The COACH Program® fact sheet

Purpose

The purpose of The Coach Program® is to improve quality of life and reduce avoidable hospital admissions for program participants. This is achieved by empowering and supporting individuals to better manage the symptoms related to their chronic disease and the associated lifestyle and biomedical risk factors.

What is The COACH Program®?

It is a structured telephone-based health program for people with or at high risk of developing a chronic disease. Developed in 1995 in Melbourne, Victoria, it is the only evidence-based “coaching” program for reducing the impact of chronic disease on the individual and health system.

How does it work?

The Coach Program® is delivered by Registered Nurses who have received additional training in the application of this self-management program. The program is delivered from the Health Contact Centre (HCC) alongside 13 HEALTH, 13QUIT and the Child Health service.

“The Coach” (Registered Nurse) contacts the client by telephone at an agreed time and delivers information and education to help clients better manage their chronic disease. Biomedical and lifestyle risk factors are discussed and targets are set based on best practice guidelines for specific chronic diseases.

For example, biomedical targets may include cholesterol levels, blood pressure, blood glucose and spirometry results. Lifestyle targets may include diet, activity levels, smoking and alcohol consumption.

The Coach Program® runs for approximately 6 months, with a call every 4-6 weeks. An information pack is included with the client’s first letter to further assist them in understanding and managing their chronic condition. At the end of each session, a letter detailing the topics discussed is sent to the client, their General Practitioner and/or their treating Specialist.

Benefits

For patients

- It is delivered over the telephone by qualified health professionals at an agreeable time.
- The program is shown to reduce the risk of future hospital admissions.
- The program is free for participants residing in Queensland.
- Enables patients to better manage their health and the symptoms of chronic disease.
- Has been shown to reduce anxiety, improve perception of general health, mood and fitness.

For health service providers

- The Coach Program® can assist health service providers by reinforcing the importance of issues such as medication compliance, risk factor management and regular follow-up appointments with their treating physicians.
- The program has been shown to reduce avoidable hospitalisations.
- This resource provides another option for those individuals who have limited access or willingness to attend conventional services.

To meet The COACH Program® criteria an individual must be:

Over the age of 18, be self-caring and a resident of Queensland and have been diagnosed with one or more of the following conditions:

- Coronary artery disease (CAD), (such as myocardial infarction, angina pectoris, cardiac stenting or heart bypass surgery)
- Type 2 diabetes
- Pre-diabetes
- Chronic obstructive pulmonary disease (COPD)

Client referrals

Telephone: 13 HEALTH (13 43 25 84) and ask for The Coach Program®
Email: Coach@health.qld.gov.au
Fax: (07) 3259 8534

Further enquires

Nurse Unit Manager, Chronic Disease
Telephone: (07) 3872 0149
Publications

Four-year follow-up of the multicentre randomised controlled trial of Coaching patients On Achieving Cardiovascular Health


The COACH Program Produces Sustained Improvements in Cardiovascular Risk Factors and Adherence to Recommended Medications —2 Years Follow-up


Fit for Purpose. The COACH Program improves lifestyle and biomedical cardiac risk factors. Heart. August 5, 2012


Reversing social disadvantage in secondary prevention of coronary heart disease


Privacy disclaimer

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For information about the right to access personal information visit Health records and personal information on the Queensland Health website (http://www.health.qld.gov.au/system-governance/records-privacy/health-personal/default.asp)