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Short Communication

Does health coaching change patients' trust in their primary care provider?

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ABSTRACT

Objective: To assess the impact of health coaching on patients' in their primary care provider.
Methods: Randomized controlled trial comparing health coaching with usual care.
Participants: Low-income English or Spanish speaking patients age 18–75 with poorly controlled type 2 diabetes, hypertension and/or hyperlipidemia.
Main outcome measure: Patient trust in their primary care provider measured by the 11-item Trust in Physician Scale, converted to a 0–100 scale.
Analysis: Linear mixed modeling.
Results: A total of 441 patients were randomized to receive 12 months of health coaching ($n = 224$) vs. usual care ($n = 217$). At baseline, the two groups were similar to those in the usual care group with respect to demographic characteristics and levels of trust in their provider. After 12 months, the mean trust level had increased more in patients receiving health coaching (3.9 vs. 1.5, $p = 0.47$), this difference remained significant after adjustment for number of visits to primary care providers (adjusted $p = .03$).
Conclusions: Health coaching appears to increase patients trust in their primary care providers.
Practice Implications: Primary care providers should consider adding health coaches to their team as a way to enhance their relationship with their patients.

1. Introduction

In primary care, there has been a move to share tasks and responsibilities traditionally reserved for the primary care provider (PCP) with other members of the patient care team, including medical assistants, nurses, pharmacists, patent educators and coaches [1]. This team approach is a central feature of the widely promoted primary care medical home (PCMH) model which has been successful in improving quality of care and patient satisfaction while holding down costs [2–6].

Concern has been raised regarding the impact of the 'team approach' on the quality of the physician–patient relationship [7]. While the relationship between patient and provider is multifaceted, patient trust seems to be a central aspect of the relationship highly valued by patients and clinicians [8–10] which predicts continuity with the provider [11], adherence to medication and treatment plans [12–16], and utilization of recommended preventive services [17]. The addition of a health coach to the patient care team could potentially change patients' trust in their PCPs. For example, health coaching might 'replace' some of the trust-building interactions PCPs have their patients. By activating and empowering the patients to ask questions or disagree with their PCP, health coaching might undermine the provider–patient relationship and thereby reduce the level of patient trust. It is also possible that health coaches could increase patients' trust in their PCP, for example by improving communication.

We examined the impact of adding a health coach to the primary care team on patients trust in their PCP in the context of a randomized clinical trial of the impact health coach vs. usual care on control of chronic disease.

2. Methods

2.1. Study design

The Health Coaching in Primary Care (HCPC) study is a randomized controlled trial of 12 months of health coaching vs.

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usual care for low-income patients with poorly controlled type 2 diabetes, hypertensions, and/or hyperlipidemia with the primary outcome being control of diabetes, hypertension, and/or hyperlipidemia. A detailed description of the HCPC study design and methods has previously been published [18]. In this paper we report on the effect of health coaching on patient trust in, and satisfaction with, their PCP.

2.2. Setting, participants, enrollment and randomization

The study was conducted at two federally qualified health centers ('safety-net clinics') in San Francisco between from March 2011 to May of 2013. Patients were considered eligible if they were between ages of 18 and 75, spoke Spanish or English, could be reached by phone, and had poorly controlled diabetes (HbA1C >8.0%), hypertension (systolic blood pressure ≥140 mmHg for non-diabetic patients or ≥130 for patients with diabetes), or hyperlipidemia (LDL ≥ 160 mg/dl for non-diabetic patients or ≥100 mg/dl for diabetic patients). A total of 664 eligible patients were identified at the two clinic sites, of which 441 (66.4%) were consented and enrolled (see Fig. 1). After enrollment and completion of baseline measures, participants were randomized to the health coaching arm (n = 224) or the usual care arm (n = 217) by opening the next randomly ordered, sealed envelope.

2.3. Health coaching intervention

Health coaches were certified medical assistants who attended 40 h of health coach training over six weeks using a curriculum developed by the study team that included instruction in using active listening and non-judgmental communication; helping with self-management skills for diabetes, hypertension, and hyperlipidemia; providing social and emotional support; assisting with lifestyle change; facilitating medication understanding and adherence; navigating the clinic; and accessing community resources. A description of the curriculum can be found at http://familymedicine.medschool.ucsf.edu/cepc/pdf/Health-CoachTrainingCurriculumJune12.pdf.

Health coaches interacted with patients at medical visits, individual visits, and by phone calls. The minimum required frequency of contacts was once every three months for in-person visits (often as part of a medical visit) and monthly for additional contacts such as phone calls. During the medical visit, the health coach met with the patient before the visit for medication reconciliation, agenda-setting, and reviewing lab numbers. The health coach usually stayed in the exam room during the medical visit and met with the patient after the visit to review the care plan and check for patient understanding. The health coach also assisted the patient in making action plans to increase physical activity, improve healthy eating, reduce stress, or improve medication adherence [19]. In addition, the health coach facilitated navigation of other resources such as diagnostic imaging or referrals to specialists by making follow up appointments, or facilitating introductions to behaviorists or other clinic resources [20].

2.4. Usual care

Patients randomized to usual care continued to have visits with their clinician over the course of the 12-month period and had access to any additional resources that are part of usual care at the clinic, including diabetes educators, nutritionists, chronic care nurses, or educational classes.

2.5. Measures

Patient demographic characteristics were assessed by survey at the time of enrollment. Patients' trust in their PCP, was measured at baseline and 12 months using the previously validated Trust in

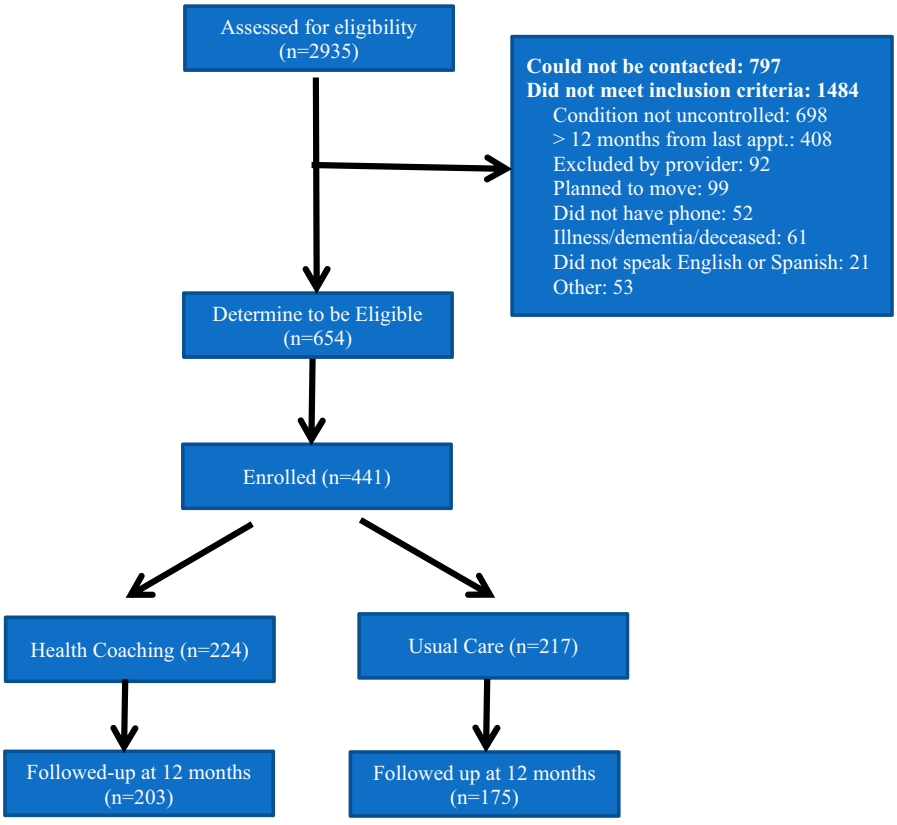

Fig. 1. CONSORT diagram.