The Lewin Group
Health Coaching and Wellness Planning to Increase Client Engagement in Self-Management: A Conversation with Judith Cook

Kristen Corcoran: Hello, and welcome to Health Coaching and Wellness Planning to Increase Client Engagement in Self-Management: A Conversation with Judith Cook, brought to you by Resources for Integrated Care. My name is Kristen Corcoran with the Lewin Group, and I'll be facilitating today's event.

The audio portion of today's presentation will automatically stream through your computer. Phone lines for the event are also available. To access the number, click the back phone widget at the bottom of your screen. Also, as a reminder, today's session will be recorded. A video replay and a copy of today's slides will be available at the ResourcesforIntegratedCare.com website. Next slide.

Today's conversation is supported through the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To learn more about our current efforts and resources, please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrated_Care. Next slide.

We will begin a conversation by introducing our speaker, Judith Cook. We will follow with a question and answer session with our speaker, based on questions we received before this event and questions we receive from the audience during the event. There is a Q&A feature in the webinar platform that you can use to submit any questions you may wish to ask. Finally, the final slides will list additional resources related to health coaching and wellness planning. Next slide.

One of the goals with our new conversation format is to engage our audience throughout today's event, so feel free to submit any questions that you have for our speakers. This slide shows how to submit a question using the Q&A feature on the lower left side of the webinar platform. Type your question into the Q&A box and press submit to send it. If you don't see a Q&A box on the left-hand side of your screen, click the red ask question button on the bottom of your screen. Next slide.

We are honored to have Dr. Judith Cook as our speaker today. Judith, I will turn it over to you to introduce yourself and provide some background on the Center of Mental Health Services, Research, and Policy. Next slide.

Judith Cook: Thank you, Kristen. I'm a professor at the University of Illinois at Chicago's Department of Psychiatry, located in the College of Medicine. I direct the Center on Mental Health Services, Research, and Policy, which conducts research, provides training, and offers technical assistance.

Most recently, I've been engaged in rigorous intervention science studies to build the evidence base on how people recover from multiple medical and mental health conditions and go on to live lives with meaning and purpose in the community.

Kristen Corcoran: Thank you, Judith. Let's go ahead and get the question and answer session started. We received several pre-submitted questions from our audience, so we will start with those questions but encourage everyone to submit any additional questions via the Q&A feature on the platform.

We only have 30 minutes for today's conversation, so we will get started now. Our first question is, "Can you provide an overview of the wellness recovery action plan?"

Judith Cook: Sure, I'd be happy to. WRAP is a health and wellness self-management intervention taught by peers who are actively using WRAP in their own lives. It's based on three important processes -- voluntary participation, peer support, and unconditional positive regard.

I think you know the first two, but the concept of unconditional positive regard was first coined by the psychologist Carl Rogers and refers to the acceptance and support of a person regardless of what the person says or does. This concept is central to promoting and sustaining engagement in WRAP. Participants begin by learning about wellness tools, which are simple, safe, and free or inexpensive things they can do to promote their own physical and emotional health, like listening to music or calling a friend.

They choose tools that comprise their wellness toolbox, which then serves as a foundation for their WRAP plan. Next, people devise a brief set of daily strategies that they commit to, called their daily maintenance plan. Like getting up at a regular time, eating nutritious food once a day, or physical exercise. Next, they learn about triggers, which are circumstances or events that make them feel very uncomfortable.

People learn how to identify their own specific triggers and devise a plan for avoiding them, or for dealing with them when they occur. Sometimes triggers lead to feelings or behaviors called "early warning signs," which are subtle signals of the need for further action, like starting to avoid people, or feeling unwell, but not knowing what's wrong.

People plan for these using tools from their toolbox. Sometimes, despite their best efforts, people may notice that their uncomfortable feelings are worsening, and that they're nearing a crisis stage called "when things are getting worse." They learn that there's still time to act at this stage and do things to avoid a full-blown crisis by developing a plan for what to do when this occurs.

Next, participants discuss indicators that they are in crisis and need their supporters to take responsibility for their care and make decisions on their behalf. These signs become part of a crisis plan that also includes what kind of help the person would like or not like, and from whom. After a crisis, people learn to give themselves time to heal, both

medically and emotionally, by devising a schedule for resuming responsibilities in a gradual fashion.

WRAP is used in all 50 U.S. states and territories, and internationally in Europe, Asia, and the Middle East. It's well-received by individuals who live on very low incomes and have other severe resource constraints -- those with low literacy and those dealing with other social determinates of health. You can learn more about WRAP at the link in the resources section at the end of today's slides that reads MentalHealthRecovery.com.

Kristen Corcoran: Thank you, Judith. Our next question is, "How does motivational interviewing help promote engagement and health behavior change?"

Judith Cook: Motivational interviewing is a counseling technique that helps people deal with ambivalent feelings in order to find the internal motivation they need to change their behavior. Often, the behavior they want to change is inhibiting their physical or emotional health. Studies show that motivational interviewing works well with people who are unmotivated or unready for change.

It's also appropriate for people who are angry or hostile. It works well with those having low levels of education, and low health literacy as well as other forms of low literacy. Ambivalence about change is manifested as a conflict between two courses of action. For example, indulging in a behavior versus restraining oneself from the behavior. Each of these courses of action has perceived benefits and costs associated with it, but many people haven't had a chance to express the often confusing, contradictory, and uniquely personal aspects of this conflict.

For example, if I stop drinking, I will feel better. But I may also feel awkward in social situations, which will make me feel unhappy and unpopular. The interviewer's task is to help people recognize and express both sides of the conflict, guiding the person to an acceptable resolution that promotes action leading to change. Motivational interviewing promotes engagement in two ways -- by creating a trusting environment and by increasing a person's self-awareness.

First, because motivational interviewing establishes a safe and open environment in which people feel hurt and understood, they're more comfortable discussing troublesome feelings and behaviors. Second, because motivational interviewing helps people become more self-aware, they're better able to explore the reasons for their ambivalence and recognize their personal motivations and methods for change.

Kristen Corcoran: Thank you, Judith. Our next question is, "What is a simple, easy tool for home health clinicians to use to assess readiness to change and promote engagement?"

Judith Cook: This is a great question, and in answering it I want to briefly review the five basic stages of readiness to change behavior. First, there is precontemplation, a stage at which the person has no intention of changing. The second stage is contemplation, in

which the person is considering a change in behavior but hasn't yet decided or committed to making that change.

The stage of preparation occurs once the person has decided to change their behavior and consists of making plans for change. In the stage of action, the person is currently engaged in behavior-change activities. Finally, the stage of maintenance is entered once the person continues their changed behavior for longer than six months.

Now that we're all familiar with stages of readiness to change, let me introduce another idea. A person's readiness to change is influenced by two things. First, the importance of the change to the individual, and second, how confident the person is that they can make the change. You can use these two dimensions to assess readiness using two visual analogue one through 10 scales.

So this is simply a piece of paper you present to someone, and at the left-hand side it has one, and then hashmarks all the way over to the right-hand side, where it says 10. And you say to the individual, "On a scale from one to 10, with zero meaning not important at all and 10 meaning very important, how important is it to you to change your X." And in this case, let's use quit smoking.

So let's say the person says, "Oh, I don't know, maybe a six." You next ask, "Why did you give yourself a six instead of a one or a two?" The answer elicits the individual's personal meaning of the change, which you then repeat back to them in order to affirm what you heard and for them to hear what their personal meaning of change would be.

Next you would ask, "So you gave yourself a six. What would it take to give yourself a nine or a 10?" In listening to this answer, you're hearing about obstacles to motivation, which you can then repeat back to the person, again, to affirm and for them to understand in their own words what are some of the things that are keeping them from feeling very confident in making a change.

Then you would say to the individual, "Now, on a scale of zero to 10, with zero meaning not confident at all and 10 meaning very confident, how confident are you that you can quit smoking?" So here, the individual might say, "Hm, I think I'm only a four there." And again, you'll ask, "Can you tell me why you gave yourself a four instead of a one or a two?" Here, you're getting motivation.

And then you'll ask, "What would it take to increase your confidence from a four to a seven or an eight?" And here, you're learning about what obstacles need to be removed, or what kinds of aids or assistance the individual might need to receive. The answers to these questions and the probes you use will give you a pretty good idea of where the person is in their readiness to make a particular change, and also will indicate the next steps you might want to take with them.

You'll learn what motivates them and also what they perceive as obstacles. For more information on using this approach, take a look in the resources section of the slides at

the website called Motivational Interview for Health Behavior Change by Dr. Margaret Dundon. I think you'll find it very helpful.

Kristen Corcoran: Thank you, Judith. The next question is, "How do peer-led interventions encourage self-management, and which ones are best practices?"

Judith Cook: Peers encourage self-management in several ways. One is that peers who undergo training and certification have learned how to share their personal experiences and stories in a manner that encourages hopefulness in the people they work with. This sharing contributes to a sense of perceived similarity and relatability between the peer and the person he or she is working with.

If this person feels that the peer has had similar experiences and can personally relate to the peer, the peer's belief that the person's life can change inspires hopefulness. Another way peers encourage self-management is by acting as role models and modeling change for people. It's one thing for you or me to talk about strategies for managing your diabetes, but it's another thing to be willing to try a self-management strategy because it worked with a peer or for a peer who describes their strategies and how they manage them, even though they were caring for children and grandchildren, being evicted from their home, not in good physical health, and had family that weren't particularly supportive.

Another way peers encourage self-management is their willingness to offer unconditional positive regard that I referred to earlier. Peers find it easier to give people the benefit of the doubt precisely because of their own experiences of the power of receiving positive regard. Many times, people give up on self-management because they don't believe in their talents and abilities.

Working with someone who does believe in the person's potential regardless of what the person says or does helps to establish a sense of self-efficacy. Some evidence-based peer support approaches include WRAP that I spoke about earlier, wellness recovery action plan, WHAM, whole health action management, BRIDGES, which stands for building recovery of individual dreams and goals through education and support, and Peer-to-Peer, which is a program of the National Alliance for Mental Illness.

These programs have been shown to improve outcomes for people with both mental health and physical health conditions, such as increased patient activation to take care of one's own health, better physical functioning, lower depression and anxiety, greater hopefulness about one's life, greater ability to self-advocate with healthcare providers, an improved sense of self-efficacy.

Kristen Corcoran: Thank you. Our next question is "How should providers ensure that they are delivering culturally competent health coaching and wellness planning services?"

Judith Cook: Well, luckily, we have a science of assessing and enhancing the cultural competency of human services, including health and behavioral health services. I don't have time to do it justice today, but I'll describe it briefly. Approaches vary, but typically, you examine five areas of your organization. Its administration, policies, and procedures, the organization's staffing, the services it delivers, the program environments in which services are delivered, and the nature of communication and language capacity of your organization, including the availability of translation services.

You start with an understanding of how and why each area is an important part of cultural competency. Next, you rate your organization on how well it meets the competency criteria in each area, consisting of a number of different kinds of criteria. Based on these ratings, you develop a plan to build competency in certain areas. This might include strategic planning, cultural competency training, implementing diverse hiring practices, revision of policies and procedures, and so forth.

And finally, you evaluate the success of your plans and continually assess and improve your organization. We have a guide we developed for this partnership with the National Alliance on Mental Illness, and there's a link to it in the resources section of today's slides. But if you'll simply google cultural competency in health delivery services, you'll find lots of resources that you can tap into.

Kristen Corcoran: Thanks. The next question is "How do you work with clients who have serious mental illness to help them set goals and work toward those goals?"

Judith Cook: I like to recommend using the SMART goal approach. SMART stands for specific, measurable, attainable, relevant, and time-based. To help the person state a specific goal, you'll encourage them to describe the desired change in as much detail as possible. So instead of "I want to exercise and be healthier," you might help participants decide their goals is "I want to become more physically fit by walking."

Next comes the measurable part, and here, you ask the person to think of some numbers that help them define each part of their goal. So now the goal might become feel more physically fit by walking 12 blocks every day. Next, you assess attainability by asking the person how confident they feel that they can reach the goal using that one to 10 scale I introduced earlier.

If they rate their confidence at six or lower, you'll ask them to make the goal a little easier until their confidence improves. In the example I'm using, the woman decided that every day was probably unrealistic, so she scaled it back to three times a week. She also wanted to be able to make up if she missed some days over the weekend, so this enabled her to do that.

Next you'll ask the person how important the goal is, again using the one to 10 scale. You're aiming for a six or better, and you're needing to be willing to start over if the stated goal isn't sufficiently relevant to the person. Remember, if it's not highly relevant, then the person isn't acting from autonomous motivation, according to self-determination

theory. Hopefully I'll get a chance to say more about self-determination theory before we end today.

Finally, you'll want to establish a timeframe for goal achievement. Is the person going to reach this goal in a week, two weeks, a month, or longer? The woman in my example decided to take four months to get up to walking three miles every week, and she was able to reach that goal, with some backsliding and some extra encouragement, because we used the SMART goal framework to set it with success in mind.

You can read more about SMART goals and see them in action by accessing “This is Your Life”, a guidebook for person-centered life planning in the resources section of your slides.

Kristen Corcoran: Thank you, Judith. The next question is "Many individuals do not return after their first sessions. How do you keep clients engaged in self-management education when they realize they are responsibility for facilitating the change needed in their lives?

Judith Cook: Another excellent question. Whenever we encounter resistance, we need to keep in mind a basic principle of motivational interviewing. Client resistance is often a signal that the counselor is assuming greater readiness to change than is in fact true for the client. Maybe this person isn't ready for self-management education, or not this much of it, or not in this format.

In any event, it's time to go back and assess readiness for change here. Not sticking with something can also be a good illustration of one of the principles of self-determination theory that I referred to earlier. In this psychological theory, which is supported by decades of rigorous empirical research, lasting behavior change occurs when it is autonomously motivated.

Autonomous motivation occurs when people engage in a behavior because they see it as consistent with their intrinsic goals and emanating from their own selves, and thus is self-determined. On the other hand, controlled motivation occurs when a person acts out of a desire to please others, like healthcare providers or family members, or because of a negative psychological state, such as fear of punishment.

A person might agree to start self-management education due to controlled motivation, but is unlikely to stick with it. Knowing what kind of motivation a person has for self-management education is important here, along with understanding what stage of change they're in. If you'd like to learn more about self-determination theory, check out the web link of the Center for Self-Determination Theory in the resources section of the slides.

Kristen Corcoran: Thank you. And our next question is, "How can I encourage an individual to follow their self-management plan once they have designed it?"

Judith Cook: I find that the best motivator is peer support, delivered in an affirming, non-judgmental fashion. This can occur in the form of ongoing peer support groups, and my center offers a manual for running such a group called the Wellness Activities manual. And there's a link to it in the resources section of today's slides.

You can also set up one-on-one meetings with a peer, check-ins via telephone trees, and Internet-based texting support to remind people to use self-management. In RAP, people are continually encouraged to work your RAP, by which they mean revisit it, revise it, remember it, and trust it. The best encouragement for using self-management is that it works, but it won't work if it's not used regularly.

You'll want to make it as easy as possible, and also painless. For example, if people have low literacy, substitute pictures cut from magazines for written text. Keep cultural competence in mind by involving family members as supporters where it's culturally expected, and with the participant's express consent.

Kristen Corcoran: Thank you. And now we will answer several additional questions that have been submitted. What are the challenges associated with utilizing self-management in health coaching and wellness planning programs?

Judith Cook: We've talked about several already. Helping people figure out what they want is one, setting appropriate, realistic, and meaningful goals is another, inspiring hope for change in people who feel hopeless and helpless is a third. I've discussed tools and resources for all of these today that I hope you'll find useful.

Kristen Corcoran: Thanks. Another question that we received is what outcomes have you seen from the RAP program, given that it is a two-month program?

Judith Cook: Our randomized control trial found lowered levels of symptoms, especially depression and anxiety, increased sense of recovery, increased quality of life, and enhanced ability to advocate for oneself with healthcare providers, and finally, an increased sense of personal empowerment compared to the control group that did not take RAP.

Kristen Corcoran: Thanks. Another question we received is how do you actively move a patient from ambivalence to self-motivated? When do you call it quits with a patient who hasn't made any progress?

Judith Cook: This is such an important question, and it's very frequently asked. Many counselors find that one of the most freeing things about using approaches like motivational interviewing is no longer feeling responsible for what the client does or doesn't do. So not making progress is not seen as being up to the counselor. Also, many people stay in precontemplation for a long time before they move into contemplation, or planning for change, so persistence usually pays off.

If a person keeps not showing up even after you have gone to them multiple times, then most likely they're indicating that they've made their decision and just not saying it with words. But strictly speaking, almost everyone is interested in some kind of change, and you haven't been successful in having the kind of conversation that elicits what the person actually wants. This would indicate that you keep trying as long as the person is willing.

Kristen Corcoran: Thank you. The next question is how does the movement towards integrated care between physical and mental health affect self-management efforts?

Judith Cook: I find that self-management really encompasses both physical and mental health, so that kind of integration was true about self-management education approaches before really we were hearing much about integration of behavioral with primary care and other forms of physical health. So the philosophy underlying all types of self-management includes addressing both mental and physical health, making it a wonderful tool for our increased emphasis on this integration.

Kristen Corcoran: Thanks, Judith. We have time for one more question. It is what are your tips on gaining medical staff buy-in and support in offering evidence-based chronic disease self-management programs?

Judith Cook: Medical staff are often your easiest sell, because they learn in their clinical training about evidence-based practice illness self-management, and that it works, and that it's required by many health payers, such as Medicaid and Medicare. Sometimes the struggle is to convince medical providers that it works for everyone, including people with significant impairments, people with low literacy, and those who seem unmotivated or angry.

I've heard some medical providers voice the opinion that self-management isn't culturally sensitive, and I always reply that it's a flexible model that can be tailored for cultural competence according to the patient's wishes. Sometimes the "self" in "self-management" becomes family or community-assisted management. Other times, self-management needs to be adjusted according to a culture's unique conception of illness and health.

But it can and does work in any culture if delivered competently, and most medical providers should have learned this in medical school and should be hearing it when they do their refresher medical education training.

Kristen Corcoran: Thanks so much, Judith. Unfortunately, we're out of time. Thank you again, Judith, for speaking today, and for answering all of our audience questions. We would like to mention that the remainder of the slide deck includes information on and links to additional resources on the topic of health coaching, wellness planning, and self-management, available on the Resources for Integrated Care website and other websites.

And lastly, we want to hear from you. Please send us your feedback. Your input is essential in developing new trainings and resources. Send us your suggestions via RIC@Lewin.com on how best to target future behavioral health webinars, trainings, and other resources to healthcare providers and plans involved in all levels of the healthcare delivery process.

We also welcome any feedback on this resource and ideas for other topics to explore. We hope this presentation was useful and thank you again for joining us and submitting questions.