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A Day in the Life of a Home Health Aide/Health Coach

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I have been a home health aide (HHA) with the Visiting Nurse Service of New York Partners in Care division since 2011. In 2014, I also became a health coach. We are piloting several coaching models, with the help of grant funding, to see which may be effective and sustainable. In some of our pilots the aides have integrated coaching into their everyday HHA work as they serve patients. In other pilots, like the one I am working on, health coaches work with the patient in addition to the usual services provided by aides, nurses, and therapists. I was one of the first health coaches trained and now help patients establish and work toward their own personal health goals. Currently, I am working with patients who have a history of stroke and continue to struggle with risk factors like high blood pressure. This initiative is part of a National Institute of Neurological Disorders and Stroke, NIH – sponsored trial. We are working to lower the risk of recurrent stroke.

It's Thursday and I will perform my usual HHA duties for the first part of the day, and my health coach duties in the afternoon. This week, I am being observed for my annual HHA compliance requirement. At 9am, I meet a nurse at a patient's home in upper Manhattan. The patient is 80-years old with a heart condition. I wash my hands, review the patient's plan of care, and ask the patient what she wants me to do for the morning. The plan of care requires daily blood pressure and blood sugar checks. Under the observation of the nurse and with the patient directing, I help the patient with both of these and put the information in the patient's log. The nurse also observes me helping the patient with transfers as she is at risk for falls. I look around the apartment, roll up and store a small throw rug, and clear paths so that the patient can more easily move around. After the nurse leaves, I stay on to wash dishes, prepare lunch and dinner, and clean up a bit. Before I leave, I make sure that patient is all set for the rest of the day. I will be back tomorrow morning.

After a quick lunch, I head to Brooklyn, a 45-minute subway ride, for a joint visit with one of our nurse practitioners (NP). The NP, Sophia, who has been working with this patient over the past four weeks, is now transitioning the case over to me. Sophia and I already talked, so I know the patient is 57-years old, had a stroke about five years ago, a heart attack last year, and is still having a hard time with his blood pressure and has memory issues. His blood pressure at this visit is 146/88, which apparently is better than it has been recently but above target. Today, we talked with the patient about tools to help him keep his upcoming medical appointments. He chose to set up an alarm on his phone and put a reminder note on

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his refrigerator. We then helped him prepare a list of questions he wanted to ask his doctors and I set up a follow-up coaching call with him.

I head back to the subway to visit another of my patients. Unfortunately the patient was not home. Some of our patients struggle to keep their appointments organized and focus on their health as a priority. I reach the patient on her cell phone and she apologizes for forgetting but still wants to have the coaching visit, so we reschedule. Since I have another patient in the area, I give him a call and he says that I can come over. This is a 65-year old patient I have been working with for a few weeks who is struggling with medical and financial issues. He is paralyzed on his right side and is very frail. He had two modest goals for the week – calling to find out his enrollment status with the Managed Long Term Care (MLTC) program he had an assessment with a couple weeks ago, and to think about accepting home delivered meals. He is significantly underweight so needs, but does not get, regular meals. At our last visit, he resisted home delivered meals but really could not say why, so he agreed to think about it a bit more. The patient is in a better mood than recent visits. His daughter had been by and left some groceries and meals. A temporary fix at least. He didn't want to talk about home delivered meals except to say that it would make him feel old if he got them. He had not yet called the MLTC program but he found the number and called while I was there. He found out that he will be enrolled next month. I noticed that his pill box was not filled and found out that he didn't have his refills. I woke up his son who was sleeping in another room and had him go to the pharmacy. The patient set up a new goal for eating three meals a day for the next two weeks and recording missed meals in a log and include why they were missed.

I head home to make a few phone calls. The first is to my coach. Yes, the coach has a coach. Antoinette works with me on my motivational interviewing (MI) technique. She is member of the MI Network of Trainers. With the permission of patients, I audio-record my coaching sessions. Antoinette listens to them and provides me with feedback on use of open-ended questions, my reflections, and the goals that I help the patients set. Today we discuss how to make my coaching calls more productive. I sometimes find it hard to engage patients on the phone and have a specific patient right now who is challenging me. We talked about using phrases like “describe what your day was like” and “tell me more about it” so I can avoid yes/no answers. We also talked about how I can become more aware of when the patient is getting off topic and how to redirect the patient back to topics we were discussing. After this I have a quick follow up call with a patient to find out how she did with getting out to the senior center – her goal for the week. She didn't make it to the center, but did get out to visit a friend.

Next, I send a quick text to one of the other NPs on the project, to confirm we are all set for a joint visit scheduled for tomorrow. Before I call it a day, I enter some of my notes into our eClinical Works, the electronic health record that both the NP and I record our notes in. The trial coordinator completes weekly fidelity reviews on Fridays and I will hear from her if my notes aren't done. As you know, the visit isn't complete until the paperwork is in!

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Suggested callouts

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