Health Coaching for Chronic Conditions
Engaging and Supporting Patients to Self Manage

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Scope of Chronic Disease

Chronic diseases are the leading cause of death and disability throughout the developed world (Sabate, 2002), and in Canada account for an estimated 89% of all deaths (World Health Organization, 2005). While heart disease (Mathers et al, 2000), and cancer predominate (Canadian Cancer Society, 2011), respiratory diseases and diabetes also contribute significantly, both in terms of mortality and in cost to healthcare system. Diabetes alone affects about 2.5 million Canadians at an estimated annual cost of $6.7 billion in 2011 (Doucet & Beatty, 2010). Similarly, nearly 2.4 million Ontarians suffer from respiratory diseases at an estimated combined cost of nearly $6 million for asthma, COPD, and lung cancer (Ontario Lung Association, 2011).

Lack of Adherence to Recommendations

Two important strategies for managing chronic disease are adherence to treatment and health-related lifestyle changes (Dunbar-Jacob, 2000). However, research shows patients with chronic conditions do not adhere to treatment, including medications. For example, non-adherence to diabetes treatment is about 50% (Haynes et al, 2002), with some estimates as high as 93% (Cramer, 2004). The economic burden of non-adherence to drug therapy in Canada is estimated at $8 billion a year (Iskedjian et al, 2002).

Research shows a similar lack of adherence to health behaviour recommendations across a wide range of conditions (Lindner, 2003). Interestingly, the first linkage of lifestyle behaviours to reducing illness and mortality is credited to a 1974 Health Canada report (Lalonde, 1974). But prescriptions for lifestyle changes, whether from primary care professional or specialist, do not lead to actual behaviour changes (Wolever et al, 2010). And while education is a necessary component it is insufficient to sustain long-term behaviour change (Pearson et al, 2007). The addition of personal coaching was significantly more effective than health education alone in helping people initiate and sustain an exercise program (King et al, 2007).

Patients Want to Self-Manage

Some critics propose that patients innately want to control their health conditions, but the healthcare system does not support “long-term consistent change” integral to self-management (Bugas & Silberschatz, 2000). Self-management is defined as the person with the chronic condition “engaging in activities that protect and promote health, monitoring and managing symptoms and signs of illness, managing impact of illness on functioning, emotions and interpersonal relationships and

adhering to treatment regimens." For patients with diabetes, for example, this may include self-monitoring of blood glucose levels and administering medication as prescribed, making difficult lifestyle changes such as losing weight and doing exercise, and dealing with emotions such as stress, anxiety, and fear.

Programs to train and support patients in self-care have been offered to patients worldwide and are considered effective in engaging patients to take responsibility and to make healthier lifestyle choices. The most widely available peer-coaching program is the Stanford Chronic Disease Self-Management Program grounded in concepts of self-efficacy and goal setting, (Lorig et al, 2001, McGowan, 2006, Jordan & Osborne, 2007).

Self-managing patients exhibit the following core competencies. They:

1. Know their condition and various treatment options.
2. Negotiate a plan of care and review and monitor the plan.
3. Actively participate in decision-making with health professionals and other caregivers
4. Engage in activities that protect and promote health
5. Monitor and manage the symptoms and signs of their condition.
6. Manage the impact of the condition on physical functioning, emotions and interpersonal relationships
7. Can and do use support services.

However, despite their popularity, lay-led programs appear to have limited impact on long-term health-related behaviours, utilization of health services, and health outcomes (Foster et al, 2007; Buszewicz,, 2006, Jordan & King, 2007).

Need for Coaching (Self-Management Support)

Self-management support, or health coaching, is increasingly recognized as a necessary complement to education-based initiatives in order to change patients' health behaviour (Pearson et al, 2007). As coaches, professionals engage in "interactions that are focused on the patient concerns and in which the patient is listened to and helped to work through issues"(Glasgow et al, 2001). To these ends, healthcare professionals must change from a traditional "expert" role of informing, directing, and deciding to a collaborative role of joint goal setting, problem solving, and follow-up. They must develop new skills, such as motivational interviewing, solution-focused goal setting, and cognitive behaviour techniques and new understandings, such as stages of change. The following are competencies exhibited by healthcare professionals to coach self-management and health behavior change. They can:

1. Use reflective listening
2. Assess and match intervention to person's "readiness" to change

3. Use decisional balance to increase (if necessary) a person's readiness to change
4. Assist the person to develop a SMART goal and action plan
5. Assist the person to identify barriers, use problem solving, and develop strategies for success

Theoretical Bases of Health Coaching

Programs of health coaching, or self-management support, are grounded in the Chronic Care Model (Bodenheimer et al, 2002), which is based on the assumption that the way clinical teams interact with patients makes a significant difference to patients' health outcomes (The Health Foundation, 2008).

Health coaching as an approach combines the principles and skills of several well-established schools of behaviour change. These are:

- Self-Efficacy is defined as people's beliefs in their ability to perform certain behaviours in certain situations directed at specific goals (Bandura, 1977). People learn self-efficacy through previous experiences of mastery, through social modeling (vicarious learning), social persuasion (reinforcement and support), and physical and emotional reactions.
- The transtheoretical (or stages of change) model proposes that change occurs through stages that include precontemplation, contemplation, planning, acting and maintaining (Prochaska & Velicer, 1997). Interventions that are stage-matched may enhance effectiveness and increase adherence to lifestyle change behaviours for chronic disease patients (Mau et al, 2001).
- Motivational Interviewing is a client-centred counseling approach rather than a theory, per se, and is used with stages of change to direct patients to exploring their ambivalence to change (i.e., creating discrepancy between what one wants and what one is doing) and thereby increasing the "readiness" to change (Rollnick & Miller,1995)
- Cognitive Behaviour Therapy is grounded in the philosophy that "negative behaviours" are learned responses and maintained by negative (often irrational) thoughts, which lead to negative emotions. These habitual ways of thinking and negative feelings can block changes. CBT helps clients to develop more positive, rational thoughts (about self), which changes their feelings and also their sense of self-efficacy (Ellis, 1975).

Integrated Health Coaching Principles

Wolever (2010) has produced a list of health coaching principles representative of most self-management support and health coaching programs.

1. The patient is the best source of information for personal behavior change strategies.
2. Education is provided when the patient is ready.

3. Goals are aligned with the patient's vision of health and personal values.
4. Emphasis is placed on how to change behavior, not why current behaviors exist.
5. Plans are established for how to deal with setbacks.
6. The coach reinforces accountability using the patient's own values and stories.
7. Only the patient is able to choose goals that are the most motivating.
8. Priorities are established balancing long-term vision and what is most salient in the patient's present life.
9. Patience and belief in the patient are critical to establish trust in the coaching relationship.
10. Coaches guide patients in linking behavior change to their life purpose.

Evidence that Health Coaching Works

There is increasing evidence of the effectiveness of health coaching not only in terms of patient self-efficacy, adherence to treatment and behaviour changes but also health service utilization and health outcomes. (Kreindler, 2008, Lindner et al, 2003)

Coaches working with families of children with asthma on lifestyle and behaviour changes were able to decrease hospitalization, emergency room, and primary care visits (by 45% to 17%) as well as use of medications by 20% (Axelrod et al, 2001). A randomized control trial using health coaching for six months with cardiovascular patients showed improvement in health behaviours and, importantly, a significant decrease in cholesterol levels (Vale et al, 2002).

Similarly, a randomized control trial comparing health coaching with usual care for patients with diabetes found significant improvements in HbA1C levels as well as self-reported treatment adherence, exercise, stress and health status (Wolever et al, 2010).

Health Coaching: Essential for Patient Self-Management

The increasing burden of chronic disease on the health system can no longer be ignored. An essential component to managing chronic disease is patient self-management, including adherence to treatment recommendations and healthy lifestyle behaviours. To engage and support patients to effectively self manage, healthcare professionals need to provide personal coaching as well as education. And health systems need to ensure coordination along the continuum of care integrating community-based, primary, and specialist care.

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