The Health Coaching Australia (HCA) Model of Health Coaching for Chronic Condition Self-management (CCSM)

Introduction and description of health coaching as a CCSM intervention

Health coaching is a generic term for a broad range of interventions with varying degrees of applicability to Chronic Conditions Self-Management (CCSM), depending on the model used. As defined by Health Coaching Australia (HCA), health coaching is a clinical health intervention, to be used only by qualified health practitioners, to facilitate lifestyle risk factor reduction and support self-management in clients with chronic health conditions.

The Health Coaching Australia (HCA) model is a collection of evidence-based interventions and techniques from various applications of psychology that assist health professionals to work with patients to change their behaviour when advice alone is not enough. In other words, health coaching is particularly relevant when barriers to health behaviour change are present. These evidence-based health coaching components have a long history in psychological practice and the behavioural medicine research literature. The model and its components are outlined below.

Health coaching is relevant to individual level intervention; either one-on-one or in small groups of 2-6 people that include individual attention and direct assistance in overcoming barriers to change for each participant.

This evidence-based model of health coaching has been endorsed and/or supported by a number of government Health Departments, Divisions of GP and community health services around Australia. The model was developed by Janette Gale of Health Coaching Australia with input from Dr Helen Lindner of the Australian Psychological Society. Both are Clinical Health Psychologists. This model is similar to the one used for the Good Life Club project, Whitehorse Division of General Practice, Victoria, that showcases the efficacy of telephone health coaching by health practitioners.

The health coaching model presented is a comprehensive approach to CCSM, with emotional, cognitive, social, and coping factors in health behaviour change being addressed to ensure adherence to medically recommended preventive and management treatments for chronic conditions, such as diabetes, asthma, heart disease, obesity and arthritis. It includes basic behaviour change skills and techniques, as outlined in the Flinders and Stanford Models of Chronic Disease Self-Management. Many health professionals complete health coaching training...
to augment their intervention skills, particularly in the areas of mild levels of negative mood, self-talk, and social isolation, for use within the Flinders and/or Stanford frameworks. It is stressed that CCSM needs to be viewed and implemented as a “team” approach to adherence to health care recommendations. This team concept has been endorsed in a report, “Adherence to long-term therapies: Evidence for action”, by World Health Organisation (WHO, 2003) where it states that “A multidisciplinary approach towards adherence in needed” (p.24). Although the health coaching model presents the theoretical and applied skills required of any health professional for an effective CCSM intervention, certain health professionals that have specific expertise should be acknowledged and used within the CCSM intervention. For example, as the medical practitioner plays a fundamental role in diagnosis and treatment recommendations for the physical condition, health psychologists need to be involved in the diagnosis and treatment of elevated levels of cognitive, behavioural, and emotional factors that a patient might present. The health coaching model represents the basic-level of knowledge and skills that all CCSM health coaching health professionals would be required to master to be an effective member of the CCSM “team”.

**Formal definition of Health Coaching:**

This Australian definition of health coaching has a clinical health focus that contrasts with definitions from the UK and USA that have a health promotion and education focus. Notwithstanding the focus on the individual or small groups, the health coaching model can be applied in primary, secondary, and tertiary healthcare situations.

Health coaching is a practice in which fully trained health professionals apply evidence-based principles and techniques from Health Psychology and Coaching Psychology to assist their patients to achieve positive health and lifestyle outcomes through attitude and behaviour change.

As outlined in World Health Organisation (2003), “Simply giving information to patients is unlikely to change behaviour; health care providers must understand the psychological principles that underlie self-management training and comprehend that motivating patients requires more than imparting brief information to the patient. “

There is a growing recognition that simply telling patients what to do is not effective in bringing about long-term behaviour change. This creates frustration for both patients and health professionals. Although earlier interventions to increase effective chronic conditions self-management have “focused on patient education, [m]ore recently, the importance of psychological and behavioural interventions has been stressed as a result of the growing recognition that knowledge alone is insufficient to produce significant changes in behaviour “ (WHO, p.79).
The WHO 2003 review (p.33) found five major barriers inextricably linked to health system and team factors:

1. Lack of awareness and knowledge about adherence
2. Lack of clinical tools to assist health professionals in evaluating and intervening in adherence problems
3. Lack of behavioural tools to help develop adaptive health behaviours or to change maladaptive ones
4. Gaps on the provision of care for chronic conditions
5. Sub-optimal communication between patients and health professionals.

Health coaching interventions help health professionals to motivate patients toward readiness to change, assist them to change unhelpful thinking patterns and encourage their self-regulation and self-management of lifestyle risk factors and treatment regimes associated with chronic illnesses.

**HCA Model of health coaching – Recommended training components for health professionals:**

In line with recommendations from WHO, a five-component model is recommended for health coaching training. These components are:

1. **Medical conditions knowledge**, including:
   - Aetiology, symptoms, treatment, and complications of major chronic illnesses (e.g., diabetes, heart disease, asthma, arthritis, COPD)
   - Impact of chronic illnesses on health and quality of life
   - Impact of lifestyle risk factors on health
   - The role of health promotion in chronic disease reduction & management
   - Adherence to medical and lifestyle prescription

2. **Behaviour change counselling techniques**, including:
   - Motivational interviewing skills
   - Solution-focused counselling skills
   - Reflective listening and other general counselling micro skills

3. **Psychological models of health behaviour change**, including:
   - Readiness to change framework (Prochaska, et al., 1992)
   - Models of barriers to health behaviour change and facilitators of change
   - Theories of motivation
   - The Self-regulatory Model of health behaviours (e.g., Leventhal, Meyer, & Nerenz, 1980) and self-management models

4. **Behaviour modification and evidence-based coaching techniques:**
   - Goal-setting, action planning, goal striving techniques
   - Learning and reinforcement principles
   - Adult learning principles
   - Behaviour modification and behavioural relapse prevention strategies
5. **Emotion Management and Cognitive Change strategies**
   - Depression and anxiety management strategies
   - Anger and other negative affect management strategies
   - Cognitive therapy techniques to address negative thinking patterns that act as barriers to health behaviour change, including cognitive relapse prevention strategies
   - Positive Psychology strategies and strengths, with a focus to build hope, acceptance, optimism and resilience, and to develop positive affect

**Components of the Health Coaching model of health behaviour change:**

It is well established in the health and medical literature that providing advice and education alone has limited efficacy (WHO, 2003). Education is a necessary part of health behaviour change, but not sufficient. Patient accountability will increase the effectiveness of health behaviour change interventions. However, even when these factors are included in research interventions, there remains considerable unexplained statistical variance that might be accounted for by the omission of psychological factors in the model.

A premise of the HCA health coaching model is that people have many barriers to change that are psychosocial in nature. If you don’t help them to work through the factors that are stopping them from adopting more positive behaviours, then they may not be willing and/or able to change.

**Component 1** requires that health coaching is conducted by qualified health professionals with an understanding of the reciprocal impact of psychosocial factors and physical health and pharmacological mechanisms.

**Component 2.** Motivational Interviewing (MI), has been recognized as being evidence-based by the Australian Government (i.e., Lifescripts and other interventions). The website [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org) is one repository of research for this component of health coaching. Solution-focused counselling is widely recognised as a valid method of conducting psychological counselling and evidence-based coaching (Stober & Grant, 2006).

**Component 3** is the important theoretical component that addresses the “Lack of awareness and knowledge about adherence” (WHO, 2003) – it outlines psychological models of health behaviour change upon which many behavioural medicine researched interventions have been based. This component of health coaching gives health professionals models to draw from to identify the factors that may be blocking patients’ change efforts. The models have considerable utility in practice. The HCA model of health coaching recognizes readiness to change as a critical factor to take into account and advocates that health practitioners use solution-focused counselling to assist patients to elicit their own strategies for change (given their specific barriers and circumstances). Eliciting client intrinsic (or autonomous) motivation is a key factor in conducting effective health coaching.
**Component 4** refers to goal setting, goal striving, monitoring, accountability, learning and reinforcement as well as other psychological principles of behaviour change that are supported by 50 years of research within the behavioural psychology/behavioural medicine literature (Locke & Latham, 2002). More recently this has been packaged as evidence-based coaching and a new field of psychology has formed called Coaching Psychology. This field is researching specific types and styles of coaching with a heavy emphasis on using only evidence-based interventions from other psychological and behavioural disciplines (see Stober & Grant, 2006).

**Component 5** has a vast literature on efficacy. The emotion management and cognitive change techniques are drawn from Cognitive Behaviour Therapy (CBT) (E.g., Beck, 1995). The body of evidence for CBT is widely accepted and CBT is a recommended intervention for patients under various Federal and State Government programs that provide assistance to people with mental health conditions and chronic health conditions. Evidence supports the importance of addressing mild and moderate levels of negative mood, such as depression and anxiety, in the effective management of chronic diseases. Additionally, the role of cognitions, such as illness perceptions and health beliefs, has been showed to impact on health behaviours.

In summary, the model components are well known to clinical health psychologists in particular, and to other mental health and health professionals generally. The model specifically dictates the basic training components recommended for health professionals to optimally assist patients to make health behaviour changes and self-manage chronic disease. The knowledge of CCSM self-management models and the acquisition of relevant intervention skills, as outlined in the Health Coaching model, will not only direct the individual health professional’s behaviour but also direct appropriate referrals within the team.

**Delivery Modes:**

The delivery of health coaching interventions is flexible, but should always be implemented within an intervention-team paradigm. It can be implemented clinically in the following ways:

- As an adjunct to usual medical, nursing and allied health practitioner consultations.
- As a dedicated health behaviour change session, face-to-face with a health coaching trained health practitioner (e.g., a Practice Nurse during Enhanced Primary Care patient management plan development).
- As a dedicated one-on-one telephone health coaching intervention conducted by a health practitioner.
- As an adjunct to program-based CCSM patient education (e.g., the Stanford Model of group education - as an Individual follow up session to maintain progress and assist with barriers to progress).
- As an adjunct to assessment protocols such as the Flinders Model of CCSM.
- As a small group health coaching intervention that includes provision of time for individual attention and direct assistance in overcoming barriers to change for each participant within group meetings.
- As an internet-based health coaching intervention that includes direct exchange of information between a health coaching health professional and a client.

**Intervention and Cost effectiveness of Health Coaching interventions**

The intervention and cost effectiveness of CCSM interventions that have included components as outlined in the HCA health coaching model, has been substantiated. A study, called the Good Life Club (GLC), was one of the demonstration projects of the Australian Government funded Better Health Outcomes Initiative (Kelly et al., 2003). It was developed to trial a telephone coaching approach to supporting clients with diabetes. The health coaches were allied health professionals trained in the Health behaviour change model, The Transtheoretical Stages of Change (Prochaska, DiClemente, & Norcross, 1992) and Motivational Interviewing (Rollnick, Heather, & Bell, 1992). The role of the coach was to assist the client to become a confident and proficient self-manager, and also to recognise their capacity for self management within their individual life context. The emphasis was on gaining control over targeted lifestyle behaviour changes, such as dietary and physical activity behaviours, and adherence to medical recommendations, such as blood glucose testing, foot care procedures, and medication prescriptions.

The empirical evidence indicated that the coaches reported a significant uptake of the health coaching skills (Lindner, et al., 2003), and that the relative risk of being well-managed was 1.28 (95%CI: 1.04, 1.58) for the GLC intervention as compared to usual care. Furthermore, the GLC intervention compared to usual care involved an additional cost of $1,457, but with an incremental cost-effectiveness ratio resulting in a benefit of approximately $16,000 (Mortimer & Kelly, 2006). The GLC members (diabetes sufferers) reported a significant association between depression and symptom experience, confidence to self-manage illness, and confidence in self-management to reduce the need to see doctor. At the six-month assessment time point, the GLC members reported significant reductions in fearfulness of health, shortness of breath, visits to the GP, and increased confidence in managing condition/disease related activities, such as fatigue, physical discomfort, emotional distress, and treatments other than medication (Browning et al., 2003).

**Health Coaching Skills Training for Health Practitioners**

**Introductory level skills training:**
The recommended introductory level skills-based training for all health professionals is 2 days minimum of intensive skills-based training. This should include:

1. Explanations and discussions of the health coaching model, evidence base and rationale;
2. Health coaching theoretical principles;
3. Health coaching practice issues;
4. Demonstrations;
5. Practice sessions with feedback; and
6. Discussions of real cases including complex cases from the participants’ and facilitators’ clinical experience.

After completion of high quality introductory level training of this nature, many health professionals possess the skills and confidence to start implementing health coaching as part of their usual practice. More experienced practitioners and those with solid counselling skills are able to integrate health coaching techniques more quickly than those practitioners who are not already competent in basic counselling skills (such as reflective listening skills).

Workshops should stipulate a maximum number of participants for each workshop in order to facilitate an adequate level of participation in discussion and adequate practice feedback for participants. As a guide, a maximum of 20 participants would be appropriate for a workshop with one facilitator and a maximum of 22 – 24 participants would be appropriate with two facilitators to supervise participant practice sessions.

Health coaching training is very effective in mixed groups of health professionals. This also builds professional understanding and respect between various health professions. This in turn facilitates better relations and enhances cooperation within multidisciplinary teams in the work place.

Trainers:

Trainers should be competent in their knowledge of health coaching principles and in conducting health coaching practice. They should have ongoing practice experience of working with clients in a health coaching context in order to address concerns and answer specific questions from participants. Trainers require a strong background in the practice of health psychology and chronic disease self-management support. At least one registered health psychologist should be present in each workshop in order to deal with psychosocial issues that sometimes arise for participants in workshops when participating in experiential health coaching practice as a client. Ideally, the primary facilitator will be a practicing clinical health psychologist. She/he will be required to analyse and discuss complex clinical cases that include how to deal with cognitive and emotional factors and other psychosocial issues that arise during health coaching consultations. Co-facilitators will ideally be a practicing health professional from

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another health discipline in order to integrate examples from a broader perspective than health psychology alone.

**Supervision or Peer Support:**

Work place-based periodic group or individual supervision or peer support sessions including discussion of cases assists health professionals to integrate their health coaching skills into their practice. These sessions also allow health practitioners to discuss difficult cases with peers and build their skill levels. Ideally, workplaces that have team arrangements for chronic condition self-management would have a clinical health psychologist on the team. The role of the clinical health psychologist would be to assist clients with complex health and psychosocial needs and also to support other team members in dealing with clients with psychosocial issues.

**Additional and Advanced Training:**

Additional or advanced training will be required for most individuals in components where skill gaps have been identified. For example:

- Basic Counselling Skills if lacking
- Motivational Interviewing techniques
- Solution-focused counselling techniques
- In-depth review of models of health behaviour change and barriers to health behaviour change
- Cognitive Therapy Techniques applied to health behaviour change
- Coaching techniques and behaviour modification strategies
- Interventions for mild levels of depression and anxiety

**Competency Assessment:**

Competency assessment is preferred to workshop attendance only. Assessment should be implemented if training and professional development budgets allow, in order to ensure that health practitioners reach the required standard of professional practice in health coaching. Participants report a much higher level of understanding and confidence in using health coaching techniques after submitting written and audio case studies and completing an exam addressing the key model components (Certificate of Competency in Introductory Level Health Coaching Skills).

**Positives about the approach:**

Health coaching provides health practitioners and organisations with practical clinical strategies to assist patients to manage chronic health conditions and lifestyle risk factors. The interviewing style aims to decrease patient resistance to change. When conducted by a *competent* practitioner, health coaching techniques elicit intrinsic motivation in patients and thereby increase the probability that patients will attempt to make behaviour changes.
In addition, health coaching techniques assist patients to identify and overcome their personal barriers to health behaviour change and thereby increase their chances of success in making and maintaining health behaviour changes.

An added advantage of using health coaching techniques is that health professionals often report having greater job satisfaction after integrating health coaching into their professional practice. They report greater success and less frustration in relation to patient outcomes. Health coaching training will preferably include practice sessions based on real life situations for participants rather than role plays. Where this occurs, health practitioners report a greater level of empathy and understanding with clients and often report changes in their own health beliefs and behaviours.

In summary, the benefits of implementing health coaching for chronic disease self-management are:

- Enhanced efficacy of interventions by all health professionals in usual medical and allied health consultations;
- The opportunity to conduct dedicated health coaching sessions for chronic condition self-management;
- Widespread application across professional domains;
- Enhanced patient responsibility;
- Enhanced practitioner job satisfaction;
- Enhanced multidisciplinary professional collaboration;
- Flexible and cost efficient delivery modes;
- Low cost and ease of up-skilling health professionals;
- Evidence-based intervention components; and
- Good fit with well-known self-management and lifestyle change models.

**Organisational challenges for implementing health coaching as a chronic condition self-management strategy:**

**Breadth of Staff Training:**

Ideally, all health practitioners with patient loads should be trained in health coaching skills to improve patient outcomes where they are dependent upon patients making health behaviour changes. Most health practitioners will have received limited training in any of the recommended health coaching training components. This has obvious cost implications for organisations and presents both an opportunity and an administrative challenge.

**Nature of Staff Training:**

Health coaching is not a ‘one size fits all’ intervention. It is necessary because patients require individual assistance with making behaviour changes that fit with their particular circumstances and priorities. Therefore, to be competent in health coaching, health practitioners need to have a sound understanding of...
fundamental health coaching principles in order to assess which particular health coaching intervention to use for a particular patient at a particular time. The appropriate interventions will depend on the client’s readiness to change as well as other psychological factors and individual circumstances.

The implication of the individual nature of patient needs is that health coaching techniques cannot be administered in a standardised, highly structured fashion. Health practitioners need to understand why they are using certain techniques in order to use them effectively with a particular patient, at a particular point in time, for a particular issue. Health coaching training, therefore, needs to be conducted by skilled practitioners. It is not appropriate for trainers to simply teach a set of procedures to participants.

Identification of Need for Supplementary Skills Training:

The amount of training required for each individual to reach competency in health coaching will depend upon pre-existing skill levels in each of the training components. This will be influenced by:

- Professional base level and advanced training – whether it included elements of the recommended training components.
- Professional Development training completed since qualifying in their profession – eg, MI, CBT, Psychosocial aspects of illness, management of mild depression and anxiety etc.
- Professional experience. More experienced practitioners will integrate the principles faster than less experienced practitioners.

During introductory training in health coaching, participants should be encouraged to identify the gaps in their skills base and engage in self-directed learning in the lacking areas. For some practitioners, it may be desirable or necessary for them to repeat the introductory workshop in order to fully understand and be comfortable with the health coaching model.

Skills Retention:

In order to retain skills from training in health coaching, participants need to start using their new knowledge and skills immediately in the workplace. To facilitate this, organisations could require newly trained staff to write up a selected number of case studies for review by a competent health coaching practitioner. Alternatively, peer support or supervision groups could be conducted periodically. Additionally, it is useful to require these staff to audio tape some of their own consultations and review these personally in order to improve their techniques over time. Ongoing self-directed or required reading of the recommended texts and papers referenced in health coaching training workshops would be desirable in order to continue to develop health coaching skills.
Human resources and organisational systems:

Health coaching interventions can be incorporated into usual health practitioner consultations. However, in order to optimally assist patients to address some barriers to change, it sometimes takes up to 30 minutes to make significant progress on an issue. In health systems where health professionals have limited consultation times (e.g., 15 minutes) and where they are expected to assess and provide advice to patients in this time, there is little time left to assess and address patient motivation and barriers to change. However, even in short consultations the health coaching interview style can elicit patient changes where they would otherwise not have occurred. The primary behaviour change aim in very short consultations may be to not increase resistance to change in patients.

Follow up consultations:

An important implication of the health coaching model outlined above is that it recognises that many patients require assistance with the process of change, even after they have committed to making changes. One-off consultations with health practitioners do not assist patients to address barriers to change when they occur after the consultation. Patients often elect to try behaviour change strategies that they have tried before, and continue to fail in their change attempts (e.g., crash dieting). Unless patients are able to receive follow up assistance, they may give up when they fail to achieve their health goals on the first attempt. Programming follow-up consultations as a matter of policy can address this problem.

Organisation Culture:

Health coaching represents an attitude shift away from the historical medical model of assessing patients, telling them what they need to do and expecting them to carry out the health practitioner’s instructions. The alternative model relies on eliciting intrinsic patient motivation and allowing patients to take responsibility for the decision-making process in relation to health behaviour change for chronic condition self-management. If the organisational culture does not support practitioners and patients working in this way and if sufficient consultation time is not allowed to achieve these aims, health coaching interventions will have less chance of success.

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