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Issue Brief:

Health Coaching: Transforming Conversations and Care Practices

A follow-up study of early adopters provides insights for the direction of this evolving field.

William Appelgate, Ph.D., Jody Hereford, BSN., MS., Kathleen Kunath, RN., Sheri Vohs, MS

Introduction

There is unparalleled experimentation with new approaches to managing chronic disease in this country. Still, we continue to have a mostly anecdotal understanding of pioneer experiences with the clinical adoption of patient engagement approaches such as Clinical Health Coaching. The Iowa Chronic Care Consortium conducted a survey of professionals recently trained in these skills to get a view "from the balcony" of this evolving field. The results suggest that professionals trained in Clinical Health Coaching are passionate about the potential for this approach to care management - but at least in some cases - Health Coaches find themselves ahead of the change curve in their own organizations.

The Emerging Field of Health Coaching[1]

As described by Bennett and others, health coaching is the process by which primary care clinicians help 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. [i]

Health coaching often is integrated into Patient Centered Medical homes (PCMH), or the broader term, Health Homes, which incorporate the care management aspects of enhanced primary care case management programs into a more formalized and sophisticated state. The emphasis of a medical home is the transformation of the primary care practice such that the physician and other engaged allied health professionals, such as Health Coaches, function in a team-environment that is patient centered.

Successfully managing chronic conditions is complex. Thirty to fifty percent of patients leave their provider visits without understanding their treatment plan, and hospitalized patients retain only 10 percent of their discharge teaching instructions. Better strategies of engaging and communicating with patients must be implemented to improve health outcomes. True engagement involves an important shift by healthcare providers from "teaching and telling" to "listening and engaging". At the same time, healthcare organizations must transform to new models of care to address the current fragmentation of services and lack of care coordination.[ii]

The aim of team-based care and health coaching, specifically, is to replace care that is episodic and initiated due to patient illness with care that is coordinated, continuous and proactive. Clinicians strive to improve physician-patient communication while educating and supporting patients, including approaches to reduce inappropriate use of the emergency room, and supporting patient involvement in decision-making.

Literature Review

Across the globe, research from a recent large study of 11 industrialized countries demonstrates that adults with complex care needs who had a medical home reported better coordinated care, fewer medical errors and test duplication, better relationships with their doctors and greater satisfaction with care.[iii] When comparing care delivered in a medical home (to care not delivered in a medical home) within each country surveyed, researchers found a difference of between 18 to 39 percentage points on questions such as whether their doctor spends enough time with them, encourages them to ask questions, explains things clearly and engages patients in managing their chronic conditions.[iv]

[1] For purposes of this article, we have used the term "health coach" to refer to the function of patient coaching, the term "Health Coach" to refer to the role or profession and the term "Clinical Health Coach" to refer to trained professionals who have mastered skills in transforming patient conversations and care processes to achieve better clinical outcomes.

Transformation to a Patient Centered Medical Home requires not only implementing new, sophisticated office systems, but also adopting substantially different approaches to patient care. Such a fundamental shift nearly always challenges doctors to reexamine their identity as a physician. For example, transformation involves a move from physician-centered care to a team approach in which care is shared among other adequately prepared office staff. To function in this team-based environment, physicians need facilitative leadership skills instead of the more common authoritarian ones.

A PCMH requires expanding the clinical focus from one patient at a time to a proactive, population-based approach, especially for chronic care and preventive services. In addition, physician-patient relationships need to shift toward a style of working in relationship-centered partnerships to achieve patients' goals rather than merely adhering to clinical guidelines.[v]

In a recent study on Patient Centered Medical Homes in 2012[vi], clinicians were asked how they educate and engage patients in the medical home. Aside from physician training, the single most referenced tool was health coaching, cited by 76 percent of the respondents as a critical resource.

The Iowa Chronic Care Consortium offers the Clinical Health Coach® training program as a 6-week experience designed for healthcare professionals who desire to attain skills in chronic care management through proactive, patient-centered strategies. Since 2008, more than 300 nurses, medical assistants, health educators and other professionals have completed this intensive program. While the Consortium retains active relationships with many of the Health Coaches we have trained, we engaged in a more formal survey of these professionals in 2013 to determine if their collective experiences match the powerful success stories that have been emerging within this evolving field.

Bennett and others define the role of the Health Coach to include:

Self-management support

A bridge between the clinician and patient

Navigation of the health care system

Emotional support

Continuity

Survey Methods

The survey was fielded to all previous clinical health coach training graduates during a three-week period in January, 2013. It posed 34-questions, including a mixture of multiple-choice and open-comment formats, requiring an estimated 10-15 minutes to complete. Survey Monkey was used as the online collection tool.

While the gross recipients totaled 318 recipients, only 290 were determined to be "contactable" based on bounce-backs (wrong e-mail address or security filters) and a small number of recipients who opted out of the survey.

The survey yielded an overall response rate of 56 percent from an "N" of 290. Response rates ranged from as high as 98 percent for recent class graduates to a low of 11 percent for graduates of the earliest classes.

Total Number of Survey Recipients	318
Less Bounce-Backs and Opt-Outs	(28)
Total Number of Contactable Recipients	**N = 290**
Total Number of Respondents	**R = 164**
Response Rate	**56%**

Survey Monkey reports its highest response rate to be 45.3 percent for surveys 1) that are personalized, 2) that take 1-4 minutes to complete, 3) that offer a reward and 4) where the respondents have a known interest in the survey subject. Given that this study required approximately 10-15 minutes for respondents to complete, the response rate of 56 percent is notable and a testament to the high interest of the respondents in the topics covered.

Findings

Almost 83 percent of the survey respondents were Registered Nurses, although the credentials and backgrounds of individuals functioning in the Clinical Health Coach role are diverse, including medical or nursing assistants, diabetic educators, dieticians, social workers, physicians, pharmacists, clinical managers and healthcare administrators.

The Health Coaching Profession Continues to Evolve

The profession of health coaching is comparatively new. The role continues to mature as payment, practice and organizational structures evolve in a new era of health care reform. Not surprisingly, most of the Health Coach professionals surveyed remain new to the field, with 68 percent having spent 5 years or less practicing in the role.

A significant finding from the survey is that 73 percent of the respondents reported that they function in the role of a Health Coach on only a part-time basis, with many indicating they are not yet actively practicing under the title of "Health Coach." Reasons for this are varied but survey comments suggest that some clinics 1) have not yet committed to a Health Coaching role, 2) are simply augmenting traditional nursing roles with the learned coaching skills, or 3) are in the process of formalizing the role and title within the organization. Many of the trained coaches have added coaching skills to their "real" positions, splitting their time between traditional nursing, care coordination and coaching.

Health Coach duties are spread over several different functions, with few respondents focusing only on one aspect of care management as their single focus. However, for those who are functioning in the Health Coach role as a primary aspect of their job, the most frequently performed duties included aspects of both behavioral and care process changes:

- Coaching conversations with patients for self-management and support
- Participating in care management or care coordination
- Preparing for planned patient visits
- Setting up and using registries

Only 8 percent of respondents report "leading change projects" as the primary focus of their job (consuming 60% or more of their work week) and less than 9 percent of respondents are focusing on "redesigning care processes" as the main focus. While this may be because other practice leaders in the organization are performing these roles, comments from the respondents suggest that Health Coaches are also being under-utilized.

When Health Coaches are asked what barriers preclude them from full utilization, 55 percent indicate they are "still building support for the position" while 48 percent indicate that "other office work or activity is given higher priority." Several respondents noted that resistance from physicians and administrators also continues to be a barrier:

What are the barriers you are experiencing?

My clinic does not have a clear role and understanding of the time needed to do the job properly…

Our upper administration feels…the role does not produce revenue in the short-term…

Paying for the position has been the struggle…

There is resistance to putting the focus on preventative measures and treating the whole person….

Health Coaches are Passionate about their Skills

Survey respondents were asked to evaluate their confidence and ability to use the skills they learned in the Clinical Health Coach program. The response was an overwhelming and passionate endorsement of their new abilities:

To what degree have your skills changed?

I feel more confident in my overall ability to use health coaching techniques.

Agree or Strongly Agree: 90%

I am better able to engage the patient, focus and guide the conversation toward change talk.

Agree or Strongly Agree: 88%

I am better able to ask patients open-ended questions.

Agree or Strongly Agree: 93%

I am better able to use reflective listening techniques

Agree or Strongly Agree: 93%

I am better able to use scales to assess readiness, importance and confidence.

Agree or Strongly Agree: 85%

I am better able to ask permission before giving advice to patients.

Agree or Strongly Agree: 85%

I feel more confident in my ability to help patients develop SMART goals.

Agree or Strongly Agree: 83%

I have used Coaching and/or Motivational Interviewing techniques more since attending the Health Coach Training.

Agree or Strongly Agree: 90%

Sixty-seven (67) percent of the respondents "agree" or "strongly agree" that their own job satisfaction and effectiveness have increased following training. Many of the respondents are not in roles that allow inside knowledge or understanding of their clinic's overall performance with care management. From their somewhat "siloed" perspective, however, most feel that their role has addressed key issues in their organization's effectiveness.

This enthusiasm for the added value of coaching occurs despite the fact that only 11 percent of respondents indicated that their organization provides a pay differential for the Health Coach position. In many instances, these clinical professionals have taken on new duties or assumed new skills without expectation of compensation. Even more notable is that 63 percent of them would consider paying for continued coaching skill development out of their own pockets.

Among the Health Coaches surveyed, there is a clear focus on the "bottom line result" to be achieved by better engagement of patients. Almost 72 percent indicated that their organization measures their

effectiveness in terms of “improved clinical patient outcomes”, followed by “a better patient experience” (54 percent) and “adherence to clinical process or outcomes measures.” (46 percent)

To what degree has coaching addressed these issues in your organization?

	Not Sure	Agree or Strongly Agree
Communication has improved within the clinic care team	20%	59%
There is greater recognition for patient-centered care	21%	58%
Our patients are better able to manage their overall health	26%	55%
We are closer to our goals for patients’ adherence to preventive care visits	25%	52%
Our patients are more satisfied with their clinical experience	28%	53%

“What has been the value of the Clinical Health Coach training program to you personally?

“It has made me more aware of the direction our health care is going and has made me motivate people differently.”

“It opens up better communication with patients, helps you get to the 'real' issues with them and their lifestyle changes or lack of.”

“It has been a wonderful experience where I have learned more about myself and how to apply knowledge to assist others to be the best they can be.”

“The program made it possible for me to partner with individuals to identify their reasons for shifting behaviors to ones that actually contributed to their future health.”

“It helped me to identify how my personality type enters into the interaction and how to flex to the clients personality type”.

“I have been a nurse for 40+ years. This is the most rewarding position I have ever had. It also is the most life changing for patients.”

Discussion

Is the Health Coaching Role Being Diluted?

Chronic disorders account for three-quarters of direct medical care costs in the United States. And of the myriad of chronic diseases, five of them – diabetes, congestive heart failure, coronary artery disease, asthma and depression – account for most of these costs.[vii]

As Christensen states in "The Innovator's Prescription"

> *….the care of chronic disease needs to be divided into two different "businesses." The first is the business of diagnosis and prescription, the second is a type of business that can help patients adhere to the prescribed therapy….because the business models are so different, different caregivers must provide each piece of the complete package of care for chronic disease – which means there is a big handoff between the two. Some entity needs to be sure that patients don't fall through this crack."*[viii]

That entity, presumably, is the Patient Centered Medical Home. The Health Coach serves as the facilitator of the vital hand-off between the physician and what the patient does (or doesn't do) in their own home in the weeks following their visit.

Yet, it appears that Health Coaches are being under-utilized. In many practices, their role is being diluted. The specific barriers identified by survey respondents suggest that some organizations are deploying *health coaching as a strategy before they have committed to practice reform*.

Health coaches close the link between physicians and providers assuring that we don't waste the resources of the office visit. They build connections with patients that extend beyond their visits into their lives.

As Nutting and others remind us: [ix]

> *Practice transformation includes new scheduling and access arrangements, new coordination arrangements with other parts of the health care system, group visits, new ways of bringing evidence to the point of care, quality improvement activities, institution of more point-of-care services, development of team-based care, changes in practice management, new strategies for patient engagement, and multiple new uses of information systems and technology.*[x]

Health coaches leverage these changes by transforming patient conversations, using skills such as motivational interviewing, reflective listening, readiness-to-change assessments, goal-setting, and engaging patients to be effective self-managers. [xi]

While most definitions of clinical health coaching encompass both "transforming conversations" and "transforming care processes," these functions - at *the practice level* - are different and require separate attention and resources. Good coach training programs include techniques for both improved care processes and patient conversations – but not as a substitute for the whole-scale changes in practice infrastructure that Nutting and others have proposed[xii]:

> *Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign. It is much more than a series of incremental changes. Since the early 1990s, theories of quality improvement emphasizing sequential plan-do-study-act cycles have dominated change efforts within primary care practices. Many NDP practices initially chose to take this incremental approach—literally checking off each model component as completed. They were soon overwhelmed with complications. Whereas the traditional quality improvement model works for clearly bounded clinical process changes, the NDP experience suggests that transformation to a PCMH requires a continuous, unrelenting process of change. It represents a fundamental re-imagination and redesign of practice, replacing old patterns and processes with new ones.*

It appears that Health Coaches are being under-utilized. In many practices, their role is being diluted. The specific barriers identified by survey respondents suggest that some organizations are deploying *health coaching as a strategy before they have committed to practice reform*.

Straddling the Fence between Volume and Value

Sicker individuals at high risk of morbidity or hospitalization often need additional clinical and self-management support, generally called care or case management, as well as help navigating the system. When Health Coaches are closely integrated with or embedded in primary care, they have been shown to improve outcomes and reduce costs for elderly and complex chronically ill populations. [xiii] The dilution of health coaching outcomes will be evident to all if Health Coaches are also expected to perform traditional nursing duties and meet all the care coordination needs of a practice. Even among organizations that made the commitment to train their staff in coaching skills, as is the case with our survey respondents, progress in integrating the role within the practice has been slow.

Why is this? Respondent comments suggest that many clinics are asking whether they can afford to add extra staff and dedicate them to the function of a Health Coach. We offer several hopeful indications that the value of health coaching is becoming recognized:

- Case studies are beginning to emerge that build the business justification for Heath Coaches. Those studies show that if one Health Coach assists three physicians, each physician would need to see just two extra patients per day to cover the costs. [xiv]

- We also see promising indications of payers starting to recognize the value of health coaching. Wellpoint, Aetna, Kaiser Permanente, Humana and United Healthcare and several Medicaid plans are investing in medical homes.[xv] In Iowa, for example, Medicaid pays health home providers a case management fee that varies from approximately $12 - $76 per-member-per-month for patients with chronic conditions. Current enrollment trends suggest a clinic with 500 Medicaid members could realize $150,000 in added gross income per year.[xvi]

- For those who wish to conduct a formal analysis, The Advisory Board Company, in partnership with Mercy Clinics, offers an online tool for clinic managers to evaluate the return on investment of dedicated health coach managing for the diabetes patient population. This tool can be adapted to test the investment return on other chronic diseases.

- Finally, the American Medical Association has added codes to the *CPT 2013 Professional Edition* for care coordination that patients with complicated, ongoing health issues may receive within a patient-centered medical home. The codes should be used for claims filed as of Jan. 1, 2013.

Conclusions

Given the complexities of preparing for a multitude of payment initiatives from payers, it is not a surprise that the Health Coach role continues to evolve. However, under-utilization of the Health Coach mitigates the increasingly well-documented promise of this role.

We offer several strategies for the profession, for coach training programs and for individual organizations and practices:

1) **Prepare for Value-Based Payment**. While we see encouraging signs that payers are starting to recognize the value of Health Coaches, many primary care practices may not adopt the kind of transformations envisioned until payment models change from volume to value-driven. Yet if Health Coaches are not fully utilized, their staffing costs can't be recovered and their potential for reducing health care costs can't be realized, promoting a lose-lose situation for practices and payers

2) **Clarify the Health Coaching Role**. We had one physician leader tell us that his practice delineated the role by focusing on what health coaches w*on't do.* "They don't answer phones, call in

prescriptions or clean exam rooms. We want them to be doing pre-visit chart reviews, using the registry, participating in a shared decision-making process and coaching patients." This same executive emphasized that the very first change that practices must make is to provide financial incentives to their physicians to manage chronic disease differently.

3) **Operationalize the Coaching Function.** Patient Centered Medical Homes need to work on process models that integrate health coaching into the care process infrastructure of clinical practice. They must continue to design business models that create efficient hand-offs for patients as well as effective therapies for chronic diseases. Hospitals need to use Health Coaches to work on care transition initiatives that personalize this process yet align with best clinical practices. All providers need to recognize patients as capable, with behaviors that are a movable equation for reducing health care costs.

4) **Document Improved ROI and Outcomes**. Payers will respond when Patient Centered Medical Homes are able to demonstrate the efficacy of the health coaching function with outcomes of improved self-management, and adherence to personal goals and heightened patient experience.

5) **Continue the Advancement of Coaching Skills.** Survey respondents expressed strong interest in expanded skills, most notably for the health coaching techniques for specific chronic conditions, such as heart failure, diabetes or cardiac rehabilitation. As payment evolves toward shared-savings opportunities, these skill enhancements should prove their return on investment. We also see the need for improved training on care transitions and readiness assessments for leaders and administrators.

Transformation is a lengthy process. Our survey results clearly confirm that the profession is still finding its place. In the meanwhile, Patient Centered Medical Homes will do well to avoid diluting the duties of Health Coaches if they hope to see different results.

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Endnotes

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[xi] Iowa Chronic Care Consortium. (2013)

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As Executive Director of ICCC, Dr. Bill Appelgate has provided leadership and guidance in the areas of chronic disease management, clinical health coaching, health risk assessments, health policy, prevention, health promotion and healthy aging. Under his leadership ICCC has led the Iowa Medicaid Enterprise in deploying statewide chronic disease programs in heart failure and diabetes to its members. He was also actively involved in the development of chronic health care cost reduction strategies within recently enacted health care reform legislation. Dr. Appelgate speaks nationally on the topics of chronic disease management, population health management and health policy. He has addressed organizations such as the American Telemedicine Association, the Care Continuum Alliance (formerly the Disease Management Association of America or DMAA), The Center for Telehealth and E-Health Law, and the Institute of Medicine.

Jody Hereford, BSN, MS

Jody Hereford is a Clinical Project Consultant for ICCC and has been a primary consultant in the development of the curriculum and design of content for the Clinical Health Coach™ training program. She also serves as faculty for the program in health coaching techniques in the clinical setting, clinical care management and leadership. Jody, who resides in Boulder, Colorado, is a certified Health Coach, a Registered Nurse/Exercise Physiologist and has completed a Cardiovascular Fellowship through the American Hospital Association's Health Forum. She has worked with hospitals as an expert in quality patient care including chronic illness care and reducing patient complications, readmissions and avoidable deaths. Jody has published extensively and spoken frequently on topics including innovative programmatic redesign, current business models and policies and procedures.

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As Clinical Project Manager for ICCC, Kathy Kunath leads disease management demonstrations, and is involved in community health improvement projects and prevention programs utilizing health risk assessments (HRAs). She currently serves as project coordinator for the Clinical Health Coach Training program and "Keep It in Check," the Iowa Medicaid Diabetes Tel-Assurance Program. She also serves on the Care Continuum Alliance (formerly DMAA) Medicaid Guidelines WorkGroup.

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Sheri Vohs brings more than 30 years of corporate and non-profit management experience to the Consortium as a Project Consultant, including 18 years of experience in health care financing, having served as vice president of provider relations at Wellmark Blue Cross and Blue Shield and as a McNerney Heintz consultant to health care systems on managed care development in Iowa and Nebraska.

Contact Information

The Iowa Chronic Care Consortium is an independent, not-for-profit entity whose purpose is to develop capacity with others to bring effective, personalized health improvement and chronic care strategies to individuals where they live and work.

To learn more about the Iowa Chronic Care Consortium, please visit
http://www.iowaccc.com

To learn more about Clinical Health Coaching programs, please visit
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