21 YEARS OF EMPOWERING PATIENTS WITH CHRONIC DISEASE TO CLOSE THEIR ‘TREATMENT GAPS’

A/Prof Margarite Vale, PhD, FCSANZ

Founder and Director, The COACH Program
Clinical Associate Professor
The University of Melbourne Department of Medicine
Australian Catholic University

www.thecoachprogram.com
Improvement of disease risk factors and adherence to guideline-recommended medications are the only proven effective treatments that are known to:

- retard the disease process,
- keep patients out of hospital; and
- prolong life.

Yet, there is evidence that clinical practice consistently fails to adhere to evidence-based guidelines and achieve targets for risk factors in most patients.

This difference between guideline-recommended care and the care patients actually receive has been referred to as the ‘treatment gap’ or ‘evidence-practice gap’.

Reasons for this gap include lack of treatment intensification in patients not meeting evidence-based goals for care, and non-adherence or discontinuation of treatment.

Originating in 1995, The COACH Program is the world’s only coaching program which addresses ‘the treatment gap’ and is proven to close ‘the treatment gap’ in the management of modifiable disease risk factors in patients with chronic disease.
Type 2 diabetes: Assessing the treatment gap

Recommended monitoring for patients with type 2 diabetes

**July 1, 2015** – Data based on:
- 410 MedicineInsight practices
- 2,010,000 RACGP active patients
- Gender: 52% male, 48% female
- Modal age: 45-64 years

<table>
<thead>
<tr>
<th>Metric</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c last 6 months</td>
<td>60%</td>
</tr>
<tr>
<td>BP last 6 months</td>
<td>70%</td>
</tr>
<tr>
<td>LDL/Total cholesterol last 12 months</td>
<td>72%</td>
</tr>
<tr>
<td>Testing for microalbuminuria last 12 months</td>
<td>51%</td>
</tr>
<tr>
<td>eGFR last 12 months</td>
<td>76%</td>
</tr>
</tbody>
</table>
Type 2 diabetes: Assessing the treatment gap

Risk factor targets for patients with type 2 diabetes

**July 1, 2015** – Data based on:
- 410 MedicineInsight practices
- 2,010,000 RACGP active patients
- Gender: 52% male, 48% female
- Modal age: 45-64 years

- HbA1c < 53 mmol/mol last 6 months: 34%
- BP < 130/80 mmHg last 6 months: 19%
- LDL < 2 mmol/L/Total cholesterol < 4 mmol/L last 12 months: 31%
The COACH Program - A proven solution to the treatment gap

- The COACH Program is a standardised coaching program in which trained health professionals ("coaches") coach patients with or at high risk of chronic disease to vigorously pursue and achieve guideline-recommended target levels for their biomedical and lifestyle risk factors and to take the medications as recommended by the guidelines for their particular medical condition(s).
- Delivered entirely by phone and mail out - no face-to-face sessions required.
- Patients usually receive 5 coaching sessions over 6 months.
- The Program examines whether each individual patient is receiving the medications as recommended by the clinical guidelines and whether they are at the dosages required to achieve the target risk factor levels.
- Patients are coached to take the initiative with their doctors and ask for measurement of risk factors; to obtain the results for their risk factor levels; discuss both the results and ways of improving the results with their doctors; discuss appropriate prescription of medications.
- Equal emphasis on medications and lifestyle to improve risk factors.
- Advice on medications is explicit and very specific.
The coach develops a plan of action with the patient to modify risk factors and improve lifestyle.

For each risk factor patients are given the targets to achieve – based upon the national guidelines for the management of their disease(s). Patients are coached according to the national evidence-based guidelines for each medical condition.

Progress towards targets are monitored at each coaching session.

Patients can contact their coach for advice and support between sessions.

Each verbal coaching session is followed by a structured written report that is a summary of the coaching session.

Guides patients step-by-step through the process of achieving their targets.

Coaches people to take control of their lives by knowing their risk factors (which influence disease), maximising their risk factor control which reduces their anxiety and improves their prognosis.

**Patients coached to take ‘ownership’ of their health; self-manage their health** - Coaching trains patients to ‘drive’ the process of achieving and maintaining the target levels for their risk factors while working in association with their usual doctor(s). The program coaches patients on how to advocate for their own health, in order to improve their outcomes.
Key points of difference compared with other disease management programs

The COACH Program stands out from all others by:

1. Informing patients of their missed opportunities/specific ‘treatment gaps’ in their management – i.e. the gaps between guideline-recommended care and the care patients actually receive.

2. Addressing all of a patients treatment gaps relating to their biomedical and lifestyle risk factors and medications; other programs merely provide lifestyle advice.

3. Coaches work with patients to close ‘treatment gaps’ and achieve the guideline recommended risk factor targets whilst the patients work with their usual doctors.

4. Initiating all contacts for coaching sessions – the program does not rely on the patient contacting the coach.

5. Coaches encourage patients to work with their usual doctors to achieve the most practical medication regimens possible, in order to facilitate lifelong adherence to recommended medication.
The COACH Program: available for patients with one or more of the following chronic conditions

**Patients with multiple conditions:** Patients are coached to achieve the target risk factor levels for all of their associated conditions, not just their principal diagnosis. For e.g. a patient with CHD who has diabetes is coached on both their CHD and diabetes risk factors.
The most widely used chronic disease management program in Australia; Accredited by ACHS (2010)

The COACH Program throughout Australia

Nationwide

Asthma Australia for people with poorly controlled asthma

HBF for privately insured patients with: CHD, PVD, Stroke/TIA, type 2 diabetes.

Diabetes TASMANIA for patients with type 2 diabetes, prediabetes, high risk of type 2 diabetes

QLD Health Health Contact Centre for all of QLD for patients with CHD, type 2 diabetes, prediabetes, COPD, heart failure, primary prevention

nib for privately insured patients with CHD, PVD, Stroke/TIA

rthealth for privately insured patients with CVD, type 2 diabetes

PeopleCare for privately insured patients with CVD

NSW Health for public hospital patients with: heart failure, type 2 diabetes, COPD, CHD, HT

Bupa for privately insured patients with CHD, PVD, Stroke/TIA, primary prevention
Win for the health system. Win for patients.

Studies validating the effectiveness of The COACH Program

The first 10 years was research only. The COACH Program was shown to be superior to usual medical care in reducing risk factors in patients with CVD in 2 RCTs (J Clin Epidemiol 2002, Arch Intern Med 2003).

The last 11 years: The COACH Program was translated from research to practice and adopted as standard care in the public and private health sectors in Australia and expanded to Europe.

Clinical audits show that the Program:

✓ Maintains the improvements long term (Heart Lung and Circ 2009, Heart 2012);
✓ Achieves greater benefit for socioeconomically disadvantaged people than the more affluent (Int J Cardiol 2014)
✓ Reaches people in remote and very remote locations where CR is impractical or impossible (MJA 2015)
✓ Is as effective in Indigenous people as it is in non-Indigenous people (MJA 2015)
✓ Keeps patients out of hospital (Circ 2004)
✓ Substantially reduces net costs to the healthcare system (DMJ 2014).
✓ And most importantly, saves lives!
• There is a common misconception that any program that follows up patients with empathetic health professionals and provides education on risk factors and medications will necessarily translate into reduced risk factors and improved outcomes in patients with chronic disease – this is false.

• Whilst most other disease management programs claim to be based on evidence contained in guidelines, the programs themselves have not been subjected to rigorous testing.

• This is relevant because of the few telephone coaching programs that have been trialed, most have not been effective in improving outcomes for patients.

• The COACH Program uses the national guidelines for each medical condition and has a 21 year track record of rigorous testing with randomised controlled trials and several follow-up studies published in international peer-reviewed medical journals.
Perplexing issues in CDM

- Do we really need to have a ‘post code lottery’ for patients to access chronic disease management programs – NO EQUITY!
- The treatment gap, although documented globally, is not perceived important enough by most parts of the public health care system. Why is it ignored when attempting to reduce hospital readmissions?
- The treatment gap involves both lifestyle and biomedical risk factors. Why would you fund programs only aimed at lifestyle?
- Why would you pay ‘big bucks’ for programs which either have no evidence-base or who claim to save money without disclosing the costs of running the program? You may end up saving pennies and spending pounds or be out of pocket.
- A trend to run pilots– experimental programs. Why gamble money and patient health on something which is unproven?

The COACH Program is the only disease management program proven to close the treatment gap.
Under licence as an in-house solution

We provide training, software and full support for qualified health professionals (employed by healthcare organisations) to deliver The COACH Program to patients with chronic disease(s) to achieve and maintain the target levels for their modifiable risk factors and to take the recommended medications as set by the national evidence-based guidelines for the management of their chronic disease(s).

Contact: margarite.vale@thecoachprogram.com

Fully outsourced solution via NPS MedicineWise

The MedicineWise Group and The COACH Program have joined forces to provide a full service offering whereby The COACH Program is now delivered by the highly trained NPS MedicineWise team of pharmacists.

The Program is subject to strict quality control, the cornerstone of The COACH Program and the MedicineWise Group programs since inception.

Contact: greg.hughes@venturewise.com.au