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Researchers Affirm Long-term Value of Health Coaching

Most Clinical Outcome Improvements Persist One Year Later

June 01, 2016 04:21 pm Sheri Porter – Authors of a recently published study on health coaching began their latest research well aware that health coaching can be an effective tool for physicians who want to encourage patients to self-manage their chronic diseases.

"Health coaching, provided by a member of a primary care team trained to support patient engagement in chronic disease self-management, is a promising intervention that helps offset the heavy workload placed on primary care providers for chronic disease management," observed the authors.

Furthermore, they noted that health coaching had been shown to improve outcomes in patients with cardiovascular risk factors such as diabetes and hypertension.

STORY HIGHLIGHTS

Researchers conducted an observational study to follow up on a one-year randomized controlled trial involving a health coaching intervention among patients in a safety-net population.

Authors concluded that most of the improved clinical outcomes persisted one year after the completion of the health coaching intervention.

Corresponding author Anjana Sharma, M.D., noted that the study results may provide impetus to clinics considering investing in a health coach.

But what they didn't know was whether the effects of health coaching could be sustained a year later.

"We conducted a pragmatic study to follow up a 1-year randomized controlled trial of a health coaching intervention among a safety-net population," the authors wrote. Their end goal was to determine whether patients were able to maintain significant improvements in their control of diabetes, hypertension and hyperlipidemia.

The results of their research are summarized in an article titled "What Happens after Health Coaching? Observational Study 1 Year Following a Randomized Controlled Trial,"(www.annfammed.org) published in the May/June issue of *Annals of Family Medicine*.

Researchers showed that the proportion of patients in the coaching arm of the randomized controlled trial (RCT) who achieved the primary outcome (being at goal for at least one of three measures evaluated [hemoglobin A1c, systolic blood pressure or LDL cholesterol]) was 47.1 percent at 12 months and dropped only slightly to 45.9 percent at 24 months. The proportion of patients who achieved the secondary outcome of being at goal for a single clinical measure -- specifically, hemoglobin A1c -- dropped from 53.4 percent to 36.2 percent during that same period. Only nonsignificant

changes were seen for the other clinical metrics between 12 and 24 months.

Authors concluded that "most improved clinical outcomes persisted one year after the completion of the health coaching intervention."

Study Methodology

Patients ages 18 to 75 years old who participated in the original RCT were enrolled and randomized to health coaching or usual care for 12 months.

Patients placed in the usual-care arm had access to resources available at their clinic site -- one of two safety-net adult medicine primary care clinics in San Francisco that serve predominantly Latino and black patients.

Patients randomized to the intervention arm of the study also had access to usual-care services plus one year of health coaching.

Health coaches were certified medical assistants -- all Latina -- and were bilingual in English and Spanish. All coaches received 40 hours of health coach training.

According to authors, the health coaches

- escorted patients to clinic visits,
- reviewed key questions and medications with patients before appointments with their primary care physicians,
- stayed with patients during the exam room portion of the appointment,
- reviewed patients' care plans after appointments and
- talked to patients by phone between visits.

It's worth noting that after the 12-month RCT was completed, all patients from the usual-care arm whose diabetes, hypertension or hyperlipidemia remained out of goal range at 12 months were offered a limited amount of health coaching (less than six months); 56 usual-care patients received this limited coaching.

The purpose of the 24-month follow-up was not to make a second round of comparisons between the arms of the RCT, said the authors, because such a comparison "would have little meaning given that selected patients from the usual care arm received nonrandomized post-intervention coaching."

Rather, they said, the observational study sought to describe the natural history of patients from each arm after the RCT by comparing outcomes at 12 and 24 months within each of three groups:

- participants from the intervention arm of the original trial,
- participants from the usual-care arm who received post-RCT coaching, and
- participants from the usual-care arm who never received coaching.

"Comparison of usual-care patients who received limited post-RCT coaching with those who did not revealed notable differences," said the authors. For those in the usual-care arm who received post-RCT coaching, the proportion that achieved the primary outcome jumped from 10.4 percent at 12 months to 33.3 percent at 24 months. For those who never received post-RCT coaching, the statistics remained essentially unchanged from 12 to 24 months.

Similar trends were seen for most secondary outcomes in the two groups.

Context From Research Author

Corresponding author Anjana Sharma, M.D., a clinical fellow in the department of family and community medicine at the University of California, San Francisco School of Medicine, provided more detail about the research for *AAFP News*.

The following Q&A is a summary of that conversation.

Q. Why is this study of critical importance at this point in time?

A. Currently, there is increasing emphasis on how patients can be better engaged in their own care and how to help patients manage chronic illness day to day when they are outside the clinic walls. Interventions such as health coaching are gaining attention as a strategy to promote this patient engagement.

Our previous research showed that medical assistants, relatively affordable members of the health care team, can provide support that helps improve cardiovascular health and diabetes control. However, for payers to buy into this model, it also is important to know if the improvements people make while they are coached are sustained after coaching is completed. Our study examines the question of whether health benefits last over time.

Q. What would you point to as the most significant finding?

A. Our primary finding was that the proportion of patients who received a year of health coaching within a 12-month randomized controlled trial maintained clinical improvements at 24 months. This aligned with our primary outcome of achieving clinical control of diabetes, hypertension and/or hyperlipidemia a full year after the health coaching intervention was completed.

Q. Were there any surprises related to your research findings?

A. First, the maintenance of most clinical improvements for a full year after the intervention is surprising in itself. That is a long time to maintain health benefits, and one might expect to see decline when the health coach was no longer present to support the patient.

Second, looking independently at each of the outcome measures, we did see a statistically significant decline in control of blood sugar from 12 to 24 months. It may be that diabetes requires longer or more frequent contact by health coaches in order to maintain clinical benefits.

Q. What's the key takeaway for your family physician colleagues?

A. Investing in health coaching may not only have immediate benefits for patients who are struggling to meet their health goals, but those benefits may persist over time. We observed maintenance of the benefits of health coaching by trained medical assistants up to one year after the health coaching intervention has completed.

Q. How can the findings from this research improve patient care?

A. This study may provide impetus to clinics who are considering investing in health coaching because the maintenance of benefit seen implies there is a cost-effectiveness argument for promoting health coaching.

Q. Is there anything else you'd like to emphasize for the readers?

A. We also saw that the patients in our usual care arm who were still not at clinical goal at 12 months, and who received a limited amount of health coaching, showed some notable improvements from 12 to 24 months even though it wasn't the full intervention.

There may be a role for targeted health coaching in which we focus on patients who are doing worst clinically, as they may have the most to gain from the intervention.

Finally, this study was conducted at two safety-net clinics, showing that health coaching is promising even in an underserved setting.