



Health Coach Overview

Overcoming barriers to improved health and wellness

Getting healthy is a goal that is hard to achieve working alone. It takes a team effort to realize our health goals. Having access to quality, affordable health services is necessary, but not sufficient to improve the health of Howard County residents. Therefore, an integral part of the Healthy Howard Plan is our Health Coach program.

Built on the chronic disease management model, this innovative effort will help residents overcome barriers to health goals, improve the public health of our community, and reduce local health care costs. Everyone enrolled in our Healthy Howard Plan will be matched with a Health Coach to help them formulate a Health Action Plan and take steps toward achieving their health goals.

The details of our Health Coach program are provided below.

Matching Health Coaches with Participants

Matching will be based on information from two documents:

1. Health Assessment completed by the primary care provider after the participant's first office visit; and
2. Health Appraisal Form filled out by the participant.

Each participant will receive a Level and Tier designation.

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|----------------|---------------|---|
| Level 1 | Tier 1 | Individuals with no chronic disease, low risk ¹ for chronic disease development. |
| | Tier 2 | Individuals with no chronic disease, high risk for chronic disease development. |
| Level 2 | Tier 1 | Individuals with 1 chronic disease, currently controlled. ² |
| | Tier 2 | Individuals with 1 chronic disease, currently not controlled. |
| Level 3 | Tier 1 | Individuals with 2 or more chronic diseases, currently controlled. |
| | Tier 2 | Individuals with 2 or more chronic diseases, currently not controlled. |

¹ Risk for chronic disease development is assessed based on an individual's body mass index (BMI), fitness level, blood pressure, cholesterol, tobacco and alcohol use, and high risk family history of chronic disease.

² A chronic disease is considered to be controlled when lifestyle modifications and/or drug treatment has allowed the patient to reach medically acceptable ranges without frequent variation.

How Health Coaching Works

The participant's designated level will determine the degree of interaction with his or her Health Coach. Participants in Levels 1 and 2 will work with Coaches from Healthy Howard, Inc. Participants in Level 3 will work with case managers from Hopkins HealthCare, LLC. Health Coaching is tailored to the needs of participants and is centered on a Health Action Plan and defined points of contact between the participant and Health Coach Team.

The Health Action Plan

- Each participant will have an initial meeting with a Health Coach to develop a Health Action Plan.
- This meeting will take place after the first doctor's visit and not more than two months after enrollment.
- Results from the doctor's Health Assessment and the participant's Health Appraisal Form will inform the creation of the Health Action Plan.
- The Health Action Plan is a "living document" that is developed every year. Short-term goals are set every three months.
- The Health Coach works with each participant to identify different options for meeting goals as well as the possible barriers to goal attainment (e.g., participant needs a gym with child care).
- Once the Health Action Plan is set, the Community Resource Coordinator works to address any identified barriers and links the participant with relevant community resources.

Defined Points of Contact

- For Level 1 participants, the Health Coach checks in via telephone every three months to review progress, set new short-term goals, and modify the Health Action Plan as needed.
- For Level 2 participants, a minimum of seven points of contact (a combination of telephone check-ins, one-on-one, or group meetings) are required each year.
- The Health Coach serves as the participant's primary contact for health and community resources.
- The Health Coach works with the primary care provider to help manage cases according to evidence-based protocols. (The health IT infrastructure developed for the Healthy Howard Plan will support this collaboration.)
- The Health Coach will track visits with the primary care provider, medication pick-up, and indicators of progress made toward defined goals such as class participation.

The Health Coach Team

While Health Coaches have direct and ongoing contact with each participant, the program will employ a team approach to case management. The Health Coach Team will hold an initial review of cases after Health Action Plans are set. At least once a month, the entire team will meet to discuss any issues or concerns regarding cases. Coaches will provide the Nurse Program Manager with brief progress reports on cases every six months. Team members will work together daily to address urgent needs, questions or concerns.

Team Members

(Team size and composition are based on a total of 2,000 participants in year one.)

Nurse Program Manager

- Provide program management; monitor compliance with evidence-based protocols; liaise with primary care provider; address medication issues; interpret medical decisions as needed; implement quality assurance measures; and assist with program evaluation.

Registered Dietitian

- Advise Health Coaches on nutrition-related goals for Health Action Plans; run workshops and classes as needed; and work with participants to develop diets and eating plans.

Social Worker

- Health Coach for Level 2 participants.

Health Educator

- Health Coach for Level 1 participants.

Community Resource Coordinator

- Develop community partnerships and link participants to needed services; and maintain resource database of classes, seminars, and other evidence-based options for Health Coaches to use in developing options for Health Action Plan goals.