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Integration of Health Coaching Concepts and Skills into Clinical Practice Among VHA Providers: A Qualitative Study

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Abstract

Background: Although studies of health coaching for behavior change in chronic disease prevention and management are increasing, to date no studies have reported on what concepts and skills providers integrate into their clinical practice following participation in health coaching courses. The purpose of this qualitative study was to assess Veterans Health Administration (VHA) providers' perceptions of the individual-level and system-level changes they observed after participating with colleagues in a 6-day Whole Health Coaching course held in 8 VHA medical centers nationwide.

Methods: Data for this study were from the follow-up survey conducted with participants 2 to 3 months after completing the training. A total of 142 responses about individual-level changes and 99 responses about system-level changes were analyzed using content analysis.

Results: Eight primary themes emerged regarding individual changes, including increased emphasis on Veterans' values, increased use of listening and other specific health coaching skills in their clinical role, and adding health coaching to their clinical practice.Four primary themes emerged regarding system-level changes, including leadership support, increased staff awareness/support/learning and sharing, increased use of health coaching skills or tools within the facility, and organizational changes demonstrating a more engaged workforce, such as new work groups being formed or existing groups becoming more active.

Conclusions: Findings suggest that VHA providers who participate in health coaching trainings do perceive positive changes within themselves and their organizations. Health coaching courses that emphasize patient-centered care and promote patient–provider partnerships likely have positive effects beyond the individual participants that can be used to promote desired organizational change.

Keywords

health coaching, veterans, provider communication skills

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Introduction

As high rates of preventable chronic diseases continue to be a significant public health threat,[1] it is becoming increasingly important to promote health behavior change in clinical practice. Indeed, clinical guidelines for the management of the most common chronic diseases, such as obesity, type 2 diabetes, coronary heart disease, and hypertension, include helping patients to make changes in behaviors such as diet, exercise, and stress management to improve outcomes.[2] However, large caseloads and time limits make addressing behavior change within the context of a clinical visit challenging. As such, strategies such as motivational interviewing (MI)[3] and health coaching (HC)[4] have been developed and disseminated, and both are generally accepted as being effective approaches to behavioral change in

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health care.[5] Moreover, there has been a growing literature showing that both health-care systems and patients demonstrate improved chronic disease outcomes when providers involve patients in decision-making and self-management.[6,7] Thus, health-care organizations are increasingly emphasizing patient-centered care as the optimal approach for improving outcomes.[8,9]

MI is a patient-centered approach to guide individuals away from ambivalence and to elicit and strengthen their intrinsic motivation to change.[3] Studies of MI have demonstrated that providers trained in the essential skills, including assessing readiness and motivation for change, building on individual strengths to make changes, and setting realistic goals, do integrate these skills into clinical practice and promote behavioral change among patients. VanBuskirk and Wetherell[10] found in a systematic review and meta-analysis that MI was more effective at achieving targeted outcomes than were control conditions across a wide range of behavioral outcomes that included substance use, physical activity, blood pressure, weight, and self-reported smoking cessation.

HC is a more recent and comprehensive approach to behavioral change than MI that also is effective in helping patients to make and sustain behaviors that support improved outcomes. In their systematic review, Wolever et al. defined health coaching as, ''a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a (trained) coach.''[4(p48)] Studies have shown that HC promotes positive health outcomes for patients with type 2 diabetes and heart disease, and healthy lifestyle behaviors, including improved nutrition, physical activity, weight management, and medication adherence.[11–14] However, to date, no studies have reported on what concepts and skills providers integrate into their clinical practices.

Prior literature has identified a number of system-level supports for the integration of patient-centered care. These include leadership at multiple levels[9,15] and staff capacity building to support a patient focus, such as trainings in communication skills and patient-centered care values.[15] Other authors have stressed the importance of collective learning in the adoption of patient-centered care, including through the use of communities of practice. Soubhi et al.[16] stress the importance of both relationships among members and the various products they develop and share with patients (such as assessment tools) as part of a community of practice. Members of a community of practice learn from their shared practice, further each other's goals, and ''promote the continued evolution of collective learning.''[16(p170)] Support from other staff and sharing concepts with other staff also have been identified as important to the increased use of concepts and skills in patient-centered care.[8] However, more needs to be learned about how system-level supports contribute to practice changes following provider trainings designed to increase skills in collaborating with patients and increasing patient engagement in their care, such as HC or MI.

Purpose

The purpose of this study was to qualitatively examine self-reported individual-level and system-level changes in clinical practice after participation in a 6-day Whole Health Coaching course at 8 Veterans Health Administration (VHA) medical centers. The HC course was part of a multifaceted effort by the VHA's Office of Patient Centered Care and Cultural Transformation (OPCC&CT) to promote personalized, proactive, patient-driven care.[17] For example, each of the sites that offered the HC course had clinical champions whose role was to promote facility-wide supports for patient-centered care. In addition, facility leadership (eg, facility and medical directors) attended the course for a brief introduction and to let attendees know how the course and its tenets were important to facility-wide efforts. Finally, OPCC&CT provided regional support for patient-centered care efforts, including having regional leaders attend trainings and provide onsite support as needed, as well as answer questions about national initiatives in patient-centered care.

The details of this training have been provided elsewhere.[18] In brief, the course included didactic instruction and mentored practice as well as a half-day session on how to integrate the skills and content into daily practice. Core skills included mindfulness, listening, using a guiding helping style, reflecting, eliciting motivation and change talk, directing attention to the values of the Veteran, and working with patients to develop goals and specific action steps. Following the course, all participants also were encouraged to take part in a community of practice that included monthly calls. These were intended to ''continue the conversation'' regarding the ideas, information, and content included in the course, share best practices among facilities that were implementing coaching in creative ways, and keep the participants connected in a community setting to share ideas, answer others' questions, and provide support.

Results from an outcome evaluation of the course using an intervention-group-only pre–post design, which was conducted by members of the same team as the current analysis,[18] showed increases in providers' preparedness and self-efficacy to use HC skills, and these increases were sustained at 2-month follow-up. We also found a medium-sized effect on increased self-reported use of HC skills between pretest and follow-up.

Another finding, however, was that at follow-up participants reported significant decreases in perceived norms about HC in their facilities. That is, participants reported that the effects of the HC course did wane over time in terms of how facilities were integrating HC into the standard of care. This study addresses gaps in the literature regarding providers' perceived integration of HC concepts and skills into clinical practice following course participation, and their perceptions of what system-level factors have supported their individual practice changes. Further investigation is needed to examine how system-level support can influence providers' HC behaviors.

Methods

Measures

The follow-up survey, which providers completed approximately 2 to 3 months after the training, asked participants to qualitatively report on (1) the most important change, if any, made in your work since participating in the Whole Health Coaching Course (individual-level changes in clinical practice) and (2) the most important change, if any, that occurred in your facility since your participation in the Whole Health Coaching Course, that has helped facilitate or support changes in your work (system-level changes).

Sample and Data Collection

Participants included individuals who took the Whole Health Coaching course at 1 of 8 VHA facilities in which the course was implemented between January and July 2014 and had completed, postcourse evaluations. The 8 facilities requested the HC course to meet patient-centered care goals in the VHA strategic plan and were spread across 7 of 18 regional Veterans Integrated Service Networks, representing a range of sizes and regions. The most frequently reported roles of participants included not only nurses, social workers, psychologists, and dietitians but also pharmacists, peer support specialists, medical assistants, physical therapists, and occupational therapists. The majority of participants volunteered to attend; however, 15% enrolled because a manager required them to do so. Facilities selected participants from among those interested to maximize clinical implementation and diversity of provider type and service representation. For the qualitative survey, the sample consisted of 258 individuals who responded on a pretest before the start of the course and who also responded to a follow-up web-based survey 2 to 3 months after the completion of the course. (The 258 who completed the pretest made up 96% of the 269 who attended the course.) Following course completion, participants who had taken the pretest and completed the course were sent a link to complete the follow-up survey. Of 258 participants who completed the pretest, 165 responded at follow-up, and of these we were able to match data across waves, yielding a follow-up sample of 163 cases (response rate of 63.2%). Of these 163 respondents, the average age was 47 and 87% were females. Most reported White (74%) as their race, 17% reported Black, and 3% reported Asian. Eighteen percent were Veterans. Occupational roles included nurses (37%), social workers (14%), dietitians (9%), physicians (7%), and health coaches (6%). Other roles included pharmacists, nurse practitioners, peer specialists, and others. The average number of years worked in the VHA was 9 years.

Of the total sample of 163 at follow-up, 123 (75%) answered the open-ended item about changes made; however, 7 of these reported no change (including no change due to not working directly with Veteran patients) and 3 made responses that could not be categorized. Therefore, 113 reported changes were themed.

In response to the open-ended follow-up item about perceived system-level changes that facilitated their individual-level change, 111 respondents (68%) provided a response. Of these 111, 27 reported "None," "Not applicable," or a similar response, and 7 reported only changes that they themselves had made. Therefore, 77 reported system-level changes were themed.

Analysis

We used a qualitative content analysis to derive relevant themes in the 2 follow-up open-ended items. Because some respondents gave more than 1 answer to each question, a preliminary step was to identify all distinct answers, which became the unit of analysis. The first author of this article reviewed the responses on each individual survey item to see what themes emerged and then developed a coding manual that included definitions and examples.[19] All responses were then coded by the first and second authors. Two types of theming differences occurred: in some cases, the 2 coders identified different themes, while in others, 1 coder identified more than 1 theme (while the other coder only identified 1). Taking these 2 types of theming differences into account, there was an interrater reliability of .85. Finally, for all responses on which there were any discrepancies between the 2 coders, the last author served as a third coder to resolve those discrepancies.

Results

Individual-Level Changes

Table 1 shows the 8 primary themes that emerged from our analysis of the 142 responses (from 113 respondents)

Table 1. Themes Identified in Participant Reported Individual-Level Changes.

- Respondent reported no change or response could not be categorized (10)

Themes Identified (n = 142)

- Increased (own) awareness of concepts (9)
- Shared/promoted concepts and use with others (12)
- Increased emphasis on Veterans' values (33)
- Increased use of listening (15)
- Increased use of other HC skills (39)
  - Increased use of goal setting (8)
  - Changed types of questions asked or how interviewed patients (7)
  - Being less directive (9)
  - Increasing focus on change talk (4)
  - Using pausing, reflecting, presencing or being mindful (9)
  - Using scaling or scaling questions (2)
- Increased empowerment of patients (10)
- Added coaching into own practice (18)
- Team or work group change (6)

to item 1. The themes were increased awareness of concepts, shared/promoted concepts and use with others, increased emphasis on Veterans' values, increased use of listening, increased use of other HC skills, increased empowerment of patients, added coaching to own practice, and team or work group change. We also show in Table 1 that there were 10 respondents who reported no change or who gave responses that could not be categorized.

Increased (own) awareness of concepts included a focus on the respondents becoming more aware of the concepts from the HC course and how to use them, while not specifically including mention of how the concepts were used. Examples included "changed mindset that patient is in the driver's seat for his/her health care" and "reminded me to use a 'whole person' approach." *Shared/promoted concepts and use with others* included informal and formal sharing or promotion of concepts from the HC course: "using concepts in staff training" and "shared coaching skills with others." *Increased emphasis on Veterans' values* centered around an emphasis on what was most important to Veterans. Typical responses included "I explore patients' values more often" and "understanding what matters to the Veteran." In addition to responses that focused on exploring the patients' values in general, a subtheme was asking patients what they needed their health for or how they defined health. *Increased use of the skill of listening* included typical responses of "more listening in conversations" and "being more mindful of letting the Veteran speak." In a number of cases, respondents who identified listening also identified other skills, including reflecting. *Increased use of other skills* included responses about skills or practices used with patients in addition to listening. Specific subthemes were (1) goal setting ("assisting the Veteran in formulating SMART goals"), (2) changing types of questions or how interviewed patients ("I have encouraged patients to talk by using open ended questions"), (3) being less directive ("Letting the Veteran give the content much of the time instead of almost always giving advice"), (4) increasing focus on change talk, (5) using pausing, reflecting, or being present/mindful with patients, and (6) using scaling or scaling questions. All these skills or practices were emphases in the HC course. Skills that were not mentioned in these responses included the use of reflections, perspectives, and stages of change. *Increased empowerment of patients* was similar to the theme of increased emphasis on Veterans' values but went further and focused on the patient contributing to decision-making on the trajectory of care. Examples of responses for this theme included "including patient in treatment plan," "trusting the patient to make choices," and "letting the patient decide what they are capable of completing." *Added coaching as part of own practice* included responses in which respondents stated they were using HC as a practice in their clinical care versus simply using some of the skills. In the majority of these responses, respondents reported using the Personal Health Inventory (PHI), which is a tool the VHA developed for patients to complete prior to clinical encounters (eg, individual and shared medical appointments, health coaching visits) to identify areas of health and well-being, including self-care and professional care, they would like to address. Examples include "using new PHI in case management with Veterans" and "using the PHI in diabetes education group classes to help guide discussion." *Team or work group change* included responses that mentioned some change beyond a respondent report of change in their own practice, for example, "I have begun meeting weekly with staff interested in promoting Whole Health Coaching."

System-Level Changes

Table 2 shows the 4 primary themes that emerged from our analysis of the 99 responses (from 77 respondents) to item 2. Themes included leadership support, increased staff awareness/support/learning and sharing, increased use of HC skills or tools, and work groups formed or active (and other organizational changes). We also show in Table 2 that there were 34 respondents who reported "None" or similar responses or who only reported individual level change.

Leadership support included responses about a range of types of leadership support, from the general ("increased support from leadership") to more specific ("leadership has given me the opportunity to assign a

Table 2. Themes Identified in Participant Reported System-Level Changes.

- Respondent reported no change or reported only individual changes (34)

Themes Identified (n = 99)

- Leadership support (20)
- Increased staff awareness/support/learning and sharing (52)
  - Increased staff awareness/buy-in/enthusiasm/support (18)
  - Monthly community of practice calls (7)
  - Positive support and sharing with team members or course participants (6)
  - Education of staff and consideration of how to integrate HC into practice (11)
  - General increased use of HC concepts and more focus on HC (10)
- Increased use of skills/tools by others in the facility with patients or staff (11)
- Work groups formed/active and other organizational changes (16)
  - Specific committees or work groups formed or active (13)
  - Specific programs developed or re-developed (1)
  - Increased referrals to integrative health (2)

nursing coaching segment within my weekly schedule''). *Increased staff awareness/support/learning and sharing* included responses within the following identified subthemes: (1) increased staff awareness/buy-in/enthusiasm/support, (2) monthly community of practice calls, (3) positive support and sharing with team members or course participants, (4) education of staff and consideration of how to integrate HC, and (5) general increased use of HC concepts and more focus on HC. *Increased use of skills/tools by others in the facility with patients or staff* included the subthemes of (1) increased use of HC skills and (2) increased use of tools such as the PHI. We only included within the final results those responses for which it was clear that the respondent was referring to increased use of HC skills or tools by staff other than the respondent. *Work groups formed or active/other organizational changes* included the subthemes: (1) committees or work groups formed or active, (2) specific programs developed or re-developed, and (3) (increased) referrals to integrative health-care services. Examples of responses were ''A committee was formed as a result of the course that is working on moving the program forward at this facility'' and ''Creation of whole health leadership group.''

Discussion

This study is among the first to investigate health-care providers' perceived personal and health-care system benefits from participating in a HC course. Findings suggest that VHA providers who participate in HC trainings do perceive positive changes both within themselves and their organizations. These data extend quantitative results reported previously,[18] which showed medium size effects in self-reported use of HC skills in respondents' own practice at follow-up. Importantly, we found that, in addition to enhancing providers' abilities to address behavior change within the context of a clinical visit, HC courses that emphasize patient-centered care and promote patient–provider partnerships may have positive effects beyond the individual participants that can be used to promote desired organizational change.

Of the themes that emerged through our analysis of self-reported individual-level changes, one commonly occurring theme was increased attention to Veterans' values. An important tenet of HC is that it is respectful of and responsive to patients' preferences, needs, and values.[4] Consistent with this tenet of HC, the course emphasized how providers can use HC to provide care that is patient-driven per the VHA's mission,[17] and in particular, recognizes patients' values as a core component of meaningful behavior change. The HC process model, which provided a map for the coaching process, incorporated exploration of values in working to further develop, and articulate a mission or purpose statement. We also identified subthemes of increased focus on how patients described ''good health'' or what they wanted their health for, and asking what the patients wanted to achieve through appointments. These subthemes reflect HC's emphasis on identifying what is important to patients and/or what they value about either achieving general health and well-being or addressing specific presenting issues for which they were referred, such as losing weight or stopping smoking.[4]

Participants reported continued use of a number of skills, with the most frequent skills being increased use of listening and being present with their patients. Listening has been identified as a key component of effective health care, with good listening being strongly associated with patient satisfaction.[20] In addition, listening is a key component of patient-centered communication, the latter of which has been shown to have a positive impact on a number of important outcomes including adherence to recommended treatment[21] and self-management of chronic diseases.[22] For example, an extensive meta-analysis[21] found that training physicians in communication skills resulted in odds of patient adherence being 1.62 times higher than when the physicians received no training. Given the extant literature in combination with the VHA's focus on patient centricity in clinical care, listening was a core skill in the HC training.

It is noteworthy that participants noticed their increased capacity to be present with patients. Mindfulness, or paying attention on purpose to the present moment without judgment,[23] was a core component of the HC training. Participants learned various mindfulness practices with the goal of helping them to be

present with patients and pay attention without judgment to the health concerns and priorities the patients identified. Mindfulness practices during each day of the 6-day course helped to cultivate this approach by providing participants opportunities to practice being present while sitting, walking, and eating. Previous research has shown that education and practice in mindful communication is associated both with improved provider well-being and improved attitudes toward patient-centered care.[24]

It is also interesting to note that 3 skills were not identified in the qualitative findings: reflections, perspectives, and stages of change. Reflection is a tool wherein the listener (coach) repeats back to the speaker (client) what s/he has heard. This can be a verbatim reflection or a reflection that adds meaning or interpretation to what was said. The use of perspectives can help individuals to see an issue from a different point of view. Briefly, the coach invites the client to describe the health behavior the client wants to change or a barrier to making change with a word or analogy, thinking of as many descriptors as possible. The coach then asks the client to think of the opposite of that description and flesh out this way of looking at the issue. The coach invites the client to explore as many perspectives on the issue as possible and then to choose one perspective that may help to resolve the conflict or barrier. Stages of change come from the Transtheoretical Model[25] and can help the coach to identify how ready or involved in behavior change the client is so that the best HC tools can be used to move the client toward change maintenance. These skills are not as easily incorporated into HC as listening, being present, or asking clients what is important to them, and thus, it is likely why they were not mentioned in the qualitative responses. Importantly, when developing future HC trainings for providers who are incorporating HC skills into clinical practice as opposed to serving in the sole role of a health coach, it may be useful to evaluate what skills were and were not used and/or considered relevant. Skills that take significant time during a clinical encounter or that take more practice and experience may not be necessary, or even desirable, to include in foundational trainings, but rather, may be saved for continuing education and/or more advanced trainings.

We found that system-level changes reported by providers as supporting their own practice changes included those cited in the literature on organizational change and patient-centered care, including leadership support,[9,15] increased staff awareness, support and sharing,[8,16] and the activities of work groups related to furthering patient-centered care or health coaching. Taking into account all responses we looked at (including those reporting no change in Table 2), about 15% of the system-level changes participants cited related to leadership. Thirty-nine percent of responses about system-level changes indicated increased staff awareness, support, and sharing. Twelve percent of responses cited the formation or development of work groups and other system changes.

The theme of increased staff awareness, support, and sharing included a range of sub-themes that encompassed both informal and more formal sharing and support among the course participants. An example of formal sharing and support was the monthly community of practice calls designed to provide ongoing support and learning. Such sharing and support are part of the process of building staff capacity to support a patient focus.[9,15] Sharing and support also relate to the importance of relationships among providers in delivering patient-centered care, and of collective learning among the community of practice members.[16] As an example, Soubhi and colleagues note that 2 components of the social context of health-care communities of practice are relationships among members and the various products and tools they develop and share (eg, assessment tools, flowcharts). Themes we identified in participants' reports of individual-level changes made included sharing and promotion of concepts among others, and adding coaching into their own practice. In the latter, as we noted earlier, a majority who reported integrating or adding coaching into their own practice specifically mentioned adding use of the PHI. These results seem to support the importance of relationships with colleagues and of products that are shared and that can give form to the group's experience and provide a basis for continual learning.[16]

The reported themes of support through work groups and through other staff suggest that among those participants who reported making some changes in their own work, some degree of collaboration was important. Examples of work groups reported as having been developed included sub-committees of patient-centered care committees devoted specifically to supporting the use of HC within a facility. This is consistent with Pelzang's[8] thesis that coordination, collaboration, and continuity of care are important to the adoption of patient-centered care.

Moran and Brightman[26] assert that it is important for change to be both top-down (to provide vision and create structure) and bottom-up (to encourage participation and generate support). The HC course reflected this with the training of individuals being combined with clinical champions and leadership support within facilities and from OPCC&CT. The same authors also note that effective change interweaves multiple improvement efforts. We found a variety of improvement efforts that included HC course participants integrating the skills they had learned into their current practice and working within teams or work groups to integrate HC into their shared work with varying levels of formalization of the change.

The primary limitations of this study are its use of self-report data from a convenience sample and the relatively small number of facilities from which the data were obtained. Another limitation is that fewer than half of participants who completed the pretest provided open-ended responses that were coded for this analysis. These individuals may not have perceived a benefit of the course or may otherwise not reflect all those who participated in the courses. Despite these limitations, we have identified themes in individual-level changes in practice after the HC course, as well as perceived system-level changes that supported these changes. Findings suggest that HC courses aimed at improving patient-centered care initiate individual and system-level changes that may support systemic change. This is especially important in large systems like the VHA, where change requires buy-in not only within individual facilities, but across the nationwide network of care. Future studies should include observational studies of providers during clinical visits to more accurately assess the effectiveness of the HC training and the degree to which clinical practices change after participation in the course.

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