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Integration of Health Coaches in a Whole Health Team Model of Chronic Pain Care: a Qualitative Study

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ABSTRACT

OBJECTIVE: Health coaching has shown promise in helping patients manage their chronic disease and in improving health outcomes, yet the implementation of health coaching in healthcare systems is understudied. Further, evidence suggests that interdisciplinary care teams may be more effective in treating chronic pain than usual care. As such, we sought to examine the benefits and drawbacks to embedding health coaches within interdisciplinary pain care teams ("Whole Health Teams").

DESIGN: As part of a multisite clinical trial (at five Veterans Health Administration sites) investigating the effectiveness of a Whole Health Team (WHT) approach to care for patients with chronic pain, qualitative interviews gathered data on how the experience of treating patients in the WHT differed from the experience treating patients outside the WHT, as well as provider experiences coordinating patient care within the WHT.

PARTICIPANTS: Twenty-two WHT members, study investigators, and study coordinators.

APPROACH: Data were analyzed using a rapid analysis approach.

RESULTS: Overall, stakeholders perceived considerable synergy within the interdisciplinary pain care team. Each provider brought a different perspective to the patient's health concerns, which stakeholders felt was valuable and increased patient progress towards goals. The team model was also viewed as efficient because everyone was committed to working together and communicating as a team. Logistically, however, stakeholders noted challenges to working as a team, especially regarding patient goal setting. Furthermore, multiple stakeholders believed the care team model required a high degree of dedication to teamwork and communication among its members to be successful.

CONCLUSIONS: Embedding health coaches within interdisciplinary pain care teams may improve care processes and accelerate patient progress. Successful implementation would require adequate training, role clarification, and expectation setting to facilitate good communication across all care team members. Additional research is needed to evaluate the clinical outcomes of integrating health coaches on WHTs versus other implementation approaches.

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INTRODUCTION

Approximately 60% of adults in the United States (U.S.) have one or more chronic diseases (e.g., chronic pain, diabetes, mood disorders).[1] Management of chronic pain and other chronic disease is costly and challenging for healthcare systems and providers, accounting for 90% of healthcare costs in the U.S.,[2] and patients frequently struggle to sift through the often complicated and contradictory guidance on how to self-manage their chronic disease.[3,4]

Health coaching has shown some promise in helping patients manage their chronic disease and in improving related health outcomes.[5–8] Health coaching is a non-clinical health behavior change modality[9] that is governed by the National Board for Health and Wellness Coaching, in partnership with the United States National Board of Medical Examiners.[10] The core tasks of health coaches have been described in national standards.[10,11] Briefly, coaches help clients articulate a clearer mission or purpose for their lives through exploration of values, strengths, and resources, which drives goal setting and action planning. Clients then determine specific action steps they need to take to achieve their goals, evaluate progress, and return to previous steps as needed. The health coaching role is relatively new to healthcare, yet health coaching is currently being implemented in healthcare settings across the country, including Veterans Health Administration (VHA) hospitals and clinics, as part of the U.S. Department of Veterans Affairs' (VA's) Whole Health initiative.[12,13] "Whole Health" refers to considering the patient as a whole person, rather than a symptom or disease, and the Whole Health initiative seeks to transform VHA care to be proactive and patient centered, with health coaching as a key role in that transformation.[12,13]

Health coaching is understudied, however, and important questions remain, especially regarding the implementation of coaching programs in healthcare settings such as the VHA.

Although all VHA coaches receive a standardized national training on health coaching skills, coaching programs across the VHA currently vary by coach discipline (e.g., clinical training) and other factors such as level of integration with other care providers. For example, most health coaches work one-on-one with patients without communicating with patients' other care providers. At some sites health coaches are embedded in a particular primary care or specialty clinic, which may enhance communication with other clinic providers. The benefits and drawbacks to health coaching implementation approaches are unclear, as are the barriers and facilitators to implementing these approaches. More knowledge is needed to inform best practices for implementation of health coaching across large healthcare systems to establish guidance that accommodates the constraints of clinical settings, reduces the potential for adverse experiences, improves interprofessional communication with other providers, and supports improved care outcomes.

The "Whole Health Team" Model

As evidence suggests that interdisciplinary care teams may be more effective in treating chronic pain than usual care,[14] it is especially relevant to understand potential benefits and barriers to leveraging health coaching as a part of pain care teams. In the study, "Implementation of a Pragmatic Trial of Whole Health Team vs. Primary Care Group Education to Promote Non-Pharmacological Strategies to Improve Pain, Functioning, and Quality of Life in Veterans" (the "wHOPE" study),[15] health coaches are a core member of an interdisciplinary clinical Whole Health Team (WHT) designed to improve outcomes for patients with chronic pain. WHTs consist of a medical provider (physician or nurse practitioner), a complementary and integrative health (CIH) provider, and the health coach, and may also include another CIH provider.

The WHT process is depicted in Figure 1. At the initial WHT study visit, the health coach meets with patients to complete a personal health inventory—an assessment of patients' health and wellness priorities, mission/purpose in life, and self-rated well-being. The coaches discuss the patients' personal health inventory with the clinical providers on the WHT, often during a pre-clinic huddle. Then, the clinical providers on the WHT meet with the patients to develop a personal health plan, emphasizing non-pharmacologic approaches, based on patients' personal health inventory and the WHT's clinical assessments. The personal health plan contains patient-specific SMART (i.e., *S*pecific, *M*easurable, *A*ttainable, *R*ealistic, and *T*imebound) goals. Subsequently, the health coach holds weekly or biweekly coaching sessions with each patient for eight sessions, focused on helping the patient achieve their SMART goals, and offers monthly optional coaching sessions with each patient for the remaining 12-month follow-up period. Meanwhile, WHT clinical providers participate in collocated clinical visits with patients (not including the WH coach). In addition, each week, the WHT (including the health coach, but not patients) meet to review and update the patients' personal health plans, ensuring that the plans remain aligned with patients' experiences and evolving personal values and goals. Goals may evolve based on input from WHT members or the patients' changing perceptions of what matters most.

As discussed above, the WHT approach differs from most health coaching programs within VHA; most health coaches outside the wHOPE trial function largely independently from other care providers, with no prearranged communication between coaches and clinical care providers. Specifically, the national VA training directs health coaches use the personal health inventory to help patients articulate health goals and work one-on-one with patients

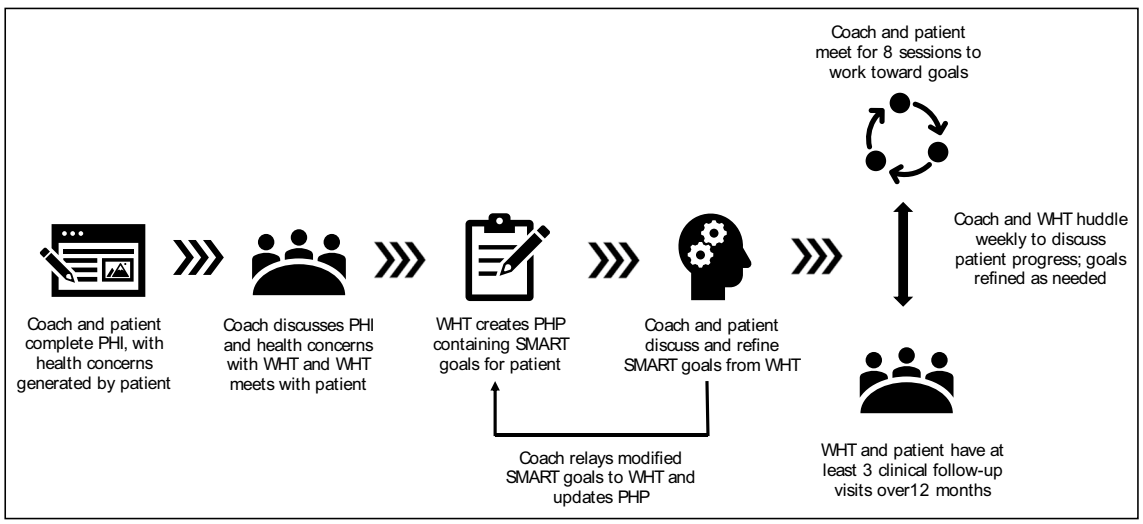

Fig. 1 Whole Health Team model. PHI, personal health inventory; PHP, Personal Health Plan.

(independent of clinician input) to plan action steps toward achieving their stated goals.

Purpose of the Current Study

A component of the wHOPE trial was to examine the benefits and drawbacks of the WHT model (i.e., integrating health coaches within WHTs) as one approach to implementing health coaching. Coaches and clinical providers in the WHT are in the unique position of practicing within and outside a WHT; they are therefore able to compare these different experiences. In this paper, we report on semi-structured interviews with WHT members and other study stakeholders (study investigators and coordinators) to inform modifications and potential implementation needs for the WHT approach.

METHODS

Setting and Participants

This study was a component of an ongoing multi-site pragmatic trial examining the effectiveness of a WHT versus primary care group education approach in veterans with chronic pain (the "wHOPE" study).[15] The study was reviewed and approved by the VA's central Institutional Review Board, and all participants were interviewed as part of their role as study staff of the larger trial or provided informed consent to participate. Five geographically diverse VHA facilities across the U.S. have been designated as active enrollment sites (Table 1). Health coaches and clinical WHT providers are staff employed at their respective VHA facility and agreed to participate as study providers in the larger trial as part of their normal duties and dedicated 10% time to WHT activities.

The rollout of Whole Health has included several national trainings for clinicians and other staff on the principles of Whole Health. To participate as a WHT provider for the wHOPE study, all clinical WHT members (non-coaches) complete a 2-h orientation which includes training on integrating whole health principles into pain management. Health coaches complete the VA national standardized training on health coaching, consisting of 96 h of virtual classroom training over three separate weeks, 12 h of practice triad sessions (with a coach mentor) between weeks, and 20 h of asynchronous learning.

WHT members, site principal investigators, and study coordinators at each site were invited to participate in semi-structured interviews about their experiences with the WHT approach and recommendations for future implementation of the WHT approach to pain care. Across all five sites, 22 stakeholders participated in interviews about their WHT perspectives, including 9 WHT coaches, 6 WHT clinicians and CIH providers, 5 site investigators, and 2 study coordinators.

Data Collection and Analysis

Interviews were conducted via telephone by an experienced interviewer between March 2022 and January 2023. The semi-structured interview guide contained questions specific to the present analysis. The first question was: "How has the experience of treating patients as part of this study differed from your experience treating patients outside of this study?" This question was followed by probes inviting thoughts on what aspects of the WHT model required some adjustments to their regular practice (i.e., drawbacks or challenges) as well as what aspects were helpful or beneficial (i.e., benefits). The second question was: "How has it been coordinating patient care with the rest of the WHT?" This second question was followed by probes inviting thoughts on challenges and benefits to coordinating with the WHT. Health coach participants were thus able to speak to benefits and drawbacks of practicing within the WHT and the clinical WHT members were able to speak to the benefits and drawbacks of working within the WHT and—specifically—the inclusion of a health coach on the WHT. The questions were modified when administered to study investigator and coordinator stakeholders to solicit their perceptions of how the WHT was functioning differently from routine care, challenges, and benefits based on their experiences working with WHT members during the study. Interviews lasted an average of 30 min.

Interviews were audio-recorded, and the recordings were analyzed using Rapid Analysis Procedures designed

Table 1 Participating Facility Characteristics

Facility name	Location	Facility complexity	Whole Health initiation year
San Francisco VA Health Care System	San Francisco, CA	1a	2018
VA Connecticut Health Care System	West Haven, CT	1a	2020
VA Portland Health Care System	Portland, OR	1a	2017
James A. Haley Veterans Hospital	Tampa, FL	1a	2018
VA St. Louis Health Care System	St. Louis, MO	1a	2017

Facility complexity 1a rating indicates the largest levels of patient volume, patient risk, research, and teaching; the largest number and breadth of physician specialists; and availability of level 5 intensive care units. "Whole Health initiation year" indicates the year Whole Health activities began

for qualitative health-services research.[16,17] This technique was designed to be time- and resource-efficient, balancing rigor with pragmatism and yielding results that are comparable to traditional qualitative methods.[18–20] An analysis template for data reduction and analysis was created by the lead analysts (McGrath, Purcell), in consultation with the project team, with topic areas based on the larger study's main research questions: Provider experience/satisfaction, Implementation considerations (include barriers, facilitators, solutions), Operational considerations (include challenges, successes, and solutions), Intervention impact/value, Improvement opportunities, Implementation advice, and Sustainability considerations. Using the template, the lead interviewer-analyst listened to the audio-recording of each interview and, within each topic area, summarized participant responses and transcribed relevant quotations. A subset of templates was independently analyzed by a second analyst and compared to the primary analyst's templates to ensure rigor and consistency. A team of analysts (McGrath, Denneson, Purcell) then collaborated to review and compare templates, identify, and discuss recurring themes, and refine a description of each theme. Any analytic discrepancies were resolved through discussion, with audio files consulted as needed to reach consensus in the identification and description of themes.

RESULTS

Whole Health Teams Are Synergistic

Overall, stakeholders perceived considerable synergy in the functioning of the WHT. In the WHT approach, each provider brought a different perspective to the patient's health concerns. Stakeholders believed this resulted in generating multiple solutions, increasing the chances of finding a personalized approach the patient found helpful. Relatedly, having multiple perspectives on each patient was also thought to reduce the likelihood of patients getting "stuck," increasing patients' progress towards goals.

> …where a patient gets this high intensity care with the health coach and the psychologist and with the physical therapist…you can see progress...it's on a time scale you see. That has been very rewarding for me as a clinician. (Medical provider participant)
>
> A lot of time providers are siloed…we can read each other's notes but a lot of times we don't come together with a strategy and a plan…put all the cards on the table and really look at this person as a whole and then strategize a focal point...it's collaborative...it's a few people treating all of it. (Health coach participant)

Stakeholders also believed that it was helpful for patients to receive consistent messages about their health concerns from multiple providers and that having multiple contacts with several providers, including a coach, reduced patients' sense of "distance" between the patient and their care because there was less time between contacts. Coaches noted that learning from the clinical providers about the patients' conditions improved their understanding of what "healthy" should be for each patient, and clinical providers believed that the coaches accelerated patient progress toward their health goals. Finally, the team model was viewed as an efficient model (i.e., reduced "time wasting") because everyone was committed to working together and communicating as a team.

> The study's premise of using health coaches is…really important. Health coaches are instrumental…I wish that were the case for all clinics…all clinics should have a health coach." (Medical provider participant)
>
> For all the reasons I listed: the collaboration, the support, the learning…the education that I'm getting…has been invaluable. (Health coach participant)

Care Coordination Is Critical for the Success of Whole Health Teams

Stakeholders strongly emphasized the importance of good communication among the WHT members. The regularly scheduled meetings were noted as "essential" to the team's functioning; the team would not have been able to rely on communication through progress notes in the electronic health record alone. Some felt that meeting even more frequently than once per week would have been desirable and one coach suggested that bringing the patient into the full WHT meetings would have enhanced coordination.

> Number one, the collaboration is super important, and number two…we're not wasting time tracking people down…that is a commitment that everyone has made to collaborate, we're not leaving it up to fate. (Health coach participant)
>
> I don't always get to talk to providers that are really active working with the patients and to have a weekly check-in with the whole team has been really beneficial. (Health coach participant)

Some teams struggled with sufficient communication, and care coordination suffered as a result. One team noted they had worked together prior to the study, and this helped them coordinate more effectively during the study than they would have otherwise. Some stakeholders discussed how some study coordinators were filling gaps in communication (a role that would not necessarily exist during future dissemination and implementation in clinical settings):

> Well, what I hear is not great news ostensibly for implementation. What I hear is that they are indebted to the research study coordinator who goes over and beyond, you know, what we would consider usual care and tracking down patients and scheduling visits and...

> coordinating care in a way that... they talk about the study coordinator, they use terms like she's the glue or ... she just makes everything happen. (Study investigator participant)

Some specific challenges to coordination were noted. One coach worried that the clinical team assigned study patients too many things to do in their treatment plans and scheduled too many appointments, which was viewed by the coach as burdensome and not feasible for most patients. One coach also felt there was a risk of patients not feeling "heard" when information about the patients' stated healthcare priorities were communicated between the coach and the other WHT members without including the patient in these communications.

"Ownership" of Goal Setting

The process of goal setting became a sticking point between some coaches and the rest of the WHT. In the WHT model, patients' goals are set with the clinical team based on the PHI and a clinical appointment with the patient. Then, the patient begins coaching sessions with the coach. Some coaches disliked the fact that frequently patients came to their first coaching session with goals that the coaches were hearing about for the first time. A few coaches began to feel expected to perform case management duties (i.e., provide service facilitation and system navigation)—typically outside their scope of practice—when patients would come to the first session with a "laundry list" of goals and "to dos" from the clinical providers on the team. Coaches noted that they then had to spend more time than they normally would helping the patients prioritize action steps.

> An example that I have is I was working with a patient who has some memory challenges...The clinical team for him had written all kinds of goals like attend this class or that class…but when I got with him the thing he wanted to work on was his eating and making sure he remembered to eat that day...we basically put together a system where he tapes a calendar to his refrigerator and makes a little mark on the calendar... each time he's eaten that day. (Health coach participant)

One coach thought the process would have worked better in the other direction—if the coaches and patients determined their goals together, then informed the rest of the care team of the patients' goals. Another coach felt that the clinical providers on the team weighed in too heavily on the patients' goals to the point of contradicting the whole health principle that the patients are in charge of their own health. On the other hand, a coach shared that having clinical teams set the patients' goals increased patient and coach confidence that the goals were right for the patients' health; and regardless of who initiates the goals, the ownership of carrying through on the goals still rested with the patients.

> Veterans…have found it really helpful…to get the medical background part…and then they get the support of their coach…they feel really supported. (Health coach participant)

DISCUSSION

The VHA and other healthcare systems have invested heavily in health coaching, but implementation approaches for health coaching have been understudied. Thus, little guidance exists on how to optimize patient care with the addition of this relatively new healthcare role. Embedding health coaches within a care team is one approach healthcare systems could use when implementing health coaching programs aimed at assisting patients in achieving their health goals. In this qualitative analysis, we examined the benefits and drawbacks to a WHT pain care approach to inform future modifications, implementation needs, and adoption considerations. Stakeholders interviewed in this study were enthusiastic about the synergistic value of having coaches integrated within a WHT, believing this model provided benefit to patient progress towards health goals while protecting provider time. However, participants cautioned that the approach takes some upfront effort in role clarification, with ongoing and timely communication essential to the success of this approach. Finally, additional up-front negotiation about provider and coach roles in the goal-setting process might improve the functioning of the WHTs and ultimately improve their ability to help patients improve pain management.

Few studies have examined the implementation of health coaching in clinical settings, and care coordination between health coaches and other care providers is typically not addressed. However, one study examined the use of "teamlets" in primary care as an approach that paired health coaches with physicians.[21] This prior work highlighted some of the challenges to integrating health coaching in primary care: timing coaching activities to avoid conflict with physicians' availability in the same patient visit, space availability for coaching in a busy clinic, and payment models disincentivizing the addition of health coaching services. These findings reflect challenges of integrating coaches on care teams related to communication and coordination, though the specific concerns differ from the current study. In another study of coaching in diabetes care, Liddy and colleagues[22] examined the implementation of health coaches across multiple practice sites. Each site implemented coaching slightly differently, according to personnel and resources available, but coaches were encouraged to attend diabetes care visits with the physician in addition to providing one-on-one biweekly coaching. Similar to the current study, communication between physicians and coaches about goals was

noted as a frustration. Other challenges arose from variation in training, workload, and lack of physician understanding of the coach role. The current wHOPE WHT approach moves beyond this prior work, as the roles of each care team member were pre-defined by the larger study's WHT treatment manual and the WHT approach aims to create a truly collaborative care team, one in which each member of the WHT is theoretically on equal footing with each other and the patient. However, challenges with coordination and goal setting remained evident in the current analysis, and participants emphasized the need for routine, planned communication among team members.

Given the strong promise of the WHT approach for pain care—which was described in the current study by participants as synergistic, with the potential to accelerate patient progress towards health goals while saving provider time—addressing the challenges to this approach merits additional consideration. First, it was evident from these findings that training and role expectation setting for all team members are critical, and perhaps should be routinely revisited until teams are running smoothly. For example, while the health coach role included aspects of care coordination, specifically maintaining a shared understanding of patient goals and open lines of communication on patient progress, the health coach role was not intended to schedule visits with other providers or remind patients of upcoming appointments. Our data suggest this distinction was unclear on some teams. Indeed, teams in the present analysis that had been working together longer experienced fewer perceived challenges to care coordination. Additionally, training reminders on aspects of the WHT approach that depart from usual practice are likely much needed, such as reminders on the WHT approach to goal setting which encourages targeting a few key goals rather than all possible goals. Although health coaches are trained to help patients prioritize and sequence goals and action steps, in our study the health coaches were sometimes surprised by the high volume of "to dos" in patients' personalized health plans. Open lines of communication, including and beyond weekly WHT meetings, would also be helpful to avoid communication gaps and misunderstandings and to facilitate a shared understanding of how to best facilitate veteran goals.

Participants in our study valued the enhanced communication among team members (as compared to usual practice) yet felt even more points of contact would have been beneficial. Frameworks for enhancing team-based care based on team science (i.e., leveraging the varied expertise and training of the team to achieve its goals[23]) may offer some additional considerations for how to strengthen the WHT approach moving forward.[24] For example, normalizing routine feedback among all team members could help address inefficiencies or misunderstandings early in the team's working relationship to solidify workflow. This could occur in regular team "huddles" in which the team assesses their patient care processes by asking, "What went well?" and, "What could have been improved?" Other work in VA examining integration of care team members in patient-centered medical homes provides additional ideas for improving WHTs. One study examined the integration of pharmacists on care teams and found that role clarity can be affected by other providers' attitudes towards pharmacists, previous experience with pharmacists, proximity, and perceived burden of communication.[25] Addressing these elements within the WHT may help improve WHT functioning.

Limitations of this analysis should be considered. We interviewed coaches, WHT members, and other stakeholders of a single study of an a WHT approach to pain care within the VA healthcare setting. As such, findings may not extend beyond VHA clinics, and may not extend beyond pain care settings, to the extent clinic structure, culture, or resources differ. However, the ongoing trial is enrolling participants from five VA sites, representing five different geographic regions of the U.S., which enhanced the likelihood of hearing a range of differing experiences. Furthermore, the health coaching approach and training used in VHA are similar to coaching approaches described in other healthcare settings[11,26] and consistent with wellness coaching certification requirements of the National Board for Health and Wellness Coaching.[10] Some stakeholders (i.e., investigators, coordinators) have limited understanding of the innerworkings of the clinical WHTs, but most attended regular meetings with the WHTs and helped troubleshoot issues as they arose, so they were aware of team functioning. Finally, the current study did not examine barriers to implementation that include reimbursement models for WHTs or health coaching. Further research is needed to address this issue, especially when multiple providers are in the same visit with patients.

Findings from this study provide valuable insight into the potential benefits and challenges to one approach to health coaching implementation. Specifically, the WHT approach, in which a health coach is embedded within an interdisciplinary clinical team, has strong potential to reduce overall care team workload by accelerating patient progress towards health goals and reducing redundancies in care for patients with complex chronic conditions, such as chronic pain. The challenges to a WHT approach identified in this analysis represent considerations for the next steps in refining this approach; open and ongoing communication among team members and role clarification may need to be monitored and recalibrated in some instances. Additional research is needed to evaluate the clinical outcomes of integrating health coaches on WHTs versus other implementation approaches.

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Declarations

Conflict of Interest *The authors have no conflicts to report.*

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