JNP

Health Coaching in Nurse Practitioner–led Group Visits for Chronic Care

Sang Mi Jeon, MSN, AGPCNP-BC, and Viola Benavente, PhD, RN

ABSTRACT

Health coaching and group visits are emerging as 2 effective strategies to improve patients' behavior in chronic care management. The purpose of this article is to describe a novel approach for behavior modification that integrates health coaching with group visits facilitated by nurse practitioners. Health coaching can strengthen nurse practitioner–led group visits by enhancing peer support through an interdisciplinary approach. This article also highlights the similarities and the differences between the 2 strategies, provides a relevant theoretic foundation, and summarizes important steps to apply health coaching in practice and overcome barriers with reimbursement.

Keywords: behavioral modification, chronic condition, group visits, health coaching, nurse practitioner, primary care

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Between 2000 and 2030, the number of Americans with 1 or more chronic conditions, such as heart disease, cancer, diabetes, stroke, and chronic lung disease, will increase by 37%.[1] They also account for 75% of health care expenditures in the United States. This disease burden portrait will exacerbate with the rapid aging population.[1] National initiatives from the Institute of Medicine, the Milbank Reports, and the Robert Wood Johnson Foundation Report emphasized patient empowerment and engagement are significant to improve quality and safety in patient care.[2] A patient-centered approach would help clinicians and patients make individualized decisions about optimal care for common clinical situations and explicitly incorporate patients' preferences.[3] Guiding people to develop the knowledge, skills, and motivation to make healthier choices is seen as an essential part of the national prevention strategy for improving the efficiency of health care in the US.[4] This article presents a novel approach for group visits enhanced by NPs who act as a health coach to improve patient behavior in managing chronic care conditions.

BACKGROUND

The current health care system, which provides a 15-minute time allotment per patient, is insufficient to teach these self-care skills, leaves patients frustrated, and increases the hospital readmission rate.[1,5] To make it worse, the Affordable Care Act–driven patient influx will increase the burden on the shortage of primary care providers. The Chronic Care Model (CCM) addresses this major deficiency in the delivery of effective chronic care management.[6] The CCM is an evidence-based framework to guide quality improvement of chronic care since its development in 2001.[7] The CCM consists of 6 elements with specific recommendations for changes in each one: self-management support, decision support, delivery system design, community resources and policies, organizational support, and clinical information systems.

The CCM fosters productive interactions between prepared, proactive patients and the health care team for both the health coaching or group visit approaches. Within the CCM, health coaching fits in with self-management and developing personal skills,

such as decision support. Group visits involve the delivery of medical care using the CCM as a framework.[8] The group visit model has expanded in primary care for decades, and adding health coaching within the group visit would make it an innovative delivery system. This type of delivery system creates a supportive environment and values peer interactions that are crucial in facilitating positive lifestyle and behavior changes. Research provides substantial evidence that applying elements of the CCM will improve care and clinical outcomes for individuals with chronic disease.[9]

PURPOSE

The purpose of this article is to describe a novel approach for behavior modification that integrates health coaching with group visits specifically led by nurse practitioners (NPs). This approach emphasizes using a lead facilitator, such as an NP who is well prepared in health coaching, in a group visit for chronic care to promote long-term behavioral changes and cost-effective care. Compared with the group visit model, there are few published reports regarding health coaching techniques and even less in practice.

THE GROUP VISIT FORMAT

NPs have been the main contributors in the group visit practice as prescribers and facilitators through an expanded scope of practice. The competency of NPs with behavioral modification in chronically ill patients was found to be particularly valuable for practices and approaches that related to self-management support, decision support, and delivery system design through a qualitative case analysis.[10] The NP is trained to think holistically and foster team building that motivates patients in a group visit setting.

However, if the lead facilitator lacks behavioral change skills, improvements of clinical outcomes in chronic patients will not be guaranteed.[6] In the absence of effective facilitation of coaching by an expert, the group visit can only be the combination of an educational session with a primary care appointment for multiple patients in a single visit.[11] The facilitation of behavioral change techniques by skilled professionals, such as health coaches, can maximize the effectiveness of the group visit.

Group visits are also known as a shared medical appointment or a drop-in group medical appointment. Major medical institutions nationwide, such as Harvard-Atrius Health, Cleveland Clinic, Massachusetts General Hospital, and Dartmouth-Hitchcock, have been aggressively promoting this type of practice. The shared medial appointment or drop-in group medical appointment model developed by psychologist Noffsinger requires a multidisciplinary team of providers.[12] In other models of care, the group visit is conducted by a physician, either alone or with a nurse to lead the education component, and can focus on different populations like the Centering Pregnancy for prenatal care discipline and Kaiser Colorado's Cooperative Health Care Clinic for the geriatric population.

Team Members

The lead facilitator can be a prescriber, nurse, or invited psychologist or behaviorist. A prescriber is either a physician, an NP, or a physician assistant (PA). Other team members are a registered nurse, a medical assistant (MA), a dietician, psychologist, and support staff. At least 3 key team members are needed for a successful group visit such as a prescriber, behaviorist health care provider, and support staff.

Qualifications

Qualifications to be a competent lead facilitator encompass several domains. Clinical competence involves medical chart review, disease-related education, clinical data interpretation, clinical reasoning ability, prescription, and medication adjustment privilege. Facilitation methods include knowing how to create well-defined parameters for the group, how to deal with certain personality types (such as dominant, troublesome, or quiet group members), and how to manage and respond to questions. Building group cohesiveness and keeping group discussions robust are also important skills to possess as a group lead facilitator. The techniques for stress management, such as breathing exercises, meditation, and muscle relaxation, can enhance patients' self-management in their chronic care outside of practice.[13] Moreover, traditional clinical training

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