Health Coaching for Patients with Diabetes: Impact on Interdisciplinary Teams

The Ottawa Hospital Academic Family Health Team
Pamela Cullen-Arseneau RN, CDE, Shannon Merizzi RD, CDE, Clare Liddy MD, MSc, CCFP, FCFP, Kate Nash MSc, Sharon Johnston, MD, LLM, Hannah Irving, MSc, Natalie Ward, PhD

Background / Introduction

At present, 2.5 million Canadians live with diabetes. In 2020 it is estimated that this number will grow to 3.7 million. The incidence of diabetes has risen by 60% in the last ten years and the projected growth for the number of patients with diabetes will grow by 87% in the next 25 years.

Optimizing health care for patients with diabetes is important. Health Coaching is a way to interact with patients and engage them in their own care. The purpose of health coaching is to help patients understand their physician's advice, to explore how this can be incorporated by the patient, and empower them to self manage their health care. Health Coaching provides increased access and greater flexibility in care provision for patients.

In the Family Health Team setting it can be challenging to make optimal use of the skills and scope of practice of all members of the allied health team. Utilizing multidisciplinary staff as trained health coaches we anticipate providing high quality patient care in a cost effective manner. This would allow for provider satisfaction and a more efficient use of resources.

This project titled: "Health Coaching in Primary Care: a feasibility model" piloted health coaching for patients with diabetes in two Family Health Teams and a Community Health Centre.

Study Design

Health Coaching
- Patients at risk of or with a diagnosis of diabetes
- Referred by their family physician
- 3 sites – FHTs and Community Health Centers
- Registered Nurses and Registered Dieticians trained as health coaches at each site
- Each consenting patient received 6 months of health coaching
- Follow up every two weeks via email, telephone, face to face or a combination of all three

Patients
- Survey to evaluate health coaching at baseline and 6 months
- HbA1c, LDL-C, BP , BMI at baseline and 6 months
- Interview with 25% (convenience sample) of patient participants

Health Coach/Practice Level
- Focus groups with coaches and coordinators at each site
- Field notes
- Assessment of Chronic Illness Care

Findings

Patient Outcomes

- Clinical Measures
  - HbA1c – 17/28 patients had reduction in levels
  - LDL-C – 16/25 patients had reduction in levels
  - Blood Pressure – 21/36 patients had decrease

  {Note: trends only, no statistical significance }

- Survey Results
  - Two areas of focus:
    - *PACIC (*Patient Assessment of Chronic Illness Care) - measures specific actions or qualities of care congruent with the patient experience of the care received
      - 66% of patients report improvement in goal setting and follow up with respect to their care from baseline to 6 months
    - *PAM* (Patient Activation Measure) - measures patient knowledge, skills and confidence to self-manage
      - 22% scored at Level 1 of Activation (i.e., they may not believe that the patient role is important; 11% scored at Level 2 (i.e., they lack the confidence and knowledge to take action; 27% scored at Level 3 (i.e., beginning to take action); and 41% at Level 4 (i.e., they may have difficulty maintaining the behaviour over time)

- Patient Interviews
  - Deeper understanding of diabetes
  - Increased awareness by the patient of their role in managing their diabetes
  - Sense of accountability "keeping me honest"
  - Valued continuity of relationship
  - Improved access to other services

Health Care Team Outcomes

- Health Coaches require autonomy and dedicated time in order to arrange timely follow up for patients
- The Multidisciplinary team needs to be made aware of the role and scope of practice of Health Coaches
- Communication of clinical and self-management roles is required
- Assessing patient readiness is important (coaches can increase readiness by increasing health literacy, conviction, and confidence)
- Health Coaches can support appropriate use of the health care system
- Health Coaches can increase referrals within the Multidisciplinary team
- Health Coaches can support care coordination for patients

Patient Feedback

- "She's an important part of the triangle"
- "The doctor is more aware, they know I have been meeting with my coach …"
- "It's a positive environment"
- "People are listening"
- "It's the availability of the people and meeting with them and discussing things, because I didn't know that things about diabetes, and I didn't know much about eating habits either. I eat a lot more fish, vegetables, and things like that than cans (now) … nothing frozen as you know, ready meal. Don't touch that because of the salt"

Implications for Health Care

Lessons Learned
- Health Coaching is acceptable to patients
- Health Coaches can reach patients who do not attend group programs
- Health Coaching is feasible
- Health Coaching has the potential to improve patient outcomes

In The Future ….

In order to sustain the Health Coaching model, we will:
- Identify patients who might benefit from health coaching
- Identify team members who can take on the coaching role through:
  - Suitability for the role
  - Available time and flexibility
  - Number of patients each coach can work with at any one time
- Continue to utilize the most appropriate/efficient referral process
- Utilize the most appropriate methods of communication between coaches/physicians/other team members
- Utilize the most appropriate methods of communication between coaches / patients (i.e., texting, Skyping, blogging)
- Document coaching interactions, including clinical and self management goals
- Create a process for evaluation

Participating affiliations:
C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute, Ottawa, Ontario, Canada
Department of Family Medicine, University of Ottawa, Ontario, Canada
Department of Sociology and Anthropology, University of Ottawa, Ontario, Canada
Department of Anthropology, Mount Allison University, Sackville, New Brunswick

Thanks and acknowledgement are extended Stephanie Pick RN, MN, CON(C) for her assistance with the design of this poster. Stephanie is part of the multidisciplinary team at The Ottawa Hospital Academic Family Health Team

Printed by: TOH Printing Services