Addressing Heart Failure Readmission through a Health Coaching Model in Nurse Managed Care

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Objectives:

- Describe the steps in interdisciplinary collaboration in health coaching for heart failure (HF) patients in nurse managed care.
- Discuss lessons learned and barriers overcome to address HF patient needs and access.
- Identify next steps in using a health coaching model.
About Our Neighborhood Healthcare Clinic (ONHC)

- HRSA Funded 2009
- First Nurse-Managed Arrangement at USA CON
- Urgent Care opened January 31, 2010 with expanding hours—targeted non-emergent ER patients
- Urgent Care located in the University Medical Center
About Our Neighborhood Healthcare Clinic (Cont.)

- Provides a number of services:
  - After hours urgent care
  - Wellness Centers (Senior Centers, Homeless Shelter)
  - Interdisciplinary Collaboration through Service Learning
  - Students Clinical Experiences
  - Opportunities for Research and Practice Projects
ONHC: Population Served

- Primary African American
- Low wealth
- Low health literacy
- Health disparities
- Chronic care management
  - Hypertension
  - Diabetes
  - Heart Failure
OHNC at USA Medical Center
OHNC at Trinity Gardens
OHNC at 15 Place
Loaves & Fish/15 Place

Services Offered
- Identification
- Showers/Laundry
- Mail/local phone service
- Lunch

Service Providers
- Healthcare for the Homeless
- Veterans Administration
- AltaPointe/mental health
- Alabama Employment Services
- ONHC/nurse managed clinic
15 Place Demographics

- June 30, 2011 to July 1, 2012
  - Race
    - American Indian: 1
    - Black: 316
    - Hispanic: 13
    - White: 275
    - Other – multi-racial: 6
  - Mentally Ill: 103
  - Veterans: 97
  - Substance Abuse: 67
  - Developmental disability: 5
  - Physical disability: 175
  - Chronic Homeless: 100
  - Total homeless: 1180
Interdisciplinary Education

Now rotating through clinic are
- Social worker students
- Physician assistant students
- Nursing students
- Emergency Medicine Technician students

- Interprofessional Education Collaboration (IPEC)
  - CON/COM/COAH/Dept. of Anthropology, Sociology, & Social Work /Biomedical Library
- Received grant to investigate interprofessional education at South Alabama
Developing therapeutic relationships

- Patient centered
  - Allow guests to tell their story
    - Needs assessment – providing care - research - quality improvement
  - Listen without judgment
    - DARN Words
    - Readiness to Change
  - Provide dissonance by sharing our concerns
  - Offers a framework to identify behaviors they may want to change
  - Empowerment to take action
  - Coach and Support behavioral changes
  - Celebrate action steps towards health and wellness
More on therapeutic relationships . . .

Koloroutis and Trout (2012) framework:

- **Wondering**: Cultivating curiosity for efficient and compassionate care
- **Following**: The Magic of palpation
- **Holding**: Creating a safe haven for the patient and family
Our desire to make a difference!

- Relationship with University Medical Center
- Relationship to Cardiologists
- Access to patients
  - Trust
  - Relationship-building
  - Meeting patients “where they are”
- “All the stars were aligned!”
Opportunity to do some pilot work

- Dean’s Grant
- College of Nursing desire to collaborate with Clinical Partners
- Working with Honor Students to learn the research process (participatory action process)
- Starting where you are, with what’s available and moving forward
- “Stars were aligned”
In the beginning . . .

- Ambitious plan for longer-term follow-up
  - 1 to ½ hours initial assessment
  - Patient fatigue
  - Patient and researcher challenges with amount of information shared, and coaching
  - Poor follow-up telephone contact if initial contact limited
In the beginning . . .

- Patients referred by cardiologists
  - Hospital admission
  - May be last day of admission ("walking out the door")
  - Consent signed, materials reviewed, coaching began (Coleman)
  - Tool Kit given (Scale, cup, medication cassette)
  - Telephone contact information exchanged for future follow-up
Protocol:

- IRB approval: Addendum
  - Shorten time from initial referral to completion of project (30 days vs. 4 ½ months)
  - Meet patients “where they are” (home visits)
  - Incentives for completing program
Protocol (Cont.)

- Referral made by cardiologist
- Contact with patient (face to face)
- Consent signed
- Various assessment
  - Health Literacy
  - Readiness for Change (Readiness Ruler)
  - Physiologic measures
  - Action Plan (Coaching Plan)
    - Self-management (Medications, Fluids, Weights, Nutrition)
Follow-Up telephone call: Review Action Plan (Coaching)
- 24 hours after first visit
- 24 hours after second visit
- Weekly until completion of 30 days
Health Coaching: Care Transition

Coleman Model:

Transition coach teaches patients with complex conditions how to self-manage medication and recognize red flags if condition gets worse.

Makes a single home visit and three follow-up phone calls

Coordinates with primary care and specialist providers, community organizations, home care agencies, skilled nursing facilities and clinics

Makes sure patients are active participants in their own care.
The Four Pillars® of Coleman Model

- Medication self-management: Patient is knowledgeable about medications and has a medication management system.
- Use of a dynamic patient-centered record: Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient or informal caregiver manages the PHR.
- Primary Care and Specialist Follow-Up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
- Knowledge of Red Flags: Patient is knowledgeable about indications that their condition is worsening and how to respond.
Metrics

- Reduced readmission to hospital
- Continued self management
  - Daily weights
  - Management of medications
  - Follow-up appointments kept
  - Continued contact with health coaches
Preliminary evaluation

☐ 6 patients enrolled
☐ No readmissions
☐ Self management continues:
  ▪ Medications taken as directed (self report)
  ▪ All patients doing daily weights
    ☐ When weight gained noted (from day to day) able to track culprit and adjust accordingly
Selected Resources


Koloroutis, M. & Trout, M. (2012). *See me as a person.* Minneapolis, Minnesota: Creative Care Management, Inc.


Parry C, Coleman EA, Smith JD, Frank JC, Kramer AM. *The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care.* Home Health Services


