Session 1

Transitions of Care

Partnership For Health Panel Discussion

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Helping Rural Elders Transition from Home Health to Chronic Disease Self Management Through Paraprofessional Outreach *

Health Coaches For Hypertension Control **

Developing Wellness through Focused Health Coaching ***

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The Chronic Care Model

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Community Health Coaches
- Informed, Activated Patient
- Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes
- Patient Safety
- Quality of Life
- Improved Health Status
- Reduced Readmissions

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Collaborative Care: Cycle of Self-Management Support

Before the Visit

1. CARE PLAN
   - Gather Clinical Data: labs, screenings, specialist reports
   - Gather Patient Experiences: symptom monitoring, medication taking, stressors

Follow Up
- revise action plan
- problem solve

Specialist Referrals
- coordinate care referrals

Community Linkages
- patient education programs
- fitness and nutrition
- faith-based health promotion programs

During the Visit

2. Front Office
   - build relationships
   - explore needs and preferences

Provider Exam
- set agenda
- review clinical and patient experience information
- collaborate to set SM goals in care plan

Nurse/MA Coaching & Support
- create action plan
- assess barriers
- support change
- patient education & skill building

After the Visit

3. Peer Programs
   - voluntary health organizations
   - web-based chat rooms
   - lay-led groups

Improved Outcomes
- Increased Healthy Behaviors
- Improved Clinical Outcomes
- Increased Collaboration between Patient and Provider
- Improved Physician Satisfaction and Retention

*The purpose of self-management support is to aid and inspire.*
HEALTH COACH TRAINING

- Communication and adult learning theory
- Behavior change strategies
- Developing Individualized Action Plans
- Personal Health Diaries for self-monitoring
- Specific content appropriate for project:
  - Lifestyle behaviors – nutrition, physical activity, stress management
  - Medication management strategies
  - Stoplights to guide symptom recognition and responses
EVALUATION METHODOLOGY

- Rural Elders Transition from Home Health Services – readmissions for same diagnostic category, cost of readmission
- Health Coaches for Hypertension Control – HRA including beliefs, behaviors, clinical measures
- VA training with coaching skills - Knowledge, attitude and demonstration of skill sets.
RECOGNITION

“Helping Rural Elders Transition from Home Health to Chronic Disease Self-Management through Paraprofessional Outreach”, was designated in 2008 by the Office of Performance Review as a “Leading Practice” in the areas of clinical practice, outreach, cultural competence, administration, and other practices that are implemented within HRSA funded programs.
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Community Health Coaches

VA Staff Training in Health Coaching Skills

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**VA Staff Training**

**Module 1** – Introduction, Basics of Health Behavior Change, Developing Individualized Action Plans

**Module 2** – Principles of Patient and Family Centered Care, Patient-Coach Communication, Managing Conflict and Resistance to Change

**Module 3** – Renovo Intelligence© Health Intervention Coach Training

**Module 4** – Motivational Interviewing Application and Skill Building, Coaching with Stress Management Tools, Clinical Applications of Coaching Models

**Module 5** - Behavior Change Review, Health Service Utilization, Adherence, Relapse Prevention, Social Support, Community Resources