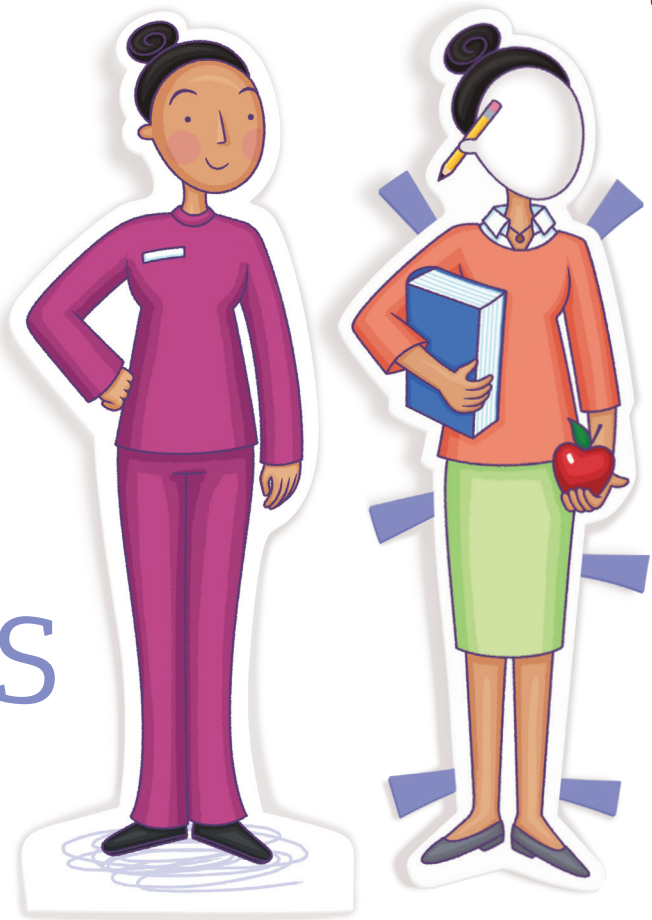


These multifaceted employees can improve patient care, generate additional net revenue, and prepare your practice for the future.

# Adding HEALTH EDUCATION SPECIALISTS to Your Practice



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Primary care practices are attempting to straddle two worlds. The majority of patient care is still delivered during face-to-face encounters with a single provider and reimbursed on a fee-for-service basis. However, new initiatives focused on quality and population care, such as the patient-centered medical home (PCMH) and meaningful use (MU) of health information technology, are bringing changes to the traditional practice model by promoting a team-based approach to patient care.

These changes raise important questions: How will

primary care practices implement quality improvement projects and keep up with the reporting requirements that these initiatives mandate? How can a practice with limited financial reserves hire additional team members to fulfill these models when it won't receive additional revenue until after these models have been fully implemented and performance has been recognized? What type of team members will practices need to hire to help fulfill these requirements? Our practice answered these questions by hiring a health education specialist (HES).

## About the Authors

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## What does a health education specialist do?

The HES in our practice serves concurrently as health educator, health coach, and practice quality coordinator (see “Health education specialist roles”). These roles are not yet widespread or standardized in our health care system, so we will first explain the general education requirements and skills of each role.

**Health educator.** A health educator is trained to encourage individuals and populations to engage in more healthy behavior and seek preventive care. They do this through directly interacting with patients, consumers, and other clients, or providing health education leadership on health teams in the practice and the community. They also develop, manage, and evaluate health education programs and services, health risk appraisal instruments, educational materials and curricula (e.g., printed, audiovisual, or web-based), and communication campaigns. In addition, they can conduct research as appropriate for program planning, implementation, and evaluation as well as market health programs and services.

It is recommended that health educators have at least a bachelor’s degree in public health, health promotion, or community health, and they can become certified through the National Commission for Health Education Credentialing. This certification ensures that an educator is proficient in the core competencies of the field and guarantees that the individual stays up-to-date by requiring 15 continuing education credits annually. Although the Centers for Medicare & Medicaid Services (CMS) does not currently require this certification, it is advantageous for the practice to require it because these individuals will be working under a physician’s license to perform initial Medicare annual wellness visits (AWVs) and subsequent AWVs.

**Health coach.** To be most effective in one-on-one patient care, the HES also should have health coaching skills. This is a patient-centered approach where the patient expresses his or her personal needs and desires for his or her health. The health coach acts as a guide and supporter as the patient truly becomes the driving force for the behavioral changes. Coaching optimally includes such steps as establishing a coaching alliance with the patient, assessing and exploring the patient’s needs, planning and committing to behavioral action steps and support, helping the patient devise a way to track and be accountable for his or her progress, evaluating behavior change over time, and developing and monitoring measurable outcomes.<sup>1,2</sup>

Educational requirements for health coaching would include a bachelor’s degree along with specialized certification in health coaching skills. There are no national standards for the field of health coaching, but several health coaching certifications are available.

**Practice quality coordinator.** The HES should also have the skills to assess needs and plan interventions and preventive services for the practice’s patient population if he or she is to be effective in guiding the practice toward meeting the objectives of PCMH, MU, and other quality-based initiatives. Criteria for both PCMH and MU require knowledge of not only electronic health records (EHRs) but also how to interpret data and incorporate strategic planning to move the practice toward patient quality indicators. The HES must be able to move between individual and population health care initiatives while motivating physicians and staff in workflow changes. In a sense, the HES must be able to coach practices through inevitable changes in the way health care is delivered.

An HES with a graduate degree in public health is ideal for this position because it provides training in assessing health characteristics and risk factors in populations; planning, implementing, and evaluating interventions to improve the health of a population; incorporating preventive practices into the care of individual patients; and conducting research and evaluating

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health outcomes. Note that adding this kind of expertise will make the position a lot more specialized and potentially more difficult and expensive to fill.

**Why not train a registered nurse or certified medical assistant?** Nurses traditionally have performed many of the HES roles described above. But we chose to hire a person trained in public health education because non-medical professionals have demonstrated that they can work effectively and well in primary care environments.<sup>3</sup> Also, an HES is specifically trained in behavioral theory and can implement interventions on the personal level as well as for the entire practice population. In addition we believe that with the ongoing primary care shortage, nursing professionals are most needed to perform their traditional roles, not to be retrained as educators.

An HES who does not have a patient care background is free to focus solely on patient education and motivation. There will not be the temptation (or patient

expectation) to provide traditional medical care or answer the inevitable medical questions that occur during coaching sessions, for example. A nonmedical HES can easily refer illness complaints back to the patient's primary care provider and stay focused on behavioral coaching.

### Our practice's experience

Our primary care practice serves a wide cross-section of our community's population. We provide approximately 24,000 patient visits annually. The payer mix includes 28 percent Medicare, 27 percent uninsured (sliding fee scale) or self-pay, 25 percent Medicaid, and 20 percent private insurance.

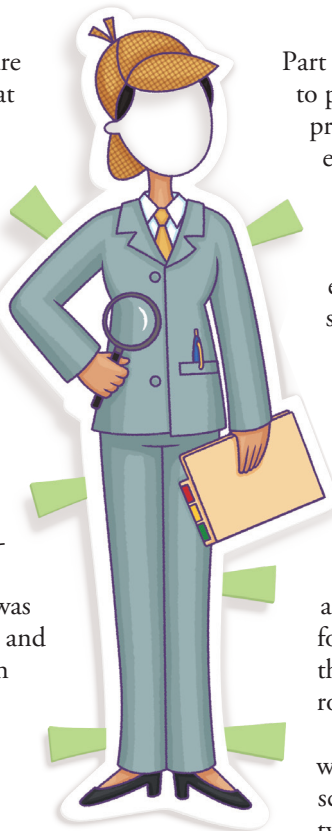
In late 2011, we hired our first HES. She was prepared at the master's level in public health and holds certifications in health education, health coaching, and motivational interviewing. Additionally, she has experience working as a health educator with similar populations in public housing.

Our HES has three specific work areas:

- Organizing, promoting, and performing our practice's Medicare AWWs,
- Participating in co-visits with a patient and his or her physician,
- Helping prepare our practice for the National Committee for Quality Assurance's PCMH recognition, MU, and Affordable Care Act requirements.

Following is an explanation of each work area in detail:

**Medicare AWWs.** Medicare has introduced three new



Part B benefits over the last few years designed to promote and improve patient health and prevention: the initial preventive physical exam (IPPE) and the initial and subsequent AWWs. The IPPE must be performed by a physician, but the AWW requires only physician supervision and not a physical exam or direct physician involvement. CMS says an AWW can be performed by a physician, a qualified nonphysician practitioner, or a medical professional, "including a health educator, registered dietitian, nutrition professional, or other licensed practitioner."<sup>4</sup> Medicare's definition of direct supervision specifies that "the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed."<sup>5</sup>

Our HES has promoted these visits with patient outreach and education. She schedules visits directly with patients. She typically sees the patient for 45 minutes to an hour during which she performs and

documents all of the items required by Medicare.<sup>4</sup> Our HES completes the note and forwards it to the patient's physician for review, which usually takes two to three minutes of the physician's time. If the patient has a medical complaint or question during the AWW, our HES schedules the patient to meet with his or her physician in a subsequent office visit unless a medical problem requires immediate attention. Since our HES took over

### HEALTH EDUCATION SPECIALIST ROLES

ROLE	JOB DESCRIPTION	TRAINING	CERTIFICATIONS
<b>Health educator</b>	Conduct annual wellness visits and act as patient resource and educator.	Bachelor's or master's degree in public health, community health, or health promotion.	Certified health education specialist – National Commission for Health Education Credentialing Inc.
<b>Health coach</b>	Conduct co-visits; work with physician and patient to clarify health goals, motivate behavioral changes, create accountability, and follow up; act as physician scribe.	Health coaching certification.	No national certification, but training programs could be accredited by third parties, such as the International Coach Federation or the National Board for Certified Counselors.
<b>Practice quality coordinator</b>	Assess, plan, implement, and evaluate practice patient quality measures, such as patient-centered medical home (PCMH), meaningful use of health information technology, and Affordable Care Act requirements.	No specialized training programs. Recommend a minimum of a bachelor's degree. MPHs, MBAs, and registered nurses have performed this role in the past.	National Committee for Quality Assurance does provide a PCMH Content Expert Certification. This is not a requirement for a practice to become PCMH-recognized. As of 2013, there were only 112 PCMH Content Experts in the United States.

## REIMBURSEMENT FOR HEALTH EDUCATION SPECIALIST VISITS

Billable Service	Who Performs Service	Physician Time	Health Education Specialist's Time	Reimbursement Rate*
Initial Preventive Physical Exam	Physician + health education specialist	15 minutes to meet with patient	45 minutes	\$156-\$165
Initial Annual Wellness Visit	Health education specialist	2 minutes to review documentation	1 hour	\$161-\$170
Subsequent Annual Wellness Visit	Health education specialist	2 minutes to review documentation	30 minutes	\$108-\$114
Health coaching co-visits	Physician + health education specialist	4-8 minutes to meet with patient, complete chronic disease follow-up, HPI, assessment, and plan	30 minutes plus weekly phone calls	\$43-107, depending on level of service charged

\* Based on nongeographically adjusted Medicare rates.

organizing and performing our practice's AWWs, visit documentation is much more complete and the percentage of our eligible patients who have completed an AWW has quadrupled.

**Co-visits.** Physicians typically initiate these for patients who they believe would benefit from health coaching, such as patients with chronic illnesses that are not well-controlled because of a lack of knowledge or medical compliance or lifestyle behaviors. We bill for co-visits similarly to how we bill for group visits<sup>6</sup> as they both involve a nonphysician doing much of the data gathering, instruction, and documentation, and then the physician meeting briefly with the patient to establish a conventional office visit.

The patient spends about 30 minutes with our HES working on education and/or personal motivation, and then the physician sees the patient for approximately five minutes to address chronic illness control. During these visits, our HES helps to facilitate history gathering and patient instructions.

For example, consider Ms. Smith, a patient with hypertension and obesity whose diabetes remains poorly controlled and who hasn't been able to lose weight despite years of regular medical care (see "Health coach co-visit algorithm"). Her physician, Dr. C, explains during a regular office visit that his practice has a new HES who helps patients achieve better control of their health challenges. Ms. Smith agrees to see Ms. L, the HES, who calls Ms. Smith to explain what health coaching is and to set up an appointment for a day when Dr. C is seeing patients.

During the appointment, Ms. L records Ms. Smith's vital signs with an automated blood

pressure machine and asks her to fill out a hypertension history form that includes all the questions in Dr. C's hypertension follow-up history. Ms. L takes a detailed diet, exercise, and motivation history. She explains that the main focus of the visit is to help Ms. Smith establish her personal health goals and that Dr. C will visit only briefly. If there are any new health issues, she will help Ms. Smith schedule another office visit with Dr. C. Ms. L documents Ms. Smith's obesity history of present illness (HPI) and loads Dr. C's hypertension template into the EHR. She notifies Dr. C that Ms. Smith made her appointment and informs him of any specific issues. Dr. C then comes in, reviews Ms. Smith's vitals, and goes over the previously completed hypertension follow-up history form. Dr. C also performs any needed physical exam. If necessary, Dr. C adjusts Ms. Smith's hypertension medications and then turns the visit back over to Ms. L. Ms. L creates and reviews patient instructions with Ms. Smith and schedules her follow-up appointment for one month.

After the visit, Ms. L completes her obesity HPI notes and documents an assessment and plan for obesity. She forwards the documentation to Dr. C. Dr. C reviews and comments on it and completes the hypertension HPI (using the form Ms. Smith filled out) and the assessment and plan, and he codes the visit as a level 3. The entire visit, including documentation, took Dr. C five to eight minutes, while the patient received 30 minutes of one-on-one health coaching from Ms. L. In addition to the face-to-face



## HEALTH COACHING CO-VISIT ALGORITHM

### 1<sup>ST</sup> APPOINTMENT PHYSICIAN

Physician offers Ms. Smith health coaching services

Physician sends referral to health education specialist (HES)

HES contacts Ms. Smith and schedules office appointment

### 2<sup>ND</sup> APPOINTMENT PHYSICIAN AND HES

#### HES DUTIES

- Takes Ms. Smith's vitals.
- Gives patient hypertension (HTN) and obesity follow-up questionnaire and helps patient complete it.
- Creates individualized health plan with Ms. Smith concerning her obesity, motivates for behavioral changes, and creates accountability.
- Documents obesity problem in chart.
- Forwards chart to physician for review.
- Maintains weekly contact with Ms. Smith for review of goals and continued accountability, documenting contact in patient's chart.

#### PHYSICIAN DUTIES

- Reviews vitals and HTN questionnaire with patient and performs any necessary physical exam.
- Documents HTN HPI (using EHR template), assessment, and plan.
- Reviews HES's obesity documentation.
- Bills for level 3 office visit.

HES schedules follow-up co-visit in 6-12 weeks.

If at any point during the co-visit, Ms. Smith presents urgent symptoms, the physician is notified immediately.



visit, Ms. L follows up with Ms. Smith weekly by phone until her next visit, reviewing her action plan, setting new behavioral targets, encouraging her, and recording her progress with medication compliance, diet, and exercise. See the co-visit charting example on page 15.

Medicare AWWs are reimbursed at approximately \$100 (see “Reimbursement for health education specialist visits”) for our practice, and Level 3 co-visits are reimbursed at approximately \$75. According to the U.S. Bureau of Labor Statistics, the median salary for a health educator in 2010 was \$45,830 plus benefits, so only three visits a day (estimated to generate \$54,000 per year, including holidays and vacation) and an additional 10 minutes per patient per week of phone time would more than cover the cost of employing a full-time HES. Meanwhile, three visits would require at most 25 minutes of physician time if they were all co-visits (AWVs would require much less), and the only additional overhead expense would be for office space. Depending on a practice's needs, we estimate a full-time HES could see six or seven patients a day.

#### Coordinating quality initiatives.

Our HES also serves as a practice quality coordinator, a role for “individuals who work with primary care practices to make meaningful changes designed to improve patient outcomes.”<sup>77</sup> Our practice obtained PCMH recognition in 2011. To accomplish this we had to pull several staff members from their daily clinic functions to help research, understand, and complete the requirements. The time requirement was significant enough that our staff members were required to work outside their normal schedules. They are unwilling to take on that extra work again, so we made the practice quality coordinator responsibility part of the HES position. As mentioned previously, the education and skill sets of an MPH graduate align ideally with this role. As we prepare to recertify for PCMH status in 2014, our HES will be responsible for coordinating clinic efforts and providing the documentation necessary to meet the requirements.

Central to these efforts is our HES's ability to retrieve data from our EHR. This training enables her

## CO-VISIT CHARTING EXAMPLE (PHYSICIAN AND HEALTH EDUCATION SPECIALIST)

### Physician-entered text is in blue.

Reason for visit: Hypertension follow-up

Vitals: BP 140/98, Pulse 98, Temp (Source) 98.4 °F (36.9 °C) (Oral), Height 5' 5" (1.651 m), Weight 297 lb. (134.717 kg), BMI 49.4 kg/m<sup>2</sup>

### Subjective:

HPI

#### HYPERTENSION

Disease monitoring.

Home BPs 140-50/upper 90s. Chest pain - No. Dyspnea - No. Medication compliance: Brings in all her meds, takes daily. Lightheadedness - No. Edema - Mild in ankles at end of day.

#### OBESITY

Current weight/BMI: BMI is 49.4 kg/m<sup>2</sup>.

How long has patient been obese? 10+ years. Course: Worsening.

Problems or symptoms it causes: HTN, patient snores loudly at night and has daytime sleepiness. Things patient has tried to improve condition: exercise.

Patient-identified concerns: Weight gain, prediabetes, sleeping difficulties.

Stage of change: Preparation. Patient has been making changes for < 6 months.

Patient-reported barriers: Inactivity, poor sleep schedule, skipping meals, not hungry, fruit juices.

Patient-reported perceived benefits: Avoid diabetes, feel and sleep better.

Self-efficacy: Patient displays low self-efficacy.

Behavior change support: Patient has a friend she works out with at the gym who is also working on weight loss.

Goals: Patient will keep 3-day activity journal including food intake, sleep schedule, activity schedule.

Patient education: We discussed myplate.gov eating guidelines: 1/2 plate vegetables, 1/4 plate starch, 1/4 plate protein. We talked about trying to eat something in the morning versus skipping breakfast and lunch.

### Objective:

Physical exam

Heart: Regular rate and rhythm. No murmurs, gallops, or rubs.

Extremities: No cyanosis, edema, or deformity noted with good range of motion of all major joints.

### Assessment & Plan:

HYPERTENSION, BENIGN SYSTEMIC

Assessment: Not well controlled.

Plan: Increase HCTZ to 25mg daily.

OBESITY, NOS

Assessment: Worsening

Plan: Continue weekly telephone counseling with HES. Patient will keep 3-day activity journal for review. Patient will go to gym 2-3 times a week with friend.

### Patient Instructions:


Measure your blood pressure regularly at home.

Keep taking the other medications and take whole HCTZ each AM.

I will call you in one week.

to identify our high-risk patients and create action plans to improve the quality of our patient care. This way we do not have patients slip through the cracks.

## Preparing for the future

Health education specialists, who have skills in health education, coaching, and practice quality coordination, can be very valuable to primary care practices. By performing Medicare AWWs and physician co-visits, they can earn their salary in our current fee-for-service world while improving documentation and patient care. Using their practice quality coordination skills, they can prepare and lead the practice into the future of population management and quality improvement. 

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