Sustainability versus Feasibility: lessons learned from a pilot health coaching project

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Learning Objectives

1. To increase understanding of the practical issues that family health teams may need to consider if they want to implement health coaching

2. To examine the potential benefits of health coaching as a self-management option for specific groups of patients

Presentation Overview

- The Health Coaching Project
- Potential benefits for patients
- Feasibility versus Sustainability
- Questions and Discussion

Presenter Disclosure

- **Presenters:** Kate Nash

- **Relationships with commercial interests:**

  Grants/Research Support: None

  Speakers Bureau/Honoraria: None

  Consulting Fees: None

  Other: Employee of CT Lamont Primary Care Research Centre, Bruyère Research Institute, Ottawa

Disclosure of Commercial Support

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- **This program has not received in-kind support**

<u>Potential for conflict(s) of interest</u>:

None

Mitigating Potential Bias

None

The Health Coaching Project

Objective

To investigate the feasibility of implementing a flexible health coaching intervention into primary care practice in a routine and consistent manner to enable primary care providers to better support patients with diabetes.

Why Health Coaching?

- 3.7 mill Canadians will be living with diabetes by 2020
- 40-49% not at target for HbA1c
- 25% attend group education
- WHO recognizes health coaching as a promising way to support people with diabetes

Why Health Coaching

- An RCT of health coaching for patients with diabetes:
  - 1.07% reduction in HbA1c coaching group
  - 0.3% reduction in HbA1c in the control group

(Thom 2013)

- Health coaching not implemented in Canadian context (to our knowledge)

- Is health coaching a practical addition to current approaches?

Patient Self-Management Tasks

- To take care of the illness
- To carry out normal activities
- To manage emotional changes

What is a Health Coach?

"An interactive role undertaken by a peer or professional to support a patient to be an active participant in the self-management of chronic illness"

Lindner 2003

Project Time Line

Fall 2011
Identify sites

Feb 2012
Lunch &
Learns

Dec 2012 & Feb 2013
Focus Groups

Mar-May 2013
Data synthesis

Dec 2011
Health
Coach
Training

Mar 2012-Mar 2013
Health Coaching

Jan 2013
Patient interviews

June 2013
Feedback to sites

The Setting

3 sites:

- 2 academic family health teams
- 1 community health centre

8 health coaches

- Identified by the teams, provided informed consent
- Diabetes educators, dietitians, nurses

Health Coach Training

- The health coaches were trained in the Peers for Progress model of health coaching
- Training took place over 11 hours (Friday evening and Saturday)
- Coaches received an honorarium for attending
- Coaches received mentoring from project coordinator

The Participants

- Physicians identified patients at risk of, or living with diabetes whom they considered might benefit from health coaching

- These patients were provided with information about the project and invited to provide their informed consent (written or oral)

The Intervention

- Each consenting participant received 6 months of health coaching
- Initial face -to- face meeting
- Depending on readiness, the health coach facilitated the patient to select a behaviour change goal
- Follow-up was every 2 weeks (suggested time interval) by email, telephone, face to face or a mixture of all three

Evaluation

Patient level

- Survey to evaluate health coaching at baseline and 6 months
- HbA1c, LDL-C, BP at baseline and 6 months
- Interviews with 25% of patient participants

Survey to Evaluate Health Coaching

- Chronic Illness Resource Survey (CIRS)
- Summary of Diabetes Self-Care Activities Measure (SDSCA)
- International Physical Activity Questionnaire (IPAQ)
- Morisky 4-Item Scale
- Patient Assessment of Chronic Illness Care (PACIC)
- Patient Activation Measure (PAM)
- SF-12
- Stanford CDSMP Sample Questionnaire

Evaluation

Health coach/practice level

- Focus groups with coaches and coordinators at sites

- Field notes

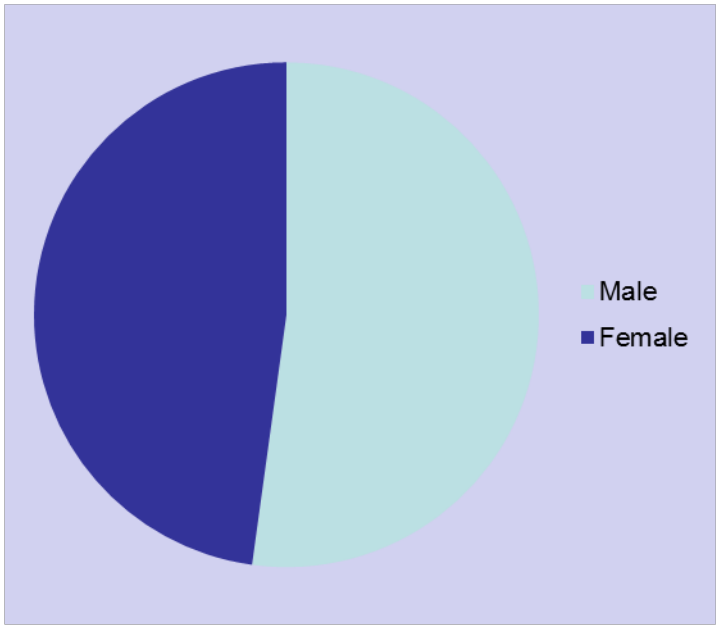
Potential Benefit for Patients

Demographics

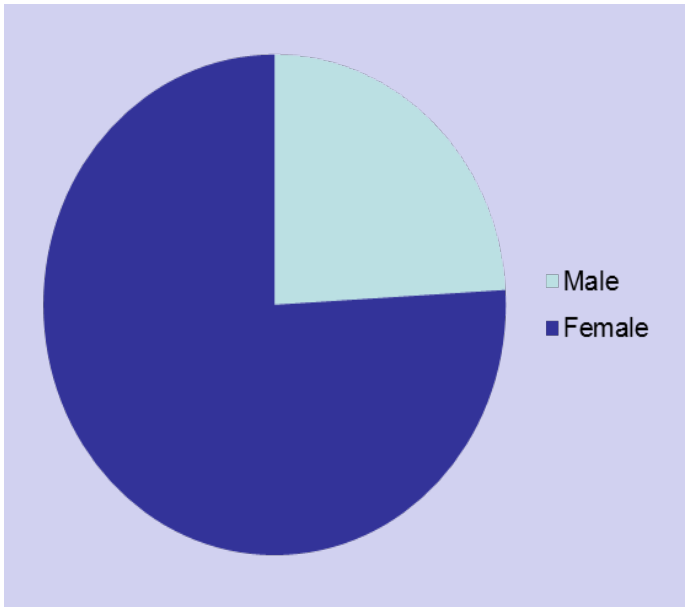
- 46 patients consented across 3 sites
- 24 (52%) male
- 24 English, 16 French, 6 other language
- 25 of the 39 who completed a survey at baseline had some education above Grade 13
- 23 of the 39 who had a diagnosis of diabetes had at least 1 other chronic condition

Gender comparison with CDSMP

Health Coaching n=46



CDSMP workshops n=80



Patient Survey Results

- 38% (15) return rate
- Missing and inconsistent data

- PACIC (Patient Assessment of Chronic Illness Care)

PACIC measures specific actions or qualities of care congruent with the CCM that the patients report they have experienced in the delivery system

- PAM (Patient Activation Measure)

PAM measures patients knowledge skills and confidence to self-manage

PACIC and PAM

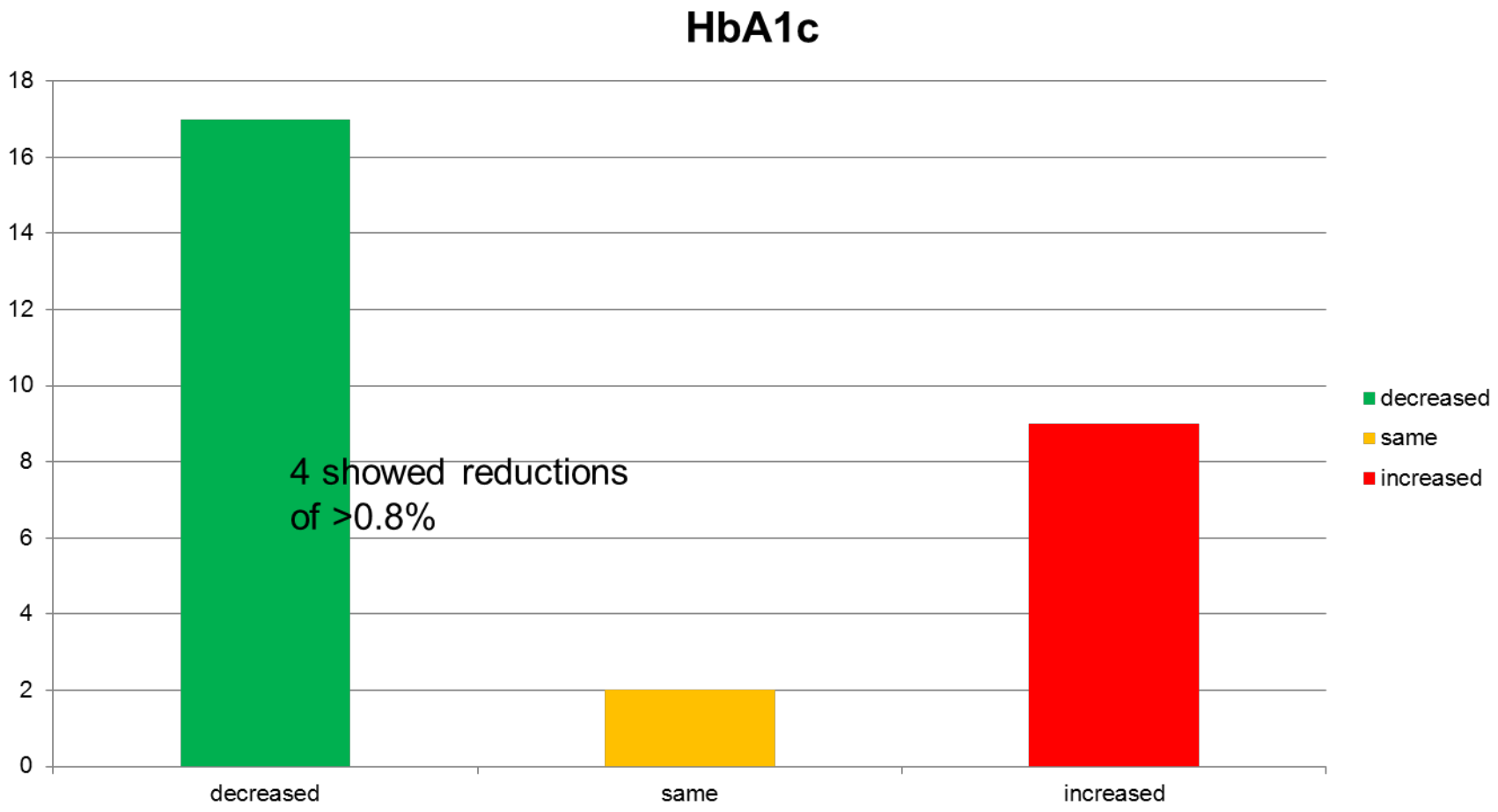
- PACIC: 10/15 indicated improvements in the subscales of goal setting and follow-up with respect to their care from baseline to 6 months

- PAM at baseline

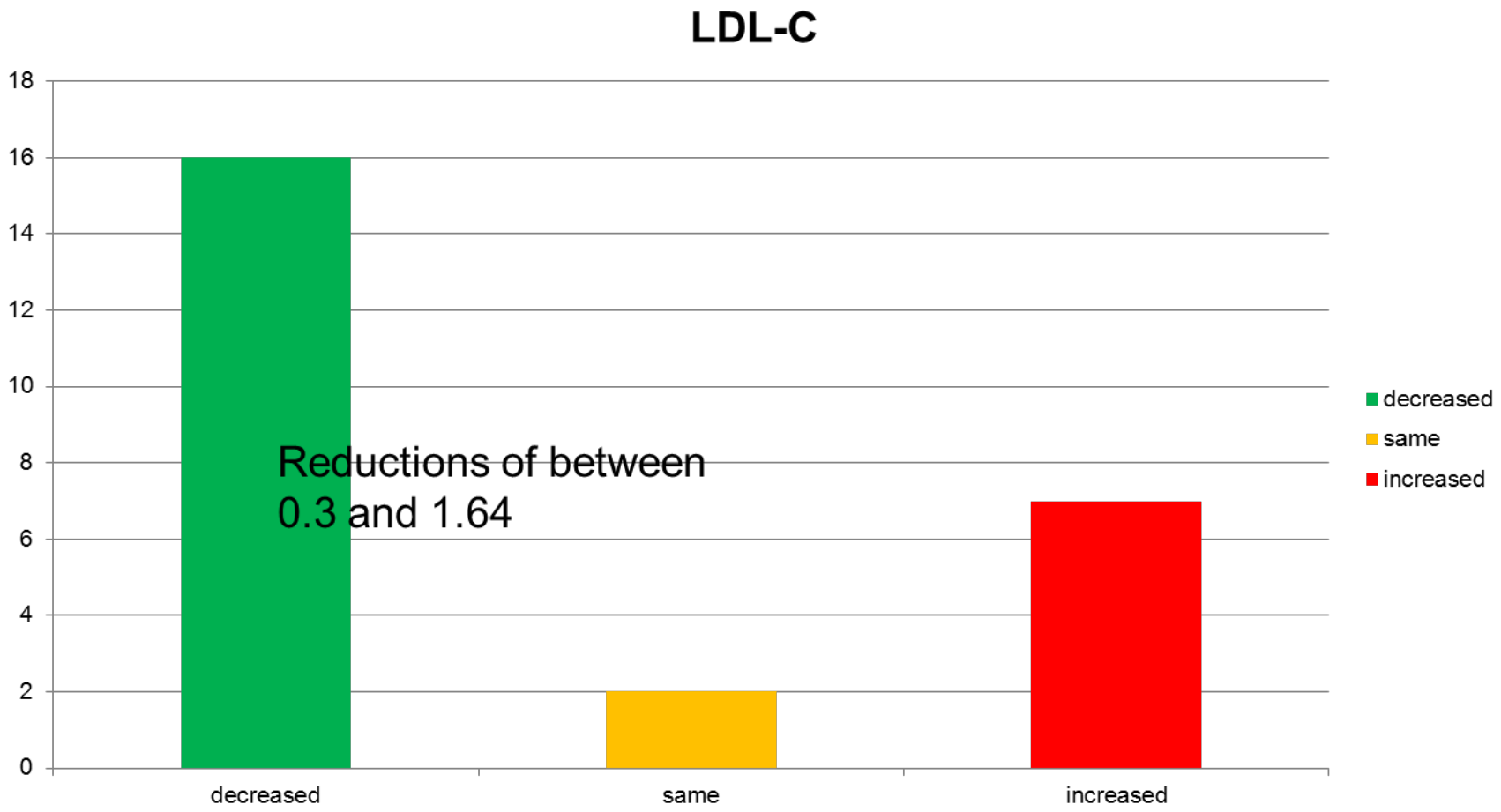
Level	Description	# patients
1	May not yet believe that the patient role is important	8
2	Lacks confidence and knowledge to take action	4
3	Beginning to take action	10
4	Has difficulty maintaining behaviours over time	15

Clinical outcomes

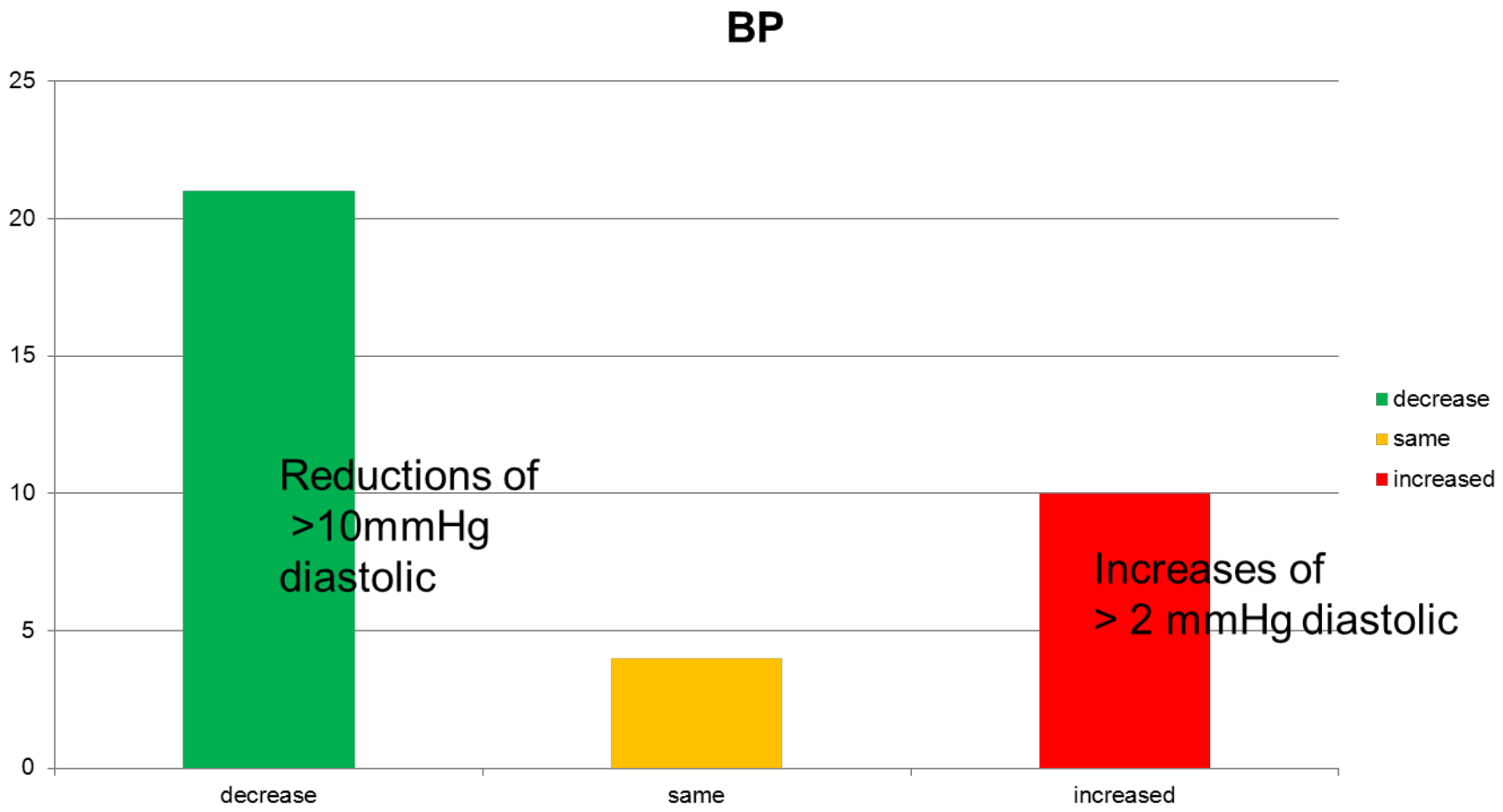
HbA1c: n=28


HbA1c
18
16
14
12
10
8
6
4
2
0
4 showed reductions
of >0.8%
decreased
same
increased
decreased
same
increased

LDL-C: n=25


LDL-C
18
16
14
12
10
8
6
4
2
0
Reductions of between
0.3 and 1.64
decreased
same
increased
decreased
same
increased

BP: n=36


BP
25
20
15
10
5
0
Reductions of >10mmHg diastolic
Increases of > 2 mmHg diastolic
decrease
same
increased
decrease
same
increased

PAM score and HbA1c reduction: n=26

	HbA1c ↓	HbA1c ↑	HbA1c →
PAM level 1 or 2 <activated	4	4	2
PAM level 3 or 4 >activated	13	2	1

Patient Interviews

Deeper understanding of diabetes

“ Right now it helps me to understand the behaviour of the situation, like what is diabetic and what is the cause of all this. … Like in the food and all that. You know, that’s my hardest part, is food.”

Increased awareness of their role

"So that's why it's a strange disease, because I don't feel it. So dealing with the coach it's, "OK, this might happen to you if you don't do this and this and that," and then it makes me realize that yeah, I have to do something about it, because I don't want this to happen."

Sense of accountability "keeping me honest"

"It keeps me honest….Well, so that if I know I'm working with someone that has access to my information and my dietary habits and what not, then that will mean that I'm going to try and stay within my dietary, good dietary habits."

Continuity of relationship

- “ … I knew there was somebody there”

- “The doctor is more aware, they know I have been meeting with my coach…”

Improved access to other services

“ And if anything, if I needed information, example, should I be going to see the kinesiologist, they (the coach) were there to help me, they’d help me make appointments, so it was very fluid. It really worked well.”

Summary of Potential Benefits

Potential Benefits of Health Coaching

- Health coaching was **acceptable** to patients
- Health coaching increased patient **awareness** of their role in managing their chronic condition
- Health coaching may have the potential to improve **access** to health services
- Health coaching may have **potential to improve clinical outcomes** especially when individuals are activated - small improvements beneficial for patients

Feasibility versus Sustainability

Focus groups

- 2 focus groups were held with the health coaches and the coordinators at the 3 sites

- several themes emerged that all have relevance for sustainability

Physician Buy-in

- Important for patient referral
- Important for the patient to know their physician and coach are on the same page
- Important for communication between the coach and the physician

Health Coach Role

- Health coaches need to have the time to incorporate coaching into their role

- It is important that all the members of the health care team understand the role of the coach:

“Being a dietitian, sometimes people were just wondering, “ Oh how come you’re doing a medication review?” Some tasks people were not used to see a dietitian doing. But it’s part of coaching…”

Communication with the Team

- Health coaches wanted to know individualized patient target and reason for referral (baseline HbA1c ranged from 5.3 to 11.2)

- Health coaching has the capacity to increase communication between the team members:

"I was always e-mailing back the nurse and the GP so they know what is going on. Even if it is was minor, they seemed really pleased to know what was happening."

Health Coach Skills

- All the coaches valued the training and used the behaviour change tools with all patients when appropriate, not just patients they were coaching

- Some coaches felt they lacked specific clinical skills

“ I find the challenge for me is I’m not a dietitian, so I’m being asked to talk about food…”

Follow-up

- Follow-up is an essential component of health coaching

- Health coaches who had some autonomy over their own scheduling found it easier to follow –up

“We make our calls or our emails and we have them all pre-set, so we have the 12 emails or calls in the schedule. I know where I’m at.”

Patient Readiness

- Depression and psychosocial factors were major barriers to behaviour change

- Health coaching should be available when patients are ready:

"I strongly believe that if you want to advocate a bit of well-being, people need to be in power. But do we have the system to be flexible enough so somebody can call and "Hey, I'm ready to talk about diabetes now!"

Comprehensive Care

- Coaches made more referrals so patients could be supported to deal with barriers to behaviour change

- Follow-up resulted in more comprehensive care

"…so I think for sure they're getting better care, more comprehensive care, because of the follow-up that they wouldn't otherwise get."

Sustainability

“ I think we learned a lot (from the health coaching pilot) and certainly took a lot away from it. And I hope we will be able to implement health coaching in some form at our centre in the next year.”

Site Chronic Disease Coordinator

Summary of Feasibility Findings

Health Coaching is Feasible

- Health coaching was successfully implemented at the 3 sites

- No extra resources given to the sites

(except for health coach training and coordination)

- Coaches had extra responsibilities

(collecting data, attending meetings, focus groups)

Sustainability

- Which patients could benefit from health coaching?

  Clinician goals, patient readiness

- Who should train as health coaches?

  Capacity, autonomy, adaptability

- Health coach training and mentoring

  Confidence, support

Sustainability

- Communication
  - Patient goals, care team, coach role
- Evaluation
  - Keep it simple but consistent
- Chronic disease management strategy
  - Where does health coaching fit?

Questions and Discussion

STEPS To Implementing Health Coaching

- This study was funded by the Public Health Agency of Canada

- Principle Investigators:

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