

TENNESSEE  
HEART HEALTH  
NETWORK

WHITE PAPER



# Implementing Health Coaching in Tennessee to Improve Cardiometabolic Health

A TENNESSEE HEART HEALTH NETWORK RESOURCE

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## Executive Summary

Tennessee faces persistent health challenges, including shorter life expectancy than the national average and higher rates of chronic conditions such as obesity, diabetes, and hypertension. These challenges demand scalable evidence-based preventive strategies to improve outcomes and reduce costs.<sup>1</sup> Motivational Interviewing (MI)-based health coaching offers an evidence-based approach to empower individuals, improve self-management, and increase access to essential preventive care. Decades of research demonstrate that MI enhances medication adherence, blood pressure control, and lifestyle behaviors, while fostering trust and engagement among patients and providers.<sup>2-4</sup>

Tennessee is well positioned to advance Make America Healthy Again (MAHA) evidence-based preventive priorities, since MAHA's focus on early intervention, prevention, and long-term wellness is highly aligned with the state's ongoing efforts.<sup>5</sup> Tennessee has already established industry leading guidelines for reimbursing health coaches in team-based care.<sup>6-8</sup> Tennessee-specific initiatives, including the Neighborhood Health Hub and Lifedoc Health programs demonstrate how integrating health coaches into care improves health outcomes.<sup>9-11</sup> These programs demonstrate the feasibility and impact of MI-based health coaching in both clinical and community settings, offering scalable models for improving health outcomes, reducing disparities, and generating cost savings.<sup>11-13</sup>

This white paper provides an overview of the evidence supporting MI-based health coaching and its application within Tennessee. It highlights national trends, state-specific health challenges, and the role of health coaching in addressing chronic disease and health disparities. The recommendations outlined here are designed to guide organizations in implementing scalable, patient-centered strategies that align with Tennessee's population health priorities.

To inform this work, the Tennessee Heart Health Network Executive Council, its Population Health Subcommittee, and Tennessee Population Health Consortium staff reviewed national and regional implementation science literature, consulted with national and regional experts, and assessed case studies documenting the experience of Tennessee health care organizations implementing health coaching programs. The results, presented in this white paper, provide a framework for Tennessee policymakers, health plans, and healthcare providers to improve care by implementing evidence-based health coaching programs. Five key recommendations for Tennessee arise from this review:

- Health coach certification standards should continue to emphasize fidelity to the evidence-based MI health counseling approach given its proven effectiveness;
- Increase access to affordable training and certification in MI-based health coaching, including:
  - Foundational MI training and certification for all healthcare workers to increase counseling effectiveness, person-centeredness, and improve clinical outcomes;
  - Advanced health coach certification should be provided for all non-licensed lay staff directly supporting behavior change;
- Promote integration and sustainability of health coaching in health systems across Tennessee by continuing to align state Medicaid, Medicare, and private insurance payment policies.<sup>6-8</sup>
- Tennessee health plans, community-based organizations, and healthcare providers should work together to increase access to MI-based personal health coaching for all Tennesseans struggling with cardiometabolic health conditions.

National and Tennessee evidence is unequivocal: Every Tennessean could benefit from access to evidence-based personal health coaching as a fundamental component of recommended preventive care. Tennessee is poised to become a national leader in prevention of chronic disease by integrating MI-based health coaching into every health system in Tennessee.

## Introduction

Nationally, chronic diseases account for 8 of the 10 leading causes of death in the United States, including heart disease, stroke, and diabetes which affect more than half of the population.<sup>14</sup> Further compounding the issue, many individuals experience multiple chronic diseases and account for a disproportionately high share of health care resources and costs. Rural populations and racially and ethnically diverse communities are disproportionately impacted, facing higher prevalence rates, greater barriers to care, and worse health outcomes.<sup>1,14,15</sup>

Tennessee faces persistent health challenges, including shorter life expectancy than the national average and higher rates of chronic conditions such as obesity, diabetes, and hypertension.<sup>1</sup> While poor outcomes affect all Tennesseans, vulnerable populations are disproportionately impacted, with notable disparities across racial, ethnic, gender, and geographic lines. Overcoming these disparities requires coordinated strategies that align with Tennessee's public health priorities and leverage evidence-based interventions to improve outcomes and reduce costs.<sup>1</sup>

Responding to Tennessee's health challenges requires scalable, evidence-based strategies that go beyond traditional care models. Motivational Interviewing (MI) based health coaching offers an evidence-based approach to empower individuals, improve self-management, and increase access to care. Decades of research demonstrate that MI enhances medication adherence, blood pressure control, and lifestyle behaviors, while fostering trust and engagement among patients and providers.<sup>2-4</sup> MI is supported by numerous published rigorous research studies including multiple meta-analyses and systematic reviews demonstrating its effectiveness across diverse populations and chronic conditions.<sup>3</sup>

Tennessee has developed industry leading state guidelines for certification and reimbursement of health coaches in the context of team-based care through the work of health plan, provider, and TennCare stakeholders participating in the Tennessee Heart Health Network ([www.TNHeartHealth.org](http://www.TNHeartHealth.org)).<sup>6-8</sup> Over three years, stakeholders reached consensus and published guidelines on health coach training and certification standards and approved billing codes for preventive and chronic care services to enable Medicaid to reimburse health coaching services in the context of team-based primary care. Tennessee's payment guidelines align Medicaid, Medicare, and private insurance in encouraging delivery of essential preventive services—such as weight management, tobacco cessation, and diabetes education—by health coaches.<sup>12</sup>

Tennessee-specific initiatives including the SafeMed Program, Management of Diabetes in Everyday Life Program, the Neighborhood Health Hub Program, and Livedoc Health's Health Coaching and Integrated Multidisciplinary Team Model demonstrate how integrating health coaches into care teams improves health outcomes and addresses social determinants of health.<sup>9-11,16-18</sup> These programs demonstrate the feasibility and impact of MI-based health coaching in both clinical and community settings, offer scalable models for improving health outcomes and reduce disparities. Strategies such as leveraging MI-based health coaching in primary care and community settings, aligning documentation and billing codes, and partnering with Managed Care Organizations can improve health outcomes, advance health equity, reduce avoidable hospitalizations and Emergency room visits which in turn reduce cost of care.<sup>12,13</sup> By expanding access to health coaching across clinical and community settings, Tennessee can continue to build on its progress to demonstrate a sustainable, high-value model of preventive care that measurably reduces chronic disease burden and enhances population health statewide.<sup>9</sup>

# National Evidence for Motivational Interviewing-based Health Coaching

## National Models for Prevention and Chronic Disease Management

Prediabetes is a major public-health challenge in the United States, affecting 115.2 million adults, or more than one-third of the adult population.<sup>19</sup> Without effective intervention, many of these individuals will progress to type 2 diabetes, significantly increasing their risk of cardiovascular disease, kidney disease, and other serious complications. A large body of research shows that structured lifestyle intervention programs play an important role in improving health outcomes and slowing the development of chronic disease, specifically the transition of prediabetes to diabetes. The landmark Diabetes Prevention Program (DPP) clinical trial provided foundational evidence, demonstrating that an intensive lifestyle intervention reduced the risk of type 2 diabetes by 58% among adults with prediabetes.<sup>20</sup> These results persist decades later in long-term follow-up studies.<sup>21,22</sup> More recent evaluations of the DPP echo these findings in real-world settings, showing improvements in cardiometabolic risk and meaningful health gains for participants.<sup>23,24</sup> In a recent study of 5,373 adults with prediabetes in a large workforce, individuals who enrolled in the program incurred substantially lower health care costs over a two-year period, averaging roughly \$4,500 less per person than nonparticipants.<sup>23</sup> These savings were driven largely by reduced hospital stays, outpatient visits, and emergency department utilization. Together, evidence from clinical trials and real-world implementation confirms that the DPP is a scalable, evidence-based preventive model that improves clinical outcomes and reduces avoidable health care cost.

Diabetes remains one of the most widespread chronic conditions in the United States, affecting more than 38 million adults.<sup>19,25</sup> National evidence consistently shows that structured self-management programs play a critical role in improving outcomes for people with diabetes. Diabetes Self-Management Education and Support (DSMES) is an evidence-based framework used to support people with diabetes in building the skills and confidence needed to manage their condition effectively. DSMEs have been shown to increase the quality of health care services and lower overall costs.<sup>26</sup> Research demonstrates that DSMES leads to meaningful reductions in A1c while strengthening self-management skills such as medication adherence, healthy eating, glucose monitoring, and problem-solving.<sup>26,27</sup> These behavior changes can reduce the risk of long-term complications and improve patients' confidence in managing their condition. Because of its documented impact on both clinical outcomes and day-to-day self-management, DSMES is regarded as a foundational component of high-quality chronic disease care.<sup>27</sup>

Hypertension affects nearly half of U.S. adults, making it one of the nation's most prevalent and consequential chronic conditions.<sup>28</sup> Given its role as a major risk factor for heart disease, stroke, and kidney disease, national clinical guidelines emphasize the importance of structured prevention and management strategies. Evidence from the ASPIRE trial demonstrates that self-measured blood pressure monitoring, especially when paired with clinical support, effectively lowers systolic blood pressure and enhances hypertension control.<sup>29</sup> Additionally these benefits are strongest when patients routinely share their reading with clinicians who can adjust medications and provide timely guidance.<sup>30</sup> Studies further show that many adults with hypertension remain either unaware of their diagnosis or unable to achieve recommended control targets, highlighting the value of coordinated, patient-centered approaches that address both clinical and behavioral aspects of hypertension management.<sup>31</sup> Health coaching represents a vital bridge between evidence-based interventions and daily patient behavior. Coaches can help individuals build confidence in using self-monitoring devices, strengthen skills in medication adherence, and integrate lifestyle practices such as healthier eating, increased physical activity, and stress reduction that complement pharmacologic management.

## Effectiveness of Motivational Interviewing

Motivational Interviewing (MI), developed by Miller and Rollnick, is “*a particular way of talking with people about change and growth to strengthen their own motivation and commitment*”.<sup>2</sup> Over the past several decades, MI has gained broad acceptance in healthcare, where it has become a foundational approach in health coaching to support behavior change and improve patient outcomes.<sup>32</sup> Unlike directive counseling, MI emphasizes collaboration and helps clients articulate their own reasons and readiness for change.<sup>33</sup> Promising effects have been reported for both disease prevention and management of chronic conditions, highlighting MI as a patient-centered approach proven to enhance long-term health outcomes.<sup>34</sup> Health coaches, as defined by the National Board for Health and Wellness Coaching, partner with clients to empower, support, and facilitate self-directed, lasting behavior changes aligned with their values.<sup>35</sup> Evidence consistently supports MI-based health coaching as more effective than traditional approaches for engaging patients in health-promoting behaviors.<sup>36,37</sup>

MI has been widely applied in interventions targeting chronic disease management and prevention and was shown to be the most effective counseling approach for empowering health behavior change.<sup>3,4</sup> MI-based health coaching has demonstrated improved self-efficacy, patient activation, and perceived health status in chronically ill populations and has demonstrated feasibility and strong acceptance among patients and providers as an alternative to traditional programs and approaches.<sup>38,39</sup> Cardiovascular disease remains the leading cause of morbidity and mortality worldwide.<sup>40</sup> Hypertension, diabetes, and obesity are among the most common chronic conditions present in Tennessee.<sup>1,41</sup> Effective management of these chronic conditions requires behavior change in areas such as tobacco cessation, physical activity, and dietary habits. Evidence supports MI as an effective patient-centered approach for facilitating these changes.<sup>33</sup> Several systematic reviews have shown that MI is associated with significant improvements in medication adherence for patients with cardiovascular disease.<sup>34,42</sup> Complementing these findings, meta-analyses reinforce its impact on chronic disease outcomes, including improved self-efficacy, medication adherence, and quality of life.<sup>3,4,43</sup> Recent reviews show significant reductions in blood pressure and improved medication adherence and self-efficacy among patients with cardiovascular disease.<sup>42-44</sup>

While individual level behavior changes are essential to chronic disease prevention and management, health improvement does not occur in isolation. The social determinates of health (SDoH) are the nonmedical factors such as economic stability, neighborhood environment, and access to care that play a significant role in shaping health behaviors and outcomes.<sup>45</sup> The SDoH also contribute to racial and ethnic health disparities and are strongly associated with the incidence and management of chronic conditions.<sup>46</sup> Addressing SDoH is essential for improving health outcomes and reducing inequities, particularly in medically underserved areas like Memphis, where shortages of primary care providers persist.<sup>47-49</sup>

Emerging research recognizes the role of health coaches in supporting clients with SDoH by identifying social needs, supporting connections to appropriate resources, and providing follow-up.<sup>9,17</sup> Health Coaches also empower clients to take an active role in their health by promoting self-management and adherence to treatment plans, guiding them through the healthcare system to enhance access to necessary services.<sup>13</sup> In addition to these efforts, health plans are increasingly incorporating MI to address social needs and improve care coordination for high-risk populations, demonstrating its value as a scalable, person-centered approach to reducing disparities.<sup>13</sup>

MI has evolved into a foundational approach for health coaching, supported by decades of research demonstrating its effectiveness in promoting sustainable behavior change and supporting social needs. Leveraging MI-based health coaches is an effective approach to support clients in overcoming social and behavioral barriers to health. As healthcare systems seek scalable strategies to address

chronic disease and health disparities, MI-based health coaching is an evidence-based solution with broad applicability and strong acceptance among patients and providers. Its emphasis on empathy, collaboration, autonomy, and empowerment makes it particularly valuable in medically underserved communities, where trust and relationship building are critical to improving outcomes.

## Cost Savings from Preventive and Chronic Disease Management Services

Strong evidence demonstrates substantial cost savings associated with delivery of preventive and chronic disease management services by lay health workers such as community health workers and health coaches. Specifically, risk reduction interventions produce approximately \$150 annual cost savings for children and youth at risk for obesity.<sup>50,51</sup> Similarly, a real-world, 2-year prospective study demonstrated that national DPP services achieve an average of approximately \$500/year per person savings through adult obesity reduction.<sup>20,23</sup> In addition, strong evidence demonstrates substantial cost savings associated with provision of diabetes prevention program (DPP) and diabetes self-management education (DSME) services. Participation in DSMES is also linked to lower health care utilization, including fewer diabetes-related hospitalizations and emergency visits, and contributes to reduced morbidity over time. Rigorous studies demonstrate annual savings of approximately \$1,850/year associated with DSME.<sup>52,53</sup> Likewise, studies have demonstrated average annual cost savings of approximately \$750 per person per year through community-based hypertension control programs.<sup>54,55</sup> Group-based delivery of these services further enhances cost efficiency and strengthens outcomes by fostering shared experience, accountability, and ownership within coaching interactions. In summary, substantial evidence demonstrates that essential preventive and chronic disease management services are high value and should be made more broadly available using cost-effective personnel such as health coaches.

## Underutilization of Preventive and Chronic Disease Management Services

Despite clear evidence that preventive care reduces disease, disability, and death, millions of Americans do not utilize recommended preventive services.<sup>56</sup> National surveillance consistently shows persistent gaps in preventive service use, with only 6–8% of U.S. adults receiving all recommended high-priority preventive services and significant disparities across age, race, income, and insurance status.<sup>56,57</sup> These gaps are especially prevalent among people experiencing socioeconomic disadvantages, members of racial and ethnic minority groups, and individuals living in rural areas, all of whom face structural barriers that contribute directly to a disproportionate burden of chronic disease.<sup>58</sup> Despite strong evidence of the benefits of DPP and DSME services,<sup>20,21,59,60</sup> gaps in access to essential DPP and DSME services are particularly acute.<sup>61,62</sup>

This underutilization of preventive care has significant implications for chronic disease management with conditions such as hypertension, diabetes, and obesity continuing to rise. These chronic conditions and other mental health conditions account for 90% of the nation's \$4.9 trillion in annual healthcare spending, emphasizing the vast economic toll of insufficient prevention and early management.<sup>14</sup> Chronic diseases remain the leading causes of death in the United States and continue to drive widespread illness, disability, and healthcare expenditures.<sup>15</sup>

## Tennessee Evidence for Motivational Interviewing-based Health Coaching

Tennessee has implemented several innovative programs that integrate MI-based health coaching to address chronic disease and health disparities. These initiatives provide real-world evidence of feasibility, impact, and lessons learned in diverse settings. The following examples highlight how MI-based health coaching has been applied across Tennessee and the outcomes associated with these efforts.

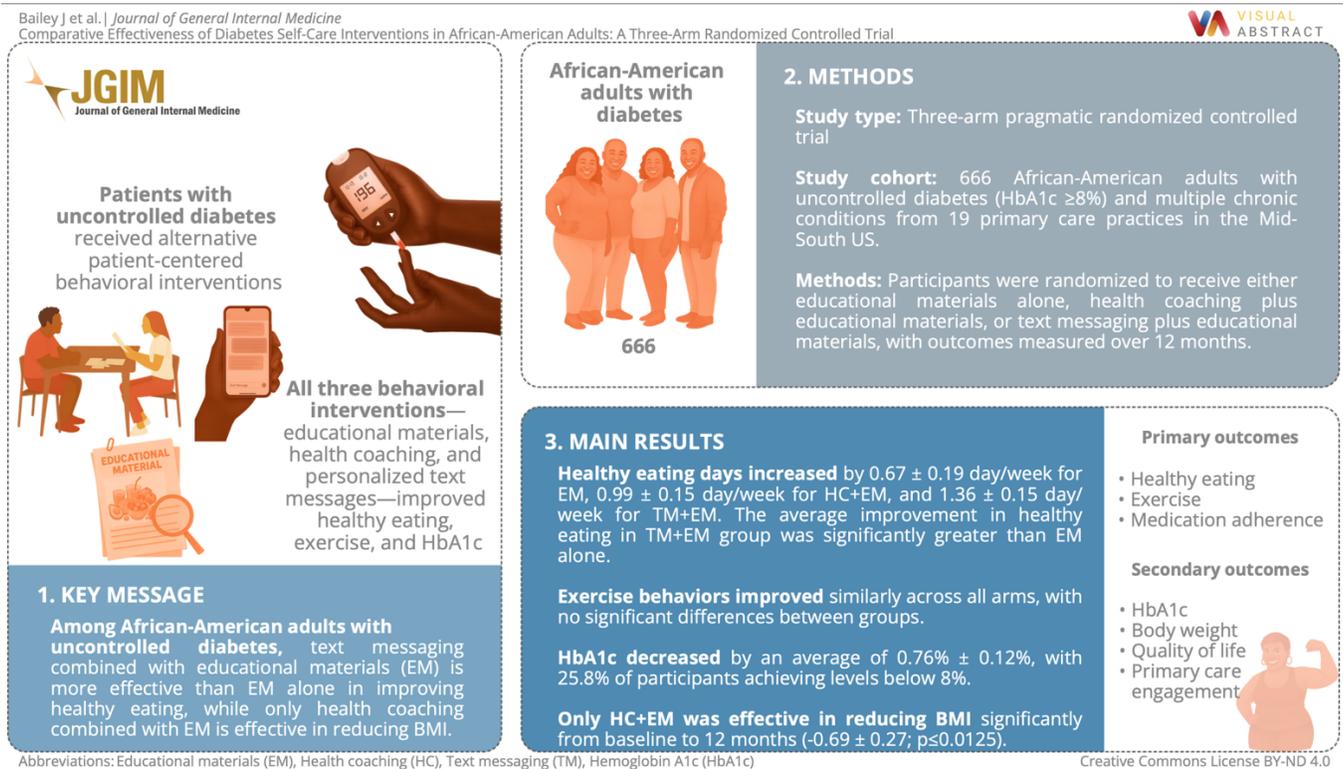
# SafeMed: Pharmacy Technician/Health Coaches Improve Transitions of Care

The SafeMed program is a care transitions initiative focused on medication management, designed to improve hospital to home transitions for patients with multiple chronic conditions and polypharmacy who frequently utilize health services.<sup>16,17</sup> The program was implemented within a large nonprofit health system providing care for medically underserved areas in Memphis. SafeMed trained certified pharmacy technicians to serve as health coaches conducting home visits and follow-up calls, supporting medication reconciliation, identifying drug therapy problems, reinforcing education provided by pharmacists, and encouraging rapid primary care follow-up. Program results showed that health coaching and navigation targeting about 200 high-need, high-cost patients per year saved over \$1,000,000 annually through reduced hospital readmissions and emergency department use, and timely primary care follow-up following hospitalization was markedly increased. SafeMed demonstrated an adjusted difference in difference in annual per person expenditures (SafeMed vs. Controls) of \$8,690 average savings and \$15,988 average Medicaid savings. The SafeMed Study demonstrated the feasibility of a health coaching model for reducing readmissions and strengthening care coordination for high-risk populations.<sup>16,17</sup>

# MODEL Study: Comparative Effectiveness of Health Coaching in Tennessee

The Management of Diabetes in Everyday Life (MODEL) Study conducted in West Tennessee assessed the comparative effectiveness of health coaching, text messaging, and educational materials in improving diabetes self-care among African American adults, a population disproportionately affected by diabetes and its complications.<sup>11,63</sup>

**Figure 1. Visual Abstract for the MODEL Study.**



The MODEL study specifically compared the effectiveness of individual MI-based health coaching with personalized text messaging and educational materials alone. Health coaches trained in MI worked one-on-one with participants to set personalized goals, build confidence, and overcome

barriers to medication adherence and lifestyle change. The intervention emphasized culturally tailored strategies to improve diet, physical activity, and blood glucose monitoring. MI-based health coaching was associated with clinically meaningful reductions in HbA1c and weight loss, and higher engagement in diabetes self-care activities. Qualitative feedback highlighted the importance of trust, cultural relevance, and individualized support in driving behavior change and focus group data showed highest satisfaction in the health coaching group. The MODEL Study highlights the effectiveness of MI-based health coaching as a culturally responsive intervention for reducing disparities and improving outcomes among high-risk populations.<sup>11,63</sup>

## Health Hub Program: Deploying Health Coaches in Neighborhoods

The Neighborhood Health Hub program, launched by the University of Tennessee Health Science Center in collaboration with Shelby County government, represents an innovative, place-based approach to addressing health disparities in medically underserved neighborhoods of Memphis. The model integrates preventive care, health education, and MI-based health coaching within community settings to improve access and engagement among high-need populations.

Health Hubs offer wellness services, including screenings for diabetes, hypertension, and obesity. Coaches also focus on providing referrals and access to primary care. Group wellness classes focused on diabetes prevention, diabetes self-management, healthy cooking, physical activity, and chronic disease self-management are available. Health coaches serve as a cornerstone of the model, employing MI and evidence-based strategies to address both clinical needs and SDoH, such as food insecurity and transportation barriers.

In an evaluation of the first year, the program conducted outreach to 355 individuals through community events, walk-ins, door-to-door engagement, telephone calls, and referrals.<sup>9</sup> Of those reached, 68% participated in individual health coaching sessions and/or group education classes. This level of engagement highlights the feasibility of delivering integrated preventive services in community-based settings. Feedback from participants highlighted increased trust in healthcare providers and reduced social isolation, both critical factors in improving health behaviors and outcomes.<sup>9</sup> Participants reported feeling more connected to resources and empowered to manage their health, suggesting that the NHH model fosters both relational and structural supports necessary for sustainable change.

Since the opening of the pilot Neighborhood Health Hub in Uptown Memphis in 2022, the neighborhood health hubs have completed over 20,000 visits to date with over 3,000 clients served. Approximately one-third of clients seen have  $\geq 1$  follow-up coaching visit and of those with  $\geq 1$  follow-up health coaching visit, there is an average of 6.3 health coaching visits per client. In addition, Shelby County health hubs have provided group sessions to over 1600 attendees with an average of 5.4 sessions attended for 8,859 total group session-person contacts. Of clients screened at health hubs, 58% positive for obesity (BMI > 30), 47% for uncontrolled hypertension (e.g.,  $\geq 140/90$ ), and 35% have high blood sugar (e.g., > 125 mg/dl).<sup>64</sup>

The Neighborhood Health Hub Program in Shelby County has demonstrated that health coaches deployed in high-need neighborhoods can dramatically improve patient outcomes. Adult clients have experienced an average weight loss of 4.1 pounds, a 10% decrease in systolic blood pressure, an 18% reduction in blood sugar levels, and a 12% reduction in average blood sugar levels (A1c) from 7.8 to 6.9%.<sup>9,64</sup>

Health Hub Experience demonstrates the potential of place-based strategies to reduce disparities by embedding culturally responsive, patient-centered interventions within neighborhoods. Recently established rural health hubs in Hardin and Decatur Counties are piloting this approach in medically underserved rural communities. By combining MI-based coaching with accessible preventive

services, the program addresses barriers to care and promotes engagement among populations historically marginalized within traditional healthcare systems. These findings position the model as a scalable approach for advancing health equity and improving chronic disease outcomes in medically underserved communities.

## Lifedoc Health: Health Coaching and Integrated Multidisciplinary Team Model

Lifedoc Health is a healthcare and research organization dedicated towards developing and implementing effective, sustainable, evidence-based models of care focused towards treating and preventing Diabetes, Obesity, and other cardiometabolic diseases. The health coaching model at Lifedoc Health shows how a practice integrated team-based approach, meaningful patient education and motivational-interviewing (MI)–driven lifestyle medicine program can operate at scale within a Medicaid population while achieving strong engagement, retention, and the desired clinical and financial outcomes. Patients co-managed by this multidisciplinary approach experienced a greater reduction in weight (4.29 kg), BMI (1.43 kg/m<sup>2</sup>), systolic and blood pressure (2.18 mmHg), and (1.97 mmHg) respectively. Additionally, they exhibited 77%, 83%, and 59% higher odds of reducing 5% of initial weight, 1 BMI point, and 2 mmHg DBP, respectively. A1c improvements were observed as well.<sup>65</sup> The model consists of 5 core components including disease-driven exercise, nutrition education, stress management, sleep, and substance abuse. In fact, A UTHSC Heart Health Network analysis found that Lifedoc engaged 3,027 Medicaid patients and delivered 16,670 preventive & diabetes counseling services, an average of 5.6 visits per patient, one of the highest rates in Tennessee.

Within Lifedoc's model, a multidisciplinary, culturally competent, support from Community Health worker (CHW), and longitudinal counseling provided by coaches has been shown to improve self-management behaviors.<sup>66</sup> According to a recent data provided by the MCOs for CY 2024, the assigned Medicaid populations this model contributed to a 27% reduction in total cost of care, 22% fewer ER visits, and 41% fewer hospital visits than comparative practices across Tennessee, while maintaining a patient satisfaction above 95%.<sup>67</sup> Patients with obesity who participated in Lifestyle coaching were 6.6 times more likely to achieve meaningful BMI reduction and demonstrated far greater engagement, 12.1 visits per year versus 6.6 for patients seen through Lifedoc's traditional primary-care setting, thereby helping prevent diabetes, hypertension, and related complications.<sup>65</sup> These results aligned with national data showing that integrated, evidence-based, pragmatic coaching models are especially effective for cardiometabolic conditions and highlight the operational requirements for success in Tennessee: intentional care-team integration, flexible scheduling, shared medical appointments, coordinated touchpoints, collaborative provider workflows, aligned billing structures, and qualified providers. In summary, Lifedoc's innovative model of care provides real-world evidence to support the effectiveness of health coaching when integrated into primary care. Tennessee providers face many barriers related to workflow, staffing, and reimbursement in their efforts to implement this model. However, Lifedoc experience suggests that health coaching, when implemented with coordinated workflows, data-driven oversight, and sustainable model of reimbursement, can serve as a scalable, high-value intervention for chronically ill and at-risk populations statewide.

## Tennessee Landscape

### Tennessee Heart Health Network Effectiveness Study

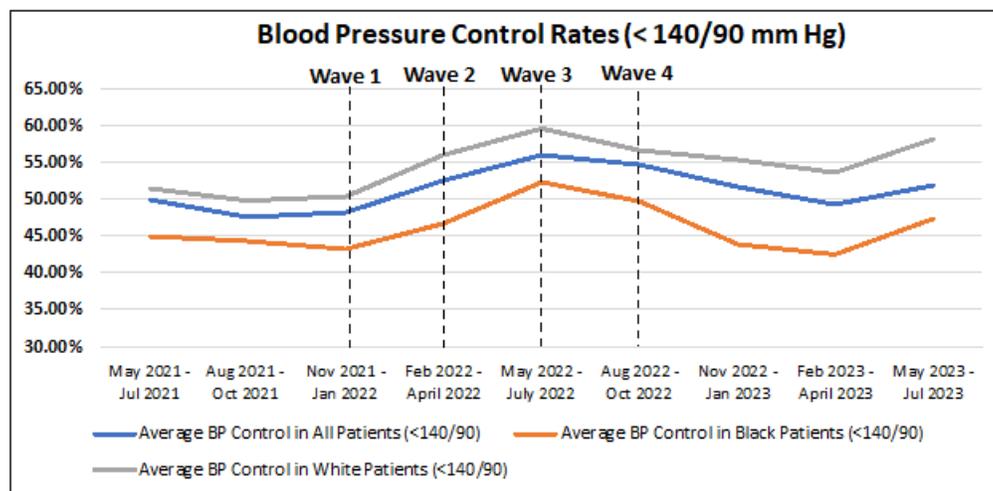
The Tennessee Heart Health Network (TN-HHN) was launched as part of an Agency for Healthcare Research and Quality (AHRQ) funded initiative to improve cardiovascular preventive care across primary care practices statewide. The program aimed to strengthen team-based care, integrate health

coaches, and enhance quality improvement processes to address hypertension and tobacco use, two leading risk factors for heart disease. By engaging 77 practices, TN-HHN evaluated changes in blood pressure control, tobacco cessation counseling, and practice capacity for implementing evidence-based interventions. This study provides critical insights into the feasibility and impact of health coaching and related strategies within diverse practice settings across Tennessee.<sup>68</sup>

Of the 77 primary care practices recruited for the AHRQ-funded Tennessee Heart Health Network (TN-HHN) initiative, 61 completed the study. These 61 participating practices had an average of 7.9 clinicians, 0.5 social workers, 0.1 health coaches, 0.8 patient navigators or care coordinators, 0.1 diabetes educators, and 0.2 nutritionists or dietitians. Most of the practices engaged were clinician-owned solo or group practices (31.2%), hospital/health system owned (37.7%), or Federally Qualified Health Center or look-alike (14.8%).

As shown in **Figure 2** below, participating practices achieved an increase in blood pressure control rates over time, especially in the first 9 months of the implementation of the TN-HHN initiative for the overall population, as well as for white and African American populations.

**Figure 2: Practice-Level Blood Pressure Control Rates (<140/90 mmHg) (N=34)**



Participating practices also achieved small improvements in delivery of tobacco cessation counseling services. In addition to the clinical outcomes, we also assessed practice characteristics associated with practice's capacity for improving cardiovascular preventive care, using results from the Change Process Capability Questionnaire (CPCQ). The adjusted model showed that an increase in the number of clinicians was positively associated with an increased capacity for change (OR 1.11 [95% CI 1.01 – 1.22]). Additionally, having a higher proportion of Medicaid patients in a practice was significantly associated with a reduced capacity for change (OR 0.70 [95% CI 0.50 - 0.98]).

However, despite program efforts to encourage practices to hire health coaches, the number of health coaches did not significantly increase during the study period, highlighting the difficulty primary care practices faced during the study period in sustainably employing health coaches. Although the majority of practices took advantage of offered health coach training and certification opportunities by training existing personnel, none of the participating practices hired new health coaching personnel during the study period. Thus, although the TN-HHN Effectiveness Study demonstrated that robust practice facilitation support can significantly improve rates of hypertension control and delivery of tobacco cessation counseling, participating practices did not achieve increases in their capacity to routinely deliver evidence-based health coaching services.<sup>68</sup>

## Aligning Medicaid and Medicare Payment Policy in Tennessee

As part of its effort to increase access to health coaching in Tennessee, the TN-HHN convened major stakeholders, including Medicaid, health plan, and safety-net provider representatives to develop and implement common guidelines for reimbursement of health coaching services focused on cardiovascular health in the context of team-based primary care. The TN-HHN Executive Council's Population Health Subcommittee oversaw an iterative process organized and facilitated by the TN-HHN, driven by the TennCare MCOs, and overseen and approved by TennCare administration to achieve Medicare and TennCare alignment on a new payment model for health coaching in the context of team-based primary care.<sup>12</sup>

Aligning billing practices across Medicaid and Medicare is essential for the sustainability of health coaching programs in Tennessee. Both payers recognize existing codes eligible for payment that can be leveraged for health coaching services, including preventive counseling, tobacco cessation, chronic care management, and intensive behavioral therapy for both cardiovascular disease and obesity.<sup>12</sup> Future opportunities include advocating for health coaching as a unique, recognized reimbursable service under TennCare's value-based payment models and exploring shared savings arrangements with Managed Care Organizations to incentivize improvements in quality metrics and reductions in emergency and hospital utilization.

### TennCare Utilization of Essential Preventive Services

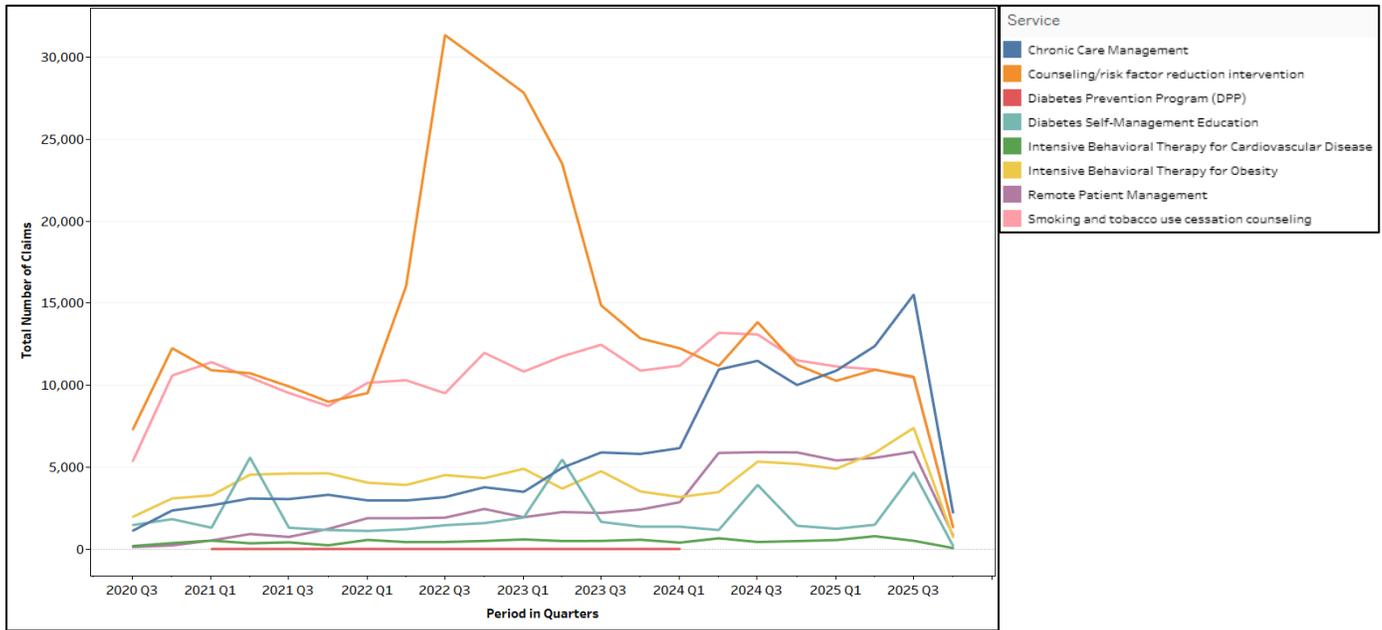
TennCare claims data confirm that billing codes for essential chronic disease management and preventive services are actively being used, demonstrating that reimbursement pathways have been created. However, utilization levels for these codes remain low. **Table 1** below shows the use of service codes by health coach in team-based care for TennCare beneficiaries using TennCare administrative claims data for the period April 2024 – September 2024.

**Table 1.** Utilization of TennCare Chronic Disease Management and Preventive Service Codes

Service	Codes	Total Unique Patients	Number of Claims
Remote Patient Monitoring	99091	51	94
	99458	785	2431
	99457	1498	4848
	99454	1119	3825
	99453	353	462
Counseling/risk factor reduction intervention	99401	10745	16916
	99402	2651	3677
	99403	287	599
	99404	1048	3007
Smoking and tobacco use cessation counseling	99406	11579	23400
	99407	1144	1943
Chronic Care Management	99439	1958	4508
	99487	537	1575
	99489	204	383
	99490	5211	15771
Diabetes Self-Management Education	G0108	1327	5462
	G0109	148	210
Intensive Behavioral Therapy for Cardiovascular Disease	G0446	632	1022
Intensive Behavioral Therapy for Obesity	G0447	5559	8437

As shown in **Figure 3** below, utilization of chronic disease management and preventive services within the TennCare population remains low, and trends in utilization of these essential services remain either flat or downward.

**Figure 3.** Trends in TennCare Utilization of Essential Chronic Disease Management and Preventive Services.



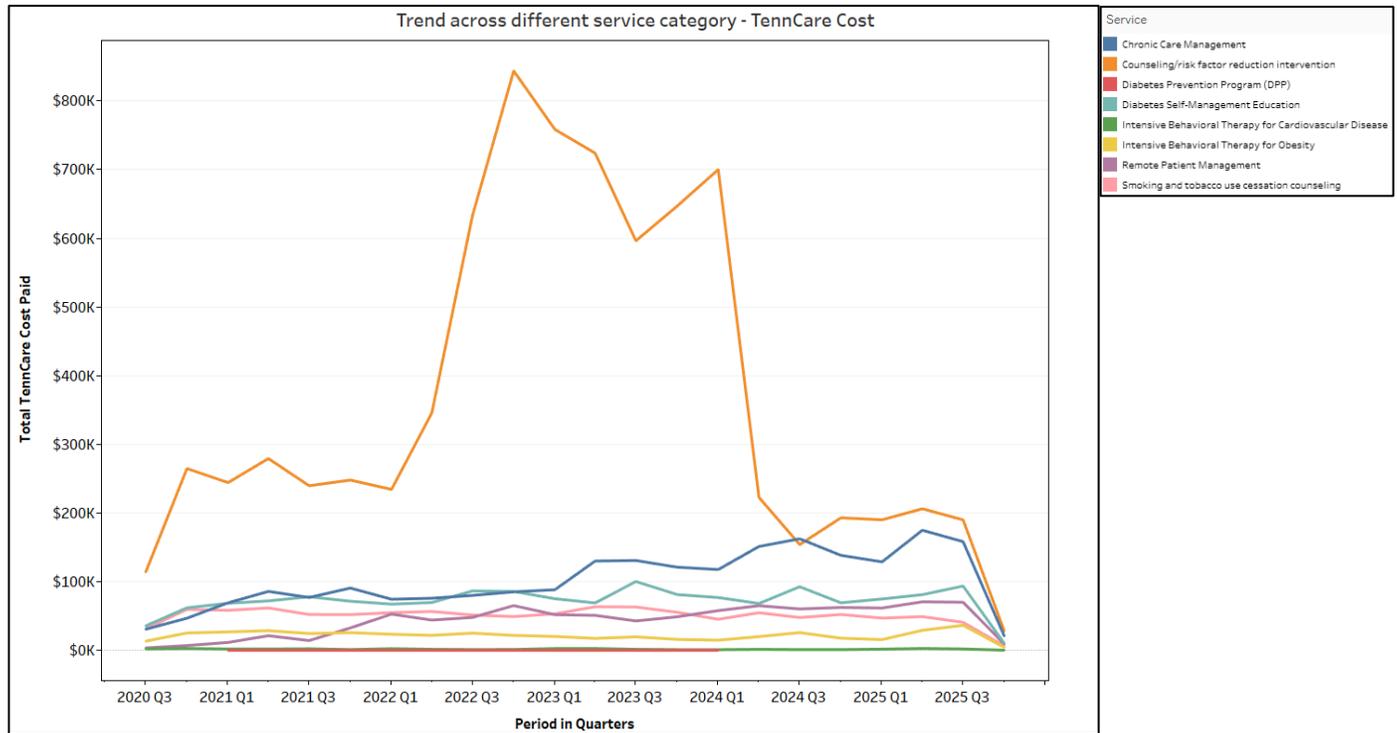
Furthermore, as shown in **Table 2** below, utilization of these key preventive services is largely limited to a fairly low number of primary care practices.

**Table 2.** Cumulative TennCare Claims for Preventive Services from August 2020 – October 2025

Practices	Facility	Total Number of Claims	Total Number of Unique Patients
CCHS	CCHS Third Street Health Center	6,864	2,173
	CCHS Broad Avenue Center	82	46
	CCHS Frayserr Health Center	65	33
	CCHS Raleigh Health Center	49	26
	CCHS Orange Mound Health Centre	36	15
	CCHS East Jackson Health Cente	32	18
	CCHS Hickory Hill Health Center	9	5
Church Health	Church Health Center	1	1
Erlanger Health System	EPHS Baroness Erlanger Hospital	7,839	2,512
	Erlanger Internal Medicine, Chattanooga	1,602	768
	Erlanger Community Health Center - Premier Healthcare, Ch..	7	4
	Erlanger Primary Care Bledsoe, Pikeville	4	3
FAH	FAST ACCESS HEALTHCARE Lifestyle	1,727	633
Lifedoc Health	Lifedoc Health (Mt. Moriah)	20,211	3,193
	Lifedoc Health (Lenox Park)	1	1
MedicalCare	Medical Care PLLC Elizabethton	3,574	1,167
Regional One Health	Regional One Health, Outpatient Center, Internal Medicine, ..	11	2
	Regional Medical Center	1	1
UTHSC	University Internal Medicine, Knoxville	9	9

**Figure 4** below shows trends in the total cost of claims reimbursed by TennCare Managed Care Organizations for key preventive services.

**Figure 4. Total Cost of TennCare Claims Reimbursed for Key Preventive Services**



## Key Lessons Learned/Best Practices

Embedding health coaches within primary care and community-based teams improves health outcomes, care coordination, and patient engagement. Tennessee programs such as SafeMed, MODEL, the Neighborhood Health Hub Program, and Lifedoc Health’s Health Coaching and Integrated Multidisciplinary Team Model highlight the importance and effectiveness of team-based approaches for addressing both clinical and social determinants of health. <sup>9-12,16-18,65,66</sup> Qualitative feedback from the Neighborhood Health Hubs Experience highlights that trust and cultural alignment drive engagement, particularly in medically underserved communities.<sup>9</sup>

Health coaching delivered via telehealth significantly improves access for rural populations, where transportation barriers and provider shortages are common.<sup>33,69-71</sup> Studies show that telehealth coaching for chronic disease management is cost-effective and associated with improved blood pressure control, medication adherence, and patient satisfaction.<sup>70-72</sup> Tennessee’s rural counties face high rates of hypertension and diabetes, making virtual coaching a critical strategy for equitable care delivery. Successful implementation requires alignment with billing codes and availability of qualified providers who can submit claims. TennCare data demonstrate utilization of CPT codes for counseling, chronic care management, and remote monitoring, confirming reimbursement pathways exist.<sup>12</sup>

## Recommendations for Implementation of Health Coaching in Tennessee

Based on available evidence to advance health outcomes and reduce disparities in Tennessee, the TN-HHN recommend MI foundational training and certification for all healthcare workers, followed by advanced health coaching certification for staff directly supporting behavior change. Training all

frontline staff in MI ensures that every patient interaction promotes autonomy, collaboration, and empowerment, principles critical for chronic disease management and preventive care.<sup>4,33</sup>

Health coaching builds on MI by equipping professionals with advanced skills in goal setting, problem-solving, accountability, lifestyle and chronic condition management, and addressing SDoH.<sup>9,17</sup> Health coaches play a pivotal role in guiding patients through complex care systems, supporting medication adherence, and connecting individuals to community resources.<sup>13,34,42</sup>

Tennessee-specific initiatives such as SafeMed and Neighborhood Health Hubs demonstrate the feasibility and impact of health coaching in medically underserved communities, improving trust, reducing social isolation, and enhancing improvement in chronic disease outcomes.<sup>9,16,17</sup>

Partnering with community-based organizations and Managed Care Organizations (MCOs) is essential for scalability. MCOs employ care managers, pharmacists, and navigators who regularly influence member health behaviors. MI and health coaching align with value-based care incentives by improving quality metrics, reducing avoidable hospitalizations, reducing emergency room utilization and enhancing medication adherence.<sup>13</sup> TennCare claims data indicate existing reimbursement pathways for counseling and chronic care management, supporting sustainability.<sup>12</sup>

Evidence shows that MI-based interventions reduce emergency department visits and readmissions, yielding cost savings while improving patient satisfaction and outcomes.<sup>3,4,38</sup> By embedding MI and health coaching into care models, MCOs can move the needle towards measurable improvements in HEDIS scores, member engagement, and long-term cost containment, all of which are critical priorities for Medicaid populations disproportionately affected by chronic disease and social needs.

Five key recommendations for Tennessee arise from this review:

- Health coach certification standards should continue to emphasize fidelity to the evidence-based MI health counseling approach given its proven effectiveness;
- Promote integration and sustainability of health coaching in health systems across Tennessee by continuing to align state Medicaid, Medicare, and private insurance payment policies;
- Increase access to affordable training and certification in MI-based health coaching, including:
  - Foundational MI training and certification for all healthcare workers to increase counseling effectiveness, person-centeredness, and improve clinical outcomes;
  - Advanced health coach certification should be provided for all non-licensed lay staff directly supporting behavior change;
- Tennessee health plans, community-based organizations, and healthcare providers should work together to increase access to MI-based personal health coaching for Tennesseans struggling with obesity, uncontrolled hypertension, prediabetes, and diabetes.

National and Tennessee evidence is unequivocal: Every Tennessean could benefit from access to evidence-based personal health coaching as a fundamental component of recommended preventive care. Tennessee is poised to become a national leader in prevention of chronic illness by integrating MI-based health coaching into every health system in Tennessee.

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