# The Good Life Club project

## Telephone coaching for chronic disease self management

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The Good Life Club project was a 3 year demonstration project funded by the Commonwealth Department of Health and Ageing (DOHA). The project utilised a number of interventions to support people with diabetes to improve self management of their condition and more effectively utilise existing local health services. These included:

- individual telephone coaching by practice nurses and allied health professionals to support behaviour change of participants (*Table 1*)
- club activities, eg. walking groups, nutrition and healthy cooking sessions, supermarket tours, using the internet to find health information
- regular club newsletters
- client health website at: www.goodlifeclub.info, and
- email newsletters.

Coaches were recruited from local community health services and general practices, and undertook a 2 day training course in motivational interviewing. Training was based on an extensive literature review and reinforced the required competencies and skills required from the coaches.[1] This included the identification of depression and anxiety as well as identifying the client's level of support. Coaches were provided with regular debriefing sessions and paid for their time. Clients were telephoned monthly by the coach to review progress toward their goal, and to support their self efficacy through enhancing positive behavioural strategies.

### Recruitment of clients

Multiple recruitment methods were employed to enrol clients, including visits to general practitioners and advertising in local networks. Specific targeted strategies were implemented to recruit older men and members from the Chinese community. The Chinese community forms approximately 5% of the population of the two local government areas of Manningham and Whitehorse (Victoria). This community was chosen because of the high prevalence of diabetes in Chinese immigrants predominately due to changes in lifestyle.[2] It is also well recognised that numerous barriers such as language, stigma, cultural responsibility, religious beliefs, literacy, use of traditional medicine and lack of culturally appropriate care can result in this population being less likely to access health programs, and therefore labelled as non-compliant by some western health professionals. Men were targeted as they are less inclined to use health services for both the detection and prevention of disease.[3]

The project enrolled 343 participants over 12 months and included a cohort of 10% Chinese speaking clients, and 43% men. The relatively high number of men engaged in the project indicates that telephone coaching may be a more acceptable form of providing support to men.

### GP engagement

Although the original project submission required that all clients have a care plan completed by their GP, the

project was established at a time when care planning rates were falling within general practice and many GPs were not yet 'sold' on their benefits. To overcome this, all clients completed a self management plan based on the Flinders University Co-ordinated Care Training Unit's 'Problems and goals assessment'. The self management plan gave both the coach and client the opportunity to highlight the client's major health concerns. From these discussions, realistic and personally meaningful medium term goals were established. Strategies for achieving progress toward these behaviours were teased out in the coaching process. Most clients wanted coaching to support behaviour change in areas such as healthy eating and weight management, as well as maintaining motivation to be physically active.

Clients were asked to discuss their self management plan with their GP who was then requested to complete a 'medical management plan' outlining current diagnoses, treatment and recommendations. Coaches could be a member of a care plan team; 16% of clients were referred via a care plan initiated by the client's GP.

### Communication with GPs

As well as providing the client's self management plan for review, the coach also provided the GP with 3 monthly written feedback in relation to the client's goals achieved in the care plan or self management plan, and identified challenges and future strategies. If required, the coach contacted the GP by phone to discuss any issues arising from the coaching.

### GP views on the project

Focus group data revealed highly positive GP responses to the club. The GPs who attended the focus groups were strong enthusiasts for the club, pointing to a high level of professionalism in the development of referral protocols and systems, and positive patient benefits. They reported a high degree of satisfaction with their advice to patients being reinforced and encouraged by frequent contact with the coach.

*'It is a very good concept. I am very keen to be involved more. I intend to join more patients and agree that self management is a good adjunct to GP services. We are often too busy so the extra coaching is very valuable. As a support it helps us to be holistic'.*

## Patient responses to the project

Clients reported a wide range of benefits from the program including increased motivation, increased ability to cope with diabetes, better knowledge of their disease and strong social supports. Most clients reported that the club intervention had motivated them to change their behaviour.

*'It's made me sort out the self discipline to a certain extent. Get my nose into gear and start doing some more of the things that I should have been doing. I have been doing some of them but I didn't know about others'.*

**Table 1. The Good Life Club telephone coaching framework**

- Motivational interviewing to assist clients to overcome their ambivalence about making lifestyle changes
- Utilisation of 'stages of change model'[4]
- Encourage adherence to treatment
- Management of negative affect, eg. identifying anxiety and depression
- Improved self efficacy
- Identified and strengthened social support

### Client health outcomes

Client health outcomes were assessed at baseline, and at 6, 12, and 18 months postbaseline to enable a measure of the long term effects of the intervention (*Table 2*). At 18 months postbaseline, the participants demonstrated statistically significant sustained positive changes in six of eight self rated symptom measures. The self rated symptom items show a strong set of positive gains that have held up over the 18 month study period. Self reported pain and shortness of breath levels have shown sustained reduction, as have levels of discouragement attributed to health problems and fear of health problems. Associated worries and frustrations with health problems have shown useful reductions for most participants.

The 18 months postbaseline data indicates that no statistically significant changes were found in health service use patterns, although these trended toward the desired directions. The lack of statistical significance was attributed to high participant variability in usage patterns. The program participants demonstrated a sustained involvement in walking as a form of exercise over the program.

It was not possible to employ a control group in the study as no provision was made for it in the program design. Diabetes is a serious chronic illness and the withholding of treatment that may reasonably be expected to

**Table 2. Self report of self rated health and symptom measures by participants at program entry, 6 months and 18 months later**

| Item | | Mean | SD | *p* value |
|---|---|---|---|---|
| General health (n=145) (5 point scale) | Baseline | 2.97 | 0.869 | NS |
| | At 6 months | 2.87 | 0.922 | |
| | At 18 months | 2.88 | 0.954 | |
| Discouraged by health problems (n=146) (6 point scale) | Baseline | 2.51 | 1.309 | <.05 |
| | At 6 months | 2.29 | 1.344 | |
| | At 18 months | 2.20 | 1.148 | |
| Fearful of health (n=140) (6 point scale) | Baseline | 2.41 | 1.454 | <.001 |
| | At 6 months | 1.84 | 1.081 | |
| | At 18 months | 1.90 | 1.013 | |
| Health a worry in life (n=140) (6 point scale) | Baseline | 2.40 | 1.403 | <.001 |
| | At 6 months | 2.07 | 1.245 | |
| | At 18 months | 2.11 | 1.093 | |
| Frustrated by health problems (n=141) (6 point scale) | Baseline | 2.72 | 1.499 | <0.001 |
| | At 6 months | 2.42 | 1.484 | |
| | At 18 months | 2.17 | 1.134 | |
| Fatigue (n=147) (10 point scale) | Baseline | 4.58 | 2.567 | NS |
| | At 6 months | 4.28 | 2.823 | |
| | At 18 months | 4.35 | 2.944 | |
| Shortness of breath (n=150) (5 point scale) | Baseline | 2.79 | 2.849 | <0.01 |
| | At 6 months | 2.15 | 2.786 | |
| | At 18 months | 2.49 | 2.736 | |
| Pain (n=150) (5 point scale) | Baseline | 3.25 | 3.111 | <.05 |
| | At 6 months | 3.26 | 3.009 | |
| | At 18 months | 2.75 | 2.819 | |

NS = not statistically significant

bring about positive gains is ethically questionable, while being methodologically convenient. The natural history of the measures used is not well known in similar study samples, therefore the project was not in a position to compare the trajectories of the study sample with known benchmarks or comparison trajectories.

However, it is fair to say for most chronic diseases, diabetes included, the natural trajectory without intervention is downward. Thus, the measures in which there have been sustained gains in this study are particularly interesting.

## How can programs such as this be sustained?

Currently the project no longer provides direct services for clients, however the DOHA have funded a 'transition plan' for a further 2 years to embed chronic disease self management into practice in a range of settings (further details are available on the Good Life Club website: www.goodlifeclub.info). The Good Life Club consortium funded five mini sustainability projects to trial a variety of strategies to promote sustainability of the model. These included:

- General practice settings
  - asthma support coach within general practice
  - incorporating self management goals in care plans.

This model is sustainable utilising the Asthma 3+ and Enhanced Primary Care Medical benefits items and won an Australian Divisions of General Practice award in 2004.

- Community health settings:
  - follow up coaching after diabetes education
  - training volunteer coaches to promote physical activity to participants following disease specific education.

A cost effectivness analysis will be undertaken to determine if there are any cost benefits in providing services in this manner as opposed to one-on-one consultations in community health settings. These projects demonstrated that it is possible to provide sustainable chronic disease self management strategies.

## Discussion

There is no doubt that with the aging population in Australia and the high incidence of chronic complex medical diseases such as asthma and diabetes, the health industry will need to look for improved models of health care that can sustain the needs of the population and contain the costs of care to the community. Ongoing education and persistent reinforcement of patients' health goals will improve adherence to healthy lifestyles and outcomes which will in turn lead to lower overall health costs.

This project has given good evidence for positive outcomes for this type of intervention. It demonstrates an augmentation of the traditional role of the GP seeing patients on an intermittent basis and having the GP's advice and management reinforced between visits.

Governments, both state and federal, and health insurers will need to seriously look at this model if they wish to contain ever spiralling health costs. It is also important for GPs to recognise the complementary roles of other health providers – and in this model, health coaches – in providing better health care to the community.

Conflict of interest: none.

### References

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