**Comments of the Integrative Health Coach and Patient Navigation Certificate Program on the Connecticut Healthcare Innovation Plan Draft 1.1**

**November 29, 2013**

The 12 credit certificate program of study, entitled the *Integrative Health Coaching and Patient Navigating (IHCPN)*, joins together the art and science of health coaching with patient navigation.

It connects the preventative aspects of patient care (i.e. wellness strategies, nutrition, and optimizing emotional, spiritual and psychological health) with the functions of helping patients and their families navigate *challenging* healthcare systems.

Health coaching is a partnership between individuals and their coaches, with the objective of achieving personal health and wellness goals. The approach is *integrative* because it draws on the principles of behavioral psychology and the practices of motivational interviewing and goal setting to make sustainable lifestyle changes.

Patient navigators guide individuals through increasingly complex healthcare systems, including the understanding of healthcare insurance and completing forms, coordinating specialty care, and securing referrals to ensure care plans are understood and followed.

By blending these different, yet inherently interconnected functions of these two fields, the program mission is to *provide the knowledge and experiential learning that will enable practitioners' to facilitate sustainable lifestyle changes to support wellness and disease prevention, and provide assistance to help overcome health system barriers that simplify timely access to medical and psycho-social care.*

This program was created in response to the growing body of evidence that demonstrates the efficacy of preventative and integrative approaches to maintaining health and wellness. It is the first and only program in the state to combine health coaching and patient navigation and is expected to fulfill a vital new occupation in the healthcare system. Participants who complete the 12-credit certificate program and the post-program 100-hour coaching practicum will be well-poised to enter this emerging profession, and are eligible to apply for their professional coaching credential with the International Coach Federation (ICF).

We thank the SIM SHIP for coming to provide the group with 2 presentations and this opportunity for feedback. Based upon thorough review of the proposal and conversations within the professional domain and with consumers of healthcare, we would like to offer the following feedback for consideration and adoption into the proposal. Each area of feedback focus is broken down and aligned with the sections in the proposal – the text from the proposal will be italicized and the comment/feedback of the IHCPN community is in bold text.

***Roles needed to implement the new capabilities and processes***
*Connecticut's AMH model will require a care team of various healthcare service and support providers. Primary care and behavioral health providers must collaborate closely for this to work. Each team will have a set of "core providers" who handle primary care (e.g., PCPs, APRNs, and care coordinators). Initially on a pilot basis and eventually more widely, we anticipate more fully integrated care teams with specialists, behavioral health providers, physician extenders, dietitians, pharmacists, oral health providers, and community health workers. Any other class of caregiver can also be included when deemed necessary.*
*The model's flexibility allows the consumer's health needs and desires and the structure of the practice or organization to shape the composition of care teams and the accountable provider.*

**Workforce Development:**
**It will be critical to define and identify the group of individuals invested in coordinating or tying all of the parts of healthcare together (Patient Navigators) and the group of individuals invested in facilitating the necessary lifestyle changes needed to restore/preserve wellness (Integrative Health Coaches).**

**The definitions in this proposal around CHWs, care coordinators, patient navigators, etc. are vague at best and open to many interpretations. This may be intentional but it makes it difficult to evaluate the program if each focus group assumes that how they define a role or construct is what is actually reflected in the plan. "Coordination" is one of those constructs. Who is overseeing and coordinating the different layers of care from the community, outpatient, inpatient and extended care settings? This is certainly not a role for one individual within a moderate/large AMH. This requires a network especially until the HIT is fully functioning. Patient Navigators could easily form the crux of this network. The integrative health coach focuses on health, not disease, and the promotion of health and wellbeing. The IHC is the critical component of the equation for better health and patient self-management, and must be identified in this document as such.**

**Whole-Person Centered Care and Team-based Coordinated Care:**
**There is an opportunity for an integrative health coaches to become part of the care team as "physician extenders", helping to improve outcomes and reduce the need for PCP and specialist visits through preventive strategies. In addition, the patient navigation aspect will be particularly necessary in creating the "warm hand-offs" between specialists, providing greater access to care, care coordination, etc.**

**Attribution of consumers to providers**:
**There is an opportunity for IHCPN's to help educate consumers on all aspects here - why and how to choose a PCP, how care may differ if they select a PCP, how to make best use of the new approach to primary care, etc.**

**Consumer Empowerment:**
**Similar to attribution, IHCPN's can play a huge role in this area both within primary care practices and outside of practices. In addition, IHCPN's may be able to assist with enhancing the tools and info being developed to enable health, wellness and illness self-management - what information and tools will be most valuable, how can they be developed and presented in a way that will motivate consumers to access *and make use of them, etc.***

*According to the draft, The SIM provides a unique opportunity to transform the partnership model between consumers and providers today. Consumers have reported barriers to engaging with their providers due to inconvenient appointment times, time constraints, during visits, limited methods for inter-visit communication, and transportation issues. Consumers also tell us that providers sometimes fail to understand their needs as a whole-person. At the same time, consumers have difficulty understanding medical information provided to them due to language and literacy barriers, limited tools to support decision-making, and a lack of quality and cost information.*
*Opportunities to engage consumers also exist outside of the care delivery system.*
*Looking beyond healthcare and benefits, we believe it is important to begin to promote methods for improving diet and exercise, health behaviors that have a great deal to do with the emergence and control of chronic illness, but which are notoriously difficult to influence through the care delivery system. Our initial steps in this direction focus on pilot initiatives to promote nutritional purchasing and healthier eating.*
*Through our extensive stakeholder engagement process, we have assembled a robust understanding of the identified needs and created mechanisms to address the issues. Employers, payers, participating providers, and the state will each play a role in executing a four-pronged strategy:*

- *Implement formal mechanisms for on-going consumer input and advocacy*
- *Provide consumer information and tools to enable health, wellness, and illness self-management*
- *Introduce consumer incentives to encourage healthy lifestyles, high value healthcare choices and effective self-care*
- *Improve access to health services*

**There is limited information in the proposal that identifies educational resources for the patient, and furthermore, if the consumer is not actively educated about how to begin to use educational resources and can identify how it can be applied and integrated into his/her life, it is useless. This is another example of where the help and guidance of the coach is critical--to ask the right questions and to support the patient/consumer by taking a personal interest and holding the individual accountable for making these changes. This is the crux of consumer empowerment and consumer/patient engagement and activation. The health coach is part of the team of healthcare professionals working together with the patient, in partnership with the patient, from a holistic and integrative health perspective. The team as well as the community at large will support the patient, but it is the integrative health coach that will work closely with the client, assisting and guiding and empowering the individual to make the self-directed changes in support of better health. Most of the chronic diseases that are to be managed are lifestyle diseases and it is the personal one on one guidance of the coach in examining the lifestyle, environmental, cultural, and economic factors facing the individual that may be barriers to change. The coach uses the skills of inquiry to compassionately assist the client to identify the changes they can easily and readily implement, and supports the client in making these changes.**

**This is where a more open-minded, culturally sensitive innovative plan would include well researched complementary therapies. It is also the perfect place for IHCs who are trained to partner with people to empower them where they are and empower them to move forward in their wellness goals. There needs to be alignment on the desired outcome, and it needs to be done with a humanistic approach, allowing the patient to move past "managing" their**

**illness, to healing their life. This also relates to health equity. Well researched complementary therapies should not be limited to those that can pay "out of pocket".**

These are initial thoughts regarding how IHCPN's can fit into the SIM proposal. However, because this is a new role, it will be extremely important to explicitly define the role of IHCPN's**. It seems that a specific section in the proposal, such as the section on Community Health Worker's, might be the best way to communicate how IHCPN's can fit into and provide value to the proposed model and future of health care in general. Alternatively, it might be useful to include IHCPN's within the CHW section, to compare and contrast the roles of these two professions.**

Regardless of how or where it is written in, it is important to include the following:

- What is the role of an IHCPN and how does it differ from CHW's?
- What do we see as the future requirements for this role/how do education requirements differ from CHW's? IHCPN's require a graduate-level certificate, and potentially in the future, state credentialing and licensure.

*Respectfully Submitted on behalf of the colleagues of the Graduate Institute's Integrative Health Coach and Patient Navigation Certificate Program, the Executive Director, Christi Holmes and Academic Directors, Bernie Siegel, M.D. and Catherine Wagner, Ed.D.*

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