Empirical Evidence for the Health Coaching Model

Dr Helen Lindner, FAPS
Health Psychologist
Manager, Strategic Projects & Liaison
Australian Psychological Society
h.lindner@psychology.org.au

Presentation Outline

- Impact of Chronic illness
- Role of adherence to Chronic Conditions Self-Management (CCSM)
- WHO review on barriers to CCSM
- Review of Coaching Models
- Evidence from the Good Life Club project

Chronic Diseases: Concern world-wide (Sabate, 2002)

- Cardiovascular disease has been identified as a major cause of death in the western world
  - (Mathers, Vos, Stevenson, & Begg, 2000; National Heart Foundation, 1999; Rich-Edwards, Manson, Hennekens, & Buring, 1995)
- Diabetes has been reported to affect approximately 150 million people world-wide
  - (King, 1999).

Positive health outcomes for chronic illness

- Require both effective treatments and ***adherence*** to these treatments
  - (Haynes, 2001)
- Adherence a major factor in treatment effectiveness
  - Dunbar-Jacob et al. (2000)
- Adherence to treatment for a chronic medical condition was generally only 50%.
  - (Haynes, 2001)

Improvement of adherence to treatment for chronic illness

- Interventions to improve adherence based on self-management strategies have been found to
  - Improve the health status of the patient
  - Reduce the costs and usage of health services

(Massanari, 2000; Valenti, 2001; Wahl & Nowak, 2000)

WHO Review (2003)

Five major barriers to CCSM that were inextricably linked to health system and team factors (p.33):

1. Lack of awareness and knowledge about adherence
2. Lack of clinical tools to assist health professionals in evaluating and intervening in adherence problems
3. Lack of behavioural tools to help develop adaptive health behaviours or to change maladaptive ones
4. Gaps on the provision of care for chronic conditions
5. Sub-optimal communication between patients and health professionals.

World Health Organisation. (2003). *Adherence to long-term therapies: Evidence for action*. Geneva: WHO.

Review of Coaching models

- Lindner, H., Menzies, D., Kelly, J., Taylor, S., & Shearer, M. (2003). Coaching for behaviour change in chronic disease: A review of the literature and the implications for coaching as a self-management intervention. *Australian Journal of Primary Health, 9*, 177-185

Health Coaching

- Coaching "as a method of patient education that guides and prompts a patient to be an active participant in behavior change" (p. 9).
  - Wilkie, Williams, Grevstad, & Mekwa (1995)

- "Coaching differs from teaching in that the coach is not placing emphasis on imparting new ideas but rather focusing on supporting others in their efforts to reach a new goal" (p. 704).
  - Hunt Joseph, Griffin, Hall, & Doherty Sullivan (2001)

Systematic review of the literature

- Level II studies
  - Randomised controlled trials and controlled clinical trials
- Level III studies
  - Controlled trials without randomisation; such as cohort, case-control, and analytic studies; and multiple time series studies, such as pre-test and post-test investigations.
- Revealed only 25 research articles that investigated coaching or health care professional support for the self-management of chronic illness

Components of coaching

- Covered three areas:

1. Disease-related education-focused support
   - Asthma Education classes, Cardiac Rehab.
2. Behaviour change-focused support
   - Goal orientated (Lorig model)
   - Readiness to change (MI & TTM)
3. Psychosocial-focused support
   - Social isolation, Depression

Health Coaching: role in improvement of self-management of chronic illness

- Insufficient research available to make strong statements concerning the relative efficacy of the three broad approaches.
  - However, it does appear that education, while important, is not sufficient in its own right for the development of long-term behaviour change required in those with chronic illness.
  - A focus on behaviour change and strategies to achieve adherence also seems to be required.
- Interventions that combine all 3 areas of focus are recommended

Continued…

- Not all individuals will be ready for immediate behaviour change
  - Focus on determining the individual's stage of change and appropriate counselling approaches received support in the literature.
  - Attention to the emotional status of individuals was also important
    - Demonstrated to inhibit the individual's ability to implement and maintain the required behavioural changes.

Evidence for practice: Good Life Club (GLC) Project

- Sharing Health Care Initiative
  - Better Health Outcomes
    - Demonstration project
    - Whitehorse Division of General Practice
- Self-management of type 2 diabetes
  - Support through telephone coaching
- Health Coach training
  - Allied Health professionals

Aim of the GLC Project

- The role of the coach was
  - to assist the client to become a confident and proficient self-manager,
  - to recognise their capacity for self management within their individual life context
- The emphasis was on gaining control over targeted lifestyle behaviour changes
  - dietary and physical activity behaviours
  - adherence to medical recommendations
    - E.g., blood glucose testing, foot care procedures, and medication prescriptions.

Health Coach Training
2-day Program Overview

1. Impact of chronic illness
2. Behaviour change counselling techniques
   - Motivational Interviewing (MI)
   - Rollnick, Heather, & Bell (1992)
3. Model of behaviour change
   - Transtheoretical Model of Change (TTMC)
   - Prochaska, DiClemente, & Norcross (1992)
4. Behaviour change strategies
5. Negative affect management strategies

Group Activities

Arrange yourselves into triads

- Client
  - Identify a health behaviour to discuss with coach (e.g., increasing exercise, water intake, reducing weight, high sugar foods, quit smoking, etc.)
- Coach
  - Discuss the target health behaviour to identify Stage of Change and the currently used processes
- Observer
  - Take notes on the interaction between client & coach

Engage in this activity for about 5-10 minutes and then swap roles

Homework activities

"Buddy" allocation

Telephone throughout week: Assess stage and processes of change, using motivational interviewing style of discussion

Reading

Hotz, S. (1999). *Putting Theory into Practice: Helping Patients Change*. **CACR Newsletter**

Debriefing sessions

- Coach debriefing/supervision sessions
  - Run 4-6 weeks following training
  - Voluntary attendance
  - Review of successful coaching experiences
  - Problem-solve challenges in health coaching
  - Consolidate skills
    - Processes for different Stages of Change
    - Managing mild levels of depression & anxiety
  - Referral pathways to specialist treatment

Motivational Interviewing

- Motivational Interviewing (MI) is a directive, client-centred counseling style for eliciting behavior change by helping clients to explore and *resolve ambivalence* to change
  - (Moyers & Rollnick, 2002; Rollnick & Miller, 1995)
- Spirit of MI
  - Collaborative rather than prescriptive
  - Encourages patient independence and self-direction on goal-oriented strategies

5 Principles of MI

- Expressing empathy
  - Seeking to understand the person's frame of reference, particularly by ***reflective listening***
- Developing discrepancy
  - ***Highlight the differences*** between the patient's goals and their current behaviour
- Avoiding argumentation
  - ***Refrain from persuading*** patient to change
- Rolling with resistance
  - Expressing an understanding of the patient's ***ambivalence to change***
- Supporting self-efficacy
  - Monitoring the patient's degree of ***readiness to change***

Components of the TTMC

- Stages of Change - 5 temporal dimensions
  1. Pre-contemplation
  2. Contemplation
  3. Preparation
  4. Action
  5. Maintenance
- Processes of Change - 10 cognitive and behaviour activities that facilitate change
- Outcome measures for health behaviour change
  - Self-efficacy assessment
  - Decision balance scale (pros & cons)

Consultation Map

- Record of Health Behaviour Change

- Section 1: Checking progress
- Section 2: Health Care Management Goals
  - Stage and processes of change (TTM)
- Section 3: Adjustment Issues
  - a) client's mood
  - b) client's thoughts

(see Kelly et al., 2003)

Health Coach data

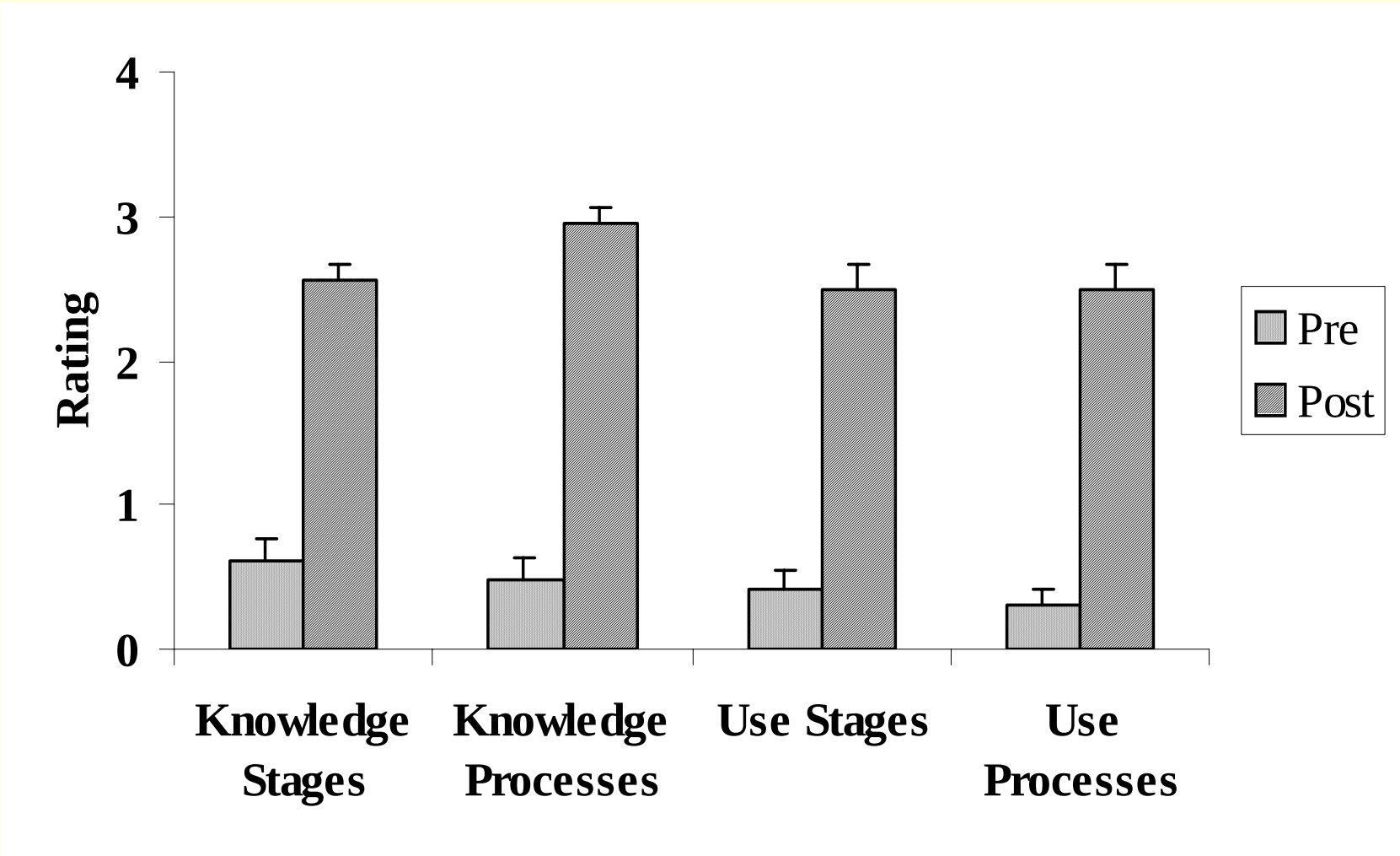
- *Summary from Lindner et al., (2003)*
- Participants
  - 47 allied health professionals who completed GLC coach training
  - 3 training groups
- Materials
  - Pre-training questionnaire
  - Post-training questionnaire
- Procedure
  - Pre-training: 1 week prior to training session
  - Post-training: 12 month (groups 1 & 2) or 6 month (group 3) post-training

Table 1

Frequency of 39 coaches' responses to development of skills following the workshop training

	None		*Somewhat*		*Completely*
	0	1	2	3	4
Skills with motivational interviewing	0	0	13	24	2
Skills with self-efficacy	0	1	20	15	3
Use of a balance sheet	5	8	18	8	0
Use of the TTMC processes sheets	4	6	8	17	4
Generalization of TTMC to other client interactions	0	1	23	11	4

Figure 1. Mean scores for the pre-training and post-training assessments for 35 coaches



Coaching contact times

- Significant reduction on time spent telephone coaching over a 10-session sample, $F(15,205) = 2.03$, $p = .015$.
- Mean time on telephone
  - Session1 = 28.36 minutes ($SD = 9.8$)
  - Session 10 = 17.46 minutes ($SD = 9.45$)

GLC coaching - client outcomes

- *Summary from Erikson & Lindner (2003)*

Time 1 data

- Depression significant associated with
  - Total symptom experience
    - (r = .668, r^2 = .45)
  - Total confidence to self-manage illness
    - (r = -.627, r^2 = .39)
  - Confidence in self-management to reduce the need to see doctor
    - (r = -.567, r^2 = .32)

GLC coaching - client outcomes

- *Summary from Browning & Thomas (2003)*

Six-month assessment data

- Significant reductions in
  - Fearful of health ($p < .001$)
  - Shortness of breath ($p < .01$)
  - Visits to GP ($p < .02$)
- Confidence in managing conditions/disease related activities
  - fatigue, physical discomfort, emotional distress, treatments other than medication (all $p < .001$)

GLC Economic Evaluation

- *Summary from Mortimer & Kelly (2006)*
- Relative risk of being well-managed:
  - 1.28 (95%CI: 1.04, 1.58) for the GLC intervention as compared to usual care.
- GLC intervention compared to usual care
  - Cost = $1,457
  - Incremental cost-effectiveness ratio > $16,000

Summary: Good Life Club Health Coaching Intervention

- The empirical evidence indicated that the
  - Coaches reported a significant uptake of the health coaching skills
  - Relative risk of being well-managed was in favour of the GLC intervention as compared to usual care.
  - GLC intervention compared to usual care showed substantial cost-effectiveness
  - GLC members (diabetes sufferers) reported a significant improvements in depression and symptom experience, confidence to self-manage illness, and confidence in self-management to reduce the need to see doctor

Summary

- Management of chronic conditions depends upon successful client self-management
- Self-management of conditions typically requires behaviour change
- Poor adherence to behaviour change is common (WHO, 2003)
- "Growing recognition that knowledge alone is insufficient to produce significant changes in behaviour." (WHO, 2003)

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