Training curriculum for health coaches

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This curriculum (a work in progress) can be accessed at the
UCSF Center for Excellence in Primary Care website
www.ucsf.edu/cepc

Introduction

Why is this training important?

Primary care clinicians can no longer do what they are supposed to do. There is not time in the 15 (or even the 20) minute visit to handle all the problems that patients bring – acute, chronic, preventive, and more. Good clinicians are forced by the 15-minute visit to work too fast and are often unable to handle all the agenda items (those items on the clinician's mind and those on the patient's mind) needing attention.

In addition, medical schools and many NP/PA training programs focus on evidence-based guidelines, leading many clinicians (especially in the rushed 15-minute visit) to tell patients what to do rather than asking patients about their preferences and finding out which evidence-based advice patients are willing and able to follow given their life situations.

As a result of these 2 realities, 50% of patients leave the medical visit without understanding the advice given, and in only 10% of visits is the patient involved in the decisions made. The majority of patients do not follow the majority of advice given by clinicians because they do not understand and/or do not agree. Thus, a large number of clinician visits are not helpful to the patient; i.e., they are wasted visits. For a review summarizing and referencing these problems in primary care, see pages 2050-2053 of the attached JAMA article.

This training is an attempt to assist primary care practices/clinics in implementing a dual innovation – health coaching and panel management – that has the potential to solve or alleviate these serious problems.

The dual innovation of health coaching and panel management

Health coaching is a primary care innovation designed to solve or alleviate the problems of patients not understanding and/or not agreeing with clinicians' advice. The goals of health coaching are 1) to enhance the patient experience in primary care, 2) to improve clinical outcomes and quality of life, and 3) to offload some work from the clinician such that the clinician can pay greater attention to complex clinical problems and spend less time on routine preventive and chronic care functions that can be handled by non-clinician personnel using clinical algorithms and standing orders.

Coaching functions can be performed by physicians, nurse practitioners/physician assistants, RNs, pharmacists, health educators, nutritionists, medical assistants, or community health workers/promotoras. It is helpful for as many people as possible in a primary care practice/clinic to receive this training. If only personnel designated as coaches receive the training and other members of the team do not, there can be serious "paradigm clashes" in which physicians and others tell patients what to do while coaches work collaboratively with patients on making decisions.

Coaching may or may not be organized as the Teamlet Model, which substitutes for the 15-minute clinician visit a longer encounter with a clinician plus health coach; the longer encounter can consist of a pre-visit with the coach, the visit with physician plus coach, a post-visit with the coach, and between-visit telephonic interactions with the coach. It is not necessary to implement the Teamlet Model in order to do coaching. The Teamlet Model is a primary care re-design model, whereas coaching is a function that can be performed in many different ways depending on the realities of personnel and workflow in a primary care practice/clinic.

Coaching is closely tied to a related primary care innovation – panel management. While coaching is a function involving individual patients or small groups of patients, panel management is concerned with the entire population of patients cared for by a primary care practice/clinic. Panel management involves using a registry to ensure that as many patients as possible enrolled in a practice/clinic complete their evidence-based preventive and chronic care tasks in a timely fashion (e.g. pap smears, mammograms, HbA1c levels, etc) and that as many patients as possible receive lifestyle counseling and are prescribed, and are taking, evidence-based medications. Many primary care practices/clinics now have registries available, but those registries are often not utilized to their full extent. Having a designated panel manager to carry out these functions can offload a great deal of routine work from the clinician, giving the clinician more time to handle diagnostic and more complex management issues.

In order for primary care practices/clinics to implement and sustain the dual innovation of coaching and panel management, they need to designate certain personnel as coaches and panel managers; more importantly, they need to guarantee coaches and panel managers protected time to perform the coaching and panel management functions. Most primary care practices/clinics will need more coaches than panel managers. All panel managers need coaching training since they perform a great deal of outreach to patients; however, coaches who will not function as panel managers do not need panel manager training.

<u>This training document</u>

This document provides materials for training health coaches and panel managers in primary care, focusing on the management of patients with cardiovascular risk: diabetes, hypertension, and hyperlipidemia. The central message of this training is the paradigm shift from the "directive paradigm" (telling patients what to do) to the collaborative paradigm (asking patients what they are willing to do and working collaboratively with patients).

The intent of this document is to allow as many people as possible to become trainers of health coaches and panel managers. There are two types of training included: 1) How do coaches and panel managers work with patients and with populations? and 2) What do coaches and panel

managers need to know about diseases and medications (this document focuses on cardiovascular risk) in order to do their job? Part 1 is useful not only for coach and panel manager trainees but also for clinicians who work with coaches and panel managers, so that the clinicians understand the collaborative paradigm. Part 2 is not needed for clinicians who already know the diseases and medications, but is very important especially for medical assistants and community health workers who need to become at least somewhat familiar with the diseases and medications of the patients they will be working with.

This training document includes the following:

- Explaining the collaborative paradigm ("ask") vs. the directive paradigm ("tell")
- Setting agendas with patients (which the coach might do in the pre-visit)
- Making sure patients understand what took place in the physician visit -- "closing the loop" (which the coach might do in the post-visit)
- Behavior-change action plans (which the coach might do in the post-visit)
- Telephone follow-up with problem-solving (which the coach might do between visits)
- Medication reconciliation (which the coach might do in the pre-visit)
- Medication concordance and adherence (which the coach might address in the pre-visit, post-visit and/or between-visit)
- Basics of cardiovascular risk reduction and cardiovascular medications
- Panel management

Structured training can be done in 6-8 1-hour sessions or in fewer sessions that are longer. Probably 6 hours of structured training is the minimum for medical assistants and community health workers to become coaches and/or panel managers. However, structured training is only the beginning of developing a highly-functioning health coach. After the training is completed, new coaches should be mentored by listening to them work with patients in the pre-visit, post-visit and/or between-visit and providing them with feedback. It is very useful to have a few structured training booster sessions after the coach has been working with patients.

Here is one sample training schedule based on 1 hour lunch-time sessions; this can be modified or reduced based on the needs of the trainees and the institution hosting the training.

Session 1: The collaborative paradigm (ask)

Session 2: Review the collaborative paradigm and introduce closing the loop

Session 3: Review closing the loop and introduce action plans

Session 4: Continue action plans and do follow-up problem solving

Session 5: Review follow-up and introduce cardiovascular disease

Session 6: More cardiovascular disease including key medications

Session 7: Medication reconciliation, concordance, adherence

Session 8: Practice doing a teamlet encounter (pre, post, between visit)

This document is designed for trainers rather than trainees. To use portions of this document for trainees, copy the appropriate dialogues without the lessons learned or the comments meant for trainers, and provide trainees with these more limited portions of this document.

OK. Here we go with the content of the training.

The collaborative paradigm (ask)

Begin the training by modeling the collaborative paradigm. Rather than starting out by telling the trainees something, start out by asking them something. For example, ask some questions about their clinical site – how many patients, what languages, are diabetes/hypertension/cholesterol common problems, is there enough time in the visit to care for all the patient's concerns, etc. Ask medical assistants, community health workers or RNs what their responsibilities are, what their day is like.

Then say something like: I was supposed to come here to lead training sessions, but for the last 15 minutes all I've done is ask you questions. Why did I do that? Probably the answer will be something like – you wanted to find out how things work at this place. Then you can say something like, Yes, and that's how all of us should be starting out relating to patients – ask them questions so you can find out what they are like.

Then have 2 people read the 2 dialogues that demonstrate the difference between the directive paradigm (tell) and the collaborative paradigm (ask). You could use dialogues 1 and 2 and/or 3 and 4. Dialogues 5 and 6 are excellent to teach ask vs. tell plus learn how to discuss HbA1c or LDL-cholesterol with patients. Dialogues 5 and 6 also are good ways for coaches to engage patients in action plan discussions. When to introduce dialogues 5 and 6 into the training depends on the trainees; they should know something about diabetes and cholesterol before using it. But at some point in the training, these are some of the most useful dialogues.

Dialogue 1

Doctor: I have bad news for you. You have diabetes.

Patient: Oh my god. Am I going to die?

Doc: I'll take good care of you. You will need to learn about diabetes, and you will need to change your diet and do exercise and take pills.

Patient: OK.

Doc: here's a diet, walk for 30 minutes every day, and in 2 weeks we'll start you on some pills Good bye.

Dialogue 2

Coach: The doc said that she just told you that you have diabetes. What do you think about that?

Patient: I'm scared. I have an uncle with diabetes and he is on kidney dialysis.

Coach: there are many things to do to prevent you from having kidney problems from your diabetes. Do you have any ideas what you can do to keep your diabetes under control?

Patient: I know my uncle had to stop eating sweets and he was taking pills, and then he had to take insulin shots. [Because the coach asked questions, the coach knows that the patient has some knowledge of diabetes, and won't start telling the patient things the patient already knows. People hate to be told things they already know]

Coach: what would you like to know about your diabetes?

Patient: I want to know how to start getting better.

Coach: Usually we start with diet and exercise, and then see if you need pills. [NOTE: the coach should never tell the patient information unless the coach knows the information is accurate]

Patient: OK. How should we start with diet? What should I do?

Coach: Is there anything you eat that you think is making your sugar go high? [Always ask to see what the patient knows before telling the patient things he/she may already know]

Patient: I know it's those sweets and that soda I like to drink.

Coach: that's right. It's sweets and also carbohydrates, like rice, bread, pasta, potatoes, or tortillas. Do you think you could stop eating any of those things, or cut down on them?

Patient: yes I could

Coach: great. Why don't we make an action plan?

Dialogue 3: didactic information-giving

Caregiver: I just checked your blood sugar. I'm afraid you have diabetes.

Patient: Diabetes? Oh my god.

Caregiver: Diabetes is a condition in which your insulin isn't adequate to help get your sugar into your cells, so the sugar stays in the blood and after several years causes problems with your circulation. We'll talk about how diabetes works, what the complications are, and what to do about it. Then we'll have you go to the diabetes class.

Patient: am I going to go blind? Will my kidneys stop working? How long do I have to live?

Caregiver: Diabetes patients need 12 areas of knowledge. We'll take them one at a time.

Dialogue 4: giving information: ask-tell-ask method

Rather than giving patients information, ask what they already know and what they want to know, then tell the information, then ask again what else they want to know:

Caregiver: I just checked your blood sugar. I'm afraid you have diabetes.

Patient: Diabetes? Oh my god.

Caregiver: Do you know what diabetes is? [ASK]

Patient: I know someone who had it, her blood sugar went up, she went into a coma and died.

Caregiver: A coma is actually very rare in your kind of diabetes.

Patient: Another person I know had his toe cut off. He also had major trouble with his eyes.

Caregiver: Those things can happen in diabetes, but they also can be prevented. Tell me this; what would you like to know about diabetes [ASK]?

Patient: I need to know how to keep my feet attached to my body.

Caregiver: Why don't we spend some time talking about how to prevent the serious complications of diabetes. Is that OK?

Patient: Let's get started. [A 10 minute informational session: TELL]

Caregiver: Next visit I'm going to ask you what you remember from our discussion. Is there anything else you would like to do next visit [ASK]?

Dialogues 5 and 6: training on LDL and A1c graphs

Pass out to each coach the two graphs of A1c and LDL (Sra. Romero and Sr. Rojas) at the end of this training document. These graphs are very helpful to educate patients about their A1c and LDL goals, help to motivate patients, and are an excellent way to begin an action plan discussion. The contrasting dialogues clearly demonstrate tell vs. ask.

Have 2 people read Dialogue 5

Dialogue 5

Coach: Sra Romero, I would like to show you this chart of your HbA1c. Is that OK?

Sra Romero: OK

Coach: Your A1c is almost 10. It's supposed to be 7. You need to bring your A1c down from 10 to 7.

Sra Romero: OK

Coach: That means you need to improve your diet, get more exercise, and take the extra pills that your doctor will prescribe.

Sra Romero: OK

Coach: So, please put this graph up on your refrigerator to keep you motivated

Sra Romero: I don't have a refrigerator

Discussion

The coach never found out whether Sra Romero understood the chart, understands HbA1c, knows her goals, or whether she is motivated to bring the A1c down. It is tell/tell/tell rather than ask/ask/ask.

Dialogue 6

Coach: I would like to show you this chart of your HbA1c. Is that OK?

Patient: OK

Coach: Do you know what this chart means?

Patient: No I don't understand (some patients will know, others won't)

Coach: Do you know what HbA1c is?

Patient: No

Coach: It is another way of measuring how your sugar is doing. It uses different numbers. 7 means your average sugar is in pretty good control. 10 means that your average sugar is around 250. So, you want your HbA1c to be 7 or below. Does that make sense?

Patient: so I need this number to be 7, and now it's about 10?

Coach: that's right. What do you think about that?

Patient: I don't like it. I want it to be 7.

Coach: What do you think you could do to bring your HbA1c down to 7?

Patient: I don't know what to do.

Coach: There are 3 things you can do. Healthy eating, more exercise, or take more medicines. Which one of those do you think you might want to do?

Patient: I think I need to do something about my eating. I know that what I eat makes my sugar go up too high.

Coach: Maybe we can make an action plan to improve your eating. Is there anything you eat that you think makes your sugar go up?

Patient: I eat 2 pan dulces every meal. Do you think that makes my sugar go up?

Coach: Yes, it does. Do you think you might be able to cut down the amount of pan dulce you eat? That could be your action plan if you want to do that.

Patient: Yes. I'll stop eating any pan dulce.

Coach: Let's do a reality check. How sure are you that you can stop eating pan dulce? 0 means you aren't sure and 10 means you are very sure.

Patient: It's 0. I don't think I can do it.

Coach: is there anything you could do about your portions of pan dulce that you feel more sure you can succeed at?

Patient: I could eat 1 every meal instead of 2. I'm 100% sure I can do that.

Coach: Great. That can be your action plan. When do you want to start?

Patient: Tomorrow. I need to get that A1c thing down to 7.

Coach: Is there a place in your house where you can put up this chart to remind you about bringing down your HbA1c?

Patient: I'll put it right on my refrigerator.

Coach: OK. Can I call you next week to see how you are doing?

Patient: Please call.

Discussion

1. This excellent coach is constantly asking the patient rather than telling the patient. Every time the coach speaks, the sentence ends with a question mark. The coach is always asking.

2. Why is asking so important?

First, the coach doesn't want to tell patients things they already know. That makes them feel stupid and they resent it. So the coach asks to find out what the patient already knows. If the patient doesn't know the answer, then the coach tells the patient.

Second, asking questions helps to see if patients are motivated to make changes. After the patient says that the HbA1c is 10 but should be 7, the coach doesn't tell the patient anything; the coach asks "What do you think about that?" This question allows patients to say if they are motivated to do something about it. The patient says, "I don't like it. I want it to be 7." Now the coach knows that the patient is motivated to make a change.

Third, the coach asks "What do you think you could do to bring your HbA1c down to 7?" This allows the coach to find out whether the patient knows about diet, exercise and medications. Again, the coach wants to find out what the patient knows rather than telling the patient things the patient already knows.

Fourth, when the patient said he/she doesn't know how to bring the HbA1c down to 7, then the coach tells the patient: diet, exercise, medications. But the coach follows this by asking: "Which one of those do you think you might want to do?" This question allows the patient to choose which behavior change the patient feels ready to make.

3. The discussion of the HbA1c chart is the ideal way to begin an action plan discussion. The LDL-cholesterol chart also works well. After the patient chooses to work on his/her diet, then the coach suggests making an action plan.

4. After the patient has chosen healthy eating as the area to work on, the coach asks another question: "Is there anything you eat that you think makes your sugar go up?" This is a great question. If the coach asks: "What do you eat each day?" then there will be a long description of the patient's diet, and often those descriptions confuse the discussion and get into the patient asking the coach many questions about nutrition that the coach doesn't know the answers to. It is best to keep the focus on the action plan. If the patient doesn't know which foods make the sugar go up, then the coach can make suggestions: "Do you eat a lot of sweets? Do you drink a lot of sodas? Do you eat a lot of bread, pasta, tortillas, rice, potatoes?" Usually the patient will be eating one or more of these things, and an action plan can be suggested to stop or reduce the amount of one of those foods.

5. When a food has been identified that makes the sugar go up, then it is time to make an action plan, probably about reducing or stopping that food. The coach should remember to check the patient's confidence level and try to develop an action plan with the confidence level at 7 or more. The coach wants the patient to succeed at the action plan. Also the coach should remember to ask the patient if it is OK to call in a week to check how things are going.

Leading the discussion:

This discussion is done by asking the participants rather than telling them. In this way the discussion leader is modeling how the coach should work with the patient. For each point, the discussion leader can ask such questions as:

Why did the coach start by asking what the HbA1c chart means? Why didn't the coach just tell the patient what the chart means?" [To find out what the patient already knows]

The patient said "I need this number to be 7, and now it's about 10." Why did the coach ask "What do you think about that" rather than telling the patient what to do about it? [To see if the patient expressed motivation to do something about it]

When the patient said he/she wanted to work on healthy eating, why did the coach ask "Is there anything you eat that you think makes your sugar go up?" [To learn whether the patient knows some things about healthy eating and to set up a discussion of an action plan]

Interpreting HbA1c and LDL-cholesterol charts

Sr. Rojas should be given a lot of positive strokes for his LDL being at goal. Some people think that Sr. Rojas doesn't need an action plan because his LDL is at goal. That is not accurate. We know that sustaining LDL and A1c over time is difficult. He needs to action plan to keep doing what he is currently doing, or to do even better.

For Sra Romero, it is also important to find out what she was doing when her A1c was at goal (before it went back up); sometimes helping people to get in touch with their successes helps to re-motivate her to have success again.

Setting agendas with patients

Setting agendas is important for clinicians, but it is also important for coaches when meeting with patients in the pre-visit or post-visit or engaging in a between-visit phone follow-up discussion. Have 2 people read the dialogues, then have a discussion about each one. Ask questions such as: was that a good discussion? What was wrong with it? What was right with it?

Dialogue 1

Caregiver: hello. It's good to see you. I want to talk about your cholesterol.

Patient: what's wrong with my cholesterol. I have a very bad headache.

Caregiver: your LDL cholesterol has gone up to 150. We need to get it down.

Patient: Oh.

Caregiver: I'm going to give you some pills called Pravastatin. Take one every day and try to

stay away from fried foods, cheese and butter. I'll see you again in a month.

Patient: My headache…

Caregiver: we'll deal with that next time

Bad job. Patient's agenda in almost every case should come first.

Dialogue 2

Caregiver: hello. It's good to see you. Let's figure out how we can best spend our time together.

Patient: I have a bad headache.

Caregiver: OK. We'll talk about that. Are there other things you are concerned about?

Patient: I don't think so.

Caregiver: There is one other thing I'd like to talk about, which is your cholesterol. Would that be OK after we deal with the headache?

Patient: OK

Caregiver does a good job.

Dialogue 3

Caregiver: hello. It's good to see you. What brings you here today?

Patient: I have a bad headache. And my right leg is swollen.

Caregiver: OK. We'll talk about those things. Is there anything else you are concerned about?

Patient: my favorite sister was just told she has cancer. I'm scared that I might have it too. And I have this form to fill out for my night school class.

Caregiver: OK. It seems that there are 4 things on your mind: headache, right leg, worry about having cancer, and a form to fill out. I don't think we can do all this in the 15 minutes that we have together. Why don't we talk about the headache and the leg, and order some tests to make sure your general health is OK so that we can talk about our worry about cancer next time. Can the school form wait until next time?

This is the reality dialogue: too many agenda items for the 15 minute visit. The caregiver handles it fairly well.

Dialogue 4

Caregiver: hello. It's good to see you. What brings you here today?

Patient: you told me to come. Is there something really wrong with me?

Caregiver: I wanted to talk about your cholesterol. It's gone up again. But why don't we see first if you have any other concerns that you want to talk about.

Patient: How can I get my cholesterol back down. I need to get it down. My father had a heart attack when he was 51 years old.

Caregiver: OK. [they discuss the cholesterol]

Caregiver: Why don't you get a blood test in a month and then see me about the cholesterol.

Patient: OK

Caregiver: (opening the door to leave): see you next time.

Patient: by the way, I have blood in my stool.

This last dialogue demonstrates what happens if the agenda is not negotiated at the beginning of the visit. The cholesterol discussion took place before all possible agenda items were put on the table. As a result, a potentially urgent problem surfaced when the visit was already over.

"Closing-the-Loop" (also some shared decision-making)

"Closing the loop" means asking patients to tell you if they understand what you said. Very few physicians do this. In the only study on closing the loop, when patients were asked to repeat the advice given, 47% of patients did not understand correctly and needed to be corrected.

First, ask 2 people to read the following dialogue.

Caregiver: You have been trying very hard to improve your diet and exercise, but your HbA1c has only come down from 10 to 8.5. I would recommend that we try to bring it down below 7. What do you think?

Patient: If it will keep my feet attached to my body, let's go for 7.

Caregiver: Your choices are to make your diet even stricter, do even more exercise, or start to take a medication called Metformin. [Shared decision-making requires offering choices]
Patient: I think we need to go for the medicine.

Caregiver: OK. [Explains about metformin: what it does, possible side effects] I would suggest we start with one pill twice a day. If you start to have problems with your stomach or bowels, cut back down to once a day for a week and then go back to twice a day.
Patient: OK.

Caregiver: Let's just make sure I was clear in what I said. Can you tell me how you will be taking your metformin? [Close loop]

Patient: Twice a day no matter what.

Caregiver: What if you have problems with your stomach or bowels?

Patient: Oh, yes. Twice a day but go down to once a day for a week if I feel problems.

Caregiver: Great. The medical assistant will be calling you in a week to see how you are doing.

Next, for training on closing the loop, divide the trainees into dyads, with one person acting as the coach and one as the patient. Give them an example of physician advice, for example "You are now taking 1 metformin two times a day; I would like you to take 2 metformin twice a day." The coach would ask "Do you remember what your doctor told you about your diabetes medicine, metformin? Just to be sure your doctor was clear, how did she want you to take the metformin?" (Alternatively, "How will you be taking your metformin starting tomorrow?") The patient answers, and if incorrect, the coach corrects the patient, asks the patient to repeat the instructions again – until the patient gets it right.

This should take no more than 2-3 minutes. Then ask the trainees who were patients: "How did it feel to be asked to repeat back the advice?" to determine if the coach asked in a respectful manner. Ask the trainees who were coaches, "Was it difficult to ask patients to repeat back the advice?" Many coaches have difficulty asking patients to repeat back the advice, and have a tendency to ask "Did you understand the advice?" and if the patient says Yes, the coach stops there. That is not closing the loop and does not assess patient comprehension. We know that patients' lack of understanding of medication advice is a major contributor to patient non-adherence.

Behavior-change action plans

The article from the journal Clinical Diabetes (2007) (near the end of this document) describes behavior-change action plans and outlines a training program for action plans. The first step in this portion of the training is to use a training program adapted from that article. Some trainers like to start with the issue of how to get started engaging patients in action plan discussions, because some coaches have difficulty getting this discussion started. The discussion can start by using HbA1c or LDL-cholesterol graphs as outlined earlier in this document. Another way is to show the patient the action plan form at the end of the document and to have 2 people read the dialogue on "Patients choosing an area for behavior change."

Patients choosing an area for behavior change

Caregiver: Your hemoglobin A1c has gone up from 7.5 to 8.5.

Patient: That's not good; it's supposed to be under 7.

Caregiver: Would you like to spend a few minutes discussing what we might do?

Patient: OK.

Caregiver: Do you have any idea about how you might bring your HbA1c back down?

Patient: Well, probably the way I eat, doing exercise, and taking my pills has a lot to do with it.

Caregiver: That's right. This action plan form has some choices for improving your HbA1c. Is there anything you might like to focus on?

Patient: I think I'd like to talk about exercise.

The next step for this patient is to engage in an action plan discussion about exercise.

Then, have 2 people read the action plan dialogue and discuss it (as suggested in the Clinical Diabetes article). This dialogue is the same as the one in the Clinical Diabetes article, reproduced here so that it can be easily copied for the trainees.

Action plan dialogue

Caregiver: Your last test shows your HbA1c has gone up to 9.2. What do you think about that?

Patient: I don't know. I'm taking my pills, I thought if I took them I didn't have to worry about eating candy and sweets every day; the pills are supposed to protect me.

Caregiver: What is it you like about eating candy?

Patient: I love chocolate; it's kind of comforting, I have all these things that stress me out, but I know that chocolate is one thing in my day I will definitely enjoy.

Caregiver: That makes sense. Is there anything you don't like about eating chocolate?

Patient: Well, it messes up that sugar. But I don't want to give it up, it makes me happy.

Caregiver: Is there anything else you enjoy doing that reduces your stress but doesn't get your HbA1c so high?

Patient: Maybe walking around the block a couple of times.

Caregiver: Do you want to give that a try?

Patient: Sure, but I'm not promising to give up chocolate.

Caregiver: I understand. Let's do a reality check? How sure are you that you can walk around the block a couple of times when you feel stress? Let's use a “0 to 10” scale: “0” means you aren't sure you can succeed and “10” means you are very sure you can succeed.

Patient: I can do it; I’m 100% sure.

Caregiver: Why don't we call it your action plan -- you will walk around the block two times when you feel the stress coming on. When do you want to start?

Patient: We’ll see.

Caregiver: Do you want to start this week?

Patient: That might work

Caregiver: OK. Why don't we agree that you will walk around the block two times when you feel stress? Could I call you next week to see how it’s going?

Patient: OK.

Lessons to discuss (ask questions to try to elicit trainees’ understanding of the dialogue)

When the patient mentions an unhealthy behavior (chocolate), the caregiver doesn’t challenge it, but uses a Motivational Interviewing technique: what do you like and what don’t you like about the unhealthy behavior. This encourages the patient, not the caregiver, to talk about change (what he/she *doesn’t* like). This may uncover a topic for an action plan – in this case, relieving stress.

The caregiver does not judge the patient’s behavior. When the patient says: “I’m not promising to give up chocolate,” the caregiver doesn’t make a judgment, but says: “I understand,” and moves on. It wouldn’t make sense to lecture the patient on why chocolate is not healthy because the patient already knows (“it messes up that sugar thing”).

The action plan should be simple and specific. The 0 to 10 scale estimates the patient’s confidence that he/she can succeed at the action plan. The purpose of the action plan is to *increase self-efficacy* (self-confidence that the patient can change something). The goal is success. It doesn’t matter how small the behavior change is; the important thing is that the patient succeeds, thereby increasing self-efficacy. To maximize the chance of success, the patient should have high confidence, at least 7 out of 10, that he/she can succeed. If, for example, a sedentary patient proposes an action plan to walk 5 miles a day, with a low level confidence (2 out of 10) that he/she can succeed, the caregiver should suggest a more achievable action plan.

At the end of the dialogue, the caregiver tries to make the action plan more specific ("When do you want to start?"), but the patient resists ("we'll see" and "that might work"). Rather than challenging the patient, the caregiver "rolls with the resistance" and goes with what the patient is willing to do. Sometimes the patient will not want to make an action plan at all.

Further Action Plan Training

These are scenarios featuring problems that come up when coaches engage in action plan discussions with patients. Have 2 people read the scenarios; after each one, ask trainees what they think.

Scenario 1

Caregiver: Hello. I was just looking at your lab tests. Your LDL cholesterol is back up to 145. Do you know what your goal is for cholesterol?

Patient: I don't remember

Caregiver: Since you had a heart attack 3 years ago, your LDL cholesterol goal is to be below 100. Now you are 145. Do you know why it has gone up again. I'll bet you haven't been taking your pills.

Patient: Sometimes I forget to take the pills. I feel good and it doesn't seem like I need the pills every day.

Caregiver: We need to make an action plan. You have to take your cholesterol pills every day. OK?

Patient: I guess so.

Caregiver: starting today, your action plan is to take your pills every day without fail. I'll call you on Thursday to check.

Clearly, the patient was not involved in making this action plan.

Scenario 2

Caregiver: we just checked your BMI and it's gone up from 29 to 31. Do you know what that means?

Patient: I don't even know what a BMI is.

Caregiver: it is a measure of your weight in relation to your height. It is the best measure of whether your weight is too high. We call a BMI under 25 normal, between 25 and 30 as overweight, and over 30 as obese. You are now 31.

Patient: are you saying that I'm obese? I don't like that.

Caregiver: that's what over 30 means.

Patient: I hate that. I'm going to lose 20 pounds. When I come back next month, my BMI will be way down below 30.

Caregiver: that's great. I'll see you next month. I'm sure you can do it.

The motivation of the patient is great, but the caregiver probably should have asked for a reality check using the 0 to 10 scale. While praising the patient's motivation, the caregiver might have made a shorter term realistic action plan to start to move toward the goal of losing 20 pounds.

Scenario 3

Caregiver: hello. I wanted to give you your lab test results. Your HbA1c has gone up from 8.2 to 9.2. Do you know what that means?

Patient: that means my sugar is getting higher. I know it is supposed to be 7 or below.

Caregiver: do you want to do something about that?

Patient: yes, I do. I need to get it down.

Caregiver: we believe in patient self-management. So you need to say how you will get your HbA1c down.

Patient: but I'm not sure what to do.

Caregiver: give it a try. What would you like to do?

Patient: I don't like this self-management thing. My doctor in Russia would tell me what I need to do and that's what I like.

Caregiver: this isn't Russia.

The caregiver did not help the patient in formulating an action plan. When patients indicate that they prefer a caregiver to make a decision for them, it is best to suggest a course of action to the patient and check to see if the patient agrees. Action plans are a partnership – part patient and part caregiver.

Scenario 4

Caregiver: Hello Mr. Tang. It's good to see you. How are things going?

Patient: good

Caregiver: Would it be OK to check on the action plan we made last week?

Patient: OK

Caregiver: how are you doing with exercising 30 minutes every day after lunch?

Patient: I'm doing fine. I'm doing 45 minutes every day.

Caregiver: That's terrific. So, do you think there is anything else we might do to get your cholesterol down? The LDL is still running around 150. Would you like to discuss healthy eating?

Patient: I'll keep exercising and that should take care of it.

It is not unusual for a coach to doubt that the patient is actually carrying out his/her action plan. However, one needs to take the patient at face value and accept what the patient says he/she is doing. On the other hand, if the LDL does not go down next time it is checked, the caregiver might suggest that exercise is not enough and healthy eating and/or medication is needed.

Scenario 5

Caregiver: Hello. How are you?

Patient: I'm fine.

Caregiver: Did you see this chart of your HbA1c? It went up from 8 to 10?

Patient: I really feel good.

Caregiver: We've talked a lot about the importance of having your HbA1c at 7. Would you like to try to get it down?

Patient: I really feel fine.

Caregiver: Would you like to talk about an action plan to get your diabetes in better control?

Patient: I eat well, I exercise, I take my pills, and I feel very well. Thank you for taking good care of me.

It is not appropriate to make an action plan with this patient. The patient needs much more education on diabetes, its long-term consequences, what can be done to avoid those consequences, and that having high sugar does not necessarily make people feel bad. The patient has made it clear that the time for this education is probably not right now.

Scenario 6

Caregiver: Hello. How are you?

Patient: I'm worried. My doctor told me my sugar is too high. I need to get it down.

Caregiver: do you know how you can get your sugar down?

Patient: I could eat less, exercise more, or take pills.

Caregiver: that's right. Do you know what you would like to do?

Patient: I need to eat less. I eat 2 bowls of rice every meal. Big bowls. I know it keeps my sugar up.

Caregiver: do you think you could do something about that?

Patient: I'm going to stop eating rice. No more rice for me.

Caregiver: That's great. I'll call you to see how it's going.

Similar to a previous scenario, it might be best for the caregiver to do a reality check using the 0 to 10 scale, while not undermining the patient's motivation to change.

Scenario 7

Caregiver: Hello. How was your visit with Dr. Evidence?

Patient: I was OK. But she told me that I had to lose 20 pounds in the next month. I don't think I can do that. She never asked me for my opinion.

Caregiver: what do you think about that?

Patient: I can't do that. It's too hard.

Caregiver: would you like to lose some weight?

Patient: yes, but I can't do it that fast.

Caregiver: Are there any foods that you think are causing your weight to go up?

Patient: it's those tortillas. We Mexicans love to eat tortilla. Maybe I could eat 8 tortillas a day instead of 12.

Caregiver: that makes sense. We could make that your action plan.

Patient: but Dr. Evidence told me I have to lose 20 pounds. Reducing the tortillas won't be enough to lose 20 pounds. I have to do what Dr. Evidence says, but I can't do it.

This scenario demonstrates the paradigm gap between physician and coach. The physician tells the patient what to do even though her advice is unrealistic and did not involve the patient in the decision. In this case, because the patient trusts Dr. Evidence, the coach would need to talk with Dr. Evidence (with the patient present or not present) to try to persuade Dr. Evidence that the patient needs to be involved and that a realistic action plan would have greater chance of success.

Action plan follow-up/problem-solving dialogue

Goal-setting/action-planning will not work without regular and sustained follow-up with problem-solving. This process can be done, often by telephone, by medical assistants, community health workers, or patients who buddy-up with one another.

Caregiver (on telephone): Hello. Is this a good time to talk for a few minutes?

Patient: OK

Caregiver: Do you remember the action plan we talked about in the office last week?

Patient: I was supposed to walk 15 minutes every afternoon. But I didn't do it. I'm scared because we just had a shooting in the neighborhood.

Caregiver: [After discussing the shooting for a few minutes] Would you like to try to make another action plan to do some exercise?

Patient: Yes, I need to do that.

Caregiver: Do you have any ideas what you might do? [Give the patient the opportunity to suggest an idea; if that doesn't work, the caregiver would suggest a few ideas]

Patient: my son visits me every week. Maybe he could drive me somewhere and we could walk together instead of going to McDonald's the way we always do

Caregiver: Maybe the first action plan could be to ask your son if that is OK. What do you think?

Patient: I'll ask him tomorrow. [Here the caregiver might assess this new action plan with a 0 to 10 confidence scale. In this case, that might not be necessary]

Caregiver: That's great. Is it OK if I call you in a couple of days to see what happened?

Problem solving requires considerable ingenuity on the coach's part, trying to come up with a solution to the very real barrier the patient faces. Some ideas on how to do problem solving:

1. Identify the problem (the most difficult and important step).
2. List ideas to solve the problem
3. Pick one, try it for two weeks
4. Assess the results

5. If it doesn't work, try another idea
6. Utilize other resources (family, friends, professionals)
7. If nothing seems to work, accept that the problem may not be solvable now.

Lorig, Holman, et al, *Living a Healthy Life with Chronic Conditions.* Boulder, Colorado, Bull Publishing, 2006.

Medication Training

There are 3 terms related to patients taking medication: Medication Reconciliation, Medication Concordance, and Medication Adherence.

What is medication reconciliation? (med-rec)

Comparing the list of medicines the doctor has prescribed with the list of medicines the patient is actually taking.

When do you do it?

Before the visit, so that the doctor knows what the patient is actually taking before seeing the patient.

Why does it need to be done?

Take the example of high blood pressure. If a doctor has prescribed 2 medicines and the patient's blood pressure is still high, the doctor may prescribe a 3rd medicine because he/she doesn't know that the patient isn't taking the 2 medicines already prescribed. Then, if the patient decides to take all 3, the blood pressure will go too low. Same could happen with diabetes, with the blood sugar dropping – which could kill the patient. This is why knowing what pills the patient is really taking is so important.

Who does med-rec?

Often it isn't done at all. Doctors often don't have time to do it, so many organizations are experimenting with MAs, LVNs, RNs, doing it. Ideally, a pharmacist would do it but there usually aren't pharmacists available to do it. Coaches can do med-rec. However, only the clinician can make decisions about whether a medication should be stopped, increased, or decreased.

Med-rec has two parts: 1) Finding out what the patient is actually taking (the detective work), which can be done by the coach, and 2) Deciding what the patient should be taking, which is a clinician function.

How do you do med-rec?

In a reminder phone call, ask the patient to bring all medicine bottles.

Print out the pre-visit medication list. Go over each medication on the pre-visit medication list (or use the bottles if patient brought the bottles) and ask the patient the following questions for each medication:

Do you know the name of this pill?
Do you know what this pill is for?
Do you know how many milligrams it is?
How often should you be taking it?
Are you taking it?
If you are not taking it as the doctor prescribed, why not?
Do you need refills?

For the first 4 questions, the coach educates the patient if needed and close the loop. For the question "Are you taking it?" write down next to each med on the med list: Yes, No, or Sometimes. If a twice a day pill is taken only once a day, write down, Once a Day. If the patient doesn't take the med as prescribed, ask the patient Why Not? and write that on the med list. Write down whether the patient needs refills, information which helps the doctor.

When you (the coach) are done, make sure the list with your notes is on the front of the patient's chart for the doctor to see. If the patient brought the med bottles, put the bottles out on the desk so that the clinician can discuss them with the patient.

Coaches should not advise the patient what to do regarding a medication that the patient is not taking; it is the clinician's job to decide whether to stop or continue the medication. So, don't tell a patient who is not taking a medication: "you should be taking this pill." Perhaps the doctor will want to stop the pill; perhaps the patient has a good reason not to be taking it. The coach's job is only to get the information from the patient.

What do you do if the patient is on 12 medications and there isn't time to do medication reconciliation? It probably isn't worth starting the process if it appears that there won't be time to finish it. In that case, the patient really needs a separate planned visit with a RN or pharmacist to sort out the complexities.

<u>What is medication concordance?</u>

In the post-visit after the clinician has left, you ask "Just to make sure the clinician was clear, can you tell me how you will be taking this medication?" This is closing the loop. If a patient has been taking a medication for a couple of weeks and comes back, you can ask: "How did the clinician tell you to take this medication?" If the patient's answer is the same as the clinician's description on the medication list, the patient is concondant with that medication. If the patient's answer is different than what is on the med list, the patient is discordant.

What would you guess – what percent of patients understand how to take their meds?

Research has shown that 50% of patients are discordant – they never understood how to take the medication. Concordance-discordance is crucial, because if a patient doesn't know how to take a medication, he/she can't be taking it correctly.

What do you do if there is medication discordance? Close the loop. Tell the patient how the doctor prescribed the medication, and ask the patient to repeat back the instructions. If the

patient gets it wrong, correct the patient and ask him/her to repeat if back again, until the patient can say it correctly. If the patient has brought in pill bottles, ask the patient to hold up the bottle for diabetes, or the bottle for blood pressure, and ask What is that pill for? Help the patient understand what the pill is for. Then ask How did the doctor want you to take that pill? If the patient gets it wrong (discordant), correct the patient. This requires constant closing the loop.

What is medication adherence?

Adherence means the patient is taking all meds as prescribed. Assuming there is concordance (the patient knows how the doctor wants the medication taken), non-adherence means that the patient knows how to take the medication but is not taking it or is only taking some of the pills. If there is discordance (the patient doesn't understand), then one can't say there is non-adherence because the patient doesn't know what to do. Non-adherence means that the patient knows what to do but choose not to do it for some reason.

How common is non-adherence? In general, 1/3 of patients take all their meds, 1/3 take some of their meds, and 1/3 take none of their meds. But not all of this is non-adherence. Remember 50% of patients are discordant (don't understand how the doctor wants them to take their meds). Some people not taking their meds are non-adherent (understand but choose not to take the med), some are discordant (don't understand).

What are common causes of non-adherence?

1) Patient has to pay for the med and can't afford it.
2) Med was not on the patient's insurance formulary and pharmacist didn't give the med.
3) Med causes side effects.
4) Pt is worried that med may cause side effects/hurt them.
5) Patient doesn't believe the med will really make a difference in his/her life.
6) Patient forgets.
7) Medication regimen is too complicated. Too many meds, and meds that need to be taken several times a day. (A medi-set might help, but better is to simplify the regimen)
8) Patient doesn't want to begin taking something that he/she may have to take for the rest of their life.

If the clinician says that a particular medication is really important to take and the patient is not taking it, what can you do?

See if the patient is willing to make an action plan that he/she will take the med. Call back in a week to see what happened.

Patients do not always tell the truth about whether or not they are adherent. How can we encourage patients to tell the truth? Here is one idea. Say to the patient, "Most people do not take all the medicines their doctors prescribe. So, it's OK if you aren't taking all of them; you are in good company." Use some personal examples like:

- I even have trouble taking a vitamin everyday!
- In fact, once when the doctor prescribed some antibiotics for me to take for a week, I only took them for 3 days.

Sometimes it works to say "No one likes to take medicines. But it would really help us to know if you are taking the medicines or not, because it helps your doctor know what to do next about your blood pressure (diabetes, or whatever the med is for)."

One way to improve adherence is to suggest to the patient an action plan in which the patient agrees to take one or two of his/her medications regularly.

Cardiovascular risk factors

Coaches working with patients with cardiovascular risk (in particular diabetes, hypertension and high cholesterol) need to know as much about these conditions as patients should know. It is important that coaches have easy access to patient education materials on these topics. Since many patients have limited health literacy and do not read patient education materials, it is very helpful for coaches to engage patients in discussions of these patient education materials using ask-tell-ask: Ask the patient a question and if the patient doesn't know the answer, read the answer from the patient education material. This helps to guard against the serious possibility that coaches are giving patients information that is incorrect.

In helping coaches learn about cardiovascular risk, it is best for the trainer to model ask-tell-ask. The training leader asks the trainees questions to see how much they know and to allow those who know more to teach those who know less. The trainer provides the information if the trainees do not know it and corrects any incorrect information. Also, the trainees are encouraged to ask any questions they want. Because it is assumed that trainers are knowledgeable about cardiovascular risk, this document focuses on the questions that are the discussion guide.

First the trainer does very brief explanation of cardiovascular risk factors – what risk means and what are the main factors, indicating that the discussion will focus on diabetes, cholesterol and hypertension. Smoking cessation counseling is a very appropriate function for coaches, but smoking cessation counseling training would require an extra training session. This document does not include a training guide on smoking cessation.

The questions to discuss on cardiovascular risk:

1. What is diabetes? (focus on type 2) What are the complications of diabetes?

What is hypercholesterolemia? What are its complications?

What is hypertension? What are its complications?

2. What is the most important measure for people with diabetes? (HbA1c) Ask if anyone knows what it means and explain it.

What is the HbA1c goal? (7 or below, except for elderly or complex patients for whom it might be higher)

What is the most important measure for people with hypercholesterolemia? (LDL) Ask if anyone knows what HDL is.

What is the LDL goal? (under 130 for most people but under 100 for people with coronary heart disease, cerebrovascular disease, peripheral arterial disease, aortic aneurysm, diabetes. We have not been using the 160 goal for low-risk patients, since most patients who need coaching will have a goal of 100 or 130).

What is the most important measure for hypertension? Systolic and diastolic blood pressure (ask/explain what they mean).

What is the BP goal? (130/80 or below. We use this goal for all patients. JNC 7 is somewhat inconsistent and using 130/80 is simple and a reasonable goal).

3. What are the ways to reduce HbA1c? (diet, exercise, meds)

What are the ways to reduce LDL (same)

What are the ways to reduce BP (same)

4. What are the most important foods to reduce/avoid for patients with diabetes? (Sweets, starches – bread, pasta, potatos, rice)

What are the most important foods to reduce/avoid for patients with high cholesterol? Saturated fats and foods with cholesterol (foods fried in certain fats/oils, red meat, cheese, ice cream, butter, eggs); also carbohydrates

What are the most important foods to reduce/avoid for patients with hypertension? Salt, fats. (DASH diet helps blood pressure – low salt and fat, high fruits and vegetables)

What are some action plans that can be done for patients interested in healthy eating? Reduce tortillas from 12/day to 8/day. Reduce rice from 1 ½ bowls per meal to 1 bowl per meal. Only eat cheese twice a week rather than every day. Substitute water for sodas.

Regarding training on healthy eating, we try to keep it simple, just listing a few key food types that patients would best reduce or avoid. The key question we suggest that coaches ask patients regarding healthy eating is “Is there any food you eat that you think makes your HbA1c (or LDL) go so high?” That question helps to set up an action plan (often relating to portion size) and helps to move away from complicated discussions on healthy eating that are best in the province of a dietician.

Cardiovascular medications

Hand out to trainees the Common medications to reduce cardiac risk. They can keep it as a reference. Tweak it based on medications used in your site and your preferences. Go around the room with the trainees and have each trainee read one medication or medication class. Then do

an “open book” question session in which trainees are encouraged to consult the common medication list. This has worked quite well, improving trainees’ confidence in doing med-rec, closing the loop with meds, and follow-up phone calls to check on medication concordance and adherence.

Common medications to reduce cardiac risk

Diabetes

Metformin 500 mg twice a day
500 mg. – 2 pills twice a day
850 mg. twice a day

Do not use if kidney disease (creatinine over 1.5)
Does not cause hypoglycemia (low blood sugar)

Glyburide or Glipizide

Start with 2.5 or 5 mg per day
Increase up to 10 mg. twice a day

Can cause serious hypoglycemia

Rosiglitazone (Avandia) or Pioglitazone (Actos)

Avandia may be related to heart attacks, so best not to use it

Actos is 15 or 30 mg per day, also may be best not to use

Can cause swelling of the feet, weight gain, heart failure

Insulin

NPH or Glargine are long acting. Usually start 10 units injection at night, increase slowly to get blood sugar to goal

Regular Insulin or Lispro (Humalog) is short acting and used at mealtimes to keep blood sugar down

Aspirin

Protects patients with diabetes from heart attacks. Should be given to patients with diabetes over 40 years of age. Dose is 81 mg. per day. Do not use if patient has a bleeding problem.

ACE inhibitors (see below under hypertension)

Patients with diabetes with too much protein in the urine are beginning to have kidney damage. Start on ACE inhibitor

Cholesterol

Any medication with name ending "statin" is for cholesterol. Lovastatin, pravastatin (Pravachol), atorvastatin (Lipitor), simvastatin (Zocor)

Doses are usually 10, 20, 40 or 80 mg. each day

Liver function tests should be checked before instituting a statin and 12 weeks after starting the statin. If liver function tests are more than 3 times normal, stop the statin.

High blood pressure (hypertension)

Hydrochlorothiazide (HCTZ): causes kidneys to excrete more urine which lowers blood pressure. Doses 12.5 or 25 mg. once a day

ACE inhibitors: ACE = Angiotensin Converting Enzyme. The ACE inhibitor reduces the amount of angiotensin, which makes the blood pressure go down by dilating arteries. ACE inhibitors are good for patients with both diabetes and high blood pressure because they protect the kidneys. ACE inhibitors have names ending in "pril." Benazepril, Lisinopril, Enalapril. Doses are usually 10, 20 or 40 mg. once a day. Side effects: can cause potassium to go up, and can cause a cough.

ARBs (Angiotensin Receptor Blockers). Work similar to ACE inhibitors, and are used if patients get a cough with ACE inhibitor. The names end in "sartan." Losartan (Cozaar) is the most common.

Beta blockers: slow down heart rate and reduce blood pressure. The names end in "lol." Most common are metoprolol and atenolol. Metoprolol dose is usually 50 mg. twice a day, going up to 100 mg. twice a day. If heart rate is below 55, dose is too high.

Calcium channel blockers: Cause blood pressure to go down by dilating arteries. Names end in "pine." Common ones are Amlodipine (Norvasc) and Felodipine (Plendil). Dose is usually 5 or 10 mg. once a day.

Questions for trainees on medications

A patient is on Metformin and Lovastatin. What cardiac risk factors does she have?

A patient is on Metformin 500 mg. twice a day. HbA1c is 8.5. Patient is doing her best at diet and exercise. What would you do next?

A 54 year old patient with diabetes is on Metformin 850 mg. twice a day and HbA1c is 6.8. Is there any other medication he should be on?

A patient with hypertension has a blood pressure of 150/90. She does an action plan to reduce her salt, and the blood pressure 2 weeks later is 140/85. What would you do next?

You are the coach and you ask the patient with LDL cholesterol of 145 whether she is taking her atorvastatin. She says her doctor never prescribed atorvastatin. She brought her med bottles and one of the bottles says Lipitor. What do you tell her?

A patient with diabetes has urine microalbumin (protein) of 150, which is too high. What type of medication should she be on?

A patient on atorvastatin calls you, the coach, and says she has severe muscle pain since the physician increased the dose from 20 to 40 mg. What do you think is happening?

A patient with diabetes is on metformin 500 mg. 2 pills twice a day. Many people consider that to be the maximum effective dose. But HbA1c is still 9. Besides improving diet and exercise, what would be the next step?

A patient with diabetes is on maximum dose of metformin and glipizide. The patient cannot take Actos because the patient already has swollen ankles. HbA1c is 8.7. Besides improving diet and exercise, what is the next step?

A patient with hypertension is on salt restriction and HCTZ 25 mg (the maximum effective dose). BP is still 150/95. The patient promises she is taking her HCTZ. The patient does not have diabetes. What is the next step?

A patient with hypertension is on HCTZ 25 mg. and metoprolol (a beta blocker) 100 mg. twice a day. Beta blockers slow down the heart rate. The patient's BP is 160/100 and the heart rate is 90. Do you add another medication?

A patient with diabetes and hypertension is on benazepril, an ACE inhibitor. The benazepril does 2 important things: lowers blood pressure and protects the kidneys. She develops a cough, a common side effect of ACE inhibitors. Do you stop the benazepril?

You are doing medication reconciliation with a patient – trying to figure out what the patient is actually taking. You have the LCR medication list print out. The patient didn't bring her bottles. What questions are good to ask the patient about each medication?

You find out that a patient isn't taking the Glipizide the doctor ordered a month ago. You ask why? What are some possible reasons why the patient isn't taking the medication?

During a follow-up phone call one week after a clinician visit, what are some questions you would ask patients about a new medication prescribed during that visit? (Answers are: Were you able to get the medication from the pharmacy and if not, why not? Do you remember how to take the medication? (closing the loop, and correcting the patient if wrong) Are you taking the medication and how often? (if not, why not). Are you having any side effects? (if so, do not decide what to do but contact the clinician about it).

Panel management training

Discuss what a registry is, and ideally show the registry used in your facility. Talk about what a registry can do: give feedback to a clinic and a provider on performance measures; identify patients overdue for mammos, paps, A1c or LDL blood tests, eye exams, etc; identify patients not in control of A1c, LDL, blood pressure who need more coaching or more extensive planned visits with RN or nutritionist.

Go over a registry sheet and discuss it in some detail. Ask such questions as:

How many patients are in your panel?
What information is available on each patient?
In the A1c testing column, which patients are overdue for A1c (assuming A1c should be done every 3 months for patients out of control and every 6 months for patients in control)
Similar for LDL and blood pressure and eye exam
In the A1c level column, which patients are at goal and which are not? Same for LDL and BP
Which patient would you prioritize for coaching or more intensive planned visit?
Which patients need medication intensification?

Go over what a panel manager job description would look like. In essence it is reviewing the registry on a regular basis, calling/sending letters and lab slips to patients who need lab work done, making appointments for eye exams, mammo and paps, and (depending on what the clinicians decide) perhaps working with clinicians to go over patients and to contact the patients to intensify medications based on the clinician's orders. The panel manager may also have the job to enter data into the registry that needs to be input (like blood pressures) and to keep the registry up to date.

The main training for panel managers is how to read the registry, how to keep the registry current, how to produce reports, how to contact patients about overdue services, and (if appropriate) how to work with clinicians on medication intensification. Much of this is dependent on the particularities of the registry in your clinic.

Where to go for more information

Action plan forms in English, Spanish and Chinese can be downloaded from the internet at http://www.ucsf.edu/cepc/_html/aims/actionPlan.html

A wealth of information on patient self-management of chronic conditions is available at http://patienteducation.stanford.edu

A monograph "Helping patients manage their chronic conditions" is available at the California HealthCare Foundation website
www.chcf.org/topics/chronicdisease/index.cfm?itemID=111768

The Institute for Healthcare Communication has resources on enhancing the dialogue between patients and clinicians www.healthcarecomm.org

Appendices

JAMA article "A 63 year old man with multiple cardiovascular risk factors" 2007;298:2048-55 that provides some of the evidence supporting these training materials
http://www.ucsf.edu/cepc/_pdf/BodenheimerJAMA2007.pdf

Clinical Diabetes article "Helping patients adopt healthier behaviors" 2007;25:66-70 that describes action plan training
http://www.ucsf.edu/cepc/_pdf/ClinicalDiabetesArticle.pdf

Training HbA1c and LDL-cholesterol graphs
http://www.ucsf.edu/cepc/_pdf/TrainingA1cGraphs.pdf

Sample registry report
http://www.ucsf.edu/cepc/_pdf/registrreport.pdf

HbA1c and LDL-cholesterol graphs for patients