REMINGTON REPORT®

Business Intelligence, Insights, and Trends

- Patient Engagement Solutions for High-Need, High-Cost Patients
- Patient Engagement Coaching Strategies
- Patient Engagement Framework for Complex Patients

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Patient Engagement Framework, Coaching, and Solutions to Improve Chronic Conditions and Readmissions

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Message From Lisa Remington

Lisa Remington
President, Remington's Home Care Leadership Think Tank and
Publisher, The Remington Report

This issue of The Remington Report explores solutions and strategies for improved patient engagement. Healthcare is in an era of patient-centered care when patients' needs and desired outcomes drive many decisions.

Three Patient Engagement Strategies

Coaching interventions have been widely touted as a potential way to prevent chronic illness and to help patients better self-manage their chronic illnesses. Our article titled, "Patient Engagement Coaching: A Strategy for Patients Living with Chronic Conditions," explains how capacity coaching co-creates an action plan for self-care and quality of life.

1. A coaching framework of techniques and tools employed by health providers is part of an intensive care management intervention and an authentic healing relationship between patients and care teams.
2. Five models and a training manual are detailed in the article titled, "Patient Engagement Framework for Chronically Complex Patients."
3. Patient engagement strategies from the voices of high-need patients help to identify their challenges to prevent ED visits and readmissions. Our article titled, "Patient Engagement Strategies for High-Need, High-Cost Patients," sheds light on their concerns.

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- Patient Engagement Strategies for High-Need, High-Cost Patients
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PATIENT ENGAGEMENT STRATEGIES

Patient Engagement Strategies for High-Need, High-Cost Patients

By Lisa Remington, President, The Remington Report and Remington's Home Care Leadership Think Tank

High-need, high-cost patients often have multiple chronic conditions, complex psychosocial needs, and limited ability to perform activities of daily living. Care delivery solutions, including care management, telehealth, and home health visits, have had mixed levels of success for various outcome measures, including system-centric ones such as total cost of services and utilization of secondary care (emergency department use and inpatient hospitalization) as well as patient-centered ones such as self-assessed health status.

Article Highlights

It has become a national priority to understand the needs of high-need, high-cost patients, identify drivers of their utilization, and implement solutions to improve their clinical outcomes while reducing their costs. In this article, learn how to prevent ED visits and readmissions from patient perspectives

An explanation for the variable success could be that many solutions are designed primarily by health system administrators, not the patient "customers" who best understand their needs. Little has been published about patients' views on the care models that target their complex healthcare needs, which aspects of current care delivery high-need, high-cost patients find beneficial, nor how health systems can partner with patients to design and implement solutions. Better serving high-need, high-cost patients must begin with improving our understanding of their needs and perspectives

Voices Patient's Perspective

To bring the voice of the patient to the forefront, qualitative researchers from Weill Cornell Medicine and the University of Florida led several focus group discussions with 21 high-need, high-cost patients and three primary caregivers, representing an urban healthcare system in New York City and a second one in Gainesville, Florida. Clinical care coordinators at each site identified patients for focus groups based on the following criteria:

- They had at least one chronic medical condition,
- Either three or more ED visits or,
- Two or more inpatient admissions during the six months before the initiation of the study (three patients were too ill to participate, so their primary caregivers functioned as proxies).

The study was published in the New England Journal of Medicine.

Study Participants

Participants ranged in age from 23 to 80 (median age was 59) and were racially diverse (15 black, seven white, and two Hispanic). Fifteen participants were female (63%) and nine were male. In the prior 12 months, the patients, on average, had visited their primary care doctors six times and the ED 16 times and been hospitalized five times. Commonly reported medical conditions included arthritis, diabetes, asthma, heart disease, chronic obstructive pulmonary disease, obesity, epilepsy, hypertension, and depression.

Participants identified five solutions that they felt would help prevent overuse of the ED and other hospital services for symptoms and/or conditions that can be well-managed at primary care clinics. These are:

- Care management
- Readily available at-home physical therapy and nursing services
- Home delivery of prescription medications and easier refills
- Telehealth
- More after-hours clinics

What High-Need High-Cost Patients Say About How to Reduce High Utilization of ED and Inpatient Services

Solution	**Quote**
Care management	It's [care coordination] (that is) very useful. She gave me the thing to call her, and I could call her at any time I'm feeling bad. I tell you, most of it is anxiety. So, when I talk to her it calms me down, and she also helps me out, she said take some...over-the-counter medication that helps me that I don't have to run to the emergency room, and she'll tell me why not to go to the emergency room.
At-home services (visiting nurse/physical therapy)	Having a home nurse come to your home or a physical therapist come to your home. Because I had both of them come to my house when I had my hips replaced. Both of them because there wasn't no sense – because I didn't want to go from the hospital to a rehab hospital and stay in the hospital more. I had the...the home nurse and then I had my home therapist come to the house. That stopped me from having to go to the hospital.
At-home medication delivery	You have to go every month and pick that prescription up. Sometimes that can be hard. Sometimes you can't make it there to get it and you do without it. I think they need to come up with a way where when they know it's time for you to come there to pick that prescription up, either mail that prescription home to them or something like that.
Larger supply of medications	They give you your medication – if instead of giving you a 30-day supply, they give you a 90-day supply and give it to you so that when you get to that last prescription bottle, you can go ahead and put that order in so that you can go ahead and get that next 90-day supply. That'll help a lot.
Telemedicine	I think that might help. 'Cause like he says, most of it comes with anxiety. If you could talk to somebody that knows your symptoms and feels comfortable talking, yeah, and explain to them what's going on, they could just let you know this is what's going on. You've been through it before. It's nothing. And also, it relaxes you. The whole idea of telemedicine works fine except that most practitioners, if they're at all concerned about it being cardiac, prefer that you get your behind over there so you can get looked at. Okay. And so, I mean, that's what I've been led to believe that there's no point in taking a chance because the price and consequences is much too great.
After-hours clinics	Instead of people...going to the emergency room a lot – have y'all ever thought about like opening up a clinic like after hours after the regular clinic is closed? Have y'all ever thought about like opening that up to solve some of the problems that, you know, they won't have to go to the emergency room quite so frequently?

Source: The Authors

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Care Management

Patients saw immense benefits in many of these solutions (see "What High-Need, High-Cost Patients Say"). For care management, patients appreciated help with appointment scheduling and reminders. Patients perceived care managers as trustworthy partners in their day-to-day healthcare – available to talk to and answer questions if they felt anxious. While the jury is still out on the return on investment of care– in terms of utilization and outcomes – the patients in the focus group were convinced of its benefits.

At-Home Services and Medication Delivery

After stays in the hospital or rehab centers, patients, especially those with mobility restrictions or transportation challenges, also appreciated home-based provider service or physical therapists. Private and public payer organizations already provide coverage for several types of home healthcare and/or personal care.

Patients also described how they sometimes cannot pick up their prescriptions for extended and appreciated the option of having medications delivered to their residences to avoid exacerbating their illnesses. Some also felt that a larger supply per refill cycle would be optimal for some medications. Several pharmacy groups are piloting automatic monthly refills and home delivery of prescription medications, and these services should be more widespread and better publicized.

Telehealth

Patients also discussed telehealth as a solution. Some recognized the potential benefit of telehealth for regular appointments or non-emergency conditions. They felt that communicating with a medical provider who was personable and familiar with their symptoms could reduce the anxiety of time-sensitive, unanswered questions that often result in an ED visit. Others, however, expressed uncertainty about the use of telehealth for conditions such as cardiovascular disease, saying that they wouldn't take a chance with remote care in case "things go wrong" and would instead seek care in a doctor's office or ED. While not every condition can be managed using telemedicine, patients must be better educated about when telehealth might be a desirable alternative.

After-Hour Availability

Finally, patients, especially those who work nine to five or whose personal caregivers are unavailable during regular business hours, felt that increasing the number of after-hours clinics at convenient locations was crucial to reducing their reliance on the ED. However, patients felt that after-hours clinics would be underutilized if transportation options were limited, reinforcing the need for convenient locations. As more health systems redesign their care delivery models, they should prioritize establishing after-hours clinics inaccessible locations and educate patients about when to use them instead of urgent care centers or the ED.

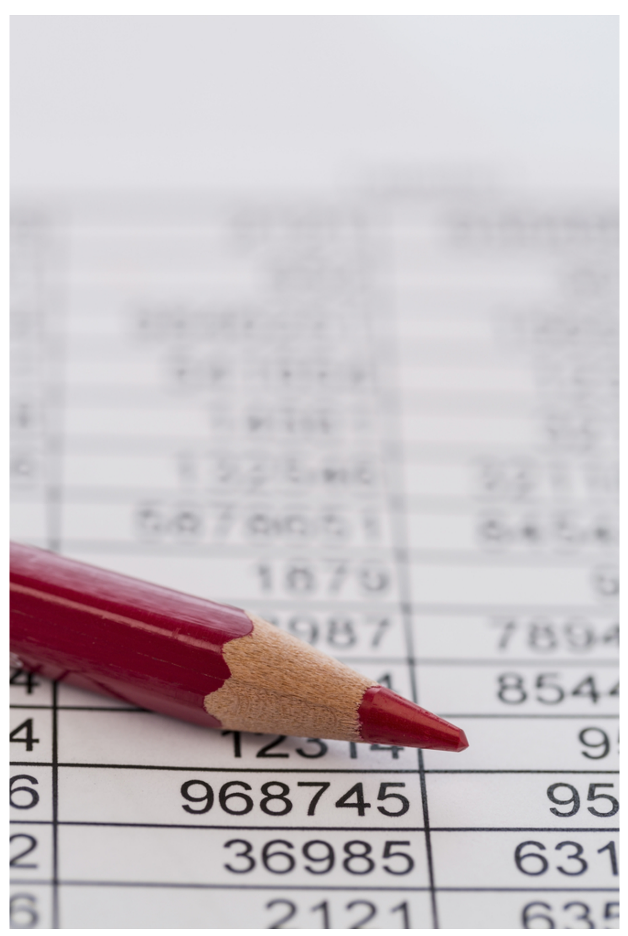
Almost all these solutions are being piloted in various settings. To enhance the success of care delivery models, healthcare systems should consider directing more resources to some of these existing solutions that patients believe could lower utilization of secondary care for chronic disease management.

We're in an era of patient-centered care, when patients' needs and desired outcomes drive many decisions healthcare organizations make. We must leverage the knowledge to reduce the expense of managing high-need patients, and engagement strategies to drive compliancy.

For care management, patients appreciated help with appointment scheduling and reminders. Patients perceived care managers as trustworthy partners in their day-to-day health care.

8 Remington Takeaways

1. Build relationships with ACOs, physicians, payers, and health systems to manage the high-need, high-cost chronic care population after discharge or beyond the physician's offices.
2. Develop a 24/7 call center for patients' access to their phone calls.
3. Integrate telehealth as a critical technology strategy for patient care management and better outcomes.
4. Work closely or develop a medication reconciliation model with the pharmacist.
5. Develop protocols with physicians/ambulance companies about ED visits.
6. Develop readmission methodologies by condition.
7. Develop relationships with after-hour clinics.
8. Increase communication about the services of home care companies to patients and referral sources to better understand how to leverage core competencies.



HOSPITALS

More Hospitals Facing Readmission Penalties in 2024

Compiled by The Remington Report Editorial Team

More hospitals will face readmissions penalties in 2024 per preliminary CMS data. The hospital readmissions performance period for fiscal year 2024 still excludes data from the first half of 2020, pulling claims from July 2019 to December 2019 and from July 2020 to June 2022. The penalties also exclude data from hospitals with approved extraordinary circumstance exceptions.

2024 Penalty Evaluation

For the upcoming year, 70.1% of hospitals will receive penalties of less than 1% on their readmissions vs. 67.1% of hospitals in fiscal 2023.
7.5% of hospitals will be charged penalties of 1% or more in fiscal 2024 – unchanged from last year. Another 22.4% of hospitals will not be assessed penalties.

Article Highlights

- For 2023, 60% of U.S. hospitals were eligible to receive a financial penalty for excessive 30-day readmissions.
- 75% of eligible hospitals received a Medicare penalty.
- The average hospital penalty is 0.43% of 2023 Medicare revenue.

Dual Eligibles Readmission Penalties Differ

Congress modified the Hospital Readmission Reduction Program through the 21st Century Cures Act of 2016, with a mandate for Medicare to account for differences in poverty levels by measuring dual enrollment in Medicare and Medicaid when assessing readmissions and penalties so that hospitals can be evaluated relative to peers with similar poverty levels.

In FY 2019, hospitals were stratified into one of five peer groups (quintiles) based on hospitals' dual proportions. Hospital performance is compared to the median of the hospital's peer group.

For hospitals with the lowest number of dual-eligible patients – peer group one – the average penalty is 0.34%.

During fiscal year 2023, groups five and one were penalized 0.23% and 0.37%, respectively, on their readmissions.

Looking Ahead in 2024

The higher number of readmission penalties for FY 2024 likely reflects hardships hospitals experienced during peak pandemic months in both 2021 and 2022, according to Akin Demehin, senior director for quality and patient safety policy at the American Hospital Association.

2024 Pneumonia Readmission Measure Resumes

The Centers for Medicare and Medicaid Services will restart its pneumonia readmissions measure. This measure had been excluded last year from its Hospital Readmissions Reduction Program due to COVID.

All Cause Readmission Rates by Top 10 Diagnosis

Rate of readmission for all causes within 30 days by principal diagnosis category at index admission, 2020

Rank	Principal diagnosis at index admission[a]	Readmission rate[b]	Number of all-cause readmissions[c]
1	Blood diseases	23.8	79,720
2	Neoplasms	19.0	212,954
3	Endocrine, nutritional, and metabolic diseases	17.3	223,149
4	Genitourinary system diseases	17.3	238,130
5	Respiratory system diseases	17.0	304,627
6	Mental, behavioral, and neurodevelopmental disorders	16.2	303,313
7	Digestive system diseases	16.0	447,677
8	Infectious and parasitic diseases	15.6	478,007
9	Circulatory system diseases	15.3	647,861
10	Skin diseases	13.4	61,403

[a] Principal diagnosis at index admission is grouped by body system according to the (CSR, which categorizes the ICD-10-CM into a manageable number of clinically meaningful categories.
[b] The readmission rate is calculated using discharges from January through November to allow for a 30-day follow-up period.
[c] The number of readmissions is the 12-month count calculated by multiplying the readmission rate by the 12-month index admission count. Source: AHRQ

LEGAL

Preventing Violence in Home Care: Action Items

By Elizabeth E. Hogue, Attorney

According to a recent analysis of Bureau of Labor Statistics data, home healthcare is one of the most dangerous places to work in healthcare. Homecare field staff members who provide services on behalf of private duty agencies, hospices, Medicare-certified home health agencies, and home medical equipment companies are extremely vulnerable. Contributing to their vulnerability is the fact that they work alone on territory that may be unfamiliar and over which they have little control. Staff members certainly need as much protection as possible.

Article Highlights

- Zero tolerance policies.
- Four essential actions to take.
- Important statistics on vulnerabilities.

First, management should develop a written policy of zero tolerance for all incidents of violence regardless of source. The policy should include animals. The policy must require employees and contractors to report and document all incidents of violence, no matter how minor. Emphasis should be placed on both reporting and documenting. Employees must provide as much detail as possible. The policy should also include zero tolerance for visible weapons when caregivers are present in patients' homes. Caregivers must be required to report the presence of visible weapons.

Four important actions for home care organizations to take include:

1. Develop quality indicators that improve efforts to protect staff. Indicators in quality and safety standards should include patient assault and other instances of violence or threatened violence. The results of these indicators should result in violence prevention plans and training programs in de-escalation of violence.
2. Strengthen data systems to monitor the exposure of staff members to aggression. More resources should be invested in measuring aggressive events and specific factors that resulted in exposure, such as patient type.
3. Encourage and support reports of violence or threatened violence. A zero tolerance policy is essential, but such a policy can be neutralized by managers who discourage or ignore reports.
4. Provide ongoing education to protect staff. Education should focus on intentional actions that staff members must take to recognize, document, and counter threatened or actual violence.

Research studies have reported a range of 18% to 65% of home healthcare workers experiencing verbal abuse from patients. As many as 41% of home healthcare workers have reported sexual harassment. Between 2.5% and 44% of home healthcare workers have reported being physically assaulted.

In one study, home healthcare registered nurses frequently reported demanding patients (34%), aggressive pets (27%), poor lighting in patient homes (21%), neighborhood violence/crime (19%), patients' challenging family members (18%), personal security fears (14%), drug use in patient homes (13%), firearms in the home (9%), and racial/ethnic discrimination (8%).

Every caregiver matters.The home care industry has lost caregivers to violence on the job in the past.Let's not repeat these terrible events.

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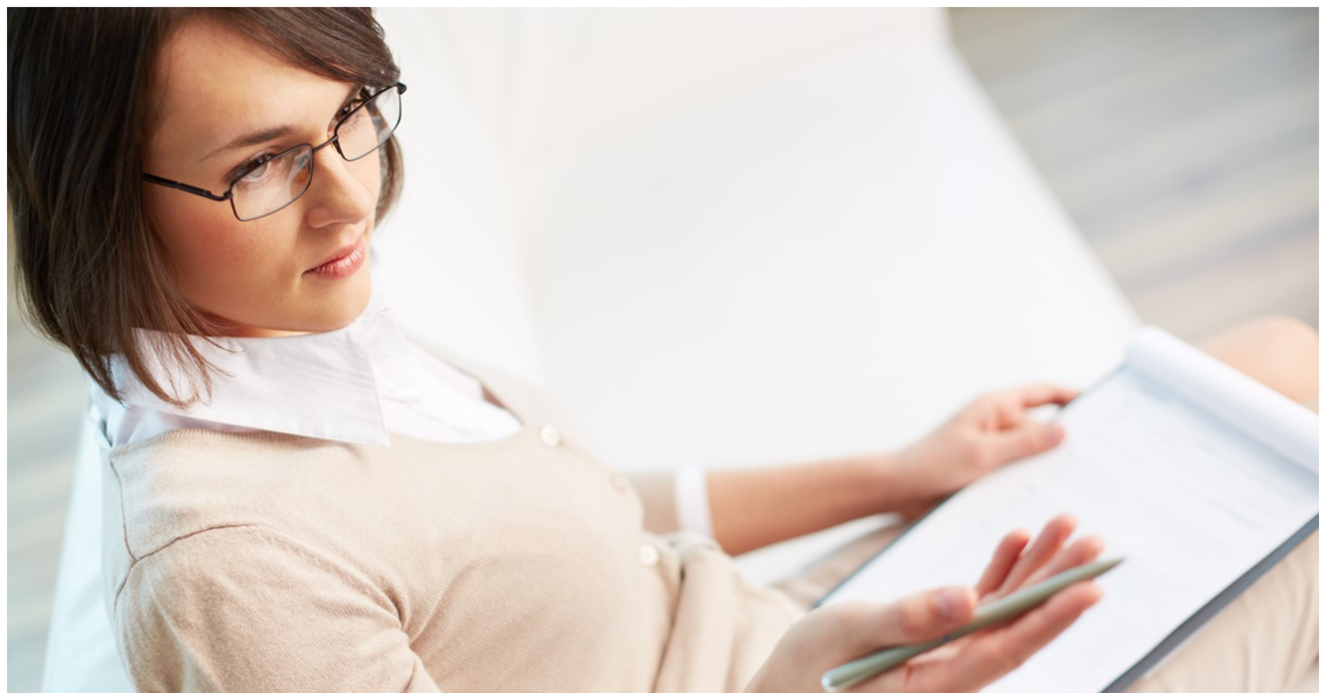


PATIENT ENGAGEMENT

Patient Engagement Framework for Chronically Complex Patients

Compiled by The Remington Report Editorial Team

Authentic healing relationships are critical to applying interventions that fully support patients in achieving their goals and focus on building relationships and empowering patients to take full control of their health. A training manual called COACH developed by The Camden Coalition seeks to improve the quality, capacity, coordination, and accessibility for medically and chronically complex individuals.
COACH is a framework of techniques and tools employed by health providers to be used as part of an intensive care management intervention. A foundation of the framework is the development of an Authentic Healing Relationship between the patient and the care team.

Article Highlights

- Five patient engagement tips.
- Training manual to improve engagement.
- Practical lessons in serving complex populations.

The five COACH model offers tips to providers who wish to enhance patient engagement.

1. Connect Tasks with Vision and Priorities: Develop a shared understanding of the patient's goals and overall vision for their life with the patient, provider, and any patient support systems.

2.Observe the Normal Routine: Take time to understand the patient's strengths and the positive and negative factors that impact their health. This is a crucial and often foundational part of the process because it provides critical information for the care plan and informs decision-making about the most effective coaching style to employ.

3. Assume a Coaching Style: Consider patient needs and ability to support goal-related tasks when assessing whether a patient is in one of the following categories:

- **I do:** "Can you show me?" – The patient has difficulty identifying the first step to accomplish a task, so the care manager performs the task and models it for the patient.
- **We do:** "Can we do it together?" – The patient can identify the first few steps to begin the task but has difficulty completing the task. The care manager collaborates with the patient to complete the task together.
- **You do:** "I can do it." – The patient has completed the task or similar tasks numerous times on their own. The care manager is there to boost the patient's confidence when needed. The goal is to transition all goals into the fully independent "You do" category, where the patient can complete goal-related tasks on their own.

4. Create a Care Plan: Create a collaborative care plan driven by the patient's own priorities and vision for themselves. Develop a set of benchmarks that can be tracked and are clearly connected to the long-term goals of the patient. Revisit the plan often and be prepared to alter it whenever necessary.

5. Highlight Progress with Data: Track progress toward health goals and celebrate success with the patient at every opportunity.

Coaching Tips

- The steps within the COACH framework are not meant to be performed sequentially. The steps are fluid and may occur simultaneously, depending on the patient's needs. For example, a care manager may need to revisit the "Create a Care Plan" or "Connect Tasks with Vision and Priorities" steps during the process, given that a patient's long-term goals could change over time.
- When determining a patient's long-term vision, which can then be connected to tasks that fulfill this vision, ask open-ended questions, and use reflective language, such as, "It sounds like...." Or, "I get the sense that...."
- Try as much as possible to avoid the tug-of-war scenario, where there is a mismatch between provider and patient goals. Providers can mitigate this by clearly identifying the patient's dominant need and reflecting that back to the patient often to ensure that it remains at the forefront of the engagement.

Download the COACH Manual here

COACH is a framework of techniques and tools employed by health providers to be used as part of an intensive care management intervention.

SENIOR CARE

4 Cost Burdens Faced by Seniors in Medicare and Medicare Advantage Plans

Compiled by The Remington Report Editorial Team

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2022 examines the financial burden of care that people 65 and older with Medicare face and how that burden differs for people with traditional Medicare and Medicare Advantage. The analysis focuses on 1,604 respondents aged 65 and older who indicated they were enrolled in Traditional Medicare and Medicare Advantage plans.

Article Highlights

- Senior financial burdens impacting healthcare.
- Comparisons between Traditional Medicare and Medicare Advantage.
- Medication implications.

A common misconception is that once a person becomes eligible for Medicare, they no longer need to worry about medical bills or choosing a health plan.

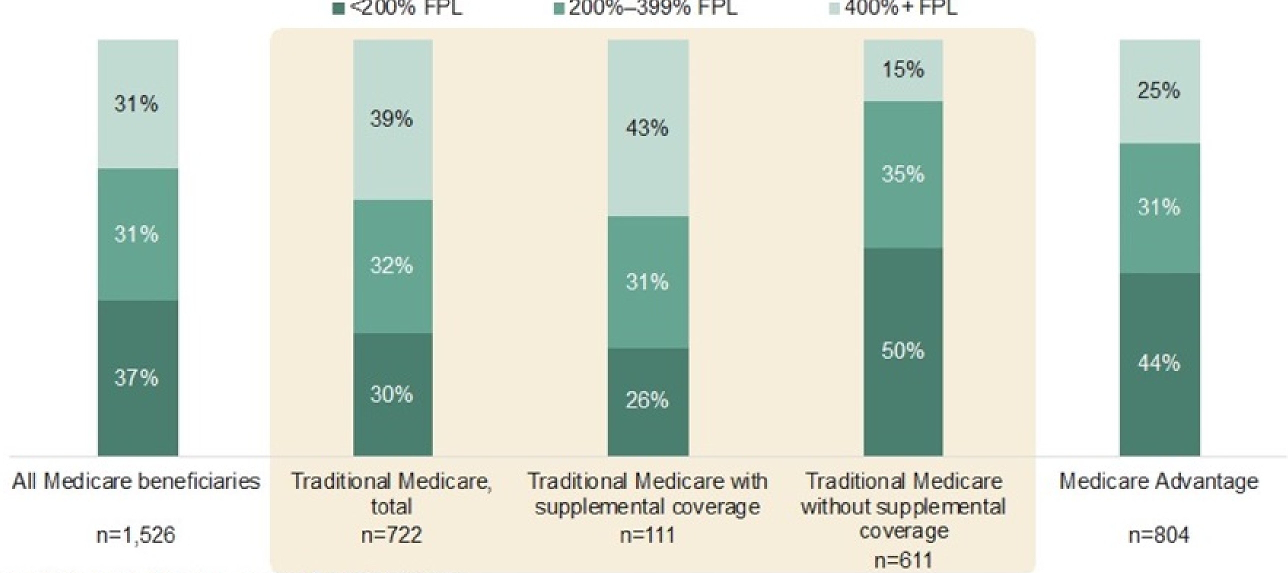
Most people choosing to enroll in traditional Medicare have supplemental coverage to help cover the required cost-sharing payments and deductibles.

Medicare Advantage plans, however, typically use tools, such as prior authorization requirements, to manage enrollees' use of services, which can pose barriers to care.

The survey examines the cost burdens, income levels, and the relationships between skipping medications and other healthcare services.

EXHIBIT 1

More than one in three older adults with Medicare coverage reported incomes below 200 percent of the federal poverty level.



Base: Adults age 65+ with Medicare coverage who were insured all year.

Notes: Coverage type given at time of survey. FPL = federal poverty level; annual income of $13,590 for an individual in 2022. Medicare excludes those beneficiaries who indicated they were also working full time and had employer-sponsored insurance (ESI). "Traditional Medicare with supplemental coverage" refers to respondents who did not have Medicare Advantage and met one of the following criteria: dually eligible for Medicare and Medicaid; had Medicare and ESI but were unemployed or working part time; or had Medicare and had another type of coverage, such as Medigap. "Traditional Medicare, total" combines respondents in the two traditional Medicare subcategories.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Source: Faith Leonard et al., *Medicare's Affordability Problem: A Look at the Cost Burdens Faced by Older Enrollees — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2022* (Commonwealth Fund, Sept. 2023). https://doi.org/10.26099/ptam-tw11

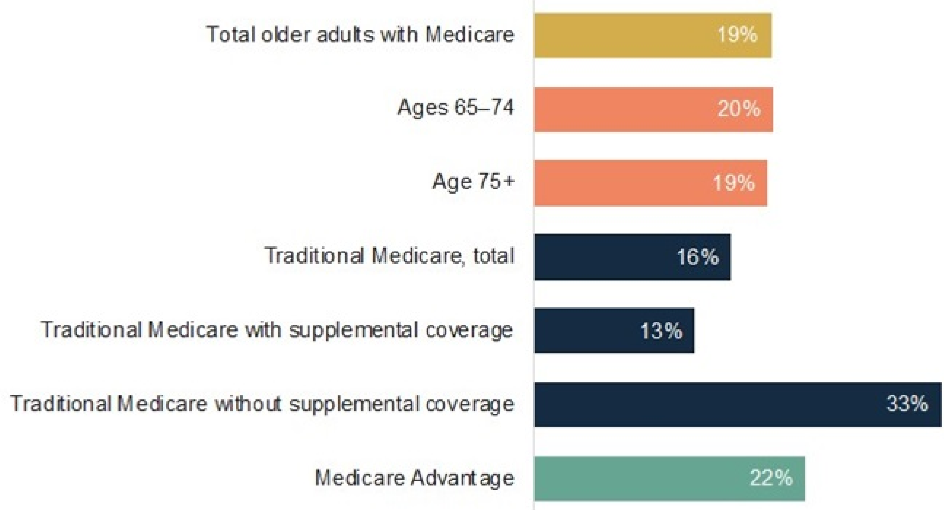
Incomes for older adults with Medicare varied across types of coverage. Compared to those with traditional Medicare along with supplemental coverage, larger shares of older adults enrolled in Medicare Advantage plans and those in traditional Medicare without supplemental coverage reported incomes below 200 percent of FPL.

Problems affording care may lead to skipping a trip to the pharmacy to fill a prescription, a follow-up with a doctor, a visit with a specialist, or a dental visit.

EXHIBIT 2

About one in five older adults with Medicare coverage reported high health care costs in the past year that make them underinsured.

Percentage of adults age 65+ with Medicare coverage who reported high health care costs



Base: Adults age 65+ with Medicare coverage who were insured all year.
Notes: Coverage type given at time of survey. "Underinsured" refers to adults who were insured all year but experienced one of following: out-of-pocket costs, excluding premiums, equaled 10 percent or more of income; out-of-pocket costs, excluding premiums, for those with low income (<200% of poverty) equaled 5 percent or more of income; or deductibles equaled 5 percent or more of income. Medicare excludes those beneficiaries who indicated they were also working full time and had employer-sponsored insurance (ESI). "Traditional Medicare with supplemental coverage" refers to respondents who did not report Medicare Advantage and met one of the following criteria: dual eligible; had Medicare and ESI but were unemployed or working part time; or had Medicare and had another type of coverage, such as Medigap. "Traditional Medicare, total" combines respondents in the two traditional Medicare subcategories.
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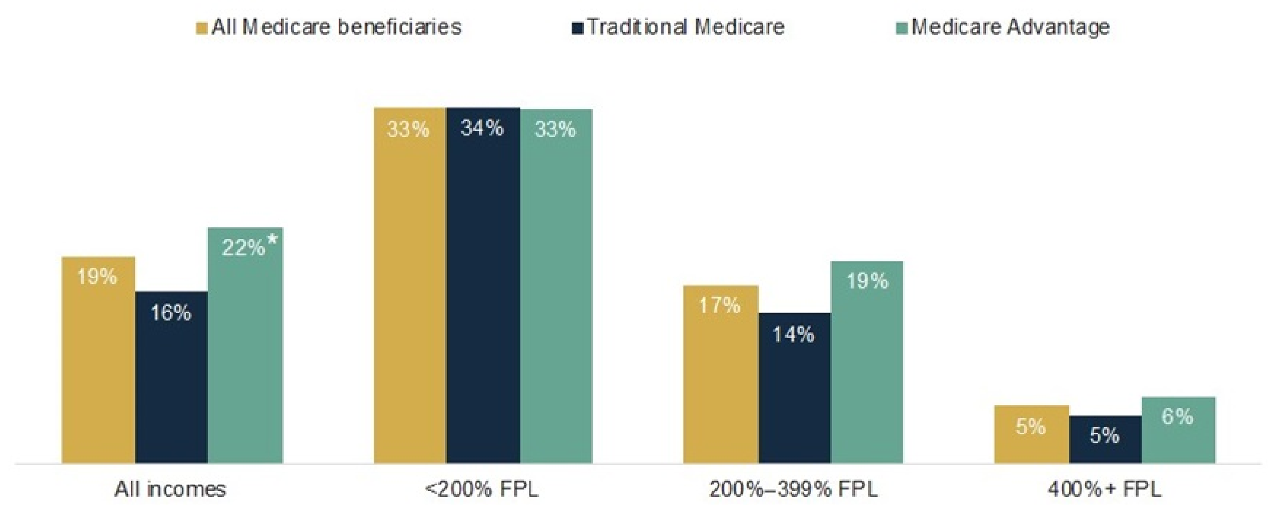
The share of older Medicare beneficiaries in the past year who were underinsured, meaning they were not sufficiently protected against healthcare costs or deductibles, was similar by age but differed by type of Medicare coverage. One-third of older adults in traditional Medicare who did not have supplemental coverage reported being underinsured.

Across types of Medicare coverage, more than one in five older adults reported cost-related problems getting dental care, and more than one in 10 reported not filling a prescription because of the cost.

EXHIBIT 3

Among older adults on Medicare, underinsured rates were highest for those with low incomes.

Percentage of adults age 65+ with Medicare coverage who reported high health care costs, by income



Base: Adults age 65+ with Medicare coverage who were insured all year.

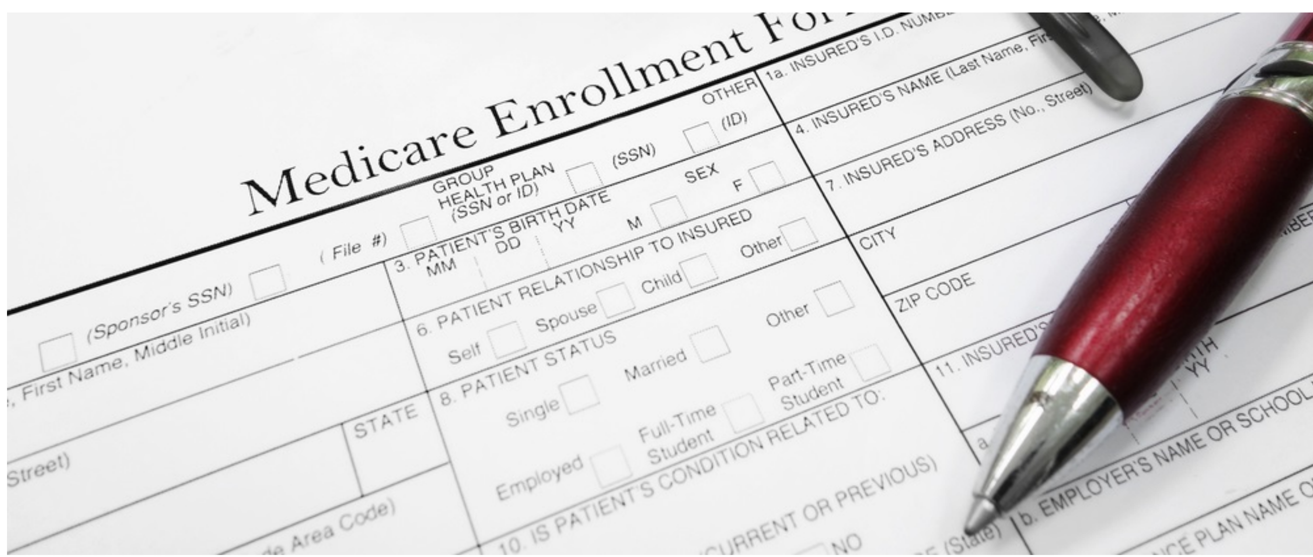
Notes: Coverage type given at time of survey. FPL = federal poverty level; annual income of $13,590 for an individual in 2022. "Underinsured" refers to adults who were insured all year but experienced one of following: out-of-pocket costs, excluding premiums, equaled 10 percent or more of income; out-of-pocket costs, excluding premiums, for those with low income (<200% FPL) equaled 5% or more of income; or deductibles equaled 5% or more of income. Medicare excludes those beneficiaries who indicated they were also working full time and had employer-sponsored insurance (ESI).

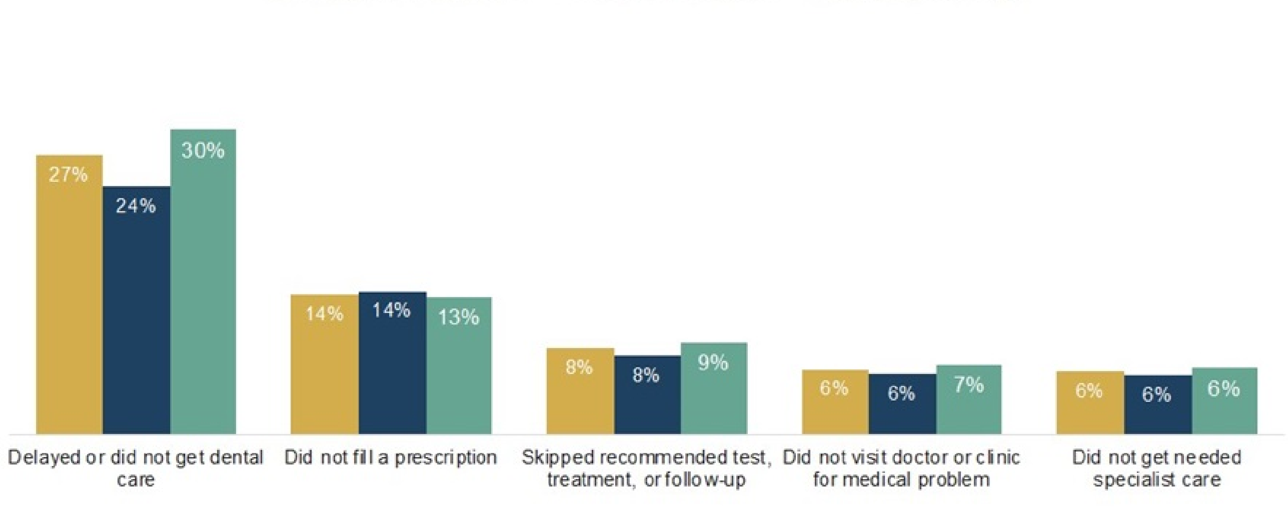
* Difference statistically different at the $p<0.05$ level for people with Medicare Advantage compared to those with traditional Medicare.

Data: Commonwealth Fund Biennial Health Insurance Survey (2022).

Source: Faith Leonard et al., *Medicare's Affordability Problem: A Look at the Cost Burdens Faced by Older Enrollees — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2022* (Commonwealth Fund, Sept. 2023). https://doi.org/10.26099/ptam-tw11

Regardless of which type of Medicare coverage they had, older adults with low incomes (below 200% of FPL) were the most likely to say they were underinsured. About one-third of beneficiaries with incomes below 200 percent of FPL had coverage that exposed them to high out-of-pocket costs or deductibles relative to their income.





Inadequate insurance coverage can make it harder to afford necessary health care. In the survey, nearly four in 10 older adults with Medicare (38%) reported experiencing at least one cost-related access problem. Problems affording care may lead to skipping a trip to the pharmacy to fill a prescription, a follow-up with a doctor, a visit with a specialist, or a dental visit.

Traditional Medicare does not cover basic dental care, but most Medicare Advantage plans cover some dental care. Some in traditional Medicare have dental coverage through Medicaid, a former employer or union, or a separately purchased dental policy.

Among adults 65 and older with Medicare, the proportion with problems accessing care because of its cost was similar for those in Medicare Advantage and traditional Medicare. Across types of Medicare coverage, more than one in five older adults reported cost-related problems getting dental care, and more than one in 10 reported not filling a prescription because of the cost.

Conclusion

The affordability of healthcare remains an issue for many adults 65 and older with Medicare, particularly those with low incomes. Regardless of the type of Medicare coverage, many reported difficulty affording dental care, didn't fill prescriptions, and skipped follow-up visits because of costs. More than one in 10 reported having medical bills and debt problems and said they suffered financial consequences from that debt.

While Medicare Advantage plans limit enrollees' out-of-pocket expenses, often have lower premiums for Part D drug coverage, have the option of lower cost-sharing requirements, and typically include some coverage for dental care, there doesn't appear to be much difference between these plans and traditional Medicare concerning affordability. Adults 65 and older in Medicare Advantage plans were as likely as those in traditional Medicare to report problems affording premiums and healthcare expenses, including dental care and prescription drugs and issues with medical debt and bills.

PATIENT ENGAGEMENT

Patient Engagement Coaching: A Strategy for Patients Living with Chronic Conditions

By Lisa Remington, President, The Remington Report and Remington's Home Care Leadership Think Tank

Coaching interventions have been widely touted as a potential way to prevent chronic illness and to help patients better self-manage their chronic illnesses. Health and Wellness Coaching (HWC) is now a respected discipline that offers certification and HWC for patients with chronic conditions has demonstrated the potential to positively change behaviors and health outcomes.

Article Highlights

- Coaching interventions can help prevent chronic illness.
- Times for patient coaching.
- Types of patient coaching.

Coaching describes a *relationship* between two people, one doing the coaching and the other receiving the coaching, and a *process* to uncover goals and work toward achieving those goals. Coaching draws from a range of strategies to tailor its response to the dynamic situation of patients and their families.

Capacity Coaching draws on the practices of the completely patient-driven spectrum of HWC and Minimally Disruptive Medicine to focus specifically on developing the capacity within patients to adapt, endure, and function optimally in their lives along with illness and treatment.

It is designed to help patients facing complexity from life, health, health care, and their interplay. Capacity Coaching is ideally integrated into the primary care team but can occur separately. When integrated into the care team, the coach-patient interaction drives how other parts of care are arranged for the patient.

Capacity Coaching tasks are illustrated in column 2 of Table 1, next to their related HWC tasks in column 1. Capacity Coaches, who may be healthcare professionals or trained peers, collaborate with patients using means such as the ICAN (Instrument for Patient Capacity Assessment) Discussion Aid (Figure 2) as a conversation starting point to facilitate asking how and to what extent illness and treatment are affecting the patient's life – for better or for worse.

The ICAN Discussion Aid helps structure the initial session and future interactions. In each instance, the discussion aid can generate conversation about how healthcare and life are working together, including what is helping the patient and what is burdensome, and how these factors manifest in various aspects of the patient's life. This approach provides an understanding of broader life demands and successes in which the patient understands and manages illness and treatment. Beginning from the practical consequences and demands of illness and treatment on diverse areas of a person's life, Capacity Coaching is oriented toward developing strategies for decreasing the burdens of illness and treatment, bolstering existing sources of capacity, and cultivating new abilities to bear and adapt to life with illness and treatment.

The prevalence of chronic conditions is growing; to date, one in four Americans lives with at least one chronic condition. Furthermore, more people – 75% of those older than 65 years – are living with multiple chronic conditions, also known as multimorbidity. Coaching interventions have been widely touted as a potential way to prevent chronic illness and to help patients better self-manage their chronic illnesses.

Table 1: Health and Wellness Coaching (HWC) Tasks and Their Modifications for Capacity Coaching

HWC Task	Modification for Capacity Coaching
Assist the client in creating a description of their ideal vision of the future	Use ICAN Discussion Aid to assess life (biography) and treatment plan fit. Assist patient in describing areas of challenge and success with fit
Establish or identify the present situation, history, previous successes and challenges, and resources associated with the client's vision	Use ICAN Discussion Aid to identify the present situation, history, previous successes and challenges, and resources associated with good or poor fit between life and care
Explore and evaluate the client's readiness to progress toward the vision	Explore and evaluate areas in which patient's capacity can be increased and readiness to progress in that direction. *Explore and evaluate areas in which patient's care team can reduce treatment burden. Communicate those to appropriate team members*
Invite the client to identify and explore patterns, perspectives, and beliefs that may be limiting lasting change	Invite the patient to identify and explore patterns, perspectives, and beliefs found within their own biography, environment, and social networks that may be limiting lasting change
Work with the client to establish goals that will lead to the vision	Work with the patient to establish "experiments" that will lead toward better treatment/life fit
Work with the client to develop a series of steps that will lead to the achievement of client-selected goals	Work with the patient to break down experiments into smaller steps if needed
Elicit the client's commitment to and accountability for specific steps	Support and develop patient capacity to undertake experiments. Work with healthcare team toward commitment to reducing areas of patient treatment burden
Collaborate as the client evaluates success in taking steps and achieving goals	Collaborate with patient and healthcare team to evaluate success in taking steps toward achieving life/treatment fit and increasing patient's capacity for self-care
Work with the client to maintain progress and changes	Work with the patient and the healthcare team to maintain progress and changes
Collaborate as the client reassesses goals and makes modifications based on personal decisions and progress made	Collaborate as the patient reassesses fit and makes modifications based on personal decisions and progress made. *Collaborate with the healthcare team to incorporate these changes as well*
Assist the client in articulating learning and insights gained in the change process	Assist the patient in articulating learning and insights gained in the Capacity Coaching process (patient and team changes)
Work with the client to develop a post-coaching plan to sustain change that promotes health and wellness	Work with the patient and their care team to develop a post-coaching plan to sustain changes that achieve treatment-life fit

Figure 2
ICAN (Instrument for Patient Capacity Assessment) Discussion Aid

What are you doing to manage your stress?

Where do you find the most joy in your life?

What else is on your mind today?

MAYO CLINIC

My Life My Healthcare
How does your healthcare fit with your life?

Are these areas of your life a source of **satisfaction**, **burden**, or **both**?

Leave blank if not part of your life	Satisfaction	Burden
My family and friends	☐	☐
My work or finances	☐	☐
Free time, relaxation, fun	☐	☐
Spirituality or life purpose	☐	☐
Where I live	☐	☐
Getting out and transportation	☐	☐

What are the things that your doctors or clinic have asked you to do to care for your health?

Do you feel that they are a **help**, a **burden**, or **both**?

Leave blank if not part of your life	Help	Burden
Take medications	☐	☐
Monitor symptoms	☐	☐
Manage my diet and exercise	☐	☐
Get enough sleep	☐	☐
Come in for appointments or labs	☐	☐
Reduce alcohol use, smoking, etc.	☐	☐

Times for Patient Coaching

Patient-coach visits may occur as a single consultation or over time, e.g., three or six months. During this period, the Capacity Coach continues to explore with the patient to co-create an action plan that adapts prescribed healthcare to the patient's situation while supporting and growing the patient's capacity for self-care and quality of life. Like HWC, at the end of the coaching visit, the patient and coach set up one or more experiments for the coming week ahead. The coach and patient can follow up to see how those experiments went on the next visit or asynchronously, e.g., through e-mail.

Although established relationships and continued follow-up are ideal in Capacity Coaching, a single consultation may be the most practical option for overwhelmed patients. This factor differs from HWC, in which established relationships are considered a pillar of the practice. Following the visit, if integrated into the healthcare team, the Capacity Coach also documents the visit summary and subsequent actions needed in the electronic medical record and shares this summary with colleagues treating the patient.

For example, if the coach identifies that the patient's four times per day insulin regimen is such a burden to the patient that she rarely can adhere more than two times per day, the coach will communicate this burden to the team member managing the patient's diabetes care (either her endocrinologist or her primary care clinician) for modification.

Capacity Coaching begins with the practical issues of living with illness, which distinguishes it from HWC, and may begin from more long-term visions of health or clinically recommended treatment regimens.

The emphasis on the day-to-day problems – particularly the burden of illness and treatment and the work that they entail – makes Capacity Coaching an approach that is particularly helpful for the growing population of patients with multiple chronic conditions. Table 2describes patient stories about how traditional HWC activities are modified in Capacity Coaching practice.

Table 2: Coaching Situations and Actions for "Joan"

	Health and Wellness Coaching	Capacity Coaching
Situation	Joan has diabetes and high blood pressure. She has recently retired and enjoys spending time with her family and friends. She has an active social life and feels that she doesn't always keep up with the actions she knows she needs to take to maintain her current health and social life. She feels she has the time to manage her health now in her retirement but needs to figure out ways that align with her strengths and preferences. She also would like to manage her conditions as much as possible with little or no medication	In a different scenario, Joan spends her Monday, Thursday, and Saturday mornings at dialysis. She feels a great loss because she used to spend Saturdays visiting with her girlfriends or playing with her grandchildren, but now she is too tired after dialysis. She takes multiple medications that must be taken 3 times a day on an empty stomach. Her husband of 45 years passed away last year, and she now feels lonely. She has since gotten a dog to keep her company. She enjoys walking the dog when she feels well but has been in too much pain to do so lately. She relies on her adult daughter, Judy, a great deal to take care of her dog and to get her to and from dialysis. Judy also has chronic conditions that now need her attention, and her ability to help her mom is becoming limited. Joan has become overwhelmed and begins missing some of her appointments
Coaching actions	Joan works with a *Health and Wellness Coach*; affirms the biometrics she and her healthcare team are working to change. The Health and Wellness Coach asks questions to learn more about Joan's strengths and values and then helps her create a vision of optimal health followed by a realistic plan to track changes on a daily and weekly basis while managing inevitable challenges along the way	Joan's *Capacity Coach* helps her work with her healthcare team to evaluate treatment/life fit, including treatment burdens she may be able to decrease or eliminate, set experiments in which she can increase the activities that bring her joy and manage her pain, and connect her with community resources that can overcome her social isolation

Health and Wellness Coaching brings considerable strengths to the table in healthcare as a method for changing behaviors to prevent and treat chronic illness and in patients' physiologic, behavioral, psychological, and social outcomes for patients. However, the growing population of patients with multimorbidity may need a slightly different approach to coaching – one that focuses on strengthening their capacity to adapt and thrive with chronic illness and that assists in orienting their healthcare teams' actions.

Capacity Coaching brings to the same table a practice of coaching that incorporates the successful key elements of the HWC process but orients them in new ways with the conceptual and theoretical structures specifically developed to meet the challenges of living with and treating multimorbidity. The type of coaching used should align with the patient's situation at the time, as determined in conversation with the patient. Clinical policymakers and managers must consider the needs of their population before deciding to offer a specific type of coaching – HWC, Capacity Coaching, or both. Resources for practitioners can be found in Table 3.

Table 3: Coaching Resources

	Health and Wellness Coaching	Capacity Coaching
Certifying bodies, courses, and resources	http://ndceducation.mayo.edu/hubcap/wellness-coach-training/ http://wellcoachesschool.com/ http://ichwc.org/ http://www.ahncc.org/certification/holistic-nurse-coach/ *The Art and Science of Nurse Coaching* *Nurse Coaching: Integrative Approaches for Health and Wellbeing*	https://minimallydisruptivemedicine.org/ican/ Mayo Clinic Annual Minimally Disruptive Medicine Workshop (https://minimallydisruptivemedicine.org/mdm-workshop/)

Capacity Coaching is oriented toward developing strategies for decreasing the burdens of illness and treatment, bolstering existing sources of capacity, and cultivating new capacities to bear and adapt to life with illness and treatment.

HEALTH EQUITY

Certificate-of-Need Ties Back to Health Equity Assessments

Compiled by The Remington Report's Editorial Team

New York State's new requirement for certain certificate-of-need (CON) applications includes a health equity impact assessment (HEIA).

New York is now the first state to implement a required equity assessment in its health facility planning and approval process that went into effect June 22.

All New York State Article 28 facilities, such as hospitals, skilled nursing facilities, diagnostic and treatment clinics, midwifery birth centers, and ambulatory surgery centers, must determine if an HEIA is required.

Article Highlights

- Health equity impact assessment requirement for certificates of need.
- Another step to require health equity plans in healthcare.
- Meant to build on the current community needs assessment requirements in certificates of need.

According to the SACHS Policy Group, many projects will fall into scope in the coming months, from consolidating service lines to moving capacity from inpatient to outpatient settings. If they haven't already, providers working on such projects and their partners must begin to consider how they will be affected.

Below are five essential takeaways so far about the HEIA process:

1. The scope of an HEIA is both broad and specific.

The HEIA template requires consideration of the impact of a project on at least 12 specific medically underserved groups based on income, race, gender, sexual orientation, age, disability status, and many other factors. This process is meant to build on the current community needs assessment requirements in CONs, making it more granular and tied to community engagement. As a result, providers and their assessors will need to think through the possible impacts of their projects on diverse groups and develop strategies on how to mitigate them.

2. Applicants will have significantflexibility in choosing their independent assessor – for now.

In recognition of the diverse types of projects and populations that this will apply to, CON applicants are free to choose their own expert to conduct the HEIA. The only requirement is that the assessor must a) have experience in "health equity, anti-racism, and community and stakeholder engagement," and b) be independent from the rest of the CON writing process.

The Department of Health has explicitly stated that it does not intend to create a certification or licensure process for HEIA conductors or provide more specific experience requirements to "allow providers to be broad in their thinking" – although it will re-evaluate this position after the first six to 12 months of the process.

3. The independence of the HEIA assessor doesn't mean that providers can't work on equity issues in parallel.

The assessor must not "help compile or write" any other part of the specific CON for which they are conducting the HEIA. However, NYS's intention doesn't seem to be to prohibit providers from addressing equity issues during the CON's development or to wall off the assessor entirely from the CON. Addressing health equity issues that arise in parallel with the development of the CON will be significantly more efficient than waiting to do so until after an HEIA is conducted. As such, entities should consider how their HEIA assessor can provide feedback and information to help guide the development of the CON without violating the conflict-of-interest policy.

4. The HEIA process can potentially help smooth difficulties with community engagement.

Many CON projects can arouse significant community opposition, particularly when they potentially reduce access to health services or appear to do so. The HEIA process offers a positive opportunity to

reassure community members and other stakeholders that they now have a formal structure to raise these concerns to an independent entity. Providers should consider how to take advantage of this to help proactively address the vital interests of the community.

5. The HEIA increases the incentive to ensure projects maximize flexibility.

Conducting and responding to the HEIA will be a significant new part of the process for providers undertaking major service line changes, whether they are expansions into new areas or removal of excess capacity. When designing a strategy for such projects, providers should keep in mind that creating capacity that has multiple uses or flexibility for conversion will be even more important than before. Maintaining flexibility will both enable the facility to address concerns the HEIA may raise about serving a wider range of potential medically underserved populations and allow it to have greater capacity to respond to shifting community needs without having to go through another CON process and a new HEIA.

Don’t miss this additional Remington Report resource: 5 Ways Health Equity is Advancing in Medicare Models

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