conditions rarely spend more than 1% of their life at a healthcare provider’s facility. It is the other 99% of one’s life - when an individual is at home - that determines whether they return to full health or not.”

-unknown-
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Managing is making sure people do what they know how to do. Training is teaching people to do what they don’t know how to do. Mentoring is showing people how the people who are really good at doing something do it. Coaching is helping to identify the skills and capabilities that are within the person, and enabling them to use them to the best of their ability.
Care Transitions Model

- The Care Transitions utilizes a Transitions Coach to encourage patients to assert a more active role in their own self-care.

- The program has consistently reduced 30-day hospital readmissions and costs as well as 180-day hospital readmissions.
Four Pillars

- **Medication self-management:** Patient is knowledgeable about their medications and has a medication management system.

- **Use of a Personal Health Record:** Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The PHR is managed by the patient.

- **Medical Visit:** Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is prepared to be an active participant in these interactions.

- **Knowledge of "red flags":** The patient is knowledgeable of indicators that his or her condition is worsening and demonstrates knowledge of how to respond.
Personal Health Record

- Personal health record:
  - Maintained by the patient and brought to each appointment;
  - Medications and allergies;
  - Advance care directives;
  - Warning symptoms or signs.

- Space to record the patient's questions for next medical encounter.

- Maintained by the patient.
Coaching, Encounters

• **Initial meeting in hospital:** The Coach meets with the patient in the hospital to establish an initial rapport, introduce the personal health record, and arrange a home visit.

• **Home visit:** The home visit ideally takes place within 48 to 72 hours of discharge.
Coaching, Encounters

- **Medication reconciliation:** Actively engages patients in reconciliation of all medications taken and models behaviors for how to address common medication discrepancies.

- **Education on how to communicate:** Through role playing and other methods educates patients on how to communicate care needs effectively during encounters with health care professionals.

- **Review of warning signs:** Reviews a list of "red flags" that indicate a worsening condition and educates patients on how to respond, should they occur.
Coaching, Encounters

• Three telephone patient visits during the first 28 days after discharge.

• Focus:
  – Reviewing the patient's progress toward established goals;
  – Discussing any encounters with health care professionals;
  – Reinforcing the importance of maintaining and sharing the personal health record;
  – Supporting the patient's self-management role.
Coaching in your Practice

• Coaching is a tool that everybody can use:
  – It is evidence based and shows that those that are engaged in the coaching process have better outcomes.

• Coaching can be used to help prevent patients going into long-term downward trends or to keep them at their new “normal”
Questions?

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