HENLEY BUSINESS SCHOOL

Does Health Coaching Work?

A critical review of the evidence for coaching in the healthcare system

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Henley Business School
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Executive summary

The provision of coaching within the healthcare service is key to improving outcomes for patients and health care workers. It enables patients to become activated and take greater ownership of their care, it can form an important element of a preventative health strategy and support employee development and wellbeing.

In this publication we review the research evidence of health coaching, and its impact on patients, service users, clients and health care professionals. In summary , we have concluded that health coaching can be a useful organisation intervention supporting health professionals to improve patient outcomes (in particular for chronic longer term conditions), create potential cost savings as well as assist clinicians and allied health professionals support patients with behavioural change. Health coaching could therefore have a wider systemic impact (e.g. on dependents).

This review calls for health stakeholders to take forward health coaching as part of both employee wellbeing, and patient care. It provides a 12-step plan for future action to take health coaching forward to its next phase of development and deployment.

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Introduction

'Doing things to people instead of with them can be profoundly disempowering. It encourages patients to believe that professionals have all the answers and that they themselves lack relevant knowledge and skills, and hence have no legitimate role to play in decisions about their healthcare…'

(Coulter, 2011: 2).

At the heart of health coaching is the notion that when patients are made to feel empowered and informed, that they become activated and can better self-manage their health. The formation of a trusted coaching partnership between patients and professionals, creates a space for informed decisions to be made.

The authors of this review believe that coaching is a fundamental part of quality healthcare provision. It provides a safe space to improve the knowledge and skills of patients, enabling them to partner with professionals. At the same time coaching builds the confidence needed to take ownership and responsibility for one's own wellbeing.

The coaching process can therefore profoundly benefit the patient, professional and the cultural setting in which they exist.

What is health coaching?

Coaching

Health coaching is a form of coaching so we will begin by defining coaching. Although there is no universally agreed, nor legally binding definition of coaching, Whitmore (2009:11) suggested that coaching;

'is unlocking people's potential to maximise their own performance. It is helping them to learn rather than teaching them'.

This supports Coulter's view about the importance of empowering people to learn, rather than 'doing things to people'.

Passmore and Fillery-Travis (2011, p70) offer a more process-based definition in an attempt to differentiate coaching from mentoring, counselling and other conversational based approaches to change. They suggested coaching involved *"a Socratic based dialogue between a facilitator (coach) and a participant (client) where the majority of interventions used by the facilitator are open questions which are aimed at stimulating the self-awareness and personal responsibility of the participant".*

Health Coaching

A debate continues over the precise definition of health coaching. One reason for this is the existence of multiple frameworks and models available within health coaching.

Wolever et al. (2013) have offered one definition;

'a patient-centered process that is based upon behavior change theory and…entails goalsetting determined by the patient, encourages self-discovery in addition to content education, and incorporates mechanisms for developing accountability in health behaviors'

(Wolever et al., 2013:38).

This definition dove-tails nicely with the broader coaching definitions but also includes patient-led goal setting and content education and accountability for healthy behaviours. The educational element has been highlighted as a limitation because coaching is difficult to extrapolate in terms of it being standalone in delivering outcomes versus other mechanisms - particularly in relation to educational programmes and other inventions.

'The health coach's main role is not to teach, advise or counsel people but rather to support people to plan and reach their own goals'

(The Evidence Centre, 2014:12).

However, in a healthcare setting, there is to an extent, always going to be an element of explanation and education. The question is whether this is invited by the patient (patient-led) or imposed.

The National Health Service ('NHS') England Health Coaching describes health coaching as helping *'people gain and use the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals'.*

This definition however falls short in our view, and risks confusing coaching with other behavioural change interventions.

In response we have suggested the following definition:

"health coaching is a client-centred process that draws on psychological, evidenced based models of behavioural change to help clients make effective and sustained changes in their thoughts, feelings and behaviours, and thus contributes to enhanced wellbeing and quality of life"

Why health coaching is essential in the healthcare setting (the case for health coaching)

It is widely reported that health is declining in the USA (where most of the research derives) and globally due to the development of unhealthy habits. In the USA, it is estimated that $42 trillion will be spent on healthcare costs and productivity loss between 2016 and 2030 (Aspen Health Strategy Group, 2019:35).

There are over 160 million people in the USA and more globally who are at risk of a chronic condition (See. Sforzo & Moore, 2019). The World Health Organisation (WHO) (2012:35) reports that 'the largest proportion of NCD (non-communicable chronic diseases) deaths are caused by cardiovascular disease (48%), followed by cancers (21%) and chronic respiratory diseases (12%). Diabetes is directly responsible for 3.5% of NCD deaths'. Long-term conditions are therefore the largest killers and behaviours such as smoking, drinking alcohol, poor nutrition and inactivity are widely reported to be the main causes.

The UK's Department of Health (2012:3-5) estimates that more than 15 million people are living with one or more long-term condition ('LTCs') in the UK and they account for 70% of the annual NHS spend. Newman (2013) reports there to be; 'a tsunami of need' with 58% of over 60-year olds in the UK with one or more LTC. They are said to account for 50% of GP appointments, 64% of outpatient appointments and over 70% of inpatient bed days. The impacts of these LTCs are not only physical but also psychological which affect people's sense of independence and control and ultimately their resilience and therefore ability to self-manage.

In the UK, the population continues to grow and is aging but not always in good health (Department of Health, 2004) and (WHO, 2002). This creates a sizable challenge to healthcare provision in relation to staffing and multiple services capacity (healthcare and social care), (Elwyn and Edward, 2009). The issues affect socio-economic groups differently too with 'the poorest having 60% higher prevalence and 30% more severity' of LTCs (Newman, 2013:2).

The impact of these issues is therefore not just an ethical problem for those working in a challenging healthcare setting yet dedicating their lives to improving patient health, but also an operational and financial problem.

In its 'Five Year Forward View', the NHS states more needs to be done to 'support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications' (NHS England, 2014:12).

Patient activation through health coaching is a vital element in the behavioural change needed for people to self-manage but the training of staff with coaching skills to support this shift is equally essential. *'Health coaching has been identified as one of five key interventions by NHS England in their 2016 'Substantial Self-care Programme'*

(NHS Health Coaching - Quality Framework).

Defining health coaching and its multiple functions/applications

A number of studies have related health coaching to a form of motivational interviewing (CPA, 2014). However, it is not the same thing as The Evidence Centre (2014:13) reports *'health coaching is often confused with or used interchangeably with methods such as motivational interviewing, counselling or consulting skills…Whilst motivational interviewing may be used as one technique within health coaching, health coaching is a wider framework, mind-set or approach rather than a specific technique'.*

In terms of the wider framework, the NHS Institute for Innovation and Improvement (2013), shows that health coaching seeks to activate both the patient and the coach and improve the culture or system in which they operate:

Activated Patient + Activated Coach + Supportive Culture

This framework moves patients away from dependency and learnt behaviours towards becoming an active participant in their own care. It moves the coach or healthcare professional away from an expert in knowledge towards a facilitator of behavioural change which helps the patient to self-discover their own solutions and achieve their own goals. Wrapped around this relationship is a professional culture of openness, inclusion good communication, encouragement and support.

Newman and McDowell (2016:147) report that *'health coaching can equip staff with additional conversational skills, techniques and the mind-set to support and empower patients toward their own goals and aspirations'.*

In terms of the functions and application of health coaching it can therefore be summarised as:

- An approach rather than a specific technique
- A potential patient activation tool
- A means by which self-efficacy can potentially be improved
- A possible way of helping patient self-discovery and self-management of conditions
- A process by which self-identified health and wellbeing goals are set
- Possibly useful with developing and promoting a culture of openness and inclusion
- Helping to develop conversational skills amongst all stakeholders
- A potential catalyst for empowerment and sustainable behavioural change.

Self-development (for all parties) is an important part of this health coaching approach. Henley Business School developed a series of questions called 'The Henley Eight' which may be useful (Passmore & Sinclair, 2021). This series of questions help guide a coach in observation, self-reflectance, and can enhance situational awareness during a coaching conversation:

The Henley Eight

1. What did I notice?
2. How did I respond - behaviourally, emotionally, physiologically and cognitively?
3. What does this tell me about myself as a person?
4. What does this tell me about myself as a coach?
5. What strengths does that offer?
6. What pitfalls should I watch out for?
7. What did I learn from this observations/reflection?
8. What might I do differently next time?

The research story so far

Research geography

Health coaching is more commonplace in the USA and Australia but the interest is ever increasing for application and implementation in the UK. As a result, the bulk of research studies have been carried out in the USA but evidence is growing in other parts of the world.

Table 1 below shows the geographical sources of studies included in The Evidence Centre's (2014:11) review of health coaching literature which confirms the majority of research is coming from the USA:

Table 1

County	Systemic Review	Randomized Controlled Trial	Other Studies	Total
UK	5	4	7	16
Europe	3	25	22	50
North America	7	66	94	167
Other Countries	3	14	25	42
Total	18	109	148	**275**

Research concludes health coaching works

The latest evidence gathered in the Compendium of Health and Wellness Coaching (HWC) in the 2019 Addendum, added another 104 peer-reviewed coaching articles to a database which doubles every four years. Storzo et al. (2019:5) concluded their review with a call to action saying; 'spread the news that coaching improves health'.

Research finds health coaching is wanted

Research from Charles et al. (2004) and Elwyn et al. (1999) into shared-decision among breast cancer specialists and into consultations for people with upper respiratory infections, showed that people would indeed like to be more active in their care. There is clearly therefore a demand for a more engaged role in their healthcare from the patient/client perspective.

Research shows long-term conditions bias

Although not unanimous, the majority of research is focussed on and suggests that health and wellness coaching ('HWC') has a favourable impact on a number of patient conditions and in particular can help prevent or treat LTCs.

US based research reported positive outcomes on specific health issues, namely; obesity, diabetes, hypertension cholesterol management, general wellness and heart disease. However, the consistently positive impact from HWC and a key characteristic of the literature reviewed in the Compendium of Health and Wellness Coaching 2019 focussed on the treatment or prevention of obesity, diabetes and wellness.

The NHS Health Coaching Quality Framework reports there could be improved health outcomes for the most prevalent LTCs in the UK which are; diabetes (see Melko et al. 2010 and Wolever et al. 2010), cardiovascular disease (see Vale et al. 2003), pain management such as cancer (see Kravitz 2011) and rheumatoid arthritis (see Sjoquist et al 2010).

Behavioural change

The NHS in the UK commissioned a bibliographic review of 7,000 studies on whether health coaching is effective in March 2014. A total of 275 studies were included and a further 67 on professional training to support behavioural change were reviewed. The resultant statement from this research was that;

"the overall message from the evidence base is that there are many benefits likely associated with health coaching, but in order to be effective health coaching may be implemented as part of a wider programme supporting education and behaviour change"

(The Evidence Centre, 2014:59).

The empirical evidence available was compiled in order to address a number of key questions around whether health coaching works.

1. What are the impacts of health coaching?

Table 2 shows the impact of health coaching across four key areas of the research: self-efficacy, self-care behaviours, health outcomes and reduced service use or cost:

Table 2

Impact	Systematic Review	Random Trial	Other Study
Improved self-efficacy	0% of 1 study	75% of 16 studies	92% of 26 studies
Improved self-care behaviours	0% of 6 studies	59% of 36 studies	89% of 37 studies
Improved health outcomes	33% of 6 studies	37% of 60 studies	84% of 43 studies
Reduced service use or cost	25% of 4 studies	30% of 12 studies	70% of 10 studies

Source: Sforzo and Moore (2019)

The findings on whether health coaching is effective across these four areas were:

1. 'There is some evidence that health coaching can support people's motivation to self-manage'.
2. 'There is some evidence that health coaching can support people to adopt healthy behaviours'.
3. 'There is mixed evidence about the impact of health coaching on physical outcomes'.
4. 'There is insufficient evidence to conclude whether health coaching reduces healthcare use or costs'.

Source: The Evidence Centre (2014)

- **Self-efficacy**

Self-efficacy means the patient's improved confidence found through health coaching, to make a positive change in their life and self-manage.

Evidence from across the globe has suggested that health coaching can lead to improvements in peoples' confidence and motivation to make a change.

Newman (2012) reports statistically significant improvements in self-efficacy in a review of the health coaching experience in NHS Midlands and East, which researched and independently reviewed 199 patients and 360 coaching appointments:

- 98% high or very high level of satisfaction
- 86% would recommend coaching to other patients
- 74% report understanding their condition better
- 61% understand their test and treatment better

Source: Newman (2012:9)

A study in Japan in 2008 of 24 patients with spinocerebellar degeneration who completed 10 telephone health coaching sessions showed that it helped patients to tell their own stories and discover more about themselves which aided their ability to work towards and achieve, their goals (see Hayashi et al, 2008).

In Denmark, 186 people with type 2 diabetes were given health coaching or education about oral health. The outcome saw greater self-efficacy in tooth brushing and the largest improvement was seen from those the lowest baseline self-efficacy (see Basak Cinar & Schou, 2014).

Similarly, in the Netherlands, 133 people in primary care, with recently diagnosed type 2 diabetes from 54 GP practices were either given usual care or assigned 3 home visits by an expert patient peer who helped them set their goals. The peer coach group of patients saw improved self-efficacy, ability to cope and reduced saturated fat intake. Again, improvement was greater in those with a low baseline self-efficacy (see Van Der Wulp et al, 2012). What is interesting here is that peer-patients were used as coaches which shows that positive results can be derived from a variety of people acting as coaches.

Ngo et al (2010) completed a case study on 'teamlets' which they describe as 'a clinician (physician, nurse practitioner or physician assistant) and health coach who work together consistently and collaboratively' using health coaching skills in primary care, (Ngo et al, 2010:2). They found that the use of health coaching bridged the gap between the physician and patient and a 'teamlets' structure helped both parties in the settings examined.

Another primary care example was in the USA, where 250 patients with diabetes were given literacy-appropriate educational materials, goal setting and nurse follow-up telephone call at two and four weeks. After three months there were 'improvements observed in participants' activation, self-efficacy, diabetes-related distress, self-reported behaviours',

(Wallace et al, 2009:1).

Here we see a blended approach with health coaching and educational integrations as having worked well.

In terms of patient satisfaction in primary care, a study of 241 with LTCs showed that following three months of internet-based health coaching, people were more satisfied with their healthcare and thought their clinician was more likely to give them useful advice, (Leveille et al. 2009). Here we see an example of improved relations between healthcare professionals and patients with LTCs.

Despite most of the studies showing a positive impact in terms of the effects of heath coaching on self-efficacy, it should be noted that most the evidence gathered was from small observational studies. It is therefore hard to prove that health coaching made the difference in terms of the patient's confidence and motivations, versus it being a result of the patient simply having regular contact with a professional. For example, in the USA, data gathered over a one-year period about a nurse telephone health coaching service found that the 24 hours per day availability of a nurse was related to higher patient satisfaction (see Licht M et al 2007).

There is also mixed evidence about whether increased self-efficacy will indeed lead to behavioural changes or improved health outcomes. Many studies report that the relationship between self-efficacy and improved outcomes is more complex and have not found a direct link (see Coulter & Ellins, 2005). However, a number of authors have written about the benefits of self-efficacy and empowerment.

- **Positive health behaviours**

We have identified 6 systematic reviews, 36 randomised trials and a combination of 37 other studies which have assessed the impact of health coaching on patient's behavioural change. These studies provide evidence that health coaching can help people adopt heathier behaviours such as eating better, cutting down smoking, appointment and medication adherence and increasing activity levels. These are some of the earlier mentioned potential causes of the LTCs being discussed. The NHS Health Coaching Quality Framework added that health coaching can help in 'changing certain behaviours, including weight management, diet, nutrition and smoking cessation (see Olsen & Nesbitt, 2010).

Eating better

In France, around 1000 children and parents were given telephone dietary coaching for eight months and a control group given no support. The results showed the group accessing monthly health coaching were more likely to achieve their dietary targets to control fat and carbohydrate intake (Paineau et al., 2008).

Despite some positive results highlighted, some research has found health coaching to make no difference to behaviour between the control group and health coaching groups. For example, a review of 38 randomized trials including over 9,000 patients in relation to dietary adherence found that only 32 of 126 dietary adherence outcomes favoured the intervention group which had health coaching, (Desroches et al., 2013).

Cutting down smoking

In the USA, 3,500 smokers were asked to either receive self-help books by post or self-help books plus telephone health coaching. In term of the latter group, health coaching "almost doubled maintained quit rates", (McAlister et al., 2004:86) and importantly, helped maintain the cessation of smoking for one year showing that health coaching improved sustainable behaviour change. Furthermore, the reported health cost saving was around $1,300 per person.

Medication adherence

From an operational point of view, there are reports of health coaching helping with appointment keeping in primary care (Sides et al., 2012) and medication adherence. In China, 62 older people with LTCs were given either usual care or health coaching regarding their medication. The health coaching group demonstrated increased knowledge of medication safety and improved medication safety behaviours (Wang et al., 2013).

Increasing activity levels

A study in the USA of 525 people admitted to hospital for acute coronary syndrome, compared those who had usual care versus those who also had heath coaching over 3 months (Holmes-Rovner et al., 2008). The results showed the health coaching group had higher self-reported physical activity over the first three months and this declined after the coaching stopped. Another study which looked into effective techniques for improved physical activity and healthy eating, concluded that "our analyses offer clear support for including self-monitoring of behaviour", (Michie et al., 2009:20). This shows that self-efficacy and accountability is an important element in the behavioural change process. Although positive results were initially seen with regards to physical activity and nutrition, there is a question about the length of health coaching needed to provide sustainable behavioural change.

Sustainable change?

There is evidence that suggests behavioural changes may not be sustained once the health coaching sessions end as shown in a study by Hawkes et al. (2013) into the effects of telephone coaching on survivors of colorectal cancer. A limitation in the research though, is that most studies do not directly compare the success of health coaching in relation to lower or higher numbers of sessions accessed by patients. The question of how many health coaching sessions is optimal, is an area for further research as sustainable behaviours are key to positive lifestyle changes.

Format of coaching

The majority of research has not compared the delivery format of health coaching and what is more effective in terms of face-to-face, telephone or online services. Most research has not directly compared whether some formats are more effective for supporting behaviour change than others.

Who delivers the coaching?

Finally, in terms of who delivers the health coaching, studies are limited into looking directly at whether better outcomes are from health professionals, professional coaches, volunteers or peer coaches. It has also been noted that health coaching may be useful when incorporated as part of a wider intervention (Yan et al 2011). In a great deal of the research to date, it is often seen that health coaching is offered alongside such aids as; visual prompts, reminders, educational materials and booklets. Therefore, a blended and integrated approach is often required and used.

- ## Health outcomes

The evidence is mixed on the impact of health coaching on physical health outcomes. It has been suggested that this could be due to the length of time it takes for positive physical outcomes to manifest themselves and the length of studies not being matched to this nor having the sample size or follow-ups necessary to measure them accurately.

However, a review of 17 randomized trials which looked at increasing the activity levels of patients with type 2 diabetes showed that health coaching helped the behaviour associated with the control of blood sugar. It was also noted that the success of the approach was in the variety of behavioural change techniques used - the more variety, the more effective (Avery et al. 2012). Individual studies have also shown improved blood sugar control for people with diabetes such as for adolescents with poorly controlled type 1 diabetes (Ammentorp, 2013) and when nurses have used coaching as an effective intervention in type 2 diabetes (Whittmore et al, 2001).

A more recent study by Dwinger S et al. (2020) into telephone based health coaching delivered primarily by trained nurses using motivational interviewing, goal setting, and shared decision-making techniques, showed some positive effects on both patient reported outcomes and behaviour changes. The participants in this study suffered with chronic conditions. The results showed that health coaching was statistically significant superior to 'usual care' regarding 6 of 19 outcomes including physical activity, metabolic rate, BMI, blood pressure, patient activation, and health literacy. Regarding stages of behavioural change, the health coaching group also showed statistically different results than the usual care group, however the conclusion was inconclusive.

In Korea, 48 survivors of breast cancer were offered usual care or face-to-face education and telephone coaching in an attempt to improve quality of life ('QOL'). The health coaching intervention resulted in 'reported higher QOL overall and higher emotional well-being', (Park et al 2012:34

In contrast, in Japan 134 people with diabetes were offered either usual care or telephone nurse health coaching and no significant differences in blood sugar control were noted. The blood pressure, body mass index, cholesterol and quality of life were not changed (Shibayama et al 2007).

A similar study in Australia by Blackberry et al. (2013) of 473 people with type 2 diabetes were randomly offered their usual care or health coaching from nurses with two days training. After 18 months, there was no difference in blood sugar control or other outcomes recorded between the groups. As with any evidence gained, perhaps the length of coach training or number of sessions (average 3 per person in this case) could have had an impact on the results.

Finally, one study in Canada into 45 students with a body mass index of over 30 were either offered coaching or education from a specialist. The follow-ups showed that the educational programme was more effective than the coaching for weight loss but the coaching resulted in lower calorie intake. Interestingly, the feedback from the health coaching group showed improved self-efficacy with comments such as feeling 'more empowered to make healthy choices' (Pearson et al 2013:11). The health coaching group also reported greater 'self-understanding and self-responsibility as primary outcomes of their experience', (Pearson et al 2013:4). Whereas, the educational group focussed on the 'value of the practical knowledge gained' (Pearson et al 2013:4). Here we see an example whereby health coaching is having potentially more sustainable effects on behaviour such as self-efficacy versus other interventions such as education in this case.

- **Reduced costs or service use - the financial case**

Despite it being clear that more evidence is required to research whether health coaching reduces healthcare use or costs, there is some encouraging research which shows a positive return on investment in relation to health coaching and related interventions.

A study by Goetzel, Ron Z et al (2014) in Colorado, USA lasting one year, examined ten modifiable health risks for 2,458 workers at 121 businesses that participated in a health promotion programme which including unlimited access to health coaching. Reductions were reported across 10 risk factors including obesity, high cholesterol, high blood glucose, stress and depression. The resultant return-on-investment (ROI) simulation model showed an overall estimated savings of $2.03 for every $1.00 invested in terms of medical savings and productivity savings for the participants concerned. The study also referenced that the benefits could extend beyond the direct participants of the programme to their dependents, showing that there may be a wider systemic impact (and ROI) of health programmes which include health coaching.

However, the counter argument is that measuring the ROI of coaching interventions is too inconsistent (in measurement methodology) to be useful. Grant (2012) suggests that by focusing on financial returns runs the risk of the real potential of coaching to create a broad range of positive outcomes being hidden from view. Grant's research also shows significant variation in reports of ROI from coaching, concluding that comparisons are unrealistic and somewhat meaningless:

For example, in relation to coaching ROI, Grant (2012) states 'RIO from other studies shows estimates of 221% (Phillips, 2007), 545% (McGovern et al., 2001) and 788% (Kampa-Kokesch & Anderson, 2001), with figures of between 500% and 700% commonly reported as being 'the' ROI for executive coaching (Anderson, 2008)'.

ROI is not just financial though. There have been some positive results on hospital admissions, and in the context of workplace wellbeing. Furthermore, some incremental cost savings were found after reviewing 24 randomised trials; '£6,000 for smoking cessation; £14,000 for telephone-based diabetes management, and £250,000 or more for promoting mammography attendance and HIV prevention amongst drug users' (The Evidence Centre, 2014:32).

Reduced hospital admissions and readmissions

A US based study looking at patients over 65 admitted to hospital and either given usual care or assigned a 'transition coach', found that 'hospital costs were lower for intervention patients ($2058) vs controls ($2546) at 180 days', (Coleman et al 2006:1822). The same randomised trial showed fewer readmissions recorded at 30, 90 and 180 days.

A larger study of 174,120 people in the USA given either usual care or health coaching support (called enhanced support) depending on if they had higher predicted medical costs or not, provided some interesting results. The enhanced group had 4% lower monthly medical and pharmacy costs per person after 12 months and this was also due to reduced admissions to hospital (see Wennberg et al, 2010).

Workplace wellbeing

A cost saving of $176 per person in healthcare expenses was recorded in the USA after an analysis over 4 years of a workplace health coaching programme. There was also a further $182 inpatient expense reduction per person resulting in a $1.62: $1 return on investment, (Naydeck et al, 2008). A similar workplace study in Lebanon over the same length of time, showed that the health coaching group, despite not showing higher cost-effectiveness ratios, had the greatest participant engagement scores and health outcomes compared to the control groups, (see Saleh et al, 2010). Again, it appears that self-efficacy improved here even if cost-effectiveness did not.

In the USA, another wellbeing programme for 1,282 people which included health coaching, personal training with 24-hour fitness centre access, personal health assessments and screening, resulted in improved health outcomes (physical activity, healthy eating, weight loss and blood pressure) but also absenteeism decreased by 25% (see Davis et al 2009). This shows that the return on investment of health coaching and other interventions extends beyond the healthcare environment into the workplace setting. If people are more engaged and better able to self-manage and sustain healthy behaviours, they are less likely to take time off for sickness which could result in higher productivity.

Limitations to research

While the research into health coaching's impact provides growing evidence of its efficacy, caution is needed. In many of the studies the research hypotheses were not proven e.g. improved health outcomes although there may have been evidence of other positive outcomes such as self-efficacy. Further questions can also be raised in many studies about the sustained impact of coaching, and whether gains made were sustained for 12 months and beyond.

Finally, a significant number of studies are emerging from the USA, due to the growth in awareness of health coaching. However, how transferrable these results are to other health care systems need to be considered.

Further research

It has been suggested that potential further areas of research include looking at what the optimal coaching 'dose' is, how to select participants for coaching, whether coaching works better for specific demographic groups e.g. ethnicity, socio-economic groups, how to improve the sustainability of health coaching and how to improve its cost-effectiveness.

Emerging trends in health coaching such as digital delivery methods, Artificial Intelligence (AI) and robotics, and individual versus group coaching are also areas of research interest.

The NHS commented in its Health Coaching Quality Framework that it did not cover 'programmes involving the informal workforce and the use of health coaching as a referral pathway, but there's likely to be significant overlap which further research could identify'. This shows that the healthcare sector in the UK is considering alternative routes to coaching such as 'prescribing' or referring patients to coaching if it cannot be provided ordinarily.

Guidance for health coaching

The Health Coaching Quality Framework has been commissioned by NHS England as a way of helping to develop effective health coaching programmes and to ensure their ongoing quality. It contains guidance on four sections as follows:

1. Programme Design - The background work on which a training programme is based and the resulting curriculum design. Identifies participants for coaching and the fit with other self-management pathways.
2. Programme Delivery - Practicalities regarding programme delivery such as pairing, length of session, frequency of coaching, method of delivery including accessibility and number of sessions.
3. Monitoring and Evaluation - This seeks to ensure the programme has achieved its aims by way of ongoing feedback on the training's effectiveness.
4. Sustainability - Monitoring of the ongoing (sustained) usefulness and effectiveness of coaching skills in the healthcare sector and how they are being embedded into the everyday culture.

The Review

This review of research evidence suggests that health and wellbeing coaching can make a positive contribution to the global healthcare sector. We invite health leaders and health care professionals to reflect on the 12-steps and what actions are appropriate to their health system context, their patients and health care workers.

12 Steps: Opportunities For Action

The following 12 steps provide a range of possible actions for the different stakeholders within the healthcare system. We believe a collaborative approach is one which is most likely to deliver sustained long term impact on health and wellbeing.

Healthcare sector leaders & commissioners

1. Commission further research to explore the impacts of health coaching using qualitative and quantitative methods to provide more evidenced-based data.
2. Collaborate across the healthcare sector and with professional coaching bodies, research centres, and coaching organisations for coaching programme development support and for research purposes.
3. Design programmes to support the development of health coaching in appropriate settings.
4. Develop a team of health coaching champions to encourage routine use of coaching and build a coaching culture within health sector organisations.

Clinicians and healthcare professionals

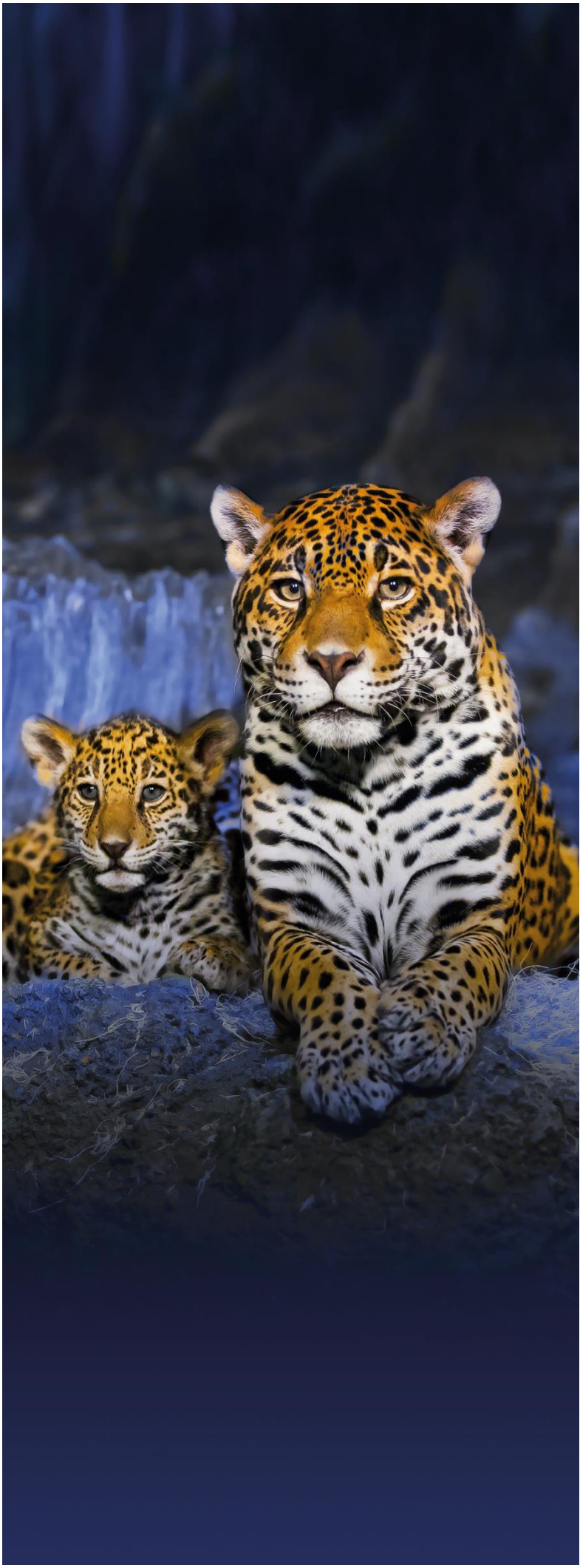
5. Use a health coaching approach and mind-set shift to interact differently with patients and colleagues.
6. Change roles from expert to enabler to move responsibility away from fixing to facilitating behaviour change.
7. Adopt a coaching approach for own personal development and resilience building.
8. Contribute to the evidence-base.

Patients

9. Engage in heath coaching to improve self-efficacy, empowerment and ownership of one's own health and wellbeing.
10. Shift mind-set away from seeing healthcare professionals as experts which have all the answers to viewing the relationship as a partnership for health.

Professional coaches, education centres, coaching organisations and professional coaching bodies

11. Share best practice with, and provide support to, the healthcare sector.
12. Support the training, accreditation and supervision of healthcare professionals as coaches.



References

Ammentorp J, Thomsen J, Kofoed PE (2013) *Adolescents with poorly controlled type 1 diabetes can benefit from health coaching: a case report and discussion.* J Clin Psychol Med Settings; 20(3): 343-350

Anderson, M.C. (2008). *What ROI studies of executive coaching tell us.* The Linkage Leader. [accessed 26 October 2020] http://www.linkageinc.com/thinking/linkageleader/Documents/Merrill_C_Anderson_What_ROI_Studies_of_Executive_Coaching_Tell_Us_1004.pdf

Aspen Health Strategy Group (2019). *Reducing the Burden of Chronic Disease.* Washington DC: [Accessed 08 January 2020) The Aspen Institute. http://aspeninstitute.org/AHSGreport2019

Association for Coaching (2019a) Coaching Supervision Guide. [Accessed 07 December 2019] https://cdn.ymaws.com/www.associationforcoaching.com/resource/resmgr/accreditation/coach_accreditation/supporting_documentation/ca_supervision_guide.pdf

Avery L, Flynn D, van Wersch A, Sniehotta FF, Trenell MI. (2012) *Changing physical activity behaviour in type 2 diabetes: a systematic review and meta-analysis of behavioural interventions.* Diabetes Care; 35(12):2681-2689

Baars, JE. Markus T, Kuipers EJ, Van der Woude CJ (2010) *Patients' preferences regarding shared decision-making in the treatment of inflammatory bowel disease: results from a patient-empowerment study*. Digestion

Basak Cinar, A & Schou, L (2014) *The role of self-efficacy in health coaching and health education for patients with type 2 diabetes.* Int. Dent Journal (published online February 2014)

Campos DC, & Graveto, JM. (2009) *The role of nurses and patients' involvement in the clinical decision-making process.* Rev Lat Am Enfermagem.

Centre for Policy on Aging (2014) *Rapid Review - Health coaches – do they work and what for?* [Accessed 07 January 2020] http://www.cpa.org.uk/information/reviews/CPA-Rapid-Review-Health-Coaching.pdf

Charles C, Gafni A, Whelan T (2004) S*elf-reported use of shared decision-making among breast cancer specialists and perceived barriers and faciliators to implementing this approach.* Heath Expect 2004; 7(4):338-348

Coleman EA, Parry C, Chalmers S, Min SJ (2006) *The care transitions intervention: results of a randomized controlled trial.* Arch Intern Med; 166(17):1822-1828

Coulter, A (2011) *Engaging Patients in Healthcare*. Maidenhead: Open University Press/McGraw-Hill

Coulter, A & Collins, A (2011) *Making Shared Decision - Making A Reality No Decision About Me, Without Me*. London: The King's Fund

Coulter, A & Ellins, J (2005) *How engaged are people in their healthcare?* The Health Foundation

Davis L, Loyo K, Glowka A, Schwertfeger R, Danielson L, Brea C, Easton A, Griffin-Blake S (2009) A comprehensive worksite wellness program in Austin, Texas: partnership between steps to a healthier Austin and capital metropolitan transportation authority. Prev Chronic Dis;6(2):

Department of Health (2004) Improving Chronic Disease Management. London: Department of Health

Department of Health (2012) Long Term Conditions Compendium of Information Third Edition [accessed 10 January 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

Desroches S, Lapointe A, Ratte S, Gravel K, Legare F, Turcotte S (2013) *Interventions to enhance adherence to dietary advice for preventing and managing chronic diseases in adults.* Cochrane Database Syst Revl 2:CD008722

Dwinger S, Rezvani F, Kriston L, Herbarth L, Härter M, Dirmaier J. (2020) *Effects of telephone-based health coaching on patient-reported outcomes and health behavior change: A randomized controlled trial.* PLoS One.;15(9)

Elwyn G, & Edwards A. (2009) *Shared decision-making in health care: Achieving evidence-based patient choice.* Oxford: Oxford University Press (2nd ed)

Elwyn G, Gwyn R, Edwards A, Grol R (1999) *Is 'shared decision-making' feasible in consultations for upper respiratory tract infections? Assessing the influence of antibiotic expectations using discourse analysis*. Health Expect 1999; 2(2): 105-117

Goetzel, Ron Z. PhD; Tabrizi, Maryam MS, PhD; Henke, Rachel Mosher PhD; Benevent, Richele MS; Brockbank, Claire v. S. MS; Stinson, Kaylan MSPH; Trotter, Margo RN, BScN, MHSc; Newman, Lee S. MD, (2014) MA *Estimating the Return on Investment From a Health Risk Management Program Offered to Small Colorado-Based Employers,* Journal of Occupational and Environmental Medicine: Volume 56 - Issue 5 - p 554-560

Grant, A. M, (2012) *ROI is a poor measure of coaching success: towards a more holistic approach using a well-being and engagement framework* Coaching: An International Journal of Theory, Research and Practice, 1-12, iFirst article: Routledge.

Hawkes Al, Chambers SK, Pakenham KI, Patrao TA, Baade PD, Lynch BM, Aitken JF, Meng X, Courneya KS (2013) *Effects of a telephone-delivered multiple health behaviour change intervention (CanChange) on health and behavioural outcomes in survivors of colorectal cancer: a randomized controlled trial.* J Clin Oncol;31(18):2313-2321

Hawkins, P (2019) *Resourcing: the neglected third leg of supervision.* In: E Turner & S Palmer (eds) The Heart of Coaching Supervision: Working with Reflection and Self-Care. Abington: Routledge, Chapter 4.

References

Hawkins, P, Turner, E & Passmore, J (2019) *The manifesto for supervision.* Henley-on-Thames: Association for Coaching, and Henley Business School. ISBN: 978-1-912473-24-3

Hayashi, A, Kayama, M, Ando, K, Ono, M, Suzukamo, Y, Michimata, A, Akiyama, MO, Fukuhara, S, and Izumi, SI (2008) *Analysis of subjective evaluations of the functions of tele-health coaching intervention in patients with spinocerebellar degeneration.* NeuroRehabiliation.

Holmes-Rovner M, Stommei M, Corser WD, Olomu A, Holtrop JS, Siddiqi A, Dunn SL (2008) *Does outpatient telephone health coaching add to hospital quality improvement following hospitalization for acute coronary syndrome?* J gen Intern Med 23(9): 1464-1470

Kampa-Kokesch, S., & Anderson, M.Z. (2001). *Executive coaching: A comprehensive review of the literature.* Consulting Psychology Journal: Practice and Research, 53(4), 205-228.

Kravitz, R. L (2011) *Cancer health empowerment for living without pain (Ca-HELP): effects of a tailored education and coaching intervention on pain and impairment.* Pain 152(7): 1572-82.

Licht M, Davis JM, Scripps A, Cone J (2007) *Whole person health for the whole population: one-year evaluation of health coaching.* Perm Journal 2007; 11(4):41-44.

Leveille SG, Huang A, Tsai SB, Allen M, Weingart SN, & Iezzoni LI. (2009) *Health coaching via an internet portal for primary care patients with chronic conditions: a randomized controlled trial.* Med Care 2009; 47(1): 41-47.

McAlister AL, Rabius V, Geiger A, Glynn TJ, Huang P, Todd, R (2004) *Telephone assistance for smoking cessation: one-year cost effectiveness estimations*. Tob Control 13(1): 85-86.

McGovern, J., Lindermann, M., Vergara, M.A., Murphy, S., Barker, L., & Warrenfelz, R. (2001). *Maximizing the impact of executive coaching: Behavioral change, organizational outcomes and return on investment.* The Manchester Review, 6(1), 1-9.

Melko, C et al (2010*) Diabetes heath coaching improves medication adherence:* A pilot study. AM. L. of Lifestyle Medicine 2: 187-194.

Michie, S et al (2009) *Effective techniques – diet and physical activity meta:* Health Psychology

Naydeck BL, Pearson JA, Ozminkowski RJ, Day BT, Goetzel RZ (2008) *The impact of the highmark employee wellness programs on 4-year healthcare costs*. J Occup Environ Med;50(2):146-156

Newman, P (2013) *The health coaching experience in NHS Midlands and East.* NHS Institute for Innovation and Improved (2012)

Newman, P. and McDowell, A. (2016) *Health changing conversations: clinicians' experience of health coaching in the East of England*. Future hospital journal 'Person-centred tools for the clinician' Vol. 3 (2) 147-51.

Ngo V, Hammer H, & Bodenheimer T. (2010) *Health coaching in the teamlet model: a case study.* Journal Gen Intern Med.

NHS England Health Coaching- quality framework [accessed 10 December 2019] https://www.hee.nhs.uk/sites/default/files/documents/Health%20coaching%20quality%20framework.pdf

NHS England (2014) Five Year Forward View [accessed 01 January 2020] www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England Health Coaching [accessed 13 January 2020] https://www.england.nhs.uk/personalisedcare/supported-self-management/health-coaching/

Olsen, J. M. & Nesbitt, B. J. (2010) H*ealth coaching to improve healthy lifestyle behaviors: an integrative review.* Am. J. of Health Promotion 25(1): e1-e12.

Paineau DL, Beaufils F, Boulier A, Cassuto DA, Chwalow J, Combris P, Couet C, Jouret B, Lafay L, Laville M, Mahe S, Ricour C, Romon M, Simon C, Tauber M, Valensi P, Chapalain V, Zourabichvili O, Bornet F. (2008) *Family dietary health coaching to improve nutritional intakes and body weight control: a randomized controlled trial.* Arch Pediatr Adolesc Med; 162(1): 34-43

Park JH, Bae SH, Jung YS, Kim KS (2012) *Quality of life and symptom expeirnce in breast cancer survivors after participating in a psychoeducational support program: a pilot study.* Cancer Nurs; 35(1):E34-E41

Passmore, J. & Fillery-Travis, A. (2011). *A critical review of executive coaching research: A decade of progress and what's to come.* Coaching: An International Journal of Theory, Practice & Research. 4(2), 70-88

Passmore, J. & Sinclair, T. (2021) Becoming a Coach: The Essential ICF Guide. New York: Springer

Pearson ES, Irwin JD, Morrow D, Battram DS, Melling CW (2013) *The CHANGE program: comparing an interactive vs. prescriptive approach to self-management among university students with obesity.* Can J Diabetes; 37(1):4-11

Phillips, J.J. (2007). *Measuring the ROI of a coaching intervention.* Performance Improvement, 46(10), 10-23.

Saleh SS, Alameddine MS, Hill D, Darney-Beuhler J, Morgan A (2010) *The effectiveness and cost-effectiveness of a rural employer-based wellness program*. J Rural Health; 26(3):259-265

Schattner, A. Bronstei, A. Jellin, N. (2006) *Information and shared-decision-making are top patients' priorities*. BMC Health Serv Res.

Shibayama T, Kobayashi K, Yakano A, Kadowaki T, Kazuma K (2007) *Effectiveness of lifestyle counselling by certified expert nurse of Japan for non-insulin-treated diabetic outpatients: a 1-year randomized controlled trial*. Diabetes Res Clin Pract; 76(2): 265-268

References

Sides EG, Zimmer LO, Wilson L, Pan W, Olsen DM, Peterson ED, Bushnell C (2012) Medication health coaching program for patients with minor stroke or TIA: A pilot study. BMC Public Health 12:549

Sforzo, G. A & Moore, M. (2019) *Does coaching improve health? I*nstitute of Coaching McLean Hospital: A Harvard Medical School Affiliate

Sforzo, Kaye, Harenberg, Costello, Cobus-Kuo, Rauff, Edman, Frates, Moore. (2019) *Compendium of Health and Wellness Coaching: 2019 Addendum.* American Journal of Lifestyle Medicine.

Sjoquist, E. S. et al (2010) *Physical activity coaching and health status in rheumatoid arthritis: a person-orientated approach.* Disabil Rehabil. 32(10): 816-25.

The Evidence Centre (2014) *Does Health Coaching Work? A Rapid Review of Empirical Evidence.* Health Education East of England: NHS

Vale, M. J. et al (2003) *Coaching patients on achieving cardiovascular health (COACH): A multicentre randomized trial in patients with coronary heart disease.* Arch Intern Med. 163(22): 2775-2783

Van der Wulp I, de Leeuw JR, Gorter KJ, & Rutten GE. (2012) *Effectiveness of peer-led self-management health coaching for patients recently diagnosed with type 2 diabetes mellitus in primary care: a randomized controlled trial.* Diabet Med.

Wallace AS, Seligman HK, Davis TC, Schillinger D, Arnold CL, Bryant-Shilliday B, Freburger JK, DeWalt DA. (2009) *Literacy-appropriate educational materials and brief counselling improve diabetes self-management.* Patient Educ Couns.

Wang CJ, Fetzer SJ, Yang TC, Wang JJ (2013) The impacts of using community health volunteers to coach medication safety behaviors among rural elders with chronic illnesses. Geriatr Nurs 34(2):138-145

Wennberg DE, Marr A, Lang L, O'Malley S, Bennett G (2010) *A randomized trial of a telephone care-management strategy.* N Engl J Med; 363(13):1245-1255

Whitmore, J (2009) *Coaching for performance: GROWing human potential and purpose: The principles and practice of coaching and leadership, 4th edn*. London: Nicholas Brealey

Whittemore R, Chase S, Mandle CL, Roy SC (2001) *The content, integrity, and efficacy of a nurse health coaching intervention in type 2 diabetes.* Diabetes Educ; 27(6):887-898

Wolever, R. Q. et al (2010) *Integrative health coaching for patients with type 2 diabetes: a randomized clinical trial.* Diabetes Educ. 36(4): 629-639

Wolever, R. Q, Simmon, L. A, Sforzo, G. A, Dill, D., Kaye, M., Bechard, E. M, Southard, M. E, Kennedy, M, Vosloo, J, and Yang, N. (2013) *A systematic review of the literature on health and wellness coaching: Definining a key Behavioral Intervention in Healthcare,* Glob Adv. Health Med. 2 (4): 38-5.

World Health Organisation (WHO) (2002) *Innovative Care for Chronic Conditions. Building Blocks for Action.* Geneva: WHO

World Health Organisation (WHO) (2012) Health statistics 2012 [accessed 13 January 2020] https://apps.who.int/iris/bitstream/handle/10665/44844/9789241564441_eng.pdf;jsessionid=6F5E3463CF27C47F0708BFF9F34A0493?sequence=1

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