

Letter to the Editor

Is a Health and Wellness Coach a Missing Link in Improving Outcomes for Patients on ECMO?

Letter to the Editor: The use of Extracorporeal Membrane Oxygenation (ECMO) dates to the early 1960s and 1970s, when it was first used in infants and shortly after in adults (1). Over the last 50-plus years, its growth has afforded it progress both strategically and clinically with its complex and demanding patient management needs. ECMO has proved to be a type of care that heavily depends on a multidisciplinary team. Over time, this team has evolved into one that requires surgeons, intensivists, nurses, perfusionists, ECMO specialists, physical therapists, respiratory therapists, pharmacists, nutritionists, x-ray technicians, cardiac sonographers, ethics committee, social workers, and palliative care providers (see Figure 1). Despite the extensive list of people involved in this multidisciplinary

team, we feel that we are missing one more vital member: a health and wellness coach (HWC).

The utilization of a HWC has been beneficial to other areas of patient care such as with child birth, diabetes management, intensive care management, hypertension management, weight loss, smoking cessation, cancer management, and hospice care. We believe that incorporating a HWC into ECMO teams can potentially improve patient care processes and outcomes.

The primary purpose of a HWC is to establish relationships with patients that empower them to “take ownership, leadership, and accountability of their well-being, using non-directive, empathic, and mindful conversations that employ motivational-interviewing and evidence-based approaches” (2).

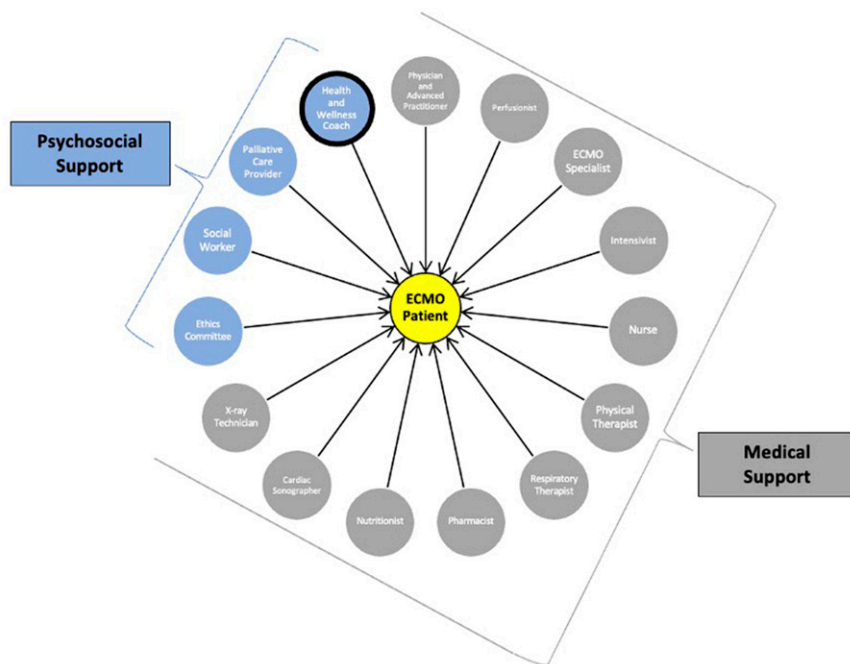


Figure 1. Patient-centered ECMO team.

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This role is relevant for long-term ECMO care, particularly for patients who are awake, and neither sedated nor not paralyzed. Awake patients on ECMO are more susceptible

to Post-Traumatic Stress Disorder (PTSD) (3). Other literature on PTSD and ECMO found that the longer a patient is in the hospital from their admission date, the more prevalent PTSD symptoms are (4). When providing care to patients on ECMO, team members may be focused on job-specific responsibilities and not have time for aspects that a HWC has the competency to address. HWCs can pay more direct and frequent attention to patients' psychosocial needs. Physicians, perfusionists, and other ECMO team members may be overwhelmed with several patients and have limited time (2). They may prioritize objective data to optimize the management of their patients while inadvertently overlooking that patient's psychosocial needs.

Patients require higher levels of mental stimulation beyond the care that involves cleaning, adjusting drips, adjusting the ventilator, and imaging. The various ECMO team members visit patients at the bedside, yet they do not have proper forms of social interaction beyond simple mechanical questions such as "are you in pain?" and "what is bothering you?" Although these patients may make clinical improvements, their mental state, and motivational drive, even social interactions nonrelated to hospital care, may not be sufficiently addressed and therefore negatively impacts their physical rehabilitation, overall potential outcome, and their ability to qualify for a transplant (2). HWC provides psychosocial support needed by patients, especially those with prolonged inpatient admissions. Therefore, we advocate for ECMO centers to reconsider expanding the members involved in ECMO care by including an HWC in their ECMO team to benefit patients requiring ECMO. Future quality improvement projects and research studies may

discern the impact of HWC members as part of the multidisciplinary ECMO teams.

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