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Health And Wellness Coaching Utilization And Perspectives Of Health Practitioners Working In American Indian Communities

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HEALTH AND WELLNESS COACHING UTILIZATION AND PERSPECTIVES OF HEALTH PRACTITIONERS WORKING IN AMERICAN INDIAN COMMUNITIES

by

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This thesis, submitted by Jill Breyen in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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Jill Breyen
July 3, 2017

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ABSTRACT

Despite increased interest in client-directed counseling methods to manage chronic disease, limited data exists about utilization of counseling skills and attitudes towards these methods among health care providers, specifically those providing care to at risk populations. The aim of this qualitative study was to explore the beliefs and practices of a multidisciplinary group of health practitioners who were trained in health and wellness coaching (HWC) that included motivational interviewing (MI) techniques. The training was sponsored by the Bemidji Area Indian Health Service Health Promotion Disease Prevention (BAO IHS HPDP) program. Forty-seven trained coaches from the BAO IHS HPDP working with American Indian health programs in Illinois, Minnesota, Michigan, and Wisconsin were invited to participate. Participants completed an anonymous, online survey exploring perceptions about and use of HWC in practice. Twenty-seven of the 47 IHS Bemidji Area coaches who qualified for the study completed it. Participants represented nine different health practice areas with the majority working for Tribal Health Programs (22 of 27). Frequent use of coaching techniques, high self-efficacy with the use of HWC skills, and observed improved adherence to treatment and client outcomes were reported. Practitioners believed HWC was an effective method for providing care to patients participating in American Indian health programs. Future research is needed to examine relationships between HWC practice and patient outcomes in populations who are from diverse cultures.

CHAPTER 1

INTRODUCTION

According to the World Health Organization (WHO, 2017) preventable chronic diseases kill an estimated 40 million people annually and contribute to the escalating costs of healthcare. The major causes of death associated with chronic diseases include cardiovascular disease, cancer, diabetes, and respiratory disease (WHO, 2017). Eighty percent of chronic disease-related deaths occur in low to middle income countries and affect all age groups. According to Indian Health Service (IHS, 2017) American Indian and Alaska Natives (AI/AN) have higher rates of death and lower life expectancies related to chronic disease than other Americans. Poverty is closely linked to chronic disease. At risk communities including AI/ANs experience high rates of health disparities with poor health outcomes. Community residents often lack access to resources to protect themselves from the risks of chronic disease. (Castor, Smyser, Taualii, Park, Lawson, & Forquera, 2011; IHS, 2017).

While healthy lifestyles have been identified as playing a key factor in improving the health status of a population, changing unhealthy behaviors related to physical inactivity, poor dietary choices, tobacco and alcohol use is difficult for many people (Miller & Rollnick, 2013; Moore & Tschannen-Moran, 2010; Pampel, Krueger, & Denney, 2010; WHO, 2017). Traditional provider interventions such as the expert providing advice often cause discord and result in poor outcomes (Clifford & Curtis. 2015; Miller & Rollnick, 2013). There is an increased emphasis on using patient-driven

programs to help individuals change their health behaviors to improve health outcomes and lower health costs (Kivelä, Elo, Kyngäs, & Kääriäinen, 2014; Rollnick, Miller, & Butler, 2008; WHO, 2017). Healthcare providers must work closely with clients to ensure active participation, understanding, and collaboration in the management of their chronic conditions. Potential barriers for change exist both with the client and provider such as provider lack of training or expertise to address behavior change, limited clinic time to explore behavior changes, competing client obligations, difficulty gaining the client's trust, and facilitating the client to engage and take an active role in his or her own care (Bennett, Coleman, Parry, Bodenheimer, & Chen, 2016; Rollnick, Miller & Butler, 2008).

The effort to identify successful behavioral intervention programs has intensified with the continued rise in rates of lifestyle-related chronic diseases. Health and wellness coaching (HWC) and motivational interviewing (MI) are two strategies that are gaining momentum in assisting clients to reach their health-related goals (Armstrong, Mottershead, Ronksley, Sigal, Campbell, & Hemmelgarn, 2011; Kivelä, Elo, Kyngäs, & Kääriäinen, 2014; Simmons & Wolever, 2013). The methods of MI and its effectiveness for improving various chronic diseases are documented in the literature (Miller & Rollnick, 2013; Söderlund, Madson, Rubak, & Nilsen, 2011). HWC, however, is a relatively new approach to behavioral change with multiple definitions and unstandardized methods and training programs. The terms "health coach" and "wellness coach" are often used interchangeably and confusion exists on what exactly encompasses coaching and coach/client roles. This has made it difficult to study its effectiveness in changing behaviors (Butterworth, Linden, and McClay, 2007; Hayes, McCahon, Panahi,

Hamre, & Pohlman, 2008; Wolever & Eisenberg, 2011; Wolever et al., 2013). Four definitions of HWC are summarized below:

1. Coaching is "the art of creating an environment, through conversation and a way of being, that facilitates the process by which a person can move toward desired goals in a fulfilling manner" [W. Tim Gallwey, tennis expert and credited by some as the originator of today's current coaching methods]. (Gallwey, 2000, p. 177).

2. Coaching is "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential." (International Coach Federation, 2015).

3. "Health and Wellness Coaches partner with clients seeking self-directed, lasting changes, aligned with their values, which promote health and wellness and, thereby, enhance well-being. In the course of their work health and wellness coaches display unconditional positive regard for their clients and a belief in their capacity for change, and honoring that each client is an expert on his or her life, while ensuring that all interactions are respectful and non-judgmental." (International Consortium for Credentialing Health and Wellness Coaches [ICHWC], 2017).

4. Coaching is the practice of health education and health promotion within a coaching context, to enhance the well-being of individuals and to facilitate the achievement of their health-related goals. Coaching is a way of assisting people to achieve a higher level of both physical and mental well-being when treatment goals have to do with health, fitness and wellness. Coaching is not about

analyzing a client's problems or telling clients what they should do, rather it's about using the practitioner's knowledge and skills to help guide the process while collaborating with the client, respecting the client's autonomy on what direction they choose to take their journey (Moore & Tschannen-Moran, 2010; Palmer, Tubbs, & Whybrow, 2003).

A 2013 review of the literature on HWC by Wolever et al., found a broad range of techniques and theories applied as well as differences in the amount of human interaction, frequency, and duration of coaching. In addition, the coach's degree of education, professional background and training in HWC varied widely. The review did conclude that agreement was evolving on certain aspects of HWC, specifically that health and wellness coaching is a client-centered method, based on behavior change theory and emphasis of client ownership for their health behaviors (Wolever et al., 2013). HWC is delivered by individuals from a wide range of health backgrounds who encourage self-discovery, active learning and client-directed goals (Moore & Tschannen-Moran, 2010). It was also noted that effective coaching took place when there was a consistent, continuous engagement with a coach trained in interpersonal processes including behavior change and motivational skills (Wolever et al., 2013).

Progress is being made in the efforts to standardize a HWC definition and its methods. In September of 2017, eligible coaches will have the opportunity to take the first National Board Certification for Health & Wellness Coaches through the ICHWC and the National Board of Medical Examiners (ICHWC, 2017). The certification aims to

deliver a minimum standard and measure of the following foundational competencies of the knowledge, tasks, and skills essential to the practice of health and wellness coaching.

An evidence-based, standardized version of HWC training called integrative health coaching (IHC) was developed at Duke Integrative Medicine and the University of Minnesota. It has shown positive client behavior change outcomes in the field of healthcare (Simmons & Wolever, 2011; Wolever et al., 2011). IHC involves using highly trained professional health coaches to provide intense intervention sessions with a minimum of six to eight visits in 30-40 minute increments. Its foundation is based on the theory that behavior changes can be maintained when linked to personal values and a sense of purpose (Grant, 2006; Wolever et al., 2011). It focuses on the whole person, working with a client throughout the entire process of change. The process begins as the coach facilitates client identification of his or her own health and wellness vision and explores core values. Discrepancies between current and desired lifestyle practices are addressed and the client moves closer to setting specific goals. Coaches assist the client to flow through this process with the use of confidence and readiness tools. When the client is ready to design a specific plan to meet his or her goal, the coach works alongside the client to cultivate a realistic, sustainable strategy that aligns with the client's values and overall sense of purpose (Smith, Lake, Simmons, Perlman, Wroth, & Wolever, 2013; Wolever et al., 2011). The goals may address any health or wellness-related need that is indirectly or directly related to chronic disease management. The coach does not try to be the "expert" or "fix" the problem, rather helps bring awareness to what is important in the client's life and to identify how these values align with the client's health and wellness goals. Strategies and techniques are used at different stages in the coaching process to

engage and empower the client, ultimately leading to positive outcomes (Simmons & Wolever, 2013).

Whereas HWC is a comprehensive, holistic approach used throughout the client's entire process of change, MI is simply one important communication tool used in HWC to help clients resolve ambivalence and make an argument for change (Simmons & Wolever, 2013). MI has been found to positively support behavior change in relationship to several chronic conditions including obesity, cardiovascular disease, diabetes, chronic pain and asthma. Improved health outcomes and patient satisfaction related to physical activity, blood pressure, lipid profiles, hemoglobin A1Cs, and medication adherence have been documented in the literature (Hettema, Steele, & Miller, 2005; Rollnick, et al., 2008; West, DiLillo, Bursac, Gore, & Greene, 2007; Woollard, Burke, Beilin, Verheijden, & Bulsara, 2003). Originally introduced over 30 years ago as a treatment for addiction by William R. Miller, PhD and Stephen Rollnick, PhD, MI is a client-centered counseling method for addressing ambivalence about behavior change while avoiding confrontation between client and provider (Miller & Rollnick, 2013). Miller and Rollnick define MI as:

> a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. (2013, p. 29)

Miller and Rollnick (2013) modified their description of MI in their most recent text from a two-phased linear process of building motivation (Phase 1) and consolidating

commitment (Phase 2) into a more complete, circular definition using four overlapping ideologies that were believed to better reflect actual practice: (1) engaging, (2) focusing, (3) evoking and (4) planning. Engaging involves developing a growth-promoting, collaborative, trusting relationship that supports the client's autonomy. Engaging involves the use of several communication skills including reflective listening. Once the client is engaged, one can move onto the process of determining a topic in which to focus. The third process, evoking, is considered to be at the heart of MI. This involves having the client voice his or her reasons for change. Finally, planning begins when the client has made the switch from sustaining a behavior to being ready to change. It involves developing an action plan that supports the building of self-efficacy. Throughout the four processes of MI, five core communication skills are strategically used: (1) asking open-ended questions, (2) affirmations, (3) reflections, (4) summaries, and (5) informing and advising with permission (Clifford & Curtis, 2016; Miller & Rollnick, 2013).

The underlying spirit of MI, or the way the provider verbally and nonverbally interacts with his or her client, is considered the core component of MI. Miller and Rollnick (2013) describe the spirit of MI in four terms: (1) partnership, (2) acceptance, (3) compassion, and (4) evocation. Partnership implies collaboration between the client and provider. It requires the provider to remove the "expert hat", offering tips with permission and only if the client gets stuck and is ready for change. Acceptance involves communicating unconditional positive regard, providing empathy, respecting the autonomy of the client to make their own choices and affirming the client's strengths and efforts. Compassion involves the commitment to focus on the well-being and best interests of the client, not the provider feels is best for the client. Lastly, evocation is

related to the provider's spirit and process of engagement with the client. It implies that the client has many of the answers, not the provider. Evoking change talk identifies what is important to the client and assists the client to hear his or her true beliefs. The spirit of MI aids the client to become aware of his or her own thoughts and feelings that are the root of their behaviors, aiding the client to resolve ambivalence and explore alternate behaviors (Miller & Rollnick, 2013; Söderlund, Madson, Rubak, & Nilsen, 2011; Welch, Rose & Earnst, 2006).

Due to their specialty of working with clients to make lifestyle changes and improve health outcomes, registered dietitians, registered nurses and certified diabetes educators are ideal candidates to become health and wellness coaches. They are often in the position to build self-efficacy and provide tools for clients to reach their health and wellness goals (May & Russell, 2013). Growing evidence suggests HWC and MI can be implemented to improve client counseling in regards to lifestyle-related issues, specifically diet, weight loss and certain diabetes self-management cares (Brug, Spikmans, Aartsen, Breedveld, Bes, & Fereira, 2007; Ekong & Kavookjian, 2016; Dilillo & Smith West, 2011; Marley, Carbonneau, Lockner, Kibbe, & Trowbridge, 2011; Olsen & Nesbitt, 2010). However, there can be a lot of inconsistencies in the utilization of HWC and MI in the healthcare setting. It is not clear if or how HWC and MI have been modified for specific populations, types of clinic settings or within a type of practice and/or across practice areas. Those who did not receive HWC or MI as part of their professional training may find it particularly challenging to incorporate into their practices (Cronk, Russell, Knowles, Matteson, Peace, & Ponferrada, 2012; May &

Russell, 2013). Little is known about how practitioners incorporate coaching or MI into their daily practices.

The aim of this study was to explore how health care providers trained in HWC modified their skills into their real-life practices, their perceptions on its efficacy and which techniques were used most often. As mentioned earlier, HWC is a relatively new approach to chronic disease management and is in the early stages of standardizing associated definitions and methods. The literature did not present any previous studies on real-life practice use and perceptions on HWC with chronic disease management. Motivational interviewing (MI) was added to the search terms in the literature review because of its well-documented effectiveness and recent successful extension into chronic disease management. MI is integrated into HWC as a communication tool to help clients resolve ambivalence and make an argument for change.

CHAPTER 2

METHOD

Participants were recruited from a list of 47 health and wellness coaches working for American Indian and Alaska Native (AI/AN) health programs in Illinois, Michigan, Minnesota and Wisconsin. The Indian Health Service's Bemidji Area Office of Health Promotion Disease Prevention (IHS BAO HPDP) program provided HWC training for practitioners from May, 2012 through April, 2016. The Bemidji Area Office (BAO) of the Indian Health Service (IHS), is located in Bemidji, Minnesota, and provides assistance to three Federal, 34 Tribally-directed, and four Urban Indian health programs in the states of Illinois, Indiana, Michigan, Minnesota and Wisconsin (IHS, n.d.). Participants were asked to indicate if they worked for a Tribal health program, Urban Indian health program, Indian Health Service program or other programs not listed on the survey.

All coaches recruited to participate in the study received intensive training from the Wellcoaches School of Coaching program, an American College of Sport Medicine (ACSM) -endorsed institute that supports the ICHWC national standards and certifications. The training course ranged from 13-18 weeks long and was completed between April, 2013 and April, 2016. The courses involved weekly interactive classes, readings and practice assignments. One participant did not complete the full length of the training for an undisclosed reason, but was allowed to complete the survey because the practitioner gained critical skills in HWC through the partially completed training.

The participants were contacted by email and asked to complete an online survey through a University of North Dakota Qualtrics password protected survey. The anonymous survey consisted of 11 questions related to basic demographic information, perceptions, and use of health coaching techniques and took approximately 5-15 minutes to complete. In total, 27 of the 47 health and wellness coaches invited to participate in the study finished the study for a completion rate of 100%.

A five point Likert scale was used to measure the clients perceived use of coaching skills, perceived success with HWC, and perceived confidence in coaching. The scale used the following responses: Always, Most of the time, About half the time, Sometimes, Never. A seven point Likert scale was used to measure the participant's view on HWC related to continued use, effect on adherence to client treatment and goals, positive outcomes, improved trust and communication, overall client-practitioner relationship, likeliness to show for follow-up visits, and importance of continued training. The scale used the following responses: Strongly agree, Agree, Somewhat agree, Neither agree nor disagree, Somewhat disagree, Disagree, Strongly disagree.

Participants were asked to mark the five health coaching techniques used most often with clients from a list of 13 options. The following options were listed: (a) asking open-ended questions; (b) affirmations; (c) simple reflections; (d) complex reflections; (e) demonstrating empathy, warmth, acceptance, non-judgmental, curious, non-confrontational demeanor (MI Spirit); (f) rulers (e.g. confidence level 0-10, motivation 0-10, importance of making a change 0-10); (g) decisional balance; (h) using agenda setting/designing client driven goals (Appreciative Inquiry-Define-Discover-Dream-Design-Deliver/Destiny); (i) working collaboratively with the client; (j) brainstorming,

(k) Setting and reviewing a wellness vision; (l) setting specific, client driven goals; and (m) other. An open ended question asked participants to describe ways they had modified their health coaching training and techniques to meet the needs of the communities and clients. A separate open ended question asked participants to identify strengths with health coaching in practice settings. Finally, participants were asked to list challenges with using health coaching in their practice.

Practitioners were asked to report the ideal time frame for an initial and a follow up HWC visit. Practitioners were asked to consider their perceived most effective time frame in which to see a client at these two types of client appointments. The select time frames were the following: (a) less than 15 minutes, (b) 16-30 minutes, (c) 31-45 minutes, (d) 46-60 minutes, (e) 61-75 minutes, (f) 76-90 minutes and (e) more than 90 minutes.

CHAPTER 3

RESULTS

The majority of providers that completed the study were employed by Tribal health programs (N=22). A total of three individuals worked for the Indian Health Service, one provider worked for an Urban program, and one provider worked for the general public. Table 1 provides the distribution of the organization of employment reported by participants.

Table 1. Participants by Organization of Employment.

Organization Type	N = 27
Tribal Health Program	22
Urban Indian Program	1
Indian Health Service	3
Other	1

Participants were asked to indicate what type of job position they held by marking all options displayed that applied to their current professional positions. Several participants held more than one positional role and credential within their organization. Sixteen distinct professional positions were indicated in all. Registered Nurse (N =12), Certified Diabetes Educator (N = 9), and Diabetes Program Coordinator (N = 6) were indicated most often. Participants were asked to indicate their current professional

positions. In total, nine coaches indicated they were certified diabetes educators, six reported being diabetes program coordinators, one was an exercise physiologist, two were licensed practical nurses, two were nurse practitioners, one was a physical therapist, four were registered dietitians, 12 were registered nurses, and two were certified personal trainers. Six professions reported "other" professional roles not included in the list including health educator, dental hygienist, community health representative, certified lactation counselor, pharmacist and family wellness coach. Table 2 provides the distribution of the professional positions reported by participants.

Table 2. Participants by Professional Role or Credential.

Profession	N
Certified Diabetes Educator	9
Diabetes Program Coordinator	6
Exercise Physiologist	1
Licensed Practical Nurse	2
Nurse Practitioner	2
Physical Therapist	1
Registered Dietitian	4
Registered Nurse	12
Certified Personal Trainer	2
Other	6

The majority of practitioners reported utilizing their HWC skills always or most of the time (N = 20). HWC was believed to be used successfully always or most of the time by 20 of 26 clients, and 21 of 26 clients reported they were confident in their HWC abilities. A total of 24 of 27 participants agreed or strongly agreed they would continue to use HWC in their practice. A total of 22 out of 27 participants agreed or strongly agreed that health coaching resulted in both positive outcomes and encouraged clients to adhere to their treatment or goals. Of the 27 total participant responses, 23 felt HWC improved client-practitioner relationships, including trust. The majority of participants (15 of 27) agreed or strongly agreed that clients were more likely to keep their visits if HWC techniques were used. An additional eight health coaches that marked health coaching somewhat made clients more likely to keep visits. Overall participants indicated (N = 22) that regular HWC training was necessary to maintain and improve skills. Participant attitudes towards HWC are presented in Table 3 and Table 4.

Table 3. Perceived Use, Success, and Confidence in Health and Wellness Coaching among Practitioners.

	N	Always	Most of the time	About half the time	Sometimes	Never
I use my health coaching skills with my clients.	27	4	16	4	3	-
I successfully use health coaching with my clients.	26	3	17	3	3	-
I am confident in my abilities to use health coaching with my clients.	26	4	17	2	3	-

Table 4. Perceived Outcomes of Health and Wellness Coaching among Practitioners.

	N	Strongly agree	Agree	Somewhat agree	Neither agree or disagree	Somewhat disagree	Disagree	Strongly disagree
I will continue to use HWC in my practice.	27	15	9	1	2	-	-	-
HWC is effective in encouraging clients to adhere to their treatments/goals.	27	11	11	3	2	-	-	-
Regular training on HWC is necessary to maintain and improve my skills.	27	10	12	3	2	-	-	-
HWC results in positive outcomes for my clients.	27	10	12	3	2	-	-	-
HWC improves client-practitioner trust and communication.	27	10	13	2	2	-	-	-
HWC improves the overall client-practitioner relationship.	27	10	13	3	1	-	-	-
My clients are more likely to keep their visits if I use HWC techniques	27	7	8	8	4	-	-	-

Participants were asked to mark the five health coaching/MI techniques used most often with clients. Asking open-ended questions (N = 21) and demonstrating empathy, warmth, acceptance, non-judgmental, curious, non-confrontational demeanor were the

most frequently report top five techniques used among practitioners (N = 21). A total of 18 out of 27 reported working collaboratively with the client. Simple reflections (N =16), affirmations (N =13), brainstorming (N = 12), and setting specific, client driven goals (N = 12) were techniques often reported in the top five among participants. Many different techniques were reported in the top five among practitioners. Thus, a broad set of HWC techniques were being utilized by participants in this study. Decisional balance (N = 0), agenda setting/designing client driven goals (Appreciative Inquiry-Define-Discover-Dream-Design-/Destiny (N = 1) and using complex reflections (N = 3) received the fewest marks. Reponses to results are presented in table 5 below.

Table 5. Top Five Health and Wellness Coaching Techniques or Skills Used Most Often among Practitioners. (N=27)

Techniques or Skills	Number of times selected
Asking open-ended questions	21
Affirmations	13
Simple reflections	16
Complex reflections	3
Demonstrating empathy, warmth, acceptance, non-judgmental, curious, non-confrontational demeanor	21
Rulers (e.g. Confidence level 0-10; Motivation 0-10; Importance of making a change 0-10)	10
Decisional Balance	0
Using agenda setting/designing client driven goals (Appreciate Inquiry-Define-Discover-Dream-Design-Deliver/Destiny)	1
Asking permission before giving advice/information	4
Working collaboratively with the client	18
Brainstorming	12
Setting and reviewing a wellness vision	4
Setting specific, client driven goals	12
Other (please specify):	0

Participants were asked to select the time frame they felt was effective for the initial and follow up coaching visits. Tables 6 and 7 present the responses. Participants reported that a 45-60 minute initial coach visit was preferred most often and 16-30 minutes was preferred most often for follow up visits. Less than 15 minutes for an initial meeting and more than 60 minutes for a follow-up meeting were not selected by any practitioners.

Table 6. Time Frame Preferred for Health Coaching Visits. (N=24)

Visit Duration	Initial Visit N=24	Follow-up Visit N=25
Less than 15 minutes	0	1
16-30 minutes	3	13
31-45 minutes	5	8
45-60 minutes	14	3
61-75 minutes	2	0
76-90 minutes	0	0
more than 90 minutes	0	0

Participants described their strengths associated with HWC in their practice. Their responses to strengths of HWC are listed as follows:

> I find I really listen more to clients and am not trying to "fix" them
>
> Asking open ended questions in a non-judgmental manner to set client driven goals allows clients to own control of their health.
>
> For me the basic philosophy came easy as I have always been more likely to put the client in the driver's seat.

Listening, learning what is important to the person that you are coaching. Offering choices that they find interesting.

It has helped the client engage in their care. They are used to listening to directions. Health coaching helps them drive the bus.

Patients seem more engaged in the appointment when using more listening skills and coaching tools, as appropriate.

Well received by patients even though they are not initially coming for health coaching but rather for health exam/treatment/management.

Better rapport with patient. Better outcomes for patients.

Opens communication

Relationship between client & coach

Better at reflecting; better at helping the client discover and set their own goals.

Curiosity: love of learning; helper

Initiating effective and compassionate care toward patients

Relationship development

Helps my patients become more involved with goal setting and maybe even why they decided to start physical therapy in the first place, ownership of goals, attendance, and compliance.

It enables me to gather more information- better assessment and get patients to share more

Shared strengths included improved communication between the client and coach, improved client engagement and autonomy with goal setting, and increased compassion and empathy for the client.

Participants identified several challenges when using HWC in their real-life practices. Their responses to challenges of HWC are listed as follows:

There are time restraints on appointments and at times we must adhere to the medical protocol, i.e. an insulin start

As I work with children, the parent/guardian compliance with an oral health plan is difficult to achieve.

The time it takes to learn and practice the techniques. I have to "think about what I am doing" as far as implementing the techniques, especially brainstorming and decisional balance. Also, I am struggling with a good way to explain wellness coaching to clients (what to expect) and how to incorporate it into existing nutrition counseling sessions.

Not being able to come up with a solution that both of us could work with due to time and deadline.

Time

The main challenge is that the interview, coaching is taking place in an active fitness center.

I don't do health coaching per say alone. I incorporate some techniques Into visits. But I honestly don't use it a lot. And I don't do a visit just for health coaching, it is a Healthy Start Home Visit.

It is difficult to separate the Health coach and the health expert roles in my appointments with patients. I am working on finding a good balance and a good flow that can incorporate both in one visit.

Pt. barriers and life complications Pt. readiness to change

Appropriately assessing the patient in order to use the appropriate (effective) health coaching techniques.

Patient's want us to be the expert and tell them what to do

Type of patients I see

Many of my clients are not prepared to think in terms of goals and visions. They expect to see an "expert."

Time restrictions; patient learning barriers

Appointments are only 20 minutes, and there is sometimes time is of the essence.

Finding time to use it to the full extent

Remembering all the techniques

Time, client adherence to follow up appointments.

Common difficulties included time constraints by both client and coach, separating the health coaching role from the health expert role by both client and coach, client barriers, and the time it takes to learn, practice and remember health coaching techniques.

Participants made several modifications to how they used their HWC training to meet the needs of both the client and coach. The participant comments are presented below:

Blending them with the educational material I have to present.

I have reduced the number of goals set and I accept any try as success.

Using techniques to further establish rapport

I like to let them tell me what they want instead of me telling them what they need.

Understanding the economic dilemmas my clients live in. How taking the time to come and talk with me is superseded by the "tyranny of the moment".

I have added more tool box tools to my daily interactions with patients as well as my coworkers.

Generally not a stand-alone appointment - integrated into health exam

Integrated it into an education session (DSME)

Cultural influences

Time frame of visits

I use bits and pieces of the dialogue: I never use the entire dialog as it is set up by Wellcoaches.

Trying to build it into every patient encounter and allow patient to take charge; guiding them and being mindful

Utilizing effective communication

Not at all

With my time frame with patients and set-up for evaluation and treatment, I have had to modify almost everything. I do not have the time to go through a full session to explore with my patient the deeper issues typically. Usually use it in bits and pieces to get the patient to think about what personally motivates them, how I frame goals toward the patient to help with compliance and effort outside of my clinic.

I tend to also use motivational interviewing with the health coaching

Multiple HWC techniques such as mindfulness and motivational interviewing strategies were incorporated into client visits instead of using the HWC in its entirety. It was noted to be integrated into health exams and diabetes self-management education. Common explanations for modifications included time constraints, cultural needs, and improving communication and goal attainment.

CHAPTER 4

DISCUSSION

The aim of this study was to explore the beliefs and practices of health practitioners who were trained in health and wellness coaching. Participants worked in AI/AN health programs and were trained by an ACSM-endorsed institute that supported national health and wellness coaching standards and certifications. The literature did not present any previous studies on real-life practice use and perceptions on HWC with chronic disease management in AI/AN health programs or in chronic disease management in general. Participants in this study found the training to be valuable and effective with the majority of practitioners (n = 22) reporting they agreed or strongly agreed they will continue to use HWC in their practice. Overall, participants reported improved client-coach communication and trust, increased client engagement, increased adherence to treatment and goals, and positive behavior outcomes. This is consistent with previous literature related to HWC (Kiveliä, et al., 2014; Lawson, Jonk, O'Conner, Riise, Eisenberg, & Kreitzer, 2013; Sharma, Willard-Grace, Hessler, Bodenheimer, & Thom, 2016).

Kiveliä, et al. (2014) reviewed 13 individual studies that examined the effects of HWC on improving health outcomes. Similar to the present study, Kiveliä, et al. (2014) identified improved communication between client and provider, improved patient activation and engagement and improved overall health outcomes in the studies. Unlike the present study, 12 studies were randomized-controlled designs and one was a quasi-

experimental design. The majority of HWC interaction was through telephone or combination of telephone visits and face-to-face communication. Rimmer, Rauworth, Wang, Heckerling, & Gerber (2009) worked with a group that was largely African American women. No other study in the review appeared to focus on minorities or underserved communities (Kiveliä, et al., 2014).

Sharma et al., (2016) used surveys to evaluate perceived maintenance of improved cardiovascular risk factors one year after a HWC intervention in a largely Latino and African-American population and reported continued positive health outcomes one year post intervention. Similar to the present study, Sharma et al., (2016) examined the use of HWC in a culturally diverse population. The study suggested that HWC was an effective intervention in low resource areas (Sharma et al., 2016).

Lawson et al., (2013) examined the effectiveness of HWC in high risk populations. Healthcare plan enrollees with several chronic diseases were invited to work with health and wellness coaches. As with the current study, increased activation and engagement in behavior change as well as improved client-established goals were observed. However, it should be noted that the clients coached in the Lawson et al., (2013) study had health care coverage. This was not the case for all clients coached in the present study. HWC is a fairly new approach to chronic disease management and is in the early stages of standardizing associated definitions and methods, making it difficult to compare with other studies. Results from previous studies that examined health practitioner attitudes and applications focused primarily on MI (Cronk,et al., 2012; Van Eijk-Hustings, et al., 2011; Linmans, van Rossem, Knottnerus & Spigt, 2015; Pollak, et al., 2016). Because MI was strongly integrated into the participant's HWC training and

the literature on HWC is lacking, it was determined the four MI studies were suitable to be used for comparison to the results found in the present study.

Comparable to the present study, Cronk, et al. (2012), Van Eijk-Hustings, et al. (2011), Linmans, et al. (2015), and Pollak, et al. (2016) explored the utilization and perceptions of the following skills: (a) expressing empathy, (b) developing discrepancy, (c) minimizing sustain talk and discord, (d) supporting self-efficacy, (e) using open-ended questions instead of closed-ended questions, (f) affirming client strength's and efforts, (g) reflective listening, (h) summary reflections, (i) evoking change talk, and (j) asking permission before offering advice. These four studies reported similar results to the present study, but all used different methods to measure outcomes (Cronk et al., 2012; Van Eijk-Hustings et al., 2011; Linmans et al., 2015; Pollak, et al., 2016).

Cronk et al., (2012) reported perceived successful use of MI skills after training but found it challenging to use with the current client care approach in the hemodialysis unit and charting format. Linmans et al. (2015) noted client improvements in hemoglobin A1C, weight, BMI, and activity level following the lifestyle intervention. The study reported participants struggled with using the skills in real-life practice, specifically meeting the clients at their level, searching for ambivalence and asking open-ended questions (Linmans, et al., 2015). Pollak et al. (2016) reported 100% of the participants made changes to their clinical practice after MI training and reported improvement in self-rated MI skills. The study concluded MI to be a promising approach to improving practitioner and client satisfaction (Pollak et al, 2016).

Van Ejik-Hustings et al. (2011) used subjective and objective methods to study MI methods and perceptions. The Motivational Interviewing Treatment Integrity (MITI)

tool was used to measure to what degree MI was being used in provider visits. Participants were also asked their perceptions on how they applied their MI skills in practice. Results indicated participants believed basic MI techniques could be utilized in daily practice and that basic level use of open-ended questions, simple reflections and identifying stages of change were being used during actual visits. Complex skills such as eliciting change talk, minimizing sustain talk and discord, rolling with resistance and complex reflections were not well utilized. Discrepancies were found between the participant estimations of MI use and the MITI test results (Van Ejik-Hustings et al., 2011).

All four studies recognized the need for consistent, efficient and effective training (Cronk et al., 2012; Van Eijk-Hustings et al., 2011; Linmans et al., 2015; Pollak, et al., 2016). Participants in the present study specifically identified the need for continued training as well, and the vast majority agreed with the statement that regular HWC training was necessary to maintain and improve their skills. This information may be beneficial in the future to focus on additional training on the techniques most utilized by practitioners and to investigate the reasons or barriers for underutilization of others with the goal of developing highly effective models of coaching.

HWC is described as a process for change involving all aspects of wellness, not only focusing on a specific health issue. Despite all participants receiving the same HWC training in the present study, the majority had modified their practice in specific ways to meet the needs of their own clients. Taking the time to develop and review a wellness vision, a strongly emphasized aspect of HWC, was not identified in the top five HWC techniques used by any of the participants. The researcher speculates that time

restrictions, communication barriers, cultural practices, poor self-efficacy may be barriers to translating this wellness vision tool to practice, along with the challenge of clients accepting greater autonomy and responsibility for their health and wellness. More research is needed to explore whether these are in fact predictors of the development of a wellness vision when providing HWC. Notably, aspects of the wellness vision were partially addressed with participants asking about client values and what mattered most to them.

Some participants were able to incorporate pieces of HWC into their practices while others struggled with transitioning between the expert role into the coaching role. Participants reported difficulty and confusion by both client and practitioner on the roles of being an educator and a coach. A number of participants stated it was uncomfortable for the client to not be told what to do or struggled personally with taking off the "expert hat." Linmans et al. (2015) noted similar issues in their study. Participants also reported problems with time limitations. Having the time to use HWC as designed as well as sufficient time to learn, remember and develop HWC skills was a challenge. This was also noted in the previous literature (Cronk et al., 2012; Pollak et al., van Eijk-Hustings et al., 2011). More research may be needed to understand how to best train and prepare practitioners for these problematic situations.

The present study found, overall, a multidisciplinary group of practitioners confidently used HWC methods to elicit healthy behavior changes in their clients living with chronic disease. Improved likelihood of the clients attending following up visits was at least partially attributed to HWC based on practitioner-reported observation in this study. A wide range of skills and techniques were used, likely related to the diverse

professional backgrounds and the effort to design the visit to meet the client's needs and goals. Regular training is valued by practitioners to maintain and improve HWC skills. Importantly, this type of training appears generally accepted and applied across several areas of practice in the health care field.

Limitations

There were some limitations to this study. First of all, it was a small sample size and all participants had been trained by the same HWC institute. That being said, in a field of varying methods and training programs, all participants received similar science and research-based training. Second, this study was subjective and lacked objective HWC measures to back up participant perceptions. Future studies would benefit by using a tool similar to the MITI for MI to increase fidelity. Finally, lack of consistent HWC definitions and methodologies may have led to missed studies on the topic.

Conclusions

Practitioners believed HWC was an effective method for providing care to clients participating in American Indian health programs. Increased trust, overall communication and positive client behavior change were perceived by participants. Regular, specialized training is needed to assist practitioners to meet the diverse and challenging needs of their clients. Targeted training on improving perceived essential HWC techniques, incorporating HWC into brief encounters, and providing training on how to elicit information or advice is warranted. More research on specific coaching training, skills and processes used in diverse cultures is needed. Progress is being made in the efforts to standardize a HWC definition, its methods and certification, which will allow for quality, evidenced based HWC.

Practice Implications

Regular opportunities to continue training in HWC is important to practitioners using this strategy with patients. Future research is needed to examine relationships between HWC practice and patient outcomes in populations who are from diverse cultures. This could allow for effective and potentially cost saving methods for the management of chronic disease.

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