The New Trend, Group Health &Wellness Coaching

by Rebecca McLean & Dr. Roger Jahnke

Current research reveals that group-based health and wellness coaching and support are a breakthrough for leveraging change in diverse populations of people who want to regain health, prevent disease, and improve the quality of their personal lives. Medical expenditures decrease and outcomes increase (health status, productivity), as group-based coaching is very cost effective. Group-based wellness coaching is the "new wave" in corporations, agencies, hospitals, clinics, parishes, agencies, universities, and corporations.

The Power of the Group Process & Accountability

Working within a group increases almost every aspect of the process of self-improvement. A group provides expanded resources for information, feedback, coping, experiences, the group's "resident wisdom," support, and the power of the accountability. Harvard research states that we are 85 percent more likely to succeed in taking positive actions if we have accountability.

Additionally, groups can create a climate in which participants are valued, strengthened, and inspired by one another. Group health and wellness coaching provide supportive social connection which research proves to have a measurably positive effect on immune function. **Testimonial**. We are so incredibly influenced by each other that the power of testimony is big medicine. When participants in a group share how they have implemented self-care practices in their lives or how they have succeeded in discontinuing a damaging behavior we are inspired and encouraged. When a peer breaks through to victory, we feel that we can, too. We are each other's mirrors.

The Benefits of Group-Based Health & Wellness Coaching

*The cost decreases and outcomes increase with group-based coaching support.

*Trained health and wellness coaches can provide effective coaching results without needing expensive experts.

*Provides people the opportunity to work in group, in addition to or as an alternative to one-to-one work—allowing for the advantages of both contexts in a more affordable context.

*Creates the opportunity for many people who could otherwise not afford conventional coaching to learn the powerful lifelong tools for healthful living.

*Creates dynamic, empowered families, community and peer accountability.

• Equally effective for groups for effective outcomes related to stress mastery (resiliency), work performance, work and home life balance, and team building

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The emergence of a new health care paradigm:

Moving from Medical Intervention

to Disease Prevention
to Health Enhancement Health and Wellness Coaching

As will be detailed further, health and wellness coaching is the master key to leveraging broad health status improvement in all populations. Everyone understands the need for personal change. Very few understand how to actually accomplish a shift in lifestyle or personal habit status. However, research has demonstrated that group support and wellness coaching are much more effective than training or education from experts. While diet, exercise, and stress management are among the keys to health improvement and disease management, coaching provides the support and accountability that is critical for actual change.

Regarding health and human functionality, there is a continuum—moving from health toward disease. The more health is lost, the greater the cost. To maximize health-sustaining behaviors as a basis of a health care system is philosophically sensible. However, for the economic case and the future of our economy globally, health promotion and wellness are brilliant. More than 70 percent of disease is preventable, according to the DHHS, in both the Healthy People 2000 and Healthy People 2010 documents.

Of America's annual medical expenditure, which totals $1.5 trillion, 70 percent could be saved. How much will we become willing to spend on health and wellness to save over $1 trillion? Therein lies the magnitude of the market opportunity for wellness.

Currently, according to market projections, "wellness" is a $200 billion business. This is only program and product revenue, and does not reveal how much is being saved on medical expenses or avoided absenteeism, stress claims elimination, and injury prevention. In just ten years, an additional $1 trillion of the U.S. economy will be devoted to providing products and services to assist people in maintaining and even maximizing their health.

A master key to the wellness revolution is coaching, wherein medical professionals and non- medical professionals help well and at-risk customers to sustain their health status and even improve it through partnering with the client in implementing healthy lifestyle-behavioral change. The following references and abstracts reveal the history, in the most highly respected medical literature, of this paradigm shift:

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I. Seminal Inception—research through Dr. C. Everett Koop, the former surgeon general, along with Drs. Fries and McGinnis, wherein the prevention vs. treatment argument is finalized in a series of proofs that have altered the future of health care toward wellness.

II. Pivotal Research—research on cardiology and diabetes, wherein it was clearly demonstrated that disease prevention is easy and inexpensive through a lifestyle change (behavioral health improvement) model including: 1) health coaching and support, 2) moderate exercise, 3) moderate diet change and the loss of 7 percent of body weight, and 4) stress management.

III. Widespread Implementation- Coaching—two sample abstracts pointing to "Coaching," chosen from many hundreds of articles on wellness, lifestyle, and behavioral change wherein it is demonstrated that "health or wellness coaching" is the master key for solving the health crisis and the problem of wasted medical dollars.

This revolution is now transitioning from the health care system into the workplace, the primary locus for prevention. Recently, the National Governors Association (http://nga.org) stated in an issue brief:

"The cost of health care for business threatens the nation's ability to compete in the global marketplace. Spending in the public and private sectors doubled between 1990 and 2001 and is expected to double again by 2012. With American workers spending nearly ½ of their lives at work, worksites have become the primary venue for promoting healthy habits. Employers who improve their wellness programs can reap the rewards of fewer sick days, greater productivity, lower health costs and increased profit." (http://www.nga.org/Files/pdf/0602CREATINGHEALTHYSTATESWORK.PDF#search='economic%20benefits%20of%20health%20coaching'):

It has become clear that health self-reliant citizens will have a tremendous impact on the efficiency of the health care system and significantly limit the cost of health care. Those companies that create tools and services to foster this change stand to participate in the solution to the health care crisis and derive immense economic benefit.

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I. The Seminal Articles

***New England Journal Medicine* 1993 Jul 29; 329(5): 321-5.**
Reducing health care costs by reducing the need and demand for medical services.
The Health Project Consortium. Fries JF, Koop CE, Beadle CE, Cooper PP, England MJ, Greaves RF, Sokolov JJ, Wright Stanford University, Calif.

Health care costs in the United States exceed 14 percent of the gross domestic product, far more than in any other nation. Overall costs were $838 billion in 1992, or over $3,000 per person. Well over 30 million Americans are uninsured, partly because of rising premium costs. We propose an approach to part of this problem that has been neglected, one that focuses on systematically reducing the need and thus the demand for medical services. This approach requires expanding the definitions of "health promotion" and "preventive care."

- A Theoretical Solution—Reducing the Need and Demand for Medical Services
- The Potential for Reducing Demand
- Much Disease Is Preventable
- Risky Behavior Costs Money
- Variability in Regional Costs Implies Slack in the System
- Self-Management Can Result in Savings
- Care for Terminal Illness Has Become Extraordinarily Expensive and Inhumane
- Health Promotion at Work Has Successfully Reduced Costs

***JAMA*, 1993 Nov 10; 270(18): 2207-12.**
Actual causes of death in the United States. McGinnis JM, Foege WH.
US Department of Health and Human Services, Washington, DC 20201.

OBJECTIVE: To identify and quantify the major external (nongenetic) factors that contribute to death in the United States.

DATA SOURCES: Articles published between 1977 and 1993 were identified through MEDLINE searches, reference citations, and expert consultation. Government reports and complications of vital statistics and surveillance data were also obtained.

STUDY SELECTION: Sources selected were those that were often cited and those that indicated a quantitative assessment of the relative contributions of various factors to mortality and morbidity.

DATA EXTRACTION: Data used were those for which specific methodological assumptions were stated. A table quantifying the contributions of leading factors was constructed using actual counts, generally accepted estimates, and calculated estimates that were developed by summing various individual estimates and correcting to avoid double counting. For the factors of greatest complexity and uncertainty (diet and activity patterns and toxic agents), a conservative approach was taken by choosing the lower boundaries of the various estimates.

DATA SYNTHESIS: The most prominent contributors to mortality in the United States in 1990 were tobacco (an estimated 400,000 deaths), diet and activity patterns (300,000), alcohol (100,000), microbial agents (90,000), toxic agents (60,000), firearms (35,000), sexual behavior (30,000), motor vehicles (25,000), and illicit use of drugs (20,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

CONCLUSIONS—Approximately half of all deaths that occurred in 1990 could be attributed to the factors identified. Although no attempt was made to further quantify the impact of these factors on morbidity and quality of life, the public health burden they impose is considerable and offers guidance for shaping health policy priorities.

Health Affairs **1998 Mar-Apr; 17(2): 70-84.**
Beyond health promotion: reducing need and demand for medical care.
Fries JF, Koop CE, Sokolov J, Beadle CE, Wright D.
Stanford University, Palo Alto, CA, USA.

A population's medical need represents its illness burden. Medical demand represents the service level requested for a particular need. Medical care costs are, in large part, a function of need and demand. Our review of health education programs designed to reduce health risks and reduce costs identified 32 programs with documented effectiveness, generally achieving claims reductions of 20 percent. Specific program features including chronic disease self-management, risk reduction, and increased self-efficacy appear important. A broadened definition of health promotion focused on increased personal responsibility for health-related actions and directed at improvement of long-term health outcomes also could reduce health care costs.

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The Pivotal Research

Ornish—Heart

***JAMA.* 1998 Dec 16; 280(23): 2001-7.**

Intensive lifestyle changes for reversal of coronary heart disease.

Ornish D, Scherwitz LW, Billings JH, Brown SE, Gould KL, Merritt TA, Sparler S, Armstrong WT, Ports TA, Kirkeeide RL, Hogeboom C, BrandDepartment of Medicine, California Pacific Medical Center, San Francisco, USA. DeanOrnish@aol.com

CONTEXT: The Lifestyle Heart Trial demonstrated that intensive lifestyle changes may lead to regression of coronary atherosclerosis after 1 year.

OBJECTIVES: To determine the feasibility of patients to sustain intensive lifestyle changes for a total of 5 years and the effects of these lifestyle changes (without lipid-lowering drugs) on coronary heart disease.

DESIGN: Randomized controlled trial conducted from 1986 to 1992 using a randomized invitational design.

PATIENTS: Forty-eight patients with moderate to severe coronary heart disease were randomized to an intensive lifestyle change group or to a usual-care control group, and 35 completed the 5-year follow-up quantitative coronary arteriography.

SETTING: Two tertiary care university medical centers.

INTERVENTION: Intensive lifestyle changes (10 percent fat whole foods vegetarian diet, aerobic exercise, stress management training, smoking cessation, group psychosocial support) for 5 years

MAIN OUTCOME MEASURES: Adherence to intensive lifestyle changes changes in coronary artery percent diameter stenosis, and cardiac events.**RESULTS:** Experimental group patients (20 [71%] of 28 patients completed 5-year follow-up) made and maintained comprehensive lifestyle changes for 5 years, whereas control group patients (15 [75%] of 20 patients completed 5-year follow-up) made more moderate changes. In the experimental group, the average percent diameter stenosis at baseline decreased 1.75 absolute percentage points after 1 year (a 4.5% relative improvement) and by 3.1 absolute percentage points after 5 years (a 7.9% relative improvement). In contrast, the average percent diameter stenosis in the control group increased by 2.3 percentage points after 1 year (a 5.4% relative worsening) and by 11.8 percentage points after 5 years (a 27.7% relative worsening) (P=.001 between groups. Twenty-five cardiac events occurred in 28 experimental group patients vs 45 events in 20 control group patients during the 5-year follow-up (risk ratio for any event for the control group, 2.47 [95% confidence interval, 1.48-4.20]).**CONCLUSIONS: More regression of coronary atherosclerosis occurred after 5 years than after 1 year in the experimental group. In contrast, in the control group, coronary atherosclerosis continued to progress and more than twice as many cardiac events occurred.**

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III. Widespread Implementation – Coaching

Diabetes

The Diabetes Prevention Program (DPP) Research Group.
The Diabetes Prevention Program (DPP): description of lifestyle intervention.
Diabetes Care 2002 Dec; 25(12): 2165-71
The Diabetes Prevention Program (DPP): description of lifestyle intervention.
Diabetes Prevention Program (DPP) Research Group.
Diabetes Prevention Program Coordinating Center, Biostatistics Center, George Washington University, Rockville, Maryland 20852, USA. dppmail@biostat.bsc.gwu.edu

The purpose of the present article is to provide a detailed description of the highly successful lifestyle intervention administered to 1,079 participants, which included 45% racial and ethnic minorities and resulted in a 58% reduction in the incidence rate of diabetes (2). The two major goals of the Diabetes Prevention Program (DPP) lifestyle intervention were a minimum of 7% weight loss/weight maintenance and a minimum of 150 min of physical activity similar in intensity to brisk walking. Both goals were hypothesized to be feasible, safe, and effective based on previous clinical trials in other countries (3-7). The methods used to achieve these **lifestyle goals** include the following key features: 1) individual case managers or **"lifestyle coaches;"** 2) frequent contact with participants; 3) a structured, state-of-the-art, 16-session core-curriculum that taught **behavioral self-management strategies** for weight loss and physical activity; 4) supervised physical activity sessions; 5) a more flexible maintenance intervention, combining group and individual approaches, motivational campaigns, and "restarts;" 6) individualization through a "toolbox" of adherence strategies; 7) tailoring of materials and strategies to address ethnic diversity; and finally 8) an extensive network of training, feedback, and clinical support.

***J Am Acad Nurse Pract*. 2006 Jan; 18(1): 31-9.**
Effective interventions for lifestyle change after myocardial infarction or coronary artery revascularization.
Cobb SL, Brown DJ, Davis LL.
Healthlink, University of North Carolina Healthcare, Chapel Hill, NC, USA.
scobb3@nc.rr.com

PURPOSE: This science clinical paper reviews medical literature and examines interventions that are currently used to assist patients in achieving lifestyle change after myocardial infarction or coronary artery revascularization. Interventions that focused on both provider- and patient-implemented strategies were included. The effectiveness of these interventions to significantly reduce coronary heart disease risk factors was explored.

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***J Am Acad Nurse Pract*. 2006 Jan; 18(1): 31-9.**
Effective interventions for lifestyle change after myocardial infarction or coronary artery revascularization.
DATA SOURCES: Original longitudinal research studies or reviews indexed in PubMed between 1999 and 2004 were included. Eight studies were identified that met the inclusion criteria and presented successful interventions to increase participants' adherence to recommended lifestyle changes.

CONCLUSIONS: Current strategies for achieving recommended risk factor reductions include frequent follow-up, intensive diet changes, individualized and group exercise, coaching, group meetings, education on lifestyle modification and behavior change, and formal cardiac rehabilitation programs.

IMPLICATIONS FOR PRACTICE: Nurse Practitioners can help close the gap between evidence-based recommendations and clinical practice by implementing education programs in their practices and in the community. Recommendations include frequent follow-up visits, negotiating personalized treatment plans, and a general emphasis on therapeutic lifestyle change as an essential component of the treatment plan.

***Diabetes Educ.* 2004 Sep-Oct;30(5):795-804. Related Articles, Links A nurse-Coaching intervention for women with type 2 diabetes.**
Whittemore R, Melkus GD, Sullivan A, Grey M.
Yale School of Nursing, New Haven, Connecticut 06536-0740, USA.
robin.whittemore@yale.edu
PURPOSE: The purpose of this pilot study was to determine the efficacy of a 6-month nurse-coaching intervention that was provided after diabetes education for women with type 2 diabetes.

METHODS: In this pilot study, 53 women were randomized to the nurse-coaching intervention or a standard care control condition. The nurse-coaching intervention consisted of 5 individualized sessions and 2 follow-up phone calls over 6 months. The nurse-coaching sessions included educational, behavioral, and affective strategies. Data were collected on physiologic adaptation (hemoglobin A1c [A1C] and body mass index [BMI]), self-management (dietary and exercise), psychosocial adaptation (diabetes-related distress and integration), and treatment satisfaction at baseline, 3 months, and 6 months.

RESULTS: Women in the treatment group demonstrated better diet self-management, less diabetes-related distress, better integration, and more satisfaction with care, and had trends of better exercise self-management and BMI. The A1C levels improved in both groups at 3 months, yet the difference between the groups was not significant. Attendance at nurse-coaching sessions was 96%.**CONCLUSIONS**: This nurse-coaching intervention demonstrates promise as a means of improving self-management and psychosocial outcomes in women with type 2 diabetes.

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Counseling Boosts Breast Cancer Recovery-Study

Sep 1, 2004 WASHINGTON (Reuters)

Ohio State University Comprehensive Cancer Center

Group therapy sessions helped breast cancer patients eat better, stop smoking, and may have boosted their immune systems, U.S. researchers reported on Wednesday.

A study of women with stage II or III breast cancer showed counseling sessions and group support helped breast cancer patients feel more relaxed and also raised the activity of immune cells called T-cells.

Writing in the Journal of Clinical Oncology, the researchers at Ohio State University Comprehensive Cancer Center say they now want to study group therapy in other cancers.

"We were so surprised with the findings about immunity that we repeated the tests over and over again as more patients entered the trial," said Barbara Andersen, a professor of psychology who led the study.

They studied 227 women, who were randomly assigned either to get a simple psychological assessment or to enter group-counseling sessions. The patients, who were all receiving chemotherapy or radiation for their cancer, discussed ways to lower their stress, improve their mood, stop smoking, eat better and follow their treatment plans.

Their blood was tested for activity of two types of immune cells—natural killer cells or T-cells. Radiation and chemotherapy can both suppress immune cells.The researchers found no significant change in the numbers of T-cell or killer cells, but found the women in group therapy had an increase in the proliferative capacity of T-cells, meaning they could respond quickly when needed for an immune defense.

The women who were not in the groups had decreased T-cell *study linking stress reduction and changes in immunity,"* said Dr. William Carson, an associate professor of medicine and molecular virology, immunology and medical genetics at Ohio State.

•Another study at Stanford University a by psychiatrist David Spiegel demonstrated that women with breast cancer who met in a weekly support group lo lived twice as long as those who did not. This extensively documented research shows that health support groups who met weekly show that health support groups create effective, positive health out comes.

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Highly Successful Group Health & Wellness Coaching Report
St. Charles Medical Center &, Bend Oregon 2004
Dr. Michael Harris - medical director
and Deb Harris RN

Program: **New Directions**
10 week 3 hour sessions for mixed diagnosis (1998 to 2004)
St. Charles Medical Center
Utilizing the Circle of Life Group mind/body health & wellness coaching model

The biggest contract though was with an insurance company who ran a pilot with us for 2 years and found their members who completed the program decreased their utilization of healthcare benefits by 57%. So other insurance's followed their decision to cover.

We kept very strict records of weekly assessments. These included record of blood pressure, weight and then a self-assessment of all body systems. Neuro, respiratory, cardiovascular, etc....This allowed us to track improvements.

We also tracked cholesterol and blood glucose levels before and after the program. Also our patients in our groups usually had Multi-system involvement; diabetes, heart disease, obesity, as well as many psychosocial symptoms.

This strict medical model is what allowed us the full reimbursement (we had to send cc of each weeks assessment to the case manager at the insurance company) as well as physician buy in for on going referrals. It was very successful and we managed to run 3 programs a year for almost 8 years in this small community.