Lessons From Health Coaching...
Rethinking Disease Management's Connection to Lifestyle Management

...by **Paul Terry**

Leah enrolled in our hypertension coaching program, so why is it that we mostly discuss her thoughts about being a woman in the workplace? More to the point, why do I encourage Leah to talk through what it's like being a female technology expert working for a male boss in a male-dominated office setting? Our coaching time didn't start out anywhere near this topic. In our first months, we reviewed how she was doing in following her doctor's orders and whether she had barriers to taking her medication or following her recommended diet. Staying true to her exercise plans proved to be her greatest challenge in our early discussions, so we focused there for several months — and we failed there for several months. Maybe it's because there is a river running through disease management and lifestyle management.

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I've written elsewhere recently about how organizations need to rethink their attachments to medical versus public health models to achieve true integration between these disciplines.* For some individuals and coaches traveling the waters between medical-self care and changing lifestyle behaviors, the current seems threatening. It's as if crossing over from decisions about a common health behavior like eating differently to medical decisions like whether to have a clinical procedure means you could suddenly get in over your head. In fact, what these kinds of decisions have in common is, well, they're both very common. Both share the need to make informed choices. Both share negative consequences for making poor choices. Most important for clients like Leah, both challenge us to consider what's most important. Not in the ideal world, but in the real world, right here, preferably now.

When clients are engaged, the river running through their decisions about both health management and disease management can be placid and clear. Research into what it takes to change a habit points to the vital role of goal setting in successful outcomes. I find the challenge for most is not so much finding the right goal; it's finding the right reason for caring enough about the goal to make it a priority. Leah has never wavered in her belief that being more active is important to blood pressure management, but she also never confronted the barriers that keep putting her plans to exercise on the shelf for another day.

Clinical practitioners navigating the river that runs through disease management and lifestyle management usually rely on a hierarchy of need, where getting disease under control trumps getting other aspects of health or life in order. To paraphrase John Lennon: if only life didn't keep happening as we're busy making other plans.

One of my favorite recent articles was published in the *American Journal of Health Promotion:* "The Face of Wellness: Aspirational Vision of Health, Renewing Health Behavior Change Process and Balanced Portfolio Approach to Planning Change Strategies." The author, Michael O'Donnell, used personal anecdotes and recent research to emphasize how understanding an individual's passions is keenly connected to whether they will set and achieve health goals. While many health promoters would like to think that others share their passion for health, the reality is that for most people health is merely a means to an end.

For Leah, being viewed as dedicated and committed to her work — and in particular, considered every bit as capable as her male colleagues — is a core value. As a working mom with young children, being there for her kids is also a core value. As a person enrolled in coaching, taking care of her health does have value, although a lesser priority. Leah's challenge, like so many others I coach, is that she wants to strike a healthy balance in all of her roles. Yet she's surrounded by men for whom work seems the *only* priority. I've teased Leah that she needs a wife. Her answer: "You got that right! Can we make that my goal?"

My coaching challenge is to help her see these mounting priorities as the setup for conflict they are and to help her

* Terry, P., "The Strength of Weak Ties Revisited: Achieving true integration of disease management and lifestyle management." *Population Health Management*. October 2009, 12(5): 217-219.

stop thinking she can be everything for everybody. Successful hard drivers like Leah are often on autopilot, and adding new goals is a given. Achieving them is another matter. So together we focus on restructuring thoughts and pushing the reset button on her health goals. This usually means discussing whether some of her thoughts that leave no room for compromise can be replaced with those about what matters most to her. I expect this will enable us to return to setting Leah's exercise plans in motion, but it's often the case that undoing old habits is as important as practicing new ones. For Leah, saying *yes* to exercise means saying *no* to competing demands. It also means tying exercise to what really matters to Leah.

In the past, disease management and lifestyle management were tributaries only occasionally connected. "Following doctor's orders" made for a simpler, though less edifying approach to healing.

Today, with lifestyle-driven chronic conditions responsible for 75%+ of healthcare costs, medical decisions and healthy behavior decisions must flow together. It's reassuring that rethinking disease management has led many health practitioners to conclude that patient/client-centered care should guide our thinking about how to blend the best of disease and lifestyle management. This model acknowledges that Leah's best route to managing hypertension is bound to her personal values and preferences... not to the values most important to me or to her healthcare providers, but to her, in her real world.

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Bridge Employment
for Better Health, Productivity

Workers who transition from full-time work experience fewer major diseases and function better day to day than those who stop working altogether, according to a study in *Journal of Occupational Health Psychology*. Researchers refer to this transition between career and complete retirement as "bridge employment" — part-time work, self-employment, or a temporary job.

A Grayer Workforce

A tighter job market combined with a slowly growing economy means more workers are delaying retirement and some early retirees are returning to work. This age group will become regular health promotion participants if you approach them with the right services. Some steps to ensure success:

- Form an advisory committee — especially if you're under 40. Older current participants can help identify needs, contribute to program design, and advise on promotions.
- Use testimonials from older participants. Without mentioning age, you can quote participants with 25 years service to the organization and/or include a photo with their testimonial.
- Depict a diverse 60+ population. Be sure your promotions include a mix of executives, line workers, clerical, and professional/technical employees as well as various ethnic backgrounds — in all shapes and sizes.
- Focus on issues of significance to the group. Eldercare, grandparenting, preparing for retirement, travel, and mentoring are just a few topics older workers are interested in; survey their priorities to stay on target.

The challenge is to attract the attention of age 60+ participants without attracting attention to them. Older workers want to be viewed as experienced and valuable, not part of an earlier generation of employees. By carefully designing your programs and promotions you can meet their needs and avoid any stigma.