

Health Coaching for Patients

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Primary care clinicians – struggling to fit multiple agenda items into the 15-minute visit – cannot meet every need of their patients with chronic conditions.¹ Half of patients leave primary care visits not understanding what their doctor told them.² Though shared decision-making is associated with improved outcomes,² only 9 percent of patients participate in decisions.³ Average adherence rates for prescribed medications are about 50 percent, and for lifestyle changes they are below 10 percent.⁴

In the face of these discouraging statistics, primary care must take on a new task: working with patients to ensure that they understand, agree with and participate in the management of their chronic conditions. Health coaching is one way to accomplish this function.

What is health coaching?

Health coaching can be defined as helping patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

The familiar adage “Give a man a fish, and he eats for a day. Teach a man to fish, and he eats for a lifetime,” demonstrates the difference between rescuing a patient and coaching a patient. In acute care, rescuing makes sense: surgery for acute appendicitis or antibiotics for pyelonephritis. For chronic care, patients need the knowledge, skills and confidence to participate in their own care. Consider the following scenario:

Mr. Olson has diabetes, hypertension and hyperlipidemia. Despite seeing Dr. James five times last year, he is confused about his six prescriptions. When he gave up eating candy, he thought that would solve some of his problems, so he stopped taking several medications. He uses his glucometer and brings his records to Dr. James so she can tell him what to do. He is frustrated when Dr. James says his diabetes and

cholesterol are still uncontrolled. Dr. James is frustrated too.

Dr. James introduces Mr. Olson to Sue, a medical assistant trained as a health coach. Sue questions Mr. Olson on his most important life goals. She helps him link his desire to avoid the amputation experienced by his brother to the importance of taking medications. She teaches him the skill of interpreting glucometer readings in relation to food, exercise and medications. Within three months, Mr. Olson’s A1C drops from 8.5 to 7.

In Mr. Olson’s example, rescuing means telling him what to do about his current glucometer readings. Coaching means helping him understand and react to his glucose values, an enduring skill that he can use every day.

Who can be a health coach?

Within the care team, everyone can integrate elements of coaching into their interactions with patients. However, to ensure that coaching takes place, at least one team member should be designated as a coach. Health coaches can be nurses, social workers, medical assistants (MAs), community health workers (*promotores*, for example), health educators or even other patients if given appropriate training and support.^{5,6}

Registered nurses (RNs) are well poised to impart skills, build confidence and provide tools for patients, particularly patients discharged from the hospital or with multiple chronic conditions. Social workers are also well equipped for this role as they receive significant exposure to coaching principles during their training and often apply them in their work to promote patient behavior change. However, since RNs and social workers are rare in primary care offices, MAs are often a good choice for filling the role. While their scope of practice prevents them from making medical assessments, MAs are ideally suited to provide linguistically and culturally concordant coaching. Working closely with clinicians or RNs, they



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With Chronic Illness

can address medication adherence and lifestyle changes.

No matter who serves the coaching function, coaching presumes a collaborative paradigm (asking patients what changes they are willing to make) rather than a directive paradigm (telling patients what to do).⁷ A good health coach understands this, grasps the shift from rescuing to coaching, has a basic knowledge of common chronic conditions and medications, and reliably follows through to gain the trust of patients and clinicians.

Specific roles of a health coach

Health coaching encompasses five principal roles:

1) providing self-management support, 2) bridging the gap between clinician and patient, 3) helping patients navigate the health care system, 4) offering emotional support and 5) serving as a continuity figure (see “The five roles of a health coach” on page 26).

Providing self-management support. Self-management support is essential for patients to extend their health care outside the clinic walls and into their real lives. Coaches train patients in seven domains of self-management support: providing information, teaching disease-specific skills, promoting healthy behaviors, imparting problem-solving skills, assisting with the emotional impact of chronic illness, providing regular follow up and encouraging people to be active participants in their care.² Patients have better health outcomes when provided with disease-specific knowledge and skills.⁷ A meta-analysis of 53 randomized controlled trials concluded that self-management support improves blood pressure and glucose control.⁸

Bridging the gap between clinician and patient.

Throughout the care process, there are plenty of opportunities for disconnects between the clinician and the patient. Prescribing medications is one example. It is a two-part endeavor: 1) writing prescriptions and 2) making sure patients obtain, understand and actually take the medications as prescribed. Physicians perform part one but lack time to address the critical second part. Health coaches can bridge these gaps by following up with patients, asking about needs and obstacles, and addressing health literacy, cultural issues and social-class barriers.

Helping patients navigate the health care system.

Many patients, particularly the elderly, disabled and



marginalized, need a navigator to help locate, negotiate and engage in services. Coaches can help coordinate care and speak up for patients when their voices are not heard.

Offering emotional support. Coping with illness is emotionally challenging. Well-intentioned but rushed clinicians may fail to address patients' emotional needs. As trust and familiarity grow, coaches can offer emotional support and help patients cope with their illnesses.

Serving as a continuity figure. Coaches connect with patients not only at office visits but also between visits, creating familiarity and continuity. This is particularly helpful in practices where clinicians work part-time or see one another's patients.

Health coaches help patients gain the knowledge, skills and confidence to become active participants in their care.

Following up with patients, helping them navigate the system and offering emotional support are among the key responsibilities of a health coach.

Two models of health coaching

The health coaching role can be added to a medical practice in a variety of ways, but two models have been particularly successful.

The teamlet model. Piloted in 2006 at the San Francisco General Hospital Family Health Center (FHC), the "teamlet" (small team) model extends the 15-minute primary care visit by several minutes, depending on the patient, to include coaching. In a teamlet, a physician is paired with an MA or health worker who has received training in self-management support and specific chronic conditions and speaks the language of the patients assigned to him or her. Health coaches conduct a pre-visit for medication reconciliation

and agenda setting, assist during the physician visit and, during a post-visit, assess whether patients understand and agree with the recommended care plan and engage patients in behavior-change action plans. Because regular follow-up improves chronic disease outcomes, between-visit phone calls are used to check on action plans and medication adherence.⁹⁻¹²

In practice, the model looks something like this:

Maria Rojas has hypertension, obesity, osteoarthritis and poor eyesight. She and Dr. Lee used to feel overwhelmed by her medical and accompanying social problems. Dr. Lee frequently admonished her to take her medications, but Mrs. Rojas felt confused about her pills and never spoke up about it. When health coach Lisabeth was brought in to assist, Mrs. Rojas was skeptical but willing to participate. Lisabeth started by asking questions to better understand Mrs. Rojas' concerns, instead of just telling Mrs. Rojas to take her pills. Mrs. Rojas came to trust Lisabeth and, over time, became an active participant in her own care rather than simply a recipient of information.

Now, a week after each physician visit, Lisabeth calls Mrs. Rojas to ask whether she has picked up her prescriptions from the pharmacy, to assess her understanding of how to take each medication and to encourage her to take the pills daily. Lisabeth always asks Mrs. Rojas to identify barriers and solutions that fit into her daily routines rather than doing this for her. She communicates these barriers to Dr. Lee so that Mrs. Rojas' care plan can be readjusted as needed.

THE FIVE ROLES OF A HEALTH COACH

Self-management support	Bridge between clinician and patient	Navigation of the health care system	Emotional support	Continuity
• Providing information • Teaching disease-specific skills • Promoting behavior change • Imparting problem-solving skills • Assisting with the emotional impact of chronic illness • Encouraging follow up • Encouraging participation	• Serving as the patient's liaison • Ensuring that patient understands and agrees with care plan • Providing cultural and language-concordance	• Connecting the patient with resources • Facilitating support • Empowering the patient • Ensuring the patient's voice is heard	• Showing interest • Inquiring about emotional issues • Showing compassion • Teaching coping skills	• Providing familiarity • Following up • Establishing trust • Being available

In acute care, rescuing makes sense. For chronic care, patients need the knowledge, skills and confidence to participate in their own care.

The hospital-to-home model. Patients discharged from the hospital often feel confused about their new medications and the conditions that they must now learn to manage. This makes them excellent candidates for health coaching. The Care Transitions Intervention is a widely-used coaching method that imparts skills, tools and confidence to patients and family caregivers as they move from hospital to home.¹³ It is focused on “four pillars” (<http://www.caretransitions.org/structure.asp>):

1. Having a reliable medication management strategy,
2. Overcoming barriers to follow-up appointments,
3. Knowing how to recognize and respond to worsening signs and symptoms,
4. Using a personal health record to record 30-day goals, health information and key questions to be shared with the physician at upcoming health care encounters.

The Care Transitions coach (nurse or social worker) visits the patient once in the hospital and once at home, and communicates with the patient three times by phone. Here’s an example:

Mrs. Lumpkin was admitted to the hospital four times in the past three months because of heart failure exacerbations. Each time, she required modest medication adjustment over two hospital days. Upon each discharge, she was given instructions and sent home. After her fourth admission, she was enrolled in the Care Transitions Intervention.

Her coach, Bernice, visited 48 hours after discharge and encouraged Mrs. Lumpkin to identify a health-related goal for the next 30

days. Without hesitation, Mrs. Lumpkin stated she wanted to attend her granddaughter’s soccer games. She admitted missing these games for fear that her urinary incontinence would embarrass her and her granddaughter. When Bernice said, “Please show me your medications and how you take them,” Mrs. Lumpkin revealed she frequently skipped diuretics due to incontinence. They then realized that her readmissions were related to untreated incontinence. Using her new personal health record, Mrs. Lumpkin wrote down questions for her physician about incontinence treatments and practiced asking the questions through a role-playing exercise to build confidence. Finally, Mrs. Lumpkin and Bernice reviewed signs and symptoms of worsening heart failure and how to respond.

The low cost of this model allows for adoption in a wide variety of settings, and the investment in coaching pays dividends downstream in reduced health care costs.¹³

The business case for health coaching in primary care

Health coaching has been shown to produce promising clinical benefits (see “A brief review of the health coaching literature” on page 28). But the bottom line for private practices or community health centers – both financed primarily by fees for clinician visits – is, “Can we afford to add extra medical assistants to work as health coaches in our practices?”

Without payment reform, the only way practices can justify the added expense of health coaches is with the added clinician productivity that coaches can create. Three

■ In the teamlet model, a physician is paired with a health coach who meets briefly with the patient before and after the physician visit.

■ Between-visit follow-up phone calls help to improve outcomes for patients with chronic diseases.

■ In the hospital-to-home model, a health coach visits the patient once in the hospital and once at home, and then follows up by phone.

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examples exist of practices that have increased the medical assistant:clinician ratio from 1:1 to 2:1, a ratio that provides more than enough staff time for health coaching. Hilton Family Practice, a private family practice in Newport

News, Va., implemented a care team with two clinical assistants (nurses or medical assistants) per physician, allowing the physician to delegate substantial work. This has increased visit volumes and collections by 60 percent.¹⁴

A BRIEF REVIEW OF THE HEALTH COACHING LITERATURE

Trials of health coaching, which can be identified by searching PubMed (<http://www.ncbi.nlm.nih.gov/pubmed>) with the terms “coaching” or “coaches,” demonstrate mixed results on the efficacy of coaching on patient outcomes. The studies were heterogeneous regarding who performed the coaching, the nature of the coaching intervention and the chronic conditions studied. A summary of findings is shown below:

Telephone coaching

Patients receiving phone coaching from peer coaches were more likely to attend colonoscopy visits.¹

Dietitian or nurse coaches working via telephone achieved greater reductions in cholesterol and better adherence to lipid-lowering drugs than usual care.²

Telephone coaching of patients with acute coronary syndrome failed to improve smoking status, medication use or quality of life.³

Diabetes coaching

Patients with diabetes who received nurse coaching demonstrated better self-reported diet compared with usual care but no significant difference in A1C levels.⁴

Elderly adults with diabetes who received coaching improved physical activity levels; combining pedometer use with coaching did not improve results.⁵

African-American adults with diabetes who had peer coaching by community health workers had nonsignificant reductions in A1C levels compared with those who had usual care.⁶

African-American and Latino adults with diabetes coached by trained community residents had significant declines in A1C levels compared with a control group.⁷

Asthma coaching

Community health workers trained as asthma coaches reduced asthma rehospitalization among African-American children compared with a control group.⁸

Hospitalized patients receiving post-discharge assistance from a “transition coach” were significantly less likely to be rehospitalized than control patients.⁹

A Cochrane Review of peer-led coaching for patients with chronic conditions found small but statistically significant reductions in pain, disability and depression in the intervention group.¹⁰

A randomized controlled trial of medical assistants coaching patients with depression in primary care practices found a significant improvement in patients with coaches compared with usual care.¹¹

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The bottom line is, “Can we afford to add extra medical assistants to work as health coaches in our practices?”

Their approach does not involve formal health coaching but does demonstrate the potential for increased productivity with the addition of an assistant. Neighborhood Healthcare, a community health center near San Diego, increased the medical assistant:physician ratio from 1:1 to 2:1, with the medical assistants performing some coaching functions. This has allowed the physicians to see two to three more patients per day, which pays for the additional medical assistants. Similarly, the University of Utah Hospitals and Clinics health system employs extra medical assistants to streamline physicians' work. As a result, productivity has increased and the health system's financial position has improved dramatically.¹⁵

These three case studies demonstrate that a business case can be made for hiring medical assistants to function as health coaches. In many cases, the medical assistant:clinician ratio would not need to be as high as 2:1, as in the examples above. For example, one health coach (paid \$15 per hour or \$36,000 per year with benefits) could assist three physicians, since only a fraction of patients need coaching. Each physician would need to see two extra patients per day at a reimbursement rate of \$40 per visit to generate \$57,600 in additional revenue, more than enough to pay for the health coach.

Paradigm shift

Health coaching is both a conceptual framework and a concrete job category with the potential to improve patient care and assist clinicians struggling with insufficient time.

Coaching involves a paradigm shift from a directive to a collaborative model so that care teams and patients pursue an active partnership, instead of patients being passive recipients of care. Ideally, everyone on the health care team would incorporate coaching in their work. Yet, to ensure that coaching happens reliably, specific team members can be designated to be health coaches. While physicians

are well-trained to “give patients a fish” – curing an acute problem or prescribing medications for a chronic condition – health coaching teaches patients and families “how to fish.” **FPM**

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The increased physician productivity that health coaches create can offset their costs.

If one health coach (MA) assists three physicians, each physician would need to see two extra patients per day to cover the costs.

Coaching involves a paradigm shift from a directive to a collaborative model of care.