CARING FOR OUR COMMUNITY LIKE FAMILY

Volunteer Health Coach Program

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Value Based Initiatives

August Leadership Meeting **Priority Areas**

Based on the findings aggregated from key stakeholder interviews, community partners, community members and patients, **Valley's top three priority areas are**:

- Access to Care
- Behavioral & Mental Health
- Chronic Health Conditions

Health Coach Program - Addressing Priority Areas

Access to Care

- Identify and reduce impact of Social Drivers of Health for each enrolled patient
- Develop Community Partnerships and facilitate patient connection to resources
- Educate on and encourage use of MyChart

Behavioral & Mental Health

- Complete PHQ9 screening if not done within past 6 months
- Provide patient education on resources available
- Partner with patients to establish with a mental health professional

Chronic Disease

- All new or worsening patient-reported symptoms are reported to the clinic RN Care Manager
- Health Screening education and advocacy
- Partner with Lifestyle Medicine and YMCA to remove financial barriers for Medical Nutrition Therapy, Prescriptive Exercise, Diabetes Prevention, and Wellness Education*
- Educate and support Self- Management of Chronic Disease
- Lifestyle Change support

**Availability of funds is not marketed to the public and is only made known to patients after enrollment*

Alignment with Quality and Safety Team

Ambulatory Care Pathways Toolkits

Advance Care Planning	Asthma	Breast Cancer Screening & Colon Cancer Screening	
Chronic Opioid Management	Concussion	COPD	COVID-19
Depression & Suicide Screening	Diabetes	Diabetes Prevention Program (Prediabetes)	Fall Prevention
Hepatology	Hypertension	LGBTQ+	Low Back Pain
Lung Cancer Screening	Monkeypox	Otitis Media/UTI	Stroke Management
Substance Use Disorder, Opioid Use Disorder, and Medications for Opioid Use Disorder		Vascular Disease Screening & Management	Wound Care

CPG - Ambulatory Care Pathways Toolkit library (sharepoint.com)

Cost of Our Services

- Services are **FREE** to patients. This includes one-to-one weekly coaching with oversight from a Registered Nurse and a Social Worker and connection to community resources
- Administrative costs of the Health Coach Program are paid through **grant funding**
- Partnerships to alleviate financial inequities and facilitate patient participation in prescriptive exercise, diabetes prevention, medical nutrition therapy, and development of self-management skills are paid through **grant funding***

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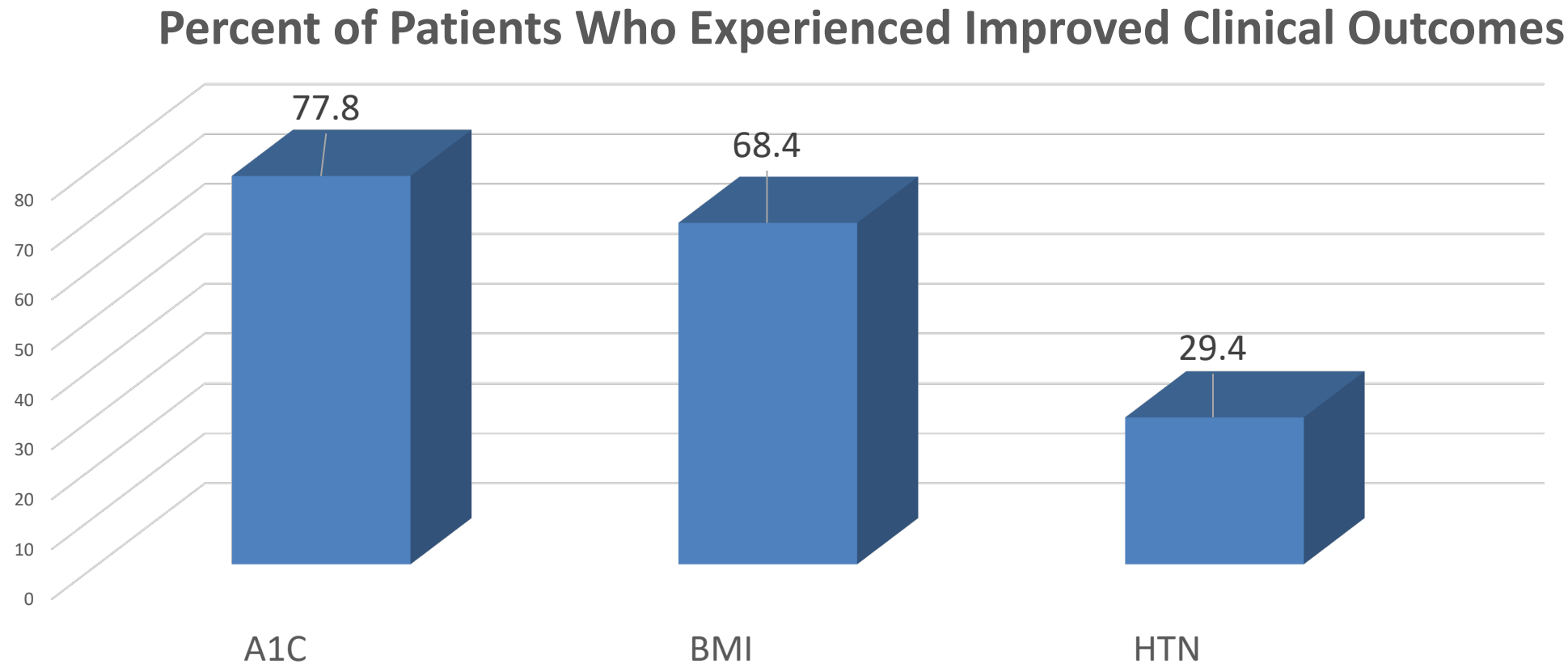
Is the Health Coach Program Effective?



As of Fall 2023. Outcomes analysis provided by UW statisticians.

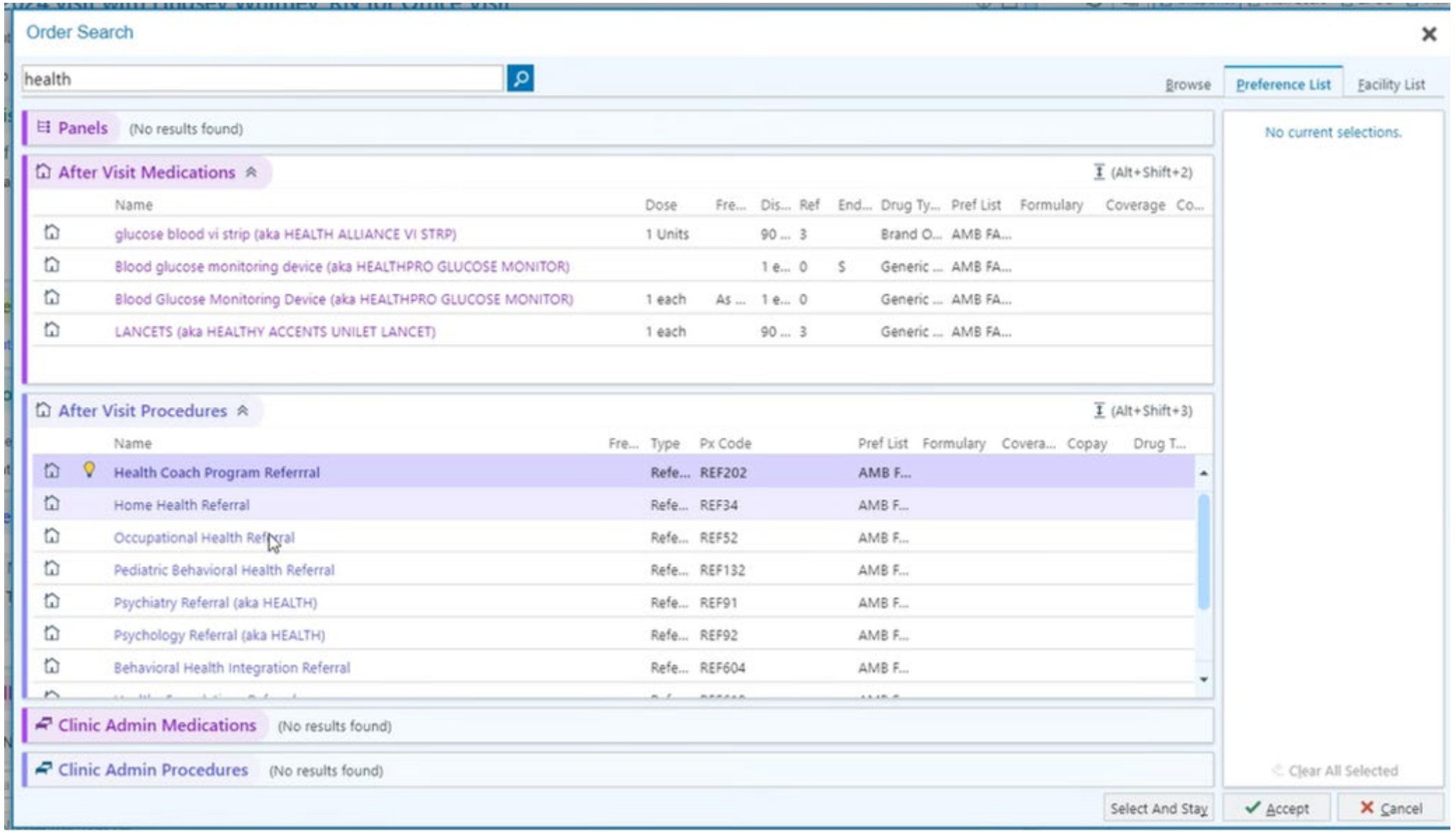
Patient Feedback. . .

- *Things are going great!* ***I love being able to talk things through*** *with Laila!* ***She's such a great listener and hype machine as well.*** *I really love working with her!*

- *Coaching with Angie is going GREAT!* ***[I] trust that she is SAFE, truly knowledgeable and GETS me*** *and the challenges I've encountered in my life. [My] previous learning and work to grow in self-awareness, skills and tools is acknowledged and appreciated by Angie.* ***It's a rare thing to be given credit for and genuinely honored as someone [who] has worked hard for a long time and just needs assistance applying things*** *day-in, day-out. I am thrilled by how everything is going. THANK YOU!*

How Do I Learn About My Patient's Progress?

- Initial enrollment interview is documented in Epic and routed to Provider for approval of our Plan of Care. Includes all SDOH-related and Clinical goals stated by patient
- A weekly visit report is included in an encounter in Epic. Available for review by any Team Member
- Any patient-reported new or worsening symptom is reported to the Clinic RN Care Manager
- A summary of the patient's progress toward goals and connection to resources is included in Epic at the end of the cohort and routed to the Provider as an fyi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Behavioral Health Integration Referral
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Clear All Selected
Select And Stay
Accept
Cancel

THANK YOU!

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