

THE CASE FOR HEALTH COACHING IN THE CLINICAL SETTING

ROI AND OUTCOME EXAMPLES

Health coaching in the clinical setting is a rapidly emerging strategy powering the practice of patient centered population health. It is a practical approach recognizing the patient and family as a potent underutilized resource with whom providers can effectively partner on the path toward better health, better healthcare and lower cost.

As a practice and strategy, health coaching has a particularly distinctive feature; it is paying its own way in healthcare organizations as they transition from volume to value based reimbursement. The following examples, most all conducted with health coaches or staff trained by the Iowa Chronic Care Consortium and the Clinical Health Coach, illustrate this promise.

HOSPITAL CLINIC SYSTEM FOCUS ON DIABETES

Designated healthcare professionals in primary care clinics of a healthcare system were trained and designated as health coaches to work with patients with diabetes. Coaches focused upon regular visits, preventative screenings, selfcare skill building and improved health behaviors. 51% increase in diabetes visits in first year, impressive control of HgA1c and elevated HEDIS scores. Reduced cost of care, CMS PQRI bonus and P4P from commercial health plan aided achievement of ROI of 4:1. *(AMGA Journal - Iowa)*

URBAN CLINIC ANNUAL WELLNESS VISITS

A recently trained Clinical Health Coach found that her physician's practice had more than 700 Medicare patients, only 17 of whom had had a Welcome to Medicare Visit (TPPI) or Annual Wellness Visit (AWV). Practice began scheduling 10-15 Medicare patients per week for TPPI and AWV. The added revenue from the TPPIs, AWVs, labs, related tests, and services averaged \$272 per patient. Revenue generated was more than \$160,000 during the first year. A new staff member was hired; the existing health coach was supported. Previously unknown chronic conditions were diagnosed and followed. Better health, better health care and lower cost was achieved. *(ICCC Case Study - Indiana)*

MEDICAID POPULATION DIABETES

Exacerbations of uncontrolled blood sugars and A1c measures for members with diabetes were often leading to hospitalizations and ER visits in Medicaid population, costing 3X cost of others in health plan. 600+ members with diabetes were engaged with an IVR system and care coordinator for coaching, selfcare skill building, information sharing, referral - driving to medical home, prevention, screening and clinical interventions. Multiyear strategy resulted in 54% reduction in inpatient stays and 20% reduction in total healthcare costs against matched control group. *(DPMC Gold Standard Letter of Validation - Iowa)*

HYPERTENSION CONTROL

A dispersed rural healthcare clinic organization in northern Minnesota participated in a demonstration program to improve hypertension control in 3,781 of their hypertensive patients. This program was a part of the ASTHO Million Hearts Project to Improve Hypertension sponsored by the Minnesota Department of Health. The clinic additionally provided health coaching to 352 of these patients with hypertension. Conducted over a two-year period, 3,429 patients without coaching achieved an 8.9% improvement in blood pressure control; those with 1-2 coaching visits a 11.8% improvement; and, those with 3 or more coaching visits a 23.9% improvement in control. *(Minnesota Department of Health, Heart and Stroke Prevention Unit - Minnesota)*

HOSPITAL READMISSIONS

Heart and vascular institute served by more than 160 cardiologists was experiencing a readmission rate of 30% for it's heart failure patients. Following implementation of a program featuring the adaptive utilization of cardiac rehabilitation professionals, IVR technology and coaching to improved selfcare and health behaviors, the 30-day readmission rate was moved to 8% and average bed days for those readmitted moved from 6.3 to 5.2. *(AACVPR - Virginia)*

RURAL CLINIC CHRONIC CARE MANAGEMENT CODE

Physician in rural practice already actively using MWVs identified that she served 635 Medicare members. From EMR/Registry determined that 307 qualified as having 2+ chronic conditions making them eligible for CMS CCM code. Succeeded enrolling 183 in CCM program; retained 88% of those enrolled through first 12 months. Added CCM revenue alone for first 14 months (\$43 PMPM) was \$91,342. CCM process management and coaching to self-management and improved health behaviors was essentially managed by health coach. Physician reports that the 183 patients enrolled had 34% fewer inpatient visits than predicted from risk profile analytics. *(ICCC Case Study - Michigan)*