COACH Reference Guide

OCTOBER 2019

This guide identifies practices and techniques to be employed by care teams with patients to establish an authentic healing relationship (AHR). It can be used to track progress in supporting patients to reach their goals. The practices and techniques below are not meant to be performed sequentially, and the timing may vary depending on the patient's unique needs.

The care team has a shared understanding of the following:

C

CONNECT
Tasks with Vision and Priorities

Use reflective, empathic language & open-ended questions to understand what the patient truly wants for him/herself beyond being healthy and staying out of the hospital; Reflect on the patient's short-term and broader vision to motivate the patient throughout the intervention and understand how to address 'tug of war' scenarios.

- ☐ **The patient's goals for the intervention.**
- ☐ **The patient's long-term vision for him/herself.**
- ☐ **The dominant core need for both the patient and care team members throughout the intervention.**

O

OBSERVE
the Normal Routine

Meet the patient where he/she is; Observe the patient without intervention or judgment and ask open-ended questions to understand how the patient manages his/her health condition, as well as social issues and barriers; Build on systems the patient already has in place.

- ☐ **The patient's strengths, level of need, and level of independence for identified domains.**
- ☐ **The situations that are "high stakes" moments for the patient.**
- ☐ **The long-term support strategy identified by the patient.**

A

ASSUME
a Coaching Style

Choose a coaching style ("I do" "We do", "You do") and model behavior based on the patient's level of independence and social support to better equip him/her with the skills to promote long-term strategies.

- ☐ **The patient's level of independence and coaching style to use for identified domains.**
- ☐ **Short-term goals for moving toward independence (moving to "You do") on identified domains.**
- ☐ **Long-term goals for moving toward independence on identified domains.**
- ☐ **Situations that are exception scenarios and do not require coaching.**

C

CREATE
a Care Plan

Use domain cards and motivational interviewing to conduct an active conversation with the patient to develop a care plan based on the patient's priorities and identify the steps necessary to achieving short and long-term goals.

- ☐ **The domains that are long-term goals.**
- ☐ **The domains that may require motivational interviewing.**
- ☐ **Care Plan for client to achieve goals, both for the duration of the Camden intervention and beyond.**

H

HIGHLIGHT
Progress with Data

Monitor the patient's progress with Care Planning Domains identified as a result of the Care Plan; Use progress templates to actively discuss and highlight progress with the patient throughout the intervention. Highlight small wins towards larger goals to continually motivate the patient.

- ☐ **The domains that are considered 'successes' for the patient.**
- ☐ **Patient progress in each of the identified domains that are priorities.**
- ☐ **Changes in the patient's medical and social status throughout the intervention.**
- ☐ **Appropriate language to use when praising the patient on progress (focus on process, not person).**

SEE REVERSE SIDE FOR THE COACH PRACTICE GLOSSARY.

COACH Practice Glossary

OCTOBER 2019

The practice glossary defines key concepts and techniques to be employed by care teams. An understanding of these core practices is essential to implementing the COACH model and to establishing an authentic healing relationship (AHR). The practices and techniques are not meant to be performed sequentially, and the timing may vary depending on the patient's unique needs.

CARE PLAN

The care plan starts with the identification of patient priorities, and the client's vision for him/herself. With an understanding of this vision and underlying core need(s), the care team develops a clear, realistic plan with the patient for meeting the patient's short-term and long-term health and social needs.

CARE TEAM

The care team is made up of a registered nurse (RN), licensed practical nurse (LPN), a community health worker, and a health coach. The care team is led by a social worker, a psychologist, and the Clinical Director.

CARE PLANNING DOMAINS

Care Planning Domains are health and social needs that may affect the client, such as transportation, legal issues, and medication support. As part of "creating the Care Plan," the care team reviews "domain cards" with the patient. This allows patients and providers to have a meaningful discussion around patient priorities, and develop a mutually agreed upon care plan.

COACHING STYLES

The goal of choosing a coaching style is for the patient to become independent and confident in performing key activities related to his/her chronic health management and systems navigation (for example, arranging transportation, making an appointment, taking medication, etc). The first step is to assess the patient's level of independence for a designated task and his/her overall level of social support, which will determine which of three coaching styles to assume:

- "I DO": The patient cannot perform the task on his/her own and/or has a limited social support system. The task could also involve a highly bureaucratic system. The care team performs the task and models it for the patient.
- "WE DO": The patient is able to start the task but gets stuck at an intermediary step. There are gaps in the patient's ability to complete the task. The care team performs the task with the patient.
- "YOU DO": The patient is able to complete the task on his/her own but may lack the confidence necessary to complete the task. The care team observes the patient completing the task to provide positive reinforcement and build confidence in the patient.

NOTE: The ultimate goal is that by the end of the Camden Coalition intervention, the patient will be a "You do" or a "We do" in partnership with the long-term support person, for all tasks that are essential to managing his/her chronic health condition and social issues/barriers. It may take multiple sessions with the care team for the patient to progress through each of the coaching styles.

DOMINANT CORE NEED

Core needs are underlying needs and desires that affect motivation and behavior. It is important for care team staff to actively identify both the patient's and his/her own dominant (primary) core need throughout the intervention. The purpose of identifying the patient's core needs is to create a common language around the patient's broader vision and to identify strategies or resources to fulfill that vision. Core needs fall into three categories:

- SIGNIFICANCE: Deep desire to feel important or recognized.
- LOVE & BELONGING: Deep desire to feel accepted and have social support.
- CERTAINTY & SAFETY: Deep desire for stability, a plan, and controlled surroundings.

NOTE: Core needs are not meant as distinct categories to label patients, but rather are used to facilitate communication amongst the care team related to "what a patient wants."

HIGH STAKES MOMENT

A high stakes moment occurs when the care team should not observe the patient's normal routine, but rather intervene and problem-solve for the patient in that particular moment. This moment could be, but is not always, a medical emergency. These moments include an event with a strict deadline, and an event that is unlikely to happen again soon.

An example of a High Stakes Moment is an Exception Scenario:

An exception scenario is a high stakes moment that is a medical emergency. In this case, the care team should not coach the patient but rather respond to and validate the patient's expertise. Exception scenarios could also be a potential medical emergency, for example when the patient has a plan to go to the emergency room.

LONG-TERM SUPPORT SYSTEM/STRATEGY

The long-term support system/strategy is identified by the client as the system/strategy that can support the patient in managing his/her chronic health condition and social issues/barriers beyond the Camden Coalition's intervention. This could be a formal (primary care physician, recovery sponsor, pharmacist, etc.) or an informal (family member, friend, partner) support person, or a community resource. Ideally, the patient will identify more than one long-term support person and/or resource.

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a client-centered, evidence-based method of facilitating behavior change. Motivational interviewing uses empathy, reflective listening, open-ended questions, and a collaborative relationship to inspire motivation to change.

"TUG OF WAR" SCENARIO

"Tug of war" scenarios occur when the priorities of the care team do not align with that of the patient, or the patient is not making progress in the Care Planning Domains identified as priorities. To avoid and/or overcome these scenarios, it is important for the care team to identify the patient's dominant core need and be able to articulate that back to the patient while connecting smaller tasks to the broader vision. Furthermore, the care team should continue to highlight small wins or progress that the patient has made thus far in the identified domains.

Guide developed in partnership with PolicyLab, Children's Hospital of Philadelphia

Camden Coalition
of Healthcare Providers