

PATIENT SELF-MANAGEMENT

Frequently Asked Questions

Health Coaching: Practical Lessons from the Field

How do I pay for a health coach when payment is not readily available for his/her services?

Incorporating health coaching responsibilities into already existing staff may be an option to get started in your practice without adding an additional FTE. Starting small and determining where your needs are in your practice can help spread the health coaching services to those patients who could benefit from it the most. Some practices find that grant funding can help offset the cost of adding a health coach.

Who can perform health coaching services?

Anyone on the health care team can serve as a health coach. Physicians, nurse practitioners/physician assistants, RNs, LPNs, pharmacists, health educators, nutritionists, medical assistants, community health workers, and even patients can all do coaching. Training is recommended for anyone who plans to provide health coaching services.

How many patients is a health coach responsible for?

A health coach's panel can vary widely depending on the volume of your practice and complexity of patients. A health coach visit can vary in length to an hour for an in-person visit to a quick check-in phone call with a patient. Rely on health coaches to give feedback to physicians on how full their panel has become. Panels fluctuate often, as patients can cycle out and new patients can be added as space is available.

How does health coaching improve patient outcomes?

Health coaching provides patients with the skills, knowledge, and tools to become active participants in their care so they can reach identified health goals. Many of the approaches used in health coaching are evidence-based and linked with behavior changes that improve chronic disease outcomes.

Motivational Interviewing: Can I Really Influence My Patient's Motivation to Change?

What should I do if a patient is not at all interested in changing the target behavior and has multiple excuses for resisting change?

When patients are not interested or ready to change, the goal becomes to raise ambivalence to the target behavior. Give patients the opportunity to explore their resistance to change. It may be helpful to ask if they are interested in talking about the target behavior (e.g., smoking), ask them to tell you about their smoking, and what their thoughts are about it. It is helpful to indicate you are not there to force change, but that you would like to hear more about the behavior and see what their thoughts are about it.

How does motivational interviewing work when a patient is in denial about a problem I identify?

The "righting reflex" is a natural reaction of health care providers to patients who resist change; however, this approach can actually prompt more resistance from the patient. When patients are precontemplative regarding the targeted behavior, the goal is for the patient to begin thinking about changing the target behavior. This can be done using thought-provoking, open-ended questions, not providing advice or trying to convince the patient against engaging in the behavior. Empathy, affirming the patient's strengths and efforts, and developing and maintaining a positive relationship will engage the patient and lay ground for further engagement.

As a physician practicing motivational interviewing, is it okay to give real life examples to a patient?

Self-disclosure should be used strategically, not as a common practice. If self-disclosure is overused, it does not result in the intended effect, and rather takes the focus off the patient and onto the physician.

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Motivational Interviewing, continued

Is it common for patients to fluctuate back and forth towards change in a session?

It is common for patients to fluctuate with change while discussing the targeted behavior. The goal of motivational interviewing in this instance is to move and respond with the patient as he or she fluctuates with changing the targeted behavior in the session.

Which health conditions is motivational interviewing effective in eliciting change?

Motivational interviewing is effective in both behavioral and physical health outcomes. Treatment adherence, lifestyle changes (physical activity, dietary change), self-monitoring (blood glucose, blood pressure), medication adherence, self-management of a chronic condition, and substance use such as alcohol or tobacco are all examples of behaviors and conditions that can be targeted with motivational interviewing.

What if there is not enough time to implement motivational interviewing into my current care delivery system?

Motivational interviewing is not something that can be fully implemented at every visit; however, the physician can add in a few reflections to get a better idea of what is happening with the patient regarding the target behavior. Maximize time by focusing on the patient and connecting with empathy to build trust. This will pave the way for future discussions regarding the target behavior and change. Any amount of time dedicated to motivational interviewing is beneficial.

Motivational interviewing acknowledges ambivalence, but does not seem to try to create cognitive dissonance.

Does cognitive dissonance have a role?

Cognitive dissonance theory has informed the development of motivational interviewing. Developing a discrepancy between where the patient was and where they want to be was one of the beginning principles of motivational interviewing.

It is now seen as more of a strategy one would use to help build discrepancy where there is none—especially when the patient is not ready to address the targeted behavior. Building discrepancy assists patients to articulate their current state and the steps they would like to take to arrive at their ideal end point.

Team Model for Integrating Self-Management Support into Patient Visits

How are medical and clinical assistants including the agenda setting in their workflow on top of other screenings and duties that are required at each visit?

Reviewing charts prior to a patient's visit can help identify necessary preventive care and screenings due at that particular visit. Armed with this information prior to the visit, it allows medical assistants (MA) to perform only needed screenings and care. Agenda setting with the patient is a technique that can identify the patient's priorities, organize the visit, and decrease the chance of the visit getting off topic (which increases physician time).

Can other non-clinician staff enter orders into the EHR?

For the most part, a majority of orders can be entered by other clinical staff as the physician signs off on the note. The team-based approach requires the team to share the work entered into the EHR. Please consult CMS and your state for more information regarding specific regulations pertaining to documentation.

How do you implement this model in a practice that has no experience or familiarity with team-based care?

Leadership support is important when implementing team-based care. Having practice leadership on-board will provide you with protected time, resources, and support to make change in your practice.

Piloting the self-management concepts of agenda setting, goal setting, and action planning with your team can be a useful approach before fully implementing in your practice. Use your peers to practice developing and refining self-management skills. Lastly, sharing your observations and experience with your peers can be helpful as you implement new self-management skills with patients.

Are health coaches necessary, or can support staff provide goal setting to patients?

If you are unable to employ a health coach, an MA can help employ the self-management services to patients.