Health coaching in South Eastern Sydney & Illawarra regions

The start of a journey

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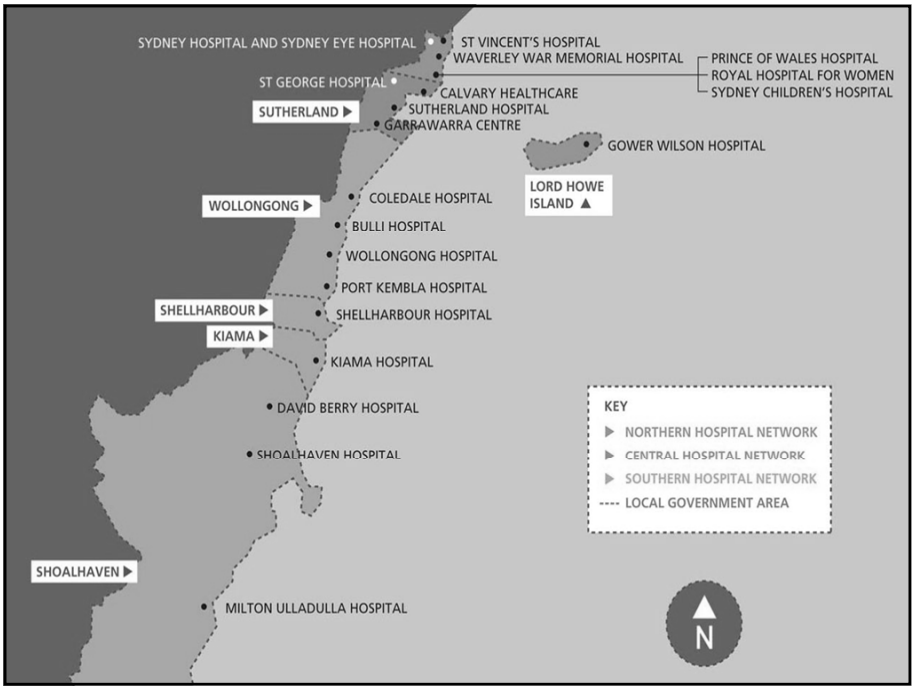

Aims of the NSW Connecting Care program

- To improve the quality of life for people living with severe chronic disease
- To create a seamless and integrated health care journey for patients with chronic disease
- To assist in the reduction of debilitating physical and social effects of chronic disease
- To reduce unplanned hospital presentations
- To reduce the burden of chronic diseases on the client, their carers and the health system

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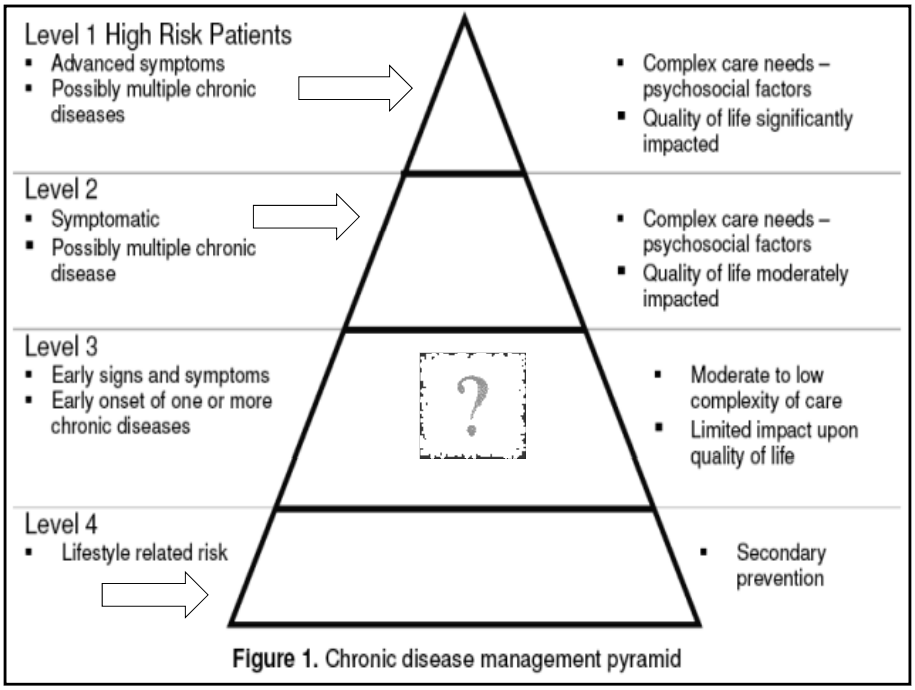

Figure 1. Chronic disease management pyramid

Background

- Program office commenced in May 2010
- Starting from minimal base
- Multiple CDM services
- Poor coordination and communication between teams
- No common eMR system
- Minimal health coaching
- Some work with Divisions of GP

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Previous health coaching

- Health coaching survey February 2010
- 14% of chronic care programs offered health coaching as a strategy
- No staff had health coaching qualifications - some had chronic disease self management certificates (9 staff) and relevant post graduate qualifications (7 staff).
- No specific budget for health coaching despite ~ 5,500 patients per annum receiving some form of self management instruction
- Some strategies specific for Aboriginal communities but no measurement of effectiveness.

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Strategy – Health Coaching

- Target those in the high risk group who are currently not receiving a chronic disease management service
- Look at provision of health coaching through an external service provider
- Up skill staff current CDM staff to provide health coaching as a part of their service
- Move towards GP referral to health coaching
- Move towards improved integration with existing CDM services

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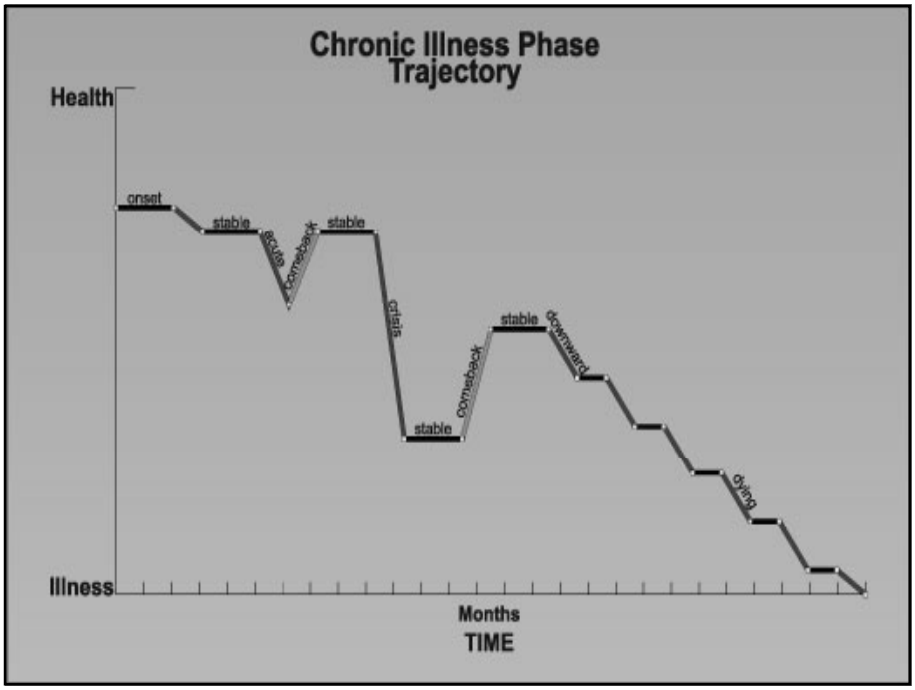

So – what have we achieved?

- Funding received April 2011
- Commenced discussions with Healthways under panel of goods and services
- Engaged Health Coaching Australia to provide workshops for staff in health coaching
- Developed ID processes for high risk group
- Developed consenting processes for transfer of demographic information
- 500 patients a month identified ~ 1/3 consenting to receive telephone based coaching

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More achievements…..

- Implemented CHIME as eMR for service. Most CDM teams now using CHIME
- Presentations on health coaching to multiple stakeholder groups – in conjunction with Healthways Australia
- HCA training commenced for Managers and CDM staff
- Development of eMR alerts to improve awareness of patients receiving health coaching
- Commenced transfer of enrolments onto the program in mid-June
- Care calls commenced end of June

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What feedback have we received?

- Fair amount of resistance from some existing CDM services – reducing over time
- Some enthusiasm
- Staff giving positive feedback about the HCA workshops:
  - Highly motivational. We plan to focus more on patients identifying their own problems.
  - It has been very helpful in identifying the patient's priorities, helping them to self-manage their chronic health problems as they see them!!
  - Assessing patient barriers; developing agenda (menu) patient driven!
  - Have started thinking during the workshop how this could be used in mental health.

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Reflections on public vs private patient groups

- They are generally an older population.
- Multiple co-morbidities.
- More polypharmacy issues.
- Very enthusiastic to receive service.
- Patients are setting goals earlier.

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Case study

- 58 year old male
- Multiple co-morbidities: unstable angina and Type 2 diabetes, chronic renal impairment & low back pain
- He is obese and has difficulties managing his blood glucose levels.
- Personal goal - “Wanting to lose weight in order to improve his general well-being.”

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Case Study - Actions

- Actions identified and in progress are:
- A review of current diet and lifestyle factors that include:
  - Education on healthy eating and lifestyle and how to maintain a healthy well-balanced diet.
  - Creating a diet and exercise plan that is achievable.
  - Referral to a Healthways dietician for consultation regarding weight loss.
  - A review of the patient’s knowledge of his health issues including the complications of diabetes and lifestyle factors that are impacting on his health.

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Case study - Outcomes

- Within two weeks of being on the program - BGL before breakfast decreased from 8.5mmol/L to 5.5mmmol/L on average
- He has started exercising by walking daily and is enjoying it
- He expressed his enthusiasm for his plan to improve his health
- Medication issues identified and referred to GP for appropriate management

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Challenges

- Moving from program implementation to whole of system change
- Optimising take up of patients for telephone based health coaching
- Development of telephone based screening to ensure health coaching is appropriate
- Working with Aboriginal and CALD communities to ensure that telephone based services are appropriate
- Linking health coaching approaches with CDM teams to telephone based coaching
- Demonstrating improved health outcomes
- Kiama NBN trial

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