

REVIEW

Health Coaching for the Underserved

对未得到完善服务的人士进行健康辅导

Formación sanitaria para las personas desatendidas

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ABSTRACT

Twelve individuals (four homeless, two formerly homeless, and six low-income) received 12 weeks of free health coaching, an intervention normally undertaken by clients who pay \$40 to \$200 out of pocket for coaching services. The health coaching relationships were conducted with protocols developed for managing executive health at a Fortune 100 firm. This experimental model was constructed to explore what happens when coaching conversations for change and possibility are delivered to marginalized and underserved communities that typically undergo vastly different interactions with authorities in law, healthcare, and social services. Phase 1 of the project recruited the homeless individuals from street sites throughout San Francisco, California, and a temporary shelter. Phase 2 of the project worked with low-income and formerly homeless individuals who occupied a subsidized housing complex. Of the coaching recipients, three were black, five were Hispanic, three were of mixed race, and one declined to disclose his ethnicity. Half were Spanish speaking; immigrant status was recent for five of the 12. None had ever talked with a health coach before; only three knew how to utilize low-cost public health clinics. This case report illustrates how the motivational power of coaching conversations was a modestly useful methodology in breaking through the social isolation and loneliness of street-dwelling adults with chronic health problems. It also was a useful methodology for developing capacity for accomplishing short-term goals that were self-identified. Additionally, health coaching presented an oppor-

tunity for transitioning poverty-level individuals from passive recipients using public health sector services to more empowered actors with first-stage awareness who initiated preventive health actions.

摘要

共有十二名人士（四名无家可归者、两名曾经无家可归者以及六名低收入者）接受了为期 12 周的免费健康辅导，而正式接受干预的患者须就辅导服务自行支付 40 至 200 美元。在一家财富 100 强企业中，就管理层健康状况制定了方案并依之开展健康辅导。建立这种实验性模式，是为了探究在与边缘化和得不到完善服务之社群就改变和可能性进行辅导谈话时会发生什么情况，因为该等社区通常会与法律、健康护理和社会服务方面的主管当局发生截然不同的互动情况。该项目的第 1 阶段是从整个旧金山的街道站点和一家临时收容所中招募无家可归的人士。该项目的第 2 阶段是与住在补贴住房综合设施中的低收入和曾经无家可归的人士合作。在辅导接受者中，有三名黑人，五名西班牙裔，三名混血人士，和一名拒绝透露其种族之人士。有一半的人士会讲西班牙语；在这 12 人中有五名最近才获得移民身份。之前，所有人都未曾与健康辅导者交谈过；只有三名人士知道如何使用低廉的公共健康诊所。本病例报告说明了辅导谈话是如何成为一个适度有效的方法，而其激励力量是如何打破身存慢性健康问题的成年街头流浪者的与世隔绝和社交孤独。它还是一个培养能力，实现自我确定之短期目标的有用方法。此外，健康辅导还提供了—次机会，将贫困级人士从使用公共健康服务的被动接受者转变成接受更多赋能的行动者，有初步意识并能主动采取预防性的健康行动。

SINOPSIS

Doce individuos (cuatro indigentes, dos exindigentes y seis personas con ingresos bajos) recibieron formación sanitaria gratuita durante 12 semanas, intervención en la que normalmente se inscriben clientes que desembolsan entre 40 y 200 dólares por los servicios de formación. Las relaciones de formación sanitaria se establecieron mediante protocolos desarrollados para controlar la salud de ejecutivos en una compañía incluida en la lista Fortune 100. Este modelo experimental se ha creado para investigar lo que sucede cuando se mantienen conversaciones de formación para el cambio y la posibilidad con comunidades marginadas y subatendidas que habitualmente poseen interacciones muy dispares con las autoridades legales, sanitarias y de los servicios sociales. En la fase 1 del proyecto, se reclutó a los indigentes de centros callejeros repartidos por San Francisco y de un refugio temporal. En la fase 2 del proyecto, se trabajó con individuos de ingresos bajos y exindigentes que ocuparon un conjunto de viviendas subvencionado. De las personas que recibieron la formación, tres eran negras, cinco hispanas, tres mestizas y una rehusó revelar su origen étnico. La mitad eran hispanohablantes; cinco de los 12 eran inmigrantes recientes. Ninguno había hablado nunca hasta el momento con un formador sanitario; solo tres sabían cómo utilizar las clínicas sanitarias públicas de bajo coste. Este caso ilustra cómo el poder motivador de las conversaciones de formación ha resultado ser un método moderadamente útil para romper el aislamiento social y

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la soledad de los adultos que viven en la calle con problemas crónicos de salud. También ha resultado ser de utilidad para desarrollar la capacidad de cumplir objetivos a corto

plazo señalados por los propios individuos. Asimismo, la formación sanitaria ha brindado una oportunidad para que las personas pobres dejen de ser receptores pasi-

vos de los servicios del sector sanitario público y sean más conscientes de las medidas iniciales necesarias para emprender acciones sanitarias preventivas.

INTRODUCTION

The growing gap of health and wealth inequity in the United States calls for renewed focus and new strategies to improve health outcomes for the poorest among us. At the same time, the ongoing economic and financial downturn has placed significant burden upon state and local public health departments and community agencies that aim to reduce health disparities among underserved populations.¹

According to the US Census Bureau, the number of poor increased by 3.7 million from 2008 to 2009, with one-third of those being children. Addressing the socioeconomic determinants of health is critical for slowing current trends.² However, what is often left out of public discourse is the recognition that lifestyle improvement is a two-step of personal responsibility along with sociocultural support. While communities need to provide cost-effective means for providing health services, accessing those services remains the responsibility of individuals or families who are ultimately the ones who muster the motivation and inner resources to make positive changes. That is where a health coach may prove most valuable.

Health coaching is a rapidly growing nonclinical health profession that offers an accessible, client-centered, holistic approach to changing attitudes, behavior, and lifestyles habits of individuals for improved health and well-being. The coach builds a trusting alliance with clients, helping them evoke their own goals from within, discover inner strengths and capacities, build action plans, and monitor progress.

Insurance reimbursement for health coaching is not universally available at this time, although employers are beginning to offer health plans (eg, Kaiser, Aetna, United) that feature two or three sessions with a telephonic health coach. Aside from the employee who may receive sessions with a health coach through an employer-sponsored health plan, health coaching is customarily an out-of-pocket expense. Those who take advantage of coaching services are usually educated, higher-income individuals who choose to enter into a contract with a health coach just as they would with a personal fitness trainer.

For the underserved, minorities, the unemployed, and the poor, not only is there an absence of financial or social incentives but it is often assumed that there is a diminished capacity for making healthful changes due to a lack of resources to fall back on as well as the need to cope with hardship and basic survival needs. Therefore, despite the fact that health coaching occupies the most affordable rung of the healthcare ladder, it remains largely inaccessible for low-income or pover-

ty-level individuals and families who suffer a disproportionate number of health disparities.

The lower the socioeconomic status in terms of income, education, and occupation, the poorer the state of health. The disadvantaged suffer an increase in chronic stress (higher allostatic load), higher blood pressure, and unhealthy body mass index and may even suffer more DNA damage as indicated by shorter DNA telomere length.³ Socioeconomic status shapes social norms and the physical environment by exposing people to more toxins and limiting access to health-care and health insurance. Low socioeconomic status directly affects behavior that affects health and illness.

The most vulnerable are often criticized for an over-dependency on social programs such as Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children, although after the welfare reforms of the Clinton era, research shows that the majority of recipients have part-time employment. Still, proposed draconian budget cuts in upcoming federal, state, and local public health budgets will affect the poorest, most vulnerable families.⁴

A RADICALLY DIFFERENT CONVERSATION

The premise for this project, Health Coaching for the Underserved, was somewhat audacious: What if a poor man or woman on the street were talked to about improving his or her lot in life just as an executive coach would talk to chief executive officers about pursuing their strategic plans? The tone and character of the conversation might be respectful and regard the client as capable, resourceful, and whole. The social conditioning of healthcare personnel to regard the person as someone needing to be treated, cured, or “fixed” would be bypassed. Coaches are trained to think that the optimal solutions for whatever problems exist are usually within the clients themselves. Contrary to medical models, the coach would follow the client’s agenda, even if that seemed questionable to the coach—again, a counterintuitive approach for healthcare personnel. Coaching conversations support the client discovering his or her own values, purpose, and goals.

Not only does this entail a shift, it comprises a radically different, day-to-day experience for the poor as they attempt to access care and receive health services. When this project was posed to the first four homeless men by the researcher/author, their reactions were filled with disbelief and sarcasm. One homeless man responded, “You’re gonna coach me like I’m a rich guy? Like I’m the man? Yeah, right.”

No prior data were available regarding how the coaching conversation, composed of powerfully evocative

questions, might influence homeless, underserved minorities or low-income individuals of diverse race, gender identification, ethnicity, and immigrant status. Research shows that public attitudes toward low-income and welfare recipients may have improved since 2003, yet the primary social interactions that the homeless and vulnerable have with health and social service authorities remains top-down in delivery and directive in tone, with expert-driven dispensation of health information. This style often fails to evoke from the individual any intrinsic motivation or life-changing, health-enhancing behavior.

In the best of cases, public health and social service workers are trained in motivational interviewing (MI) techniques, which bring a nonjudgmental atmosphere to the client-practitioner relationship.⁵ Barriers to resistance are recognized and not confronted but “rolled with” in a way that keeps the conversation going and the client fairly engaged until the possibility for change can be manifested.^{6,7} For the populations discussed in this case report, a coaching methodology with MI techniques was employed in the one-on-one sessions. It proved particularly useful in coaching individuals diagnosed with mental health problems and substance abuse. MI has a solid record of effectiveness for individuals struggling with addictions.

SCOPE AND PARAMETERS OF THE PROJECT

The following case report examines an experimental approach in bringing a type of health improvement strategy known as integrative wellness coaching (IWC) to homeless and low-income individuals. The project was undertaken to assess the feasibility of the health coaching model and general responsiveness of the individuals and families who received it. The IWC model is taught within the master of arts program in Integrative Health Studies at the California Institute of Integral Studies, San Francisco, a member of the National Consortium for Credentialing Health and Wellness Coaches. IWC is a client-centered process that facilitates a supportive means for clients to tap into inner resources and external allies and develop their capacity for change in order to improve health and well-being.

The project took place during a 24-month period, with Phase 1 directed toward homeless individuals or people in and out of temporary shelters. Phase 2 of the project was part of an Aetna Foundation grant designed to promote healthy behaviors among residents of a low-income apartment complex constructed by Mercy Housing and managed by Catholic Charities CYO. The site houses 425 low-income and formerly homeless residents. Faculty and graduate students delivered health coaching services to these residents, and the project is ongoing. The Mercy Housing project was designed to occur in five stages: (1) assessment and planning; (2) social marketing and relationship building; (3) delivery of IWC services; (4) evaluation of coaching effectiveness through case studies; and (5) leadership training to empower residents as peer wellness coaches. In addition

Tasks of the Integrative Wellness Coach

- Co-create the holistic coaching relationship, based on building trust and rapport
- Establish clear lines of responsibility and accountability for the client
- Facilitate values of clarification, readiness for change, and identification of resources, both internal and external
- Clarify client's desire for goal attainment, behavioral changes, or performance enhancement
- Maintain focus on capacities for growth and learning vs pathology or problems
- Develop action plans and set short- and long-term goals; monitor and track progress
- Facilitate growth in self-efficacy, recovery from relapse, capacity to learn
- Refrain from being the expert; move into a consultation role only after asking permission
- Be knowledgeable in lifestyle improvement including diet, exercise, stress management, and access to healthcare
- Provide facilitation for client to discover and embrace healthful changes
- Access tools such as the Wellness Wheel, guided imagery, and nonviolent communication as needed
- Use evidence-based methodologies and frameworks for behavior change, including adult learning theory, motivational interviewing, and aspects of cognitive behavioral therapy in terms of identifying limiting attitudes, beliefs, and lifestyle habits (cognitive restructuring)
- Facilitate client's navigation of integrative and complementary health options for improving health
- Tie health improvement goals to overall wellness vision and sense of purpose, meaning, and belonging; facilitate bonds to community and supportive allies
- Obtain consent, maintain confidentiality, and follow the International Coach Federation Code of Ethics for professional coaching

to free IWC, graduate students provided intake interviews and comprehensive assessments, a Family Fitness Fair, wellness workshops, and leadership programs with the goal of reducing obesity and chronic illness and promoting healthy behaviors.

Though some lines are blurred between health education and health coaching, there are distinct differences, and the coaches were instructed to try to not function as health educators but to do their best to remain in a coaching role. This meant they attempted to evoke from the client what the client wanted to do and refrained from teaching about the risks of chronic preventable diseases unless the client's choices or actions warranted intervention. For example, if weight loss was an expressed goal and the client insisted on following an unproven fad, the coach would ask if the client had any

success with it or knew how to get valid information about it.⁸ This type of evocative inquiry is often difficult for health coaches who are eager to teach “right” choices and behaviors. The coaches often asked, “Why would I ask him what he wants to eat when I know his diet is already horrible for his health?” Resisting the “righting reflect” is a primary task within coaching.

BACKGROUND

Homelessness in San Francisco is a widely studied phenomenon. As any visitor to the city knows, while it bustles with “Silicon Valley” starts-ups for digital natives, the stark contrast of this burgeoning wealth with pervasive homeless individuals and street youth is disturbing and relentless. An estimated 5000 to 10500 individuals (in a city of 725 000) have no permanent homes and sleep in vacant lots, doorways, alleys, and public areas, often with their belongings pouring out of shopping carts or plastic bags. The exorbitant cost of living in the Bay Area, the lack of affordable housing, a temperate climate, and policies (now discontinued) that paid monthly cash stipends to homeless people are some of the factors cited and contested regarding the large per capita homeless population.²

Homeless people in and out of shelters struggle with loneliness, isolation, dislocation from significant support, and social marginality and are often undereducated and coping with developmental deficits and a lack of skills training. Almost one third are dually diagnosed with mental disorder and substance abuse. San Francisco has one of the highest per capita spending levels on public health and an office dedicated to reducing health disparities, yet the problem is unabated.

Compared to the responsibilities of healthcare and social service professionals, the coach has the freedom to operate in a hands-off, nonsupervisory role. For this project and unlike the public health workers, the coach did not have to perform comprehensive assessments of mental and physical health on the poor. Coaches did not have to perform drug and alcohol screening tests or monitor the effects of medication and chart benefits and risks in medical records. They never have to agree to a treatment plan or facilitate coordination among county agencies and public health clinics and shelters. Healthcare and social service workers must maintain professional competence, promote harm-reduction strategies, and interface with multidisciplinary teams.

THREE CASE STUDIES

Case 1: Homeless Man

“Zack” is a 48-year-old man who had lived on the urban streets for the past 15 years. He was approached more than 2 years ago by the IWC coach (this particular coach was also a registered nurse) in a steady, non-threatening manner and asked if he would like to have a free health coach for 12 sessions. It took three brief encounters before Zack was willing to talk about his health; he first stated he was uninterested in anything but securing cash, alcohol, or cigarettes. The coach

could not access medical records for him, but he appeared to have serious substance dependence (drugs and alcohol) and mental illness, perhaps schizoid personality disorder. As with many individuals with dual diagnoses, he exhibited odd behavior, gave vent to distorted views and beliefs about reality, dressed in peculiar ways (heavy coats on hot days), and was generally anxious or paranoid toward people who were near his shopping cart or street space. His affect was often inappropriate, and the excessive social anxiety he displayed was understandable for the amount of social isolation he endured. While other homeless individuals occupied the same alley for over a year’s time, Zack was persistently on the outs with these other street dwellers; the coach witnessed him being chased away and belittled twice. Zack complained of being harassed, robbed, and beaten, “but the mayor—he could give a damn.”

Zack said he was “a professional surfer” and another time identified his situation as “having a big job—I just don’t have to do that anymore.” He is an active user of heroin, methadone, and “bud and caviar” (marijuana and cocaine or crack). He has access to medical marijuana, which he reported receiving for chronic pain and what appears to be peripheral neuropathy, as he complains of numbness or “crawlies” in his extremities. His legs and arms show signs of avascular necrosis typical for HIV/AIDS infection. He has been told in the past he has chronic hepatitis B or C. Within the assorted large trash bags he carries with him in a shopping cart are several empty bottles from expired medications including tricyclic antidepressants, methadone, Lyrica (pregabalin), aspirin, and oxycodone. His last hospital admission was for evaluation of nausea. “I was just sick to my stomach but they don’t know nothing at the General,” he said, referring to San Francisco General Hospital.

During the first two coaching sessions, he was visibly agitated but later looked forward to the coaching encounter, showing up early with a list of requests and his inevitable sack of recycled plastic trash, illegible papers, and empty pill bottles. He refused to participate in some sessions since “he wasn’t getting paid for them,” although he did always receive coupons for Starbucks, gift certificates for local fast food chains, or vouchers for a soup kitchen with each coaching session.

While most of the coaching sessions were devoted exclusively to establishing trust and rapport and the process of evoking intrinsic goals from within Zack was often a futile enterprise, there was one major accomplishment. Zack acknowledged that street life was deleterious to his health. This occurred in session 8. He agreed that real housing, not in a shelter which he adamantly refused (“they’ll kill ya there”) but in a residential hotel would be far preferable. The coach was able to lay out the step-by-step strategy for getting a residential hotel space from a local Christian-based foundation that had a successful, active social work center.

The center required that Zack attend a drug and alcohol rehabilitation program for 1 year and also participate in a modest skills job training program. Zack

considered the last item an unreasonable demand. The MI techniques were employed, allowing the coach to acknowledge Zack's ambivalence and resistance—a crucial tool at this point. Zack screamed about being caged in, until the coach said, “I really see what you mean. You think that the whole rehab program might be something you're willing to do, but that job training is just not a fit for you right now. I get it. I truly do.” That type of coaching conversation was the only way to keep Zack engaged in the possibility of ending the cycle of self-imposed isolation and poverty and opening the door for this possibility in his unfortunate life. Zack did not show up for the last scheduled coaching session and has not been seen in the neighborhood by any of the other street dwellers for the past 4 months.

Case 2: Shelter Resident

“Theresa,” a 39-year-old mother of two young children, was recently separated from her unemployed partner after a violent altercation and was forced out of their shared rooms in his brother's apartment. She reported having a physical disability that prevents her from full-time employment, although the disability is not apparent. She appeared to be physically strong; her emotional states exhibited a personality that is assertive, defensive, and often impulsive. She worked part-time at a Good Will Industries station “sorting and stuff” and earns a wage that is below the poverty level for a family of four. She had been on and off the streets with her two children for the past year, as the relationship with her partner grew more volatile. She had no health insurance and states she has been rejected for Medicaid due to “somebody bungled the paperwork.” At the shelter, she reported enjoying a degree of safety and security for the first time in years. She thought talking with a health coach would be “OK, if it will help me get this other stuff I need,” requiring the coach to continually reinforce the difference between social service and coaching through their time together.

Theresa co-created with her coach the following goals: (1) keeping her children in “that good school” and “in that after-school program,” (2) getting “better food in them—and me,” and (3) “getting rid of these headaches.” She said she “didn't know about wellness,” but was interested in getting some acupuncture “if it didn't hurt and didn't cost nothing.”

Her children (girls, ages 9 y and 11 y) attended a local public school “most days” and sometimes attended a subsidized after-school program that Theresa could not afford most months, so their care was inconsistent. Theresa credited the coaching with helping her figure out how to get into the Supplemental Nutrition program (food stamps) she previously had applied for but never received, saying, “This time I got that step-by-step thing worked out. That was cool.” She excelled at being coached with clear action plans. Resource checklists were developed and followed, as Theresa kept a record of her actions on a spiral-bound mini-notebook tucked in her pocket. These new capabilities in accom-

plishing clearly defined short-term weekly action steps were celebrated by Theresa, her coach, and the organizers at the women's shelter. She wasn't willing to share her relationship with her coworkers at Good Will Industries, however, as she was afraid of losing her job.

The coach found that reinforcing lines of accountability was challenging with Theresa. On two occasions, she was convinced that her record of weekly action steps were not her responsibility but rather actions that the coach was supposed to take, saying, “You were supposed to do that.” She insisted during the fifth session that the coach was supposed to apply for additional city and county assistance. When she was reminded that coaching was different from social service agencies, she grew angry and blamed the coach for “wasting her time and messing” with her.

Progress was slow with Theresa, with almost as much backsliding as forward movement. Through an envisioning and clarification process with the coach, she came to realize that her goals of more money and better food and housing for her family were not going to be attained by her current behavior or thinking. The coach worked to help her identify her strengths (loyalty, humor, resourcefulness, strong will), but her cognitive ability to map out a new strategy was not always apparent: She quickly grew distracted, confused, and “foggy-brained” and resorted to blame and threats. Relapses were common, and although she would verbally declare her readiness to change (“I'm beyond ready; I don't know why you don't believe me!”), she often wasn't able to follow through with agreements.

Finally, in the third and final month of coaching, Theresa seemed to enjoy a coach brainstorming session (“Come up with ten hot ideas—sky's the limit—nothing is a bad idea; just dream big”), and she decided to go to a city-sponsored job fair. Once there, she surpassed her short-term action goal and actually applied for computer skills training programs. However, she did not hand in the application, stating that she suddenly had to be somewhere else. A difficult conversation ensued with the coach about what may have really happened that prevented her from completing the application process.

This coaching technique of pushing the client to truthfully examine obstacles in the path of her success was perhaps too much confrontation for Theresa. She skipped the next scheduled coaching session. The provocative powerful coaching questions that are suitable for individuals with strong ego structure should only be asked when sufficient trust and rapport have been established and when the client can assume responsibility and build autonomy. Theresa skipped out on the next two sessions. When she did return, she talked about her growing worries that she couldn't make ends meet and said she often goes hungry in order to pay for extras for her children. She was fearful that she couldn't push forward on the job training.

At this point, the coach created a lot of permission for backsliding and failure in the goal-setting process,

letting Theresa know that this is typical for everyone and normalizing the behavior. Theresa continued to berate herself and blame others for her not getting ahead. The conversations grew discordant and divergent as she cited past trauma and arguments with her parents and ex-partners that prevented her from getting her needs met. The coach had to reinforce that some of these topics may be better suited for a counselor that she could see through the community mental health clinic but indicated that if Theresa wanted to get back on track with her goals for earning more money and improving her quality of life, the coach was ready to pick up where they left off.

This sudden shift in the conversation is classic in the defining territory of what constitutes coaching vs therapy. When a coach considers someone capable, the coach is actively listening for the possibility that change can happen. When Theresa was cut off from a long tirade of blaming others, she was stunned that her coach wouldn't pursue the topic or at least listen. It was a tricky moment but proved to be a successful risk in the coaching relationship.

Theresa dropped the discourse and said, "Let's work on something else then." She wanted help resolving her frequent headaches and wondered if it was linked with the one time she went to the free obstetrics/gynecology clinic and "they told me I had high blood pressure. You think I do?" This led to a new coaching goal of exploring her health, blood pressure, weight management, and more. Theresa renewed her coaching relationship for another 12 weeks because, as she said, "If my health goes, then these kids got nothing."

Case 3: Subsidized Housing Residents

"Gloria" was a working mother, resident of subsidized housing, formerly homeless and now employed. She and her coach worked on Gloria's stated goal of improving her diet and finding physical activities that would help her better manage the stress in her life. She said she was constantly worried about keeping her apartment and her job and maintaining this new status of a better life. The conversations usually began with questions regarding nutritional practices she wanted to change. She knew fast food was not the best choice and wanted to know if some healthy, more economical options were available. The coach evoked from Gloria the idea of trying whole grains that she heard about; for instance, she might try brown rice in place of white rice and reduce her intake of processed food. Gloria created goals of eating two servings of fruit and vegetables per day. She decided to be mindful of drinking more water and made a goal of drinking four bottles of water per day. She and the coach celebrated her accomplishment of all of her nutritional goals. She then focused her attention on exercise and after a lot of coach guidance decided to walk with her son "Daniel" to school and attend a Zumba class 1 day per week.

Gloria made the most improvement in self-regulating her response to stress through adopting the

deep breathing exercises she practiced with her coach. The goal began with trying to focus on deep breathing before bed or in moments of feeling anxious at least 3 days during the week for as little as 2 to 5 minutes. Eventually, she performed the deep breathing exercise almost every day as a calming practice when she felt anxious or stressed. She advanced to mindfully notice when tension was held in her body so that the deep breaths could be employed whenever she needed them.

Overall, the positive effects of coaching included Gloria increasing her intake from two servings of fruits and vegetables per day to three per day; increasing her relaxation/stress management exercises from 3 days per week to 5 days per week; and gaining an overall better knowledge of healthy nutritional choices for her and her son.

"Maria" was a resident of Mercy Housing who complained of a long-standing fibromyalgia. In her first coaching session, she referred to her former self as "Wonder Woman," constantly on the go and taking care of everyone. At the time of the first session she felt like she barely had enough energy to take care of herself. She rarely left the house and spent most of her days in bed doing paperwork. She had difficulty sleeping, which adds to her daytime fatigue. Maria found it challenging to go about daily tasks; she said putting her shoes on was exhausting. In previous years, Maria had a passion for cooking but found the process to take three times as long as it used to, which created frustration.

During the first conversation, the health coach realized Maria was being really hard on herself. She was constantly comparing herself to her former "Wonder Woman" self. This comparison added to her stress, depleting more energy. The goal of the coaching sessions was to create an awareness of these negative thoughts (whether they were judgments or comparisons) and observe. The goal of observing her thoughts was to create a space of compassion for herself that in turn would help to alleviate stress.

Throughout 12 weeks of coaching, the external resource options (going to a gym, taking long walks in her neighborhood) for stress reduction were met with excuses, limitations, and frustrating setbacks. Rather than seek additional external resources, Maria discovered through her coach the internal methods of relaxation. These were immediate and free and required no travel. She began listening to music, cooking healthful meals when time and energy permitted, relaxing in the thoughts of past joyful memories, and engaging in breath work. Mindfulness and breath work were consistently appreciated and employed by Maria for going to sleep and calming herself at work.

At the end of the last session, Maria reported being compassionate with herself and taking the time to allow herself to relax. By observing her thoughts and treating herself with kindness and compassion, she was able to reduce her stress and connect with her inner "Wonder Woman" that was there the entire time.

Table 1 How the Coaching Conversation Changes For Street Dwellers

Timeline	0-3 Mo on the Street	4-6 Mo on the Street	Over 6 Mo on the Street	Housing Secured
Behavior	Crisis mode, learning how to survive, new conflicts, aggression, defensiveness, fearful of authorities	Equilibrium regained, street-smarts in progress, conflicts habitual but not serious, health conditions deteriorating	Assimilated into street ethic, learned “right” and “wrong” ways to survive, sense of ownership over area	Anxious about staying, not getting “kicked out.” Worried about being discovered
Coaching Intervention	Coach asks what they know about reducing harm to themselves, establishing safety, and finding shelter. Coaching had greatest potential at this stage for getting someone off the street.	Coach evokes from client the practical solutions client can focus on now to deal with ongoing problems. Describe a good day. What goes right? How do you repeat that?	Coach introduces possibility thinking, despite entrenched setting. How would you like things to be different? Where have you given up? What do you see as a possibility now?	Coach develops a wellness vision and action plan with concrete strategies for staying in housing, keeping employed, improving health, keeping kids in school. Coach reinforces how to connect with social agencies and public health support.

DISCUSSION

The strength in using the IWC model for low-income and vulnerable populations centered on bringing self-awareness and insights to individuals who could build self-efficacy for the first time through the uniquely supportive alliances with coaches. Most of the individuals in this project were unfamiliar with the accountability talk that is unique to coaching. They responded favorably to creating specific, measurable, realistic goals, building concrete plans, and identifying their values and strengths.

The coaching outcomes were most successful with residents of subsidized housing, slightly less successful with individuals in shelters, and least successful with those living on the streets. For the homeless, the Table demonstrates how the coach had the most positive outcomes with individuals who were on the street for less than 3 months. For those who were on the street for more than 6 months, coaching was nothing more than a friendly alliance; no positive changes in lifestyle or health improvement were noted.

Just as the diagnostic codes of “depression” or “anxiety” do not tell the whole story of vulnerable people uprooted from bulldozed neighborhoods, neither do the coaching lexicons of “intrinsic motivation” and “motivational enhancement” tackle the challenge of living in resource-poor social environments.⁸ Coaching the very poorest (street dwellers and those in temporary shelters) requires more attention to the upstream needs of safe housing; access to healthcare, education, and job training; and freedom from street violence.⁹ Coaching in and of itself cannot address the full epigenetic and neuropathological assault on the individual from poverty, oppression, social nonattachment, and unrelenting stress.

Downstream and Upstream

Coaching works on two fronts: tapping into individual strengths and identifying external resources. This internal-and-external dance worked well for those in subsidized housing, where systems and personnel were in place to aid connection with external resources.

Two case managers and an onsite program director are available at all times to assist residents in the Mercy Housing units. The services provided by Catholic Charities CYO include support to help clients keep their apartments, maintain jobs, keep children in school, receive after-school daycare, receive family support programming, access healthier foods through onsite food bank delivery, take part in onsite exercise classes, get help with tax preparation, take computer classes, and improve their health and reading literacy.

For the individuals on the street and in temporary shelters, the social milieu remained dislocated and health depleting. One coach working with the homeless concluded,

The cards are stacked against these folks. My “client” had to move every day to another alley, and still he shared his cardboard mat with me when we’d meet. There was no place to get decent food, no available shelters, and he was in need of a knee operation but had no means of getting to the clinic.

Some coaching relationships with the homeless ended prematurely. In the debriefing sessions, the coaches discussed how impoverished social environments cause risk factors for illness that cannot be solved with individualized behavior change. Therefore, it was considered both unreasonable and uncompassionate to place the onus for change on the shoulders of the disenfranchised while simultaneously—because of sequestered budgets and depleted social services—witnessing the rise of the old, familiar agents of social illness and chronic disease: high unemployment, a crumbling education system, loss of affordable housing, lack of preventive health services, transportation barriers, closed mental health centers, and even the lack of a local grocery store. The coaches were in lockstep with the sentiments expressed in a Robert Wood Johnson survey of physicians in which 85% recognize unmet social needs of their patients but did not feel competent in dealing with those needs.¹⁰

Structural Competency

The notion of structural competency is replacing cultural competency as the very thing that needs attention. Structural competency implies that practitioners and healthcare organizations apply the skills to reduce health inequalities by acting on the social policies, institutional structures, and environmental conditions that determine mental and physical health (H. Hansen, oral communication, April 12, 2013). The old thinking in cultural competency no longer serves healthcare providers in considering “Gloria” as someone who doesn’t make individual-level behavior change because her ethnicity is somehow a stumbling block or hasn’t been addressed with the proper cultural sensitivity or linguistic competency. The new thinking in structural competency allows us to move with renewed focus into addressing the social economic determinants where health disparity is firmly rooted, regardless of the cultural background of the clients.

Limitations

The limitations in this project include language barriers. Coordinating with interpreters and translators was sometimes difficult, especially for residents in subsidized housing who spoke and read only Cantonese or Spanish. Planned measurements (biometric data including body mass index, body composition, blood glucose, lipid profile) for determining program effectiveness were abandoned when they were met with resistance and emotional upset: Body fat testing was viewed by residents as embarrassing and discouraging, and coaches expressed concern that families would drop out of the coaching alliance. Plans to develop peer wellness coaches were not successful, as individuals and housing residents were in need of extensive support themselves and unwilling to assist others with behavioral health changes. As a result, the next implementation of the coaching project will recruit peer mentors/coaches from the larger community and offer a 4-week training session in basic peer coaching.

The relationship-building phase was formidable and required a much longer process than initially planned to surmount language and class barriers. However, it is not clear that more time would necessarily be a solution, as one of the major findings was that resource-poor social environment for the underserved remains the primary obstacle for improving health and reducing disparities. To address this issue, future project activities include monthly collaborative brainstorming sessions with site case managers, San Francisco Department of Public Health educators, local low-cost clinic providers, and integrative medicine physicians involved in the Integrative Medicine for the Underserved (im4us.org) project.

Summary

The Integrative Wellness Coaching and Leadership Pilot Project was a first step in developing best practices for delivering wellness coaching to vulnerable communities. The IWC model evolved from the business

world, where coaching technology centers on active listening, evocative inquiry, and generative thinking that helps people tap into inner strengths and external resources for personal growth and goal attainment.

Evoking behavior change from executives through proven coaching techniques has had striking parallels to eliciting healthy habits from low-income individuals who lived within supportive social, political, and environmental interventions.¹¹ However, transferring this coaching model to those at the lowest rungs of society’s ladder (homeless individuals stripped of supportive environments) was anything but straightforward. Yet it has proven to be a positive learning laboratory for developing the following recommendations for healthcare providers.

- Add coaching communication skills for their interactions with patients in which personal lifestyle change is warranted.
- Move from the narrow view of cultural competency to the broader understanding of structural competency by recognizing that impoverished social environments are the micro-aggressions of everyday life for the poor and that the health disparities resulting from higher rates of obesity, smoking, hypertension, medication noncompliance, post-traumatic stress disorder, and depression are downstream consequences of upstream social and environmental policies.
- Advocate for liberalized reimbursement and treatment codes to allow time for interaction with health educators and health coaches skilled in working with vulnerable populations.
- Close the gap of unmet social, clinical, and personal needs with programs and alliances that cut across boundaries and link doctors, health coaches, and social sector workers who already know how to connect people with resources.

REFERENCES

1. Economic Policy Institute. The state of working America. 12th ed. <http://www.epi.org/news/prolonged-recession-pushes-more-people-into-poverty/>. Accessed March 3, 2013.
2. Auerswald C, Eyre SL. Youth homelessness in San Francisco: A life cycle approach. 2010. http://www.nccp.org/publications/pdf/text_552.pdf Accessed April 30, 2013.
3. Epel ES, Blackburn EH, Lin L, et al. Accelerated telomere shortening in response to life stress. *Proc Natl Acad Sci*. 2004;101(49):17312-5.
4. Baum A, Garofalo J, Yali A. Socioeconomic status and chronic stress. Does stress account for SES Effects on Health? *Ann N Y Acad Sci*. 1999;896:131-44.
5. Rollnick S, Miller W, Butler, C. *Motivational interviewing in health care*. New York: Guilford Press; 2008.
6. DiClemente CC, Velasquez MM. Motivational interviewing and the stages of change. In: Miller WR, Rollnick S, editors. *Motivational interviewing: Preparing people for change*. New York: Guilford Press; 2003:309-30.
7. Swanson AJ, Pantalon MV, Cohen KR. Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. *J Nerv Ment Dis*. 1999;187(10):630-5.
8. Pearce N, Smith GD. Is social capital the key to inequalities in health? *Am J Public Health*. 2003 Jan;93(1):122-9.
9. McKinlay JB. The new public health approach to improving physical activity and autonomy in older populations. In: Heikkinen E, editor. *Preparation for aging*. New York: Plenum; 1995:87-103.
10. Health care’s blind side. Robert Wood Johnson survey webinar, April 5, 2012. <http://community.rwjf.org/community/healthcaresblindside> Accessed April 30, 2013.
11. Witherspoon R, White, RP. (1996). Executive coaching: a continuum of roles. *Consult Psychol J Pract Res*. 1996;48(2):124-33.