



What Do Patients with Diabetes Think of Health Coaching?

Findings from Interviews with Health Coach Clients

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Health coaching programs have attracted growing interest in recent years, driven in part by the growing share of adults in the US (60 percent) who have chronic conditions. Coaching programs are helpful when a patient's condition can be improved through lifestyle changes or when it requires a patient to learn new approaches for monitoring and managing their day-to-day health. Coaching programs often target people with chronic but controllable conditions such as diabetes or prediabetes.

In this brief, we examine the health coaching model of City Health Works, an organization that addresses chronic disease among low-income Harlem residents. The City Health Works coaching program involves one-on-one sessions once a week over an initial period of three to five months, then less frequent phone calls over another nine months (or indefinitely, depending on the insurer). Coaches use an evidence-based curriculum and motivational interviewing¹ to educate clients about their conditions and give them strategies to improve their nutrition, medication adherence, physical activity, stress management, and engagement with primary care providers. Lay coaches are hired locally, receive intensive up-front and ongoing training, and consult with an in-house registered dietician/diabetes educator and a social worker on individual cases. For this analysis, we interviewed 14 patients with diabetes who had completed the initial phase of coaching and either were receiving periodic check-in phone calls or had completed the coaching program.

Interviewees were effusive in their praise for coaches. Several clients developed trusting friendships with their coaches, which made them more receptive to the coaches' advice. Coaches focused on teaching clients how to eat a healthier diet, and most clients reported that making those changes lowered their hemoglobin A1c levels and made them feel better physically and emotionally. Most clients were pleased with the coaching they received and said that it helped them better understand and self-manage their medical condition, but some wished that the intensive phase of coaching lasted longer to allow for more frequent contact with coaches.

Introduction

Health coaching programs have attracted growing interest in recent years (Bovbjerg et al. 2013), partly because most adults in the US (60 percent) now have chronic health conditions, generating 90 percent of the country's health care spending (Buttorff, Ruder, and Bauman 2017). Health coaches are usually lay community health workers who receive training and then educate patients (often about diet²), help them follow prescribed treatment regimens, and help them navigate the health care system (Bovbjerg et al. 2013). Coaching programs are especially helpful when a patient's health can be improved through lifestyle changes, such as eating healthier, exercising more, or adhering more closely to medication regimens. They can also be helpful when patients have been diagnosed with complicated medical conditions that require them to learn new approaches for monitoring or managing their health. Coaching programs often target people with diabetes or prediabetes (Andrews et al. 2004; Norris et al. 2006; Palmas et al. 2015), who are at risk for serious complications (see box 1) and make up a growing share of the US population (CDC 2017a). About 12 percent of US adults have diabetes, and 25 percent of seniors have diabetes; another 34 percent of US adults have prediabetes (CDC 2017b).

Medicare, the country's largest and most influential insurer, recently began paying for health coaching by adding billing codes to pay for lay community health workers to teach classes to beneficiaries with prediabetes.³ Meanwhile, other innovators have been testing their own coaching interventions, often combining disease-specific coaching with referrals to social services.⁴ One such innovator is City Health Works, which has recruited and trained community residents to coach clients with chronic conditions in the Harlem neighborhood of New York City since 2013.

7.9 years

Increase in life expectancy associated with modifying major diabetes risk factors, for a 55-year-old man five years after diagnosis

Source: Jose Leal, Alastair M. Gray, and Philip M. Clarke, "Development of Life-Expectancy Tables for People with Type 2 Diabetes," *European Heart Journal* 30, no. 7 (April 2009): 834–39, <https://doi.org/10.1093/eurheartj/ehn567>.

As the inaugural Janice Nittoli Practitioner Fellow, City Health Works founder Manmeet Kaur collaborated with the Urban Institute on research related to the organization's coaching model in 2017. City Health Works offers coaching to patients with diabetes, hypertension, asthma, and congestive heart failure. Its coaching approach involves 30- to 60-minute in-person coaching sessions once a week over an initial period that usually lasts three to five months, followed by less frequent phone calls for the next nine months (or indefinitely, depending on the insurer). Coaching sessions focus on

- educating patients about their chronic condition (diabetes, hypertension, asthma, or congestive heart failure),
- suggesting lifestyle changes to help patients better manage their condition (e.g., changes in diet, exercise, smoking, and alcohol consumption),
- using motivational interviewing techniques to motivate clients to adopt these lifestyle changes,
- educating clients about their prescription drugs and encouraging them to follow their doctor's recommendations on medication use, and
- inquiring about and advising on medical appointments (see figure 1 for a detailed description of City Health Works's coaching approach).

Coaches are hired locally from the neighborhood in which they will be working; receive intensive, customized up-front and ongoing training from City Health Works; and consult with City Health Works's in-house registered dietician/diabetes educator and social worker on individual clients. City Health Works regularly obtains information from, and passes back information for, individualized care plans maintained by clients' primary care providers. Coaches work with patients using evidence-based curricula, such as coaching plans based on curricula developed by the American Association of Diabetes Educators, American Heart Association, and American Lung Association. Most City Health Works clients are between 50 and 70 years old, and clients often begin coaching after having an uncontrolled chronic condition for several years; most have multiple chronic conditions. Clients enter coaching in one of three ways: by being referred by their primary care practitioner; by receiving a call from City Health Works, after a provider or health insurance plan has identified them as a candidate for coaching; by contacting City Health Works after hearing about it through word of mouth.

Many quantitative studies of health coaching interventions for people with diabetes have reported reductions in hemoglobin A1c levels (Palmas et al. 2015) and other improved outcomes (such as increased knowledge and access to health services; Andrews et al. 2004; Norris et al. 2006), but less qualitative information has been collected about patients' experiences in these programs (Heisler et al. 2009). To help fill this gap in the literature, Urban Institute researchers interviewed patients with diabetes receiving health coaching from City Health Works to better understand how patients feel about the coaching intervention, what aspects of this coaching model are most helpful, and what aspects could be improved.

BOX 1

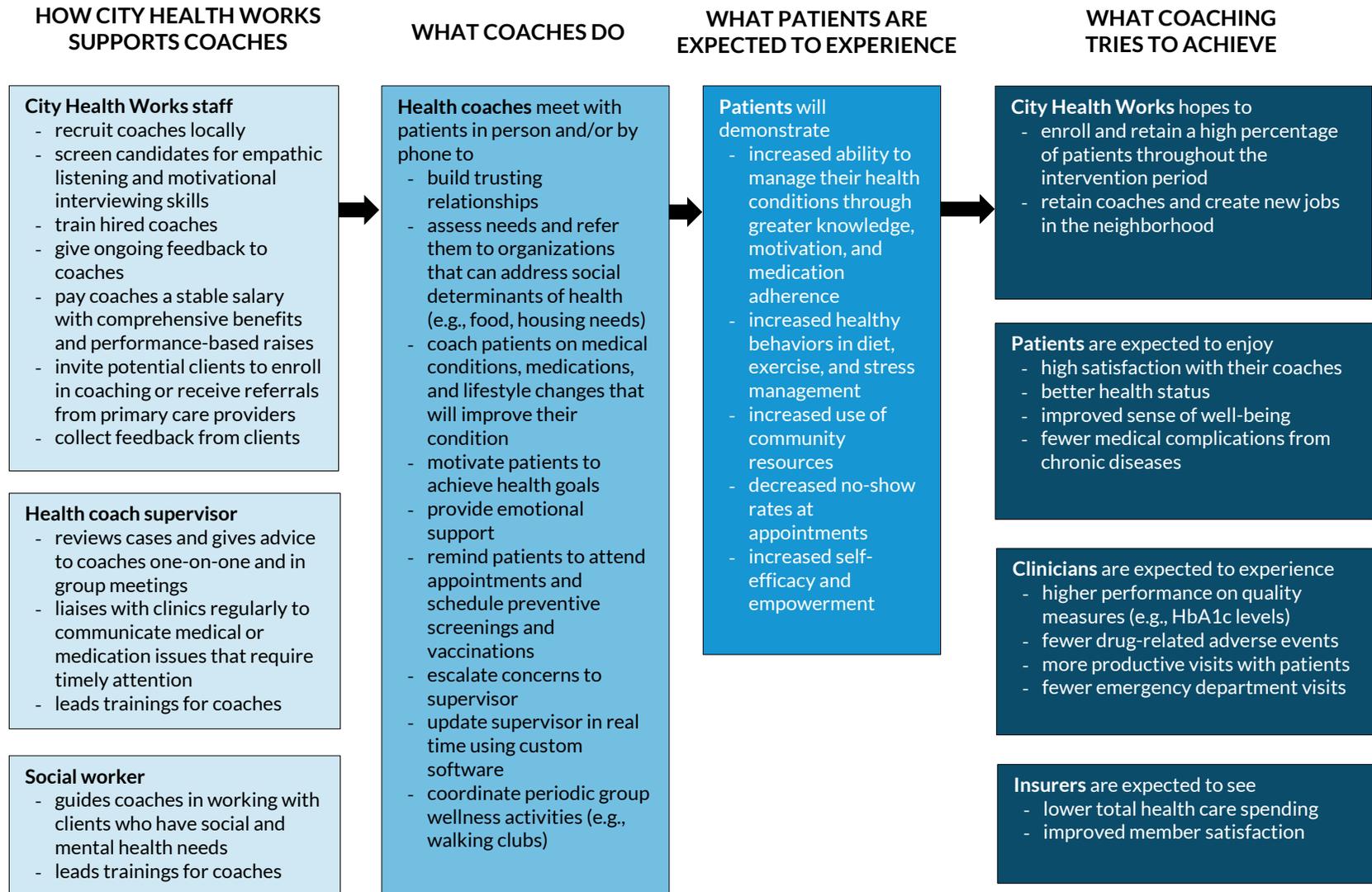
Diabetes Complications

- Cardiovascular disease (including heart attack, stroke)
- Nerve damage (tingling, numbness, burning, and pain in the tips of toes and fingers, gradually spreading)
- Kidney damage (including kidney failure and end-stage renal disease)
- Eye damage (cataracts, glaucoma, blindness)
- Foot damage (poor ability to heal from cuts and blisters, which can develop into infections leading to amputations of toes, feet, or legs)
- Skin conditions (bacterial and fungal infections)
- Hearing impairment
- Alzheimer's disease

Source: "Diabetes," Mayo Clinic, accessed January 29, 2018, <https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444>.

FIGURE 1

City Health Works Coaching Activities and Intended Impacts



Research Methods

Urban Institute researchers interviewed City Health Works clients in early November 2017. All interviewees received primary care from the same safety net provider in New York City and had completed the initial intensive phase of City Health Works coaching, which involved weekly in-person visits over about three to five months. Although City Health Works offers coaching in both English and Spanish, this study only included clients comfortable communicating in English. City Health Works offers coaching focused on managing diabetes, hypertension, asthma, and congestive heart failure, but we restricted our interviews to clients with diabetes because City Health Works has the most experience coaching individuals with this condition. A total of 25 clients met these inclusion criteria and received phone calls inviting them to be interviewed in person or by phone; 14 of these individuals (working with four different City Health Works coaches) agreed to be interviewed, three declined to be interviewed, seven did not respond to our phone calls or letters, and one agreed to be interviewed but was unreachable at the time of the interview. (Although City Health Works gave us a list of the 25 clients who met our inclusion criteria, the identities of the 14 clients we interviewed were not disclosed to City Health Works to protect their confidentiality.)

Most interviewees were between 50 and 70 years old; had a history of uncontrolled diabetes; and lived in Harlem, where the median income is about half the national median income.⁵ Interviewees had begun working with a City Health Works coach 6 to 18 months before our interviews; some had completed the coaching program, while others were still receiving check-in phone calls from their coaches. Several interviewees had other chronic conditions (e.g., hypertension, heart disease, chronic obstructive pulmonary disease, and/or asthma) and were unemployed or underemployed because of diabetes complications.

We gave each interviewee a \$40 honorarium to thank them for participating in a 30- to 45-minute interview. The questions that we asked interviewees were developed in consultation with City Health Works leadership, but no staff from City Health Works participated in collecting or analyzing data. Half the interviewees chose an in-person interview; these were conducted in a location of their choice, such as their apartment, a local fast food restaurant, or a senior day care center. The other half chose a phone interview. Interviews were audio-recorded, and notes from interviews were coded using NVivo software for retrieval of passages on different topics. Researchers also wrote down preliminary impressions of their key findings at the end of each day of interviews, then confirmed, clarified, and supplemented these preliminary impressions by reviewing the complete set of coded interview notes. Our study approach was reviewed and approved by the Urban Institute's Institutional Review Board to ensure that human subjects were adequately protected.

Interview Findings

Interviewees were effusive in their praise for their coaches and highly valued their interpersonal relationships with coaches. Interviewees often developed trusting friendships with their coaches, which

and made suggestions gently. One interviewee noted, “We set goals, and it was up to me to achieve them in a manner that was suitable for me.” Interviewees often told us they had developed close personal relationships with their coaches, which they likened to the type of relationship they would have with a child or a friend. Meanwhile, one interviewee said they had more of a professional relationship with their coach. All interviewees said they were pleased with the type of relationship they had with their coach, suggesting that both personal and professional communication styles can work well. Interviewees consistently said that they trusted their coaches to give them good advice, and that their coaches always listened to them when they had an opinion about what was best for them or when they mentioned their personal preferences or constraints.

“She would tell me things that she thought could help: ‘Try it out. If it don’t work, we’ll try something else.’ Wasn’t demanding at all. She said, ‘After all, it’s your body. I can’t make you do anything, but this may help.’”

Some interviewees suggested that they listened to their coaches more because they had positive foundational relationships with them. For example, one client said, “It is important for him to win my friendship if he is talking to me how he does.” Another client felt that having the sessions in clients’ homes contributed to good relationships with coaches: “When you’re in the hospital, you feel a little tense. But if someone comes to your home, you feel a little more free to speak how you feel. You’re more relaxed at home.”

“[My coach] gets to know her clients and makes suggestions according to what they are doing and provides that incentive to go further.”

Most interviewees thought it helped that coaches lived in the same neighborhood that they worked in. One interviewee explained that a coach from the neighborhood can more effectively “relate” to a client, which meant clients “will listen to you more.” Another interviewee said that being from the neighborhood made their coach knowledgeable about the diets prevalent in the neighborhood. This meant that the coach understood how difficult it might be for clients to make certain dietary changes, and could offer realistic advice:

Because in different neighborhoods, you have different cultures, and different cultures, they eat differently. Like us Hispanics, we love the starchy food, the fried chicken, all that—and you can still have it, [but] cook it in a different way, or have it in moderation.

Whereas if you go to 96th Street, where there are more white people, they eat different—because some of them grow up with eating regular vegetables, some of them don't eat fried food, because they know how to stay away from it, because that's how they grew up. Here in Spanish Harlem or in a black neighborhood, our grandmothers cooked fried chicken, rice and beans and all that. There's nothing wrong with it, but in moderation.

One interviewee also noted that coaches from the neighborhood could spend less time commuting to and from appointments and between their office and home, leaving more time to coach clients.

Clients with a coach who also had diabetes said they could relate to their coach that much more. One interviewee said that if a coach doesn't have diabetes, "they aren't fully aware of how it affects you. If they understand the ups and downs you have, it is easier to take instructions from them, than someone who doesn't deal with the disease on a constant basis." Interviewees with coaches who did not have diabetes did not feel that a coach needed to have diabetes, if they were properly trained in managing the disease. One interviewee said that coaches did not need to have diabetes themselves because "most people already have someone in their family with diabetes they can relate to."

Diet-Focused Coaching

Although City Health Works coaches people in a wide array of topics (as shown in figure 1), clients reported that their coaching sessions focused on eating healthier, including eating fewer carbohydrates such as rice and beans, reading the nutrition labels on food packaging, eating more vegetables, and eating three meals a day instead of two. Interviewees often mentioned the handouts their coaches left behind after visits; they referred to these handouts to refresh their memories about diabetic dietary guidelines. One interviewee reported that her coach accompanied her to the grocery store, and a few others mentioned that their coaches gave them measuring cups for their food.

"She did help me learn how to buy certain things, what to look for. Before, I wasn't really looking for anything like that...She gave me a chart, so if I would go down [to the grocery store], I would take it with me—what I should and shouldn't eat, what I should eat more or eat less of."

Coaches also educated clients about their diabetes medications, explaining what each medication did and how and when their doctor wanted them to be taken. Several interviewees reported that their coaches had given them a container to separate out the medications they needed to take in the morning and evening each day of the week, which they appreciated. They also reported that coaches occasionally made phone calls to get prescriptions refilled on patients' behalf and convinced primary care offices to

assign clients a consistent clinician and see them sooner. That being said, clients reported no change in their interactions with their primary care practitioners during or after health coaching, although several said their doctor supported their working with a diabetes coach.

“Before eating, I have to do my insulin—and then eat. I can’t do my insulin with an empty stomach...That’s what she explained to me. Before, I used to do my insulin and not eat at all...I didn’t know. I didn’t know none of this.”

Clients also said their coaches encouraged them to exercise, such as by walking or riding a bike. Several interviewees said they followed this advice: one now walks to their doctor appointments instead of taking public transportation, another walks at least two miles every day, a few take exercise classes, and two with limited mobility do chair exercises.

A few clients said that their coaches also helped them address socioeconomic needs, such as by introducing them to local food pantries, helping them obtain vouchers for fresh produce at farmers markets, or helping them apply for Section 8 housing vouchers.

Several interviewees liked the certificates of completion they received through the City Health Works coaching program—first, after completing the initial three- to five-month intensive coaching phase; second, three months later, after completing part of the maintenance period; and third, after graduating from the program. One interviewee said that when she started eating less healthily, her home health aide (unaffiliated with City Health Works) took away one of her certificates, which motivated her to eat better so she could get the certificate back.

Although interviewees said that their coaches increased their knowledge of how to manage their diabetes, some said that working with a coach was more about helping them to develop a “consciousness” about diabetes, becoming more “mindful,” and helping them to “concentrate” or “focus” on making the necessary lifestyle changes. For one interviewee, “it wasn’t about lack of knowledge”; another said their coach explained “why” they were supposed to do certain things they had previously been told to do. Another said that “sometimes we need to be pushed a little.”

“I learned to set goals and focus on them and to develop a program to reach that goal.”

Clients often noted that their coaches helped them identify a motivation for making these changes—for example, to improve their health so they could make a trip to see an aging relative, to take care of a child, or to preserve their eyesight and watch their grandchildren grow up.

“She gave me the incentive that I am here for a purpose...Other than that, I would have been wilting out here, doing nothing. She gave me a will to live. Before, I didn’t care. It was big. This stranger came into my life, helping me with my diabetes, but she is changing me altogether.”

Better Diets and Lower Hemoglobin A1c Levels

Interviewees consistently reported that they had greater knowledge of how to manage their diabetes, and that the single most helpful thing they had learned from their coaches was how to eat better. Clients said that they still occasionally ate things they knew they should not, but most reported that they had lowered their hemoglobin A1c levels, and several reported that they had lost weight since they began working with their coaches. One client became emotional as she talked about the substantial amount of weight she had lost and noted that she hadn't been admitted to the hospital in over a year; she saw this as an accomplishment because she had been in and out of the hospital frequently before. Most interviewees said they felt better physically, even if they had not lost weight. One interviewee said that “I used to have problems with my feet,” but since they started exercising and eating differently, their feet “don’t hurt as much anymore.” A few interviewees said they no longer felt “so sluggish,” had “more energy,” or were “able to do more.” Several interviewees said that their family members had changed their diets as well, and one reported that a family member had lost weight from these changes: “She was on the cusp of diabetes, and she doesn’t have it now.”

“I changed my diet. She kept reminding me I was neglecting myself with vegetables. She reminded me that I need to eat vegetables. It was like programming in my head. So when I’m making a meal, I think, ‘Wait a minute, it works better if I put vegetables in it.’”

Clients often had friends and/or family who had been diagnosed with diabetes and had experienced some of the more serious complications of the disease (box 1) or died from it. Several clients were beginning to experience some of these symptoms, such as problems with their feet (including nerve damage) and eyesight. This seemed to have one of two effects on clients. Some clients reported that the

symptoms caused them to feel depressed or overwhelmed, as if experiencing these complications was inevitable. For example, one interviewee said they initially interpreted their diabetes diagnosis as “a death sentence” and felt like “throwing in the towel.” But a few interviewees felt a push to fight the disease so that they would not face the same fate as some of their loved ones. One of these interviewees said, “My friend had complications with diabetes—foot cut off, dialysis—and then he died. And I was scared. I didn’t want to be like that.”

Regardless of how they interpreted the prevalence of diabetes around them, most clients said their coaches made them feel better about living with diabetes and equipped them with tools to change their trajectories. One interviewee said, “I know what to do to help my blood pressure come down, how to bring up my sugar levels when I need to, how to control it. I feel more comfortable.” Another interviewee said, “Before, I didn’t care. Now, I think about what she has been telling me. She gives me an incentive to try to improve myself.” A few clients described an almost therapist-like relationship. One interviewee said of their coach, “I call her when I’m feeling depressed and down, and she helps me and listens, gives me advice on how to calm down. It helps a lot.”

“She is a coach, and I’m a client, but we are like friends. I can say anything to her.”

Advice for Improving Coaching Interventions

When asked what coaches could do to improve, clients usually could think of no changes they wanted to make. Nevertheless, a few suggestions for City Health Works and other coaching programs emerged:

1. **Remind clients how long the coaching relationship will last so that they can mentally prepare for it to taper off.** Several interviewees said they didn’t know that the intensive in-person phase of coaching would only last a certain number of months, and they were surprised when their coach announced that they had reached their last in-person session; this left some “sad” or “heartbroken.”
2. **Lengthen the coaching period for clients who want to keep meeting regularly.** Some clients wanted coaching to last longer and suggested extending the initial period of weekly in-person meetings to up to 12 months. Others were comfortable with the length of the coaching intervention.
3. **Host a peer support group for people with diabetes.** One interviewee suggested that an Alcoholics Anonymous–style peer support group would allow people with diabetes to share tips on dealing with their disease and to call each other when they are feeling depressed. Another interviewee said she was now calling her coach when she felt the urge to eat chips or soda, at her coach’s suggestion; this sort of sponsor relationship is a hallmark of mutual support models and could be incorporated into a peer support group for people with diabetes. Such a group

could help coaches taper off their engagement with patients more easily, giving clients an outlet for talking about their diabetes and a way of obtaining diabetes-specific emotional support.

Advice for the Health Care Sector

Our findings also yield some suggestions for the broader health care sector:

1. **Develop tailored care models that address chronic disease self-management** in a way that is specific to populations of varying medical and social complexity.
2. **Consider hiring or contracting with local community health workers to equip patients with self-management support**, allowing other members of care teams to operate at the top of their skill set while improving overall patient care. Coaches can surface challenges that health care providers are unaware of and may not be fully equipped to address.
3. **Provide sufficient training, dedicated clinical supervision, and clear communication linkages** with primary care teams to enable lay health workers to support patients with chronic illnesses. In communities struggling with complex medical and social needs, provide sufficient training and social work supervision so that lay health workers can be cross-trained in both or specialize in either as part of interdisciplinary teams.

Discussion

Some findings from these interviews will be especially helpful to other coaching programs and primary care practices interested in increasing their patients' ability to manage their diabetes. First, although City Health Works provides coaching on a variety of topics, clients said their coaches focused on changing their diets. This makes sense because diet is closely linked to blood glucose levels and because many people need help to make and sustain changes to their diet and to understand how the timing of meals interacts with their medication. Second, coaching seemed to be just as much about motivating people to make changes as it was about educating them about lifestyle changes they could make. Third, clients wanted more notice of the transition from frequent in-person meetings to less frequent check-in phone calls, and some wanted to lengthen the initial period of frequent in-person meetings. Finally, several clients said that their coaches had talked to them about feeling down, which is important because people with diabetes have an increased risk of depression, and depression is associated with nonadherence to diabetes self-care (including adherence to dietary restrictions, medication compliance, and blood glucose monitoring; Katon 2008).

Given growing concerns among primary care providers about the number of topics they must cover during brief office visits (Bitton et al. 2012; Morrison and Smith 2000),⁶ lay health coaches may be just what care teams need. Because coaches do not need extensive clinical training, they can offer valuable services at a low cost. They can interview patients, identify knowledge gaps, provide customized

information and guidance, align with care plans set by doctors, and motivate clients to adopt healthier lifestyles, drawing on evidence-based practices and consulting clinical supervisors as needed.

Coaches used the motivational interviewing approach to present themselves as friendly peers available to gently offer suggestions, rather than as clinical experts trying to prescribe changes. Clients often described coaches as good listeners—caring, friendly, easy to talk to, understanding, and courteous. At City Health Works, candidates for coaching jobs are carefully screened for their natural ability to empathically listen and engage in motivational interviewing; additional training is offered to coaches once hired. Other coaching programs may benefit from adopting similar hiring criteria and training offerings.

Helping people with diabetes make changes in diet and exercise is likely to have ripple effects because family members often influence each other's habits or cook meals for each other. Indeed, one of the main risk factors for developing diabetes is whether a parent or sibling already has diabetes.⁷ Even in the short time that interviewees worked with a City Health Works coach, several noted that some of their adult family members changed their eating habits after seeing the changes that clients had made; one client's daughter had even lost enough weight to prevent a diabetes diagnosis. Insurers' investments in robust diabetes coaching may offer an important prevention opportunity for family members and community networks, especially among those not likely to be reached by formal diabetes prevention classes.

Limitations

One limitation of this study is that we did not interview all the City Health Works clients who met our inclusion criteria. The 11 people we did not interview may have had negative experiences with coaching, so the sample we interviewed may be biased. Three clients refused to be interviewed outright (and did not give a reason for doing so), four clients did not return our phone calls, three did not have voicemail and/or did not have a working phone number, and one set up an interview with us but was then unable to make the scheduled time. The population targeted by this study faces multiple challenges, including a high burden of disease, low income, and work and family responsibilities, all of which could influence a person's interest in making time for an interview.

Another limitation is the short duration of clients' participation in the City Health Works coaching intervention. Future research should follow clients over a longer period to see if they maintain the lifestyle changes and self-management skills they developed through working with their coaches. Understanding the long-term effectiveness of coaching programs, including the optimal frequency and duration of coaching sessions and the optimal length of the coaching period, should help build the business case for private insurers to financially support coaching programs, particularly in their Medicare Advantage and Medicaid managed care plans. It may also convince state Medicaid programs and the traditional Medicare program to add billing codes to pay for new types of coaching. In addition, future research could study the effect of coaching on clients' relationships with their clinicians, the effects of coaching on referrals to social services in the community, and the impacts of coaching on clients' feelings of depression and social isolation.

Notes

1. Motivational interviewing “is an evidenced-based counseling approach that health care providers can use to help patients adhere to treatment recommendations. It emphasizes using a directive, patient-centered style of interaction to promote behavioral change by helping patients explore and resolve ambivalence” (Levensky et al. 2007).
2. Sarah Haskins, “What’s a Health Coach?,” *Eat + Run* (blog), US News, February 4, 2015, <https://health.usnews.com/health-news/blogs/eat-run/2015/02/04/whats-a-health-coach>.
3. 42 C.F.R. § 410.79 (2017).
4. “State Community Health Worker Models,” National Academy for State Health Policy, last updated August 2017, <https://nashp.org/state-community-health-worker-models/>.
5. The median income in East Harlem in 2015 was \$30,973, compared with \$55,775 nationally. “East Harlem PUMA, NY,” Data USA, accessed January 31, 2018, <https://datausa.io/profile/geo/east-harlem-puma-ny/>; and “United States,” Data USA, accessed January 31, 2018, <https://datausa.io/profile/geo/united-states/>.
6. John Henning Schumann, “Doctors Look for a Way off the Medical Hamster Wheel,” *Shots* (blog), NPR, August 14, 2013, <https://www.npr.org/sections/health-shots/2013/08/13/211698062/doctors-look-for-a-way-off-the-medical-hamster-wheel>; and Parija Kavilanz, “Doctors: A Tough Job Just Got Tougher,” *CNN Money*, April 8, 2010, http://money.cnn.com/galleries/2010/news/1004/gallery.doctors_react_to_health_care_legislation/index.html.
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The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

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