Health Coaching Research

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Introduction

Health coaching supports people's efforts to change health-related behaviors, prevent illness, and deal with symptoms and challenges of illness. This form of health coaching is usually termed "patient coaching" since most people who seek health coaching are dealing with chronic health conditions; however, we should not underestimate the potential role of coaching in the prevention of disease. The term "health coaching" will be used in this chapter, to integrate other terms which are available such as "health and wellness coaching", "wellness coaching", "personal health coaching" (see also chapter: "Health in Coaching"). In 2013 Wolever and colleagues conducted a systematic literature review with the purpose of identifying existing definitions and conceptualizations of health coaching (Wolever et al., 2013). They concluded that though health coaching includes diverse approaches, there is some consensus in the literature about what are its main features. The definition which emerged from this review and which is currently most widely used is that health and wellness coaching is:

> a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The coach is a healthcare professional trained in behavior change theory, motivational strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being (Wolever et al., 2013, p. 52).

Coaching patients is a field that has a long history both in terms of research and practice. A related area—coaching in healthcare more broadly—includes coaching

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healthcare providers such as physicians, nurses, medical residents, and healthcare leaders (Wolever et al., 2017). Several recent studies illustrate the potential for coaching to reduce burnout (see chapter: "Burnout Prevention"), and physicians' intentions to leave the profession (Dyrbye et al., 2019; McGonagle et al., 2020).

Health coaching emerged primarily in response to the increasing prevalence of chronic illnesses, and the understanding of the psychological, behavioral, and relational dimensions of these illnesses. The National Center for Chronic Disease Prevention and Health Promotion in the USA defines chronic disease as one which lasts a year or more, requires medical management, or limits activities of daily living (National Center for Chronic Disease Prevention, 2020). The Center identifies seven main chronic diseases, which also contribute highly to mortality risk, and stresses the role of lifestyle in preventing and ameliorating these conditions—reducing tobacco use, improving nutrition, increasing physical activity, and reducing alcohol consumption. Interventions based on health coaching principles have been shown to have a significant potential to support people in these behavioral changes as well as in improving their health status.

Health and Well-being Outcomes of Health Coaching

The impact of health coaching has been studied extensively over the past decade, and overall has illustrated the important role it could have in maintaining and improving health and well-being. An early integrative review of research in health coaching was published a decade ago and included only 15 articles in line with the inclusion criteria (Olsen & Nesbitt, 2010). The healthy lifestyle behaviors which were assessed in the reviewed publications included nutritious diet, increased physical activity (PA), weight management, medication adherence, and others; findings indicated that coaching interventions showed improvement in the target behaviors in 40% of the reviewed studies.

The key systematic review mentioned earlier was conducted a few years later by Wolever et al. (2013). It called for a unified definition of health coaching in future research, in order to allow for a comparison of research findings on its effectiveness (as a practice which is "patient-centered and incorporating patient-determined goals, self-discovery processes, accountability mechanisms, and content information, in the context of an ongoing helping relationship", p. 53). The review included 284 full-text articles which fit the inclusion criteria, most of which were empirical, others were expert opinions on the characteristics of health coaching. This review gave the authors a base for recommendations for future research, which include describing the coaching methods and components used in the study, the theoretical framework which informs the coaching, the duration of the coaching engagement and number of sessions provided, and the professions and training of the coaches.

Since then, empirical research on the effectiveness of health coaching has blossomed. From the two editions of the compendium on health coaching (Sforzo et al., 2018, 2020) we can see the rapid growth in the number of publications. Sforzo

et al. (2018) used the definition offered by Wolever and colleagues to select publications in the field of health coaching and found 219 articles (of which 150 were empirical) meeting the inclusion criteria published between 1989 and 2017 in the English language. Two years later an Addendum to the compendium was published (Sforzo et al., 2020), in which the authors identified an additional 104 articles, of which 81 are empirical, just within these two years. More recently, a systematic review of health coaching research in chronic disease was published; it selected only randomized control trials (RCTs) or quasi-experimental designs (Kivelä et al., 2014). Another review that will select RCTs comparing health coaching to usual care or other types of interventions is currently being planned (Yang et al., 2020). Other recent systematic reviews have chosen specific topics and inclusion criteria, such as focusing on health coaching in the field of rehabilitation and prevention (Dejonghe et al., 2017); effects of health coaching on PA (Oliveira et al., 2017); on behavior change for adults with cardiovascular risk factors (An & Song, 2020) and the role of the employed modality on coaching outcomes (Singh et al., 2020b).

The following is not meant to be an exhaustive review of the literature, but rather to highlight the main and diverse areas of study and trends, by providing several examples of recently published research from the past decade.

Health Status and Indicators of Physical Health

Health coaching is being implemented as a supportive practice for people with chronic health conditions such as obesity, diabetes, heart disease, hypertension, high cholesterol, and to some extent cancer. A significant number of studies are also assessing the role of health coaching in the category which can be identified as "wellness" which can be described as health coaching for prevention of chronic disease, reduction of health risk behaviors such as smoking cessation and stress management as well as improving health-promoting behaviors. These studies assess a wide variety of coaching outcomes, including symptoms, health status, physiological, psychosocial, and behavioral indicators, and usually a combination of these. A report by the UK The Evidence Center in 2014 reviewed 275 studies and concluded that the evidence for improvement of health status (as indicated by blood pressure, blood glucose control, cholesterol, and weight loss) was mixed, as overall approximately one-third of the reviews and the randomized clinical trials showed improvement (The Evidence Center, 2014).

Health coaching in diabetes and pre-diabetes is one of the most often studied areas. Common indicators for control of the condition are glycosylated hemoglobin (HbA1c); body mass index (BMI), waist circumference, and diabetes medical symptoms are also evaluated. Many recent studies have found a positive impact of health coaching on improving glycemic control (as indicated by reducing HbA1c) through promoting self-management of blood glucose levels, PA, and diet. Both reviews by Sforzo et al. conclude that the majority of studies (78% and 85%

respectively) find a positive impact of health coaching on levels of HbA1c (Sforzo et al., 2018, 2020). A meta-analysis of randomized controlled trials came to a similar conclusion, finding that glycemic control was improved after coaching engagements ranging from less than 3 months to 18 months (Pirbaglou et al., 2018). Thus, the overall conclusion is that health coaching is a promising support intervention for behavior changes leading to improvements in biological markers of diabetes. When compared with a health education intervention, health coaching emerged as more successful in achieving glycemic control (Cinar & Schou, 2014).

In recent years, the interest in the role of health coaching for managing obesity has grown significantly, becoming the most frequently studied condition in health coaching (Sforzo et al., 2020). The majority of the studies focusing on obesity and overweight, published between 1989 and 2016, 87% find that health coaching leads to a reduction in weight, or BMI (Sforzo et al., 2018); and 74% of studies published between 2016 and 2019 find the same (Sforzo et al., 2020). A retrospective cohort study evaluated a large sample of N = 500 participants in a high-intensity lifestyle intervention program based on weekly group coaching sessions. It illustrated significant weight loss, which was a function of the length of participation in the program, reaching 20.7% loss of initial body weight for the group which participated longest in the program—for 13–24 months (Gotthelf et al., 2018). Significant improvements were also observed in lipid profiles, and there were some positive changes in blood pressure and fasting glucose. A significant number of patients were able to decrease their medication use for dyslipidemia, hypertension, and diabetes.

Maintaining the achieved weight loss is of great importance, thus some studies aim to track the impact of coaching over longer periods of time. The evidence for sustainable weight loss with the support of different forms of health coaching is mixed. For example, Godino et al. (2016) are one of the few teams who tracked weight over 2 years through an RCT design and an intervention based on mobile technology as well as access to a health coach (Godino et al., 2016). They found significant weight loss for the young adults in the intervention group compared to the control group up to 12 months, however, after that the difference between the two groups was no longer significant.

Health Behaviors

As health coaching's framework is most often based on behavioral change and lifestyle change, uptake and change in health behaviors are frequently used as an indicator of the efficacy of coaching. These are behaviors that could have health-promoting effects for a range of chronic conditions (smoking, PA, healthy diet, medication adherence, overall self-care). Such behaviors are sometimes the main focus of the study as in Oliveira and colleagues, who focus on PA in older adults (Oliveira et al., 2017), or are assessed as secondary outcomes of studies with other primary aims.

The findings point to a mixed outcome of coaching in regards to behavior change—some studies have not observed health-promoting behavior change, while others, particularly recent ones, show significant change as a result of coaching (Kivelä et al., 2014; The Evidence Center, 2014). The role of coaching has been studied for improving PA and nutrition (DeJesus et al., 2018a; Miller et al., 2018), medication adherence (Wu et al., 2018), tobacco cessation (Sforzo et al., 2014) and others.

Here I highlight coaching as related to increasing physical activity, as it has been identified as the behavior which has the strongest and widest positive benefits for health—for example by the Academy of Medical Royal Colleges in the UK (McNally, 2020). PA has a significant positive impact on overall health, and multiple studies conclude that coaching increases PA compared to control groups or compared to initial levels. Coaching has been showing a positive impact on PA in studies for the past decade (Rimmer et al., 2009). More recently several studies showed a sustained impact of coaching on PA. Annesi et al. (2016) worked with a group of women with obesity and implemented The Coach Approach exercise-support protocol based on cognitive-behavioral models. They found increased PA during the weight loss phase and the weight loss maintenance phase (Annesi et al., 2016). In a group of cardiac patients, Duscha et al. (2018) implemented a program using mHealth and coaching, to maintain the PA levels the patients had achieved during cardiac rehabilitation. While in the group under usual care PA decreased, they found that in the intervention group it increased (Duscha et al., 2018).

In a different setting, specifically with university employees, Bezner et al. (2018) implemented a workplace wellness program consisting of group coaching sessions. This is a theory-informed program based on the trans-theoretical model and self-determination theory, which targeted and tracked the psychological constructs which predicted PA change. Several indicators of PA (as well as relevant psychological constructs such as PA self-efficacy) improved after only an average of 2.3 group coaching sessions (Bezner et al., 2018).

Some studies have explored whether coaching can have a sustained effect on PA after the coaching engagements end. For example, Viester et al. (2017) conducted an RCT with employees of a large construction company. They found that there was a significant effect of the coaching program on meeting the public health guideline of vigorous PA during the six months of the program, but the difference between the groups was not significant at the 12-month follow-up (Viester et al., 2017).

A systematic review and meta-analysis by Oliveira et al. (2017) focused on existing studies assessing the impact of health coaching on increasing PA specifically for older adults (Oliveira et al., 2017). This review selected only RCTs studying PA in this age group and found 27 publications that fit these criteria. It concluded that health coaching has a small but significant effect on increasing PA among adults over 60, as compared to the control groups, immediately after intervention. Interestingly, both trials which used objective and self-report measures of PA found similar levels of the effect of health coaching on PA. The authors conclude with a recommendation for practitioners to include health coaching, especially

considering that it is a relatively low-cost intervention and that it was equally effective for both healthy adults and those with existing health conditions.

Psychosocial Outcomes

In addition to physiological outcomes and health behaviors, health coaching has shown improvement in psychological outcomes such as quality of life, self-efficacy, and indicators of mental health. Quality of Life (QoL) is a frequently measured indicator of psychosocial well-being in the health coaching literature. Clark et al. (2014) found a significant reduction in perceived stress, and depressive symptoms, as well as improvement in the five domains of QoL for employees participating in a wellness coaching program. The program continued for 12 weeks, and the changes were maintained at the 24-week follow-up (Clark et al., 2014).

In the meta-analysis of 22 RCT studies on coaching in Type 2 diabetes, which analyzed HbA1c levels, a qualitative synthesis was conducted for the psychological outcomes (Pirbaglou et al., 2018). It illustrated that more than half of the RCTs included in the review assessed diabetes-related distress, but only three of these showed a significant reduction in distress as a result of the coaching (compared to usual care groups). Similarly, QoL was evaluated in 10 of the publications, and one study showed significant improvement. This study illustrated improvements in the Diabetes Quality of Life Scale which were significant for the coaching group compared to the waitlisted group (Kim et al., 2015). Considering that programs geared toward diabetes self-management do not usually target psychosocial dimensions, the authors recommend designing interventions that more explicitly address the psychological condition (Pirbaglou et al., 2018).

A recent systematic review and meta-analysis of publications on coaching for patients with chronic obstructive pulmonary disease (COPD) included 10 RCTs (Long et al., 2019). The inclusion criteria were that the studies should measure general QoL or disease-specific health-related quality of life (HRQoL) which is significantly impaired in patients with COPD. The review found that four of the ten studies illustrated improvement in QoL, and the metanalysis showed a positive effect of health coaching. Coaching significantly reduced COPD-related hospital admissions.

Coaching for cancer patients is not often studied, as illustrated in the recent compendiums (Sforzo et al., 2018, 2020). However, for cancer patients, QoL can be an important outcome and in coaching studies, it is often the primary target, along with health-promoting behaviors. Hawkes et al. (2014) studied multiple behaviors and psychosocial outcomes for colorectal cancer survivors, attending a coaching program, randomized to an intervention and usual care groups (Hawkes et al., 2014). They identified an improvement in cancer-specific QoL (particularly in the physical symptoms sub-scale) after the 6 months of the program and at follow-up at 12 months, compared to the control group. Similarly, Park et al. (2012) assessed QoL and psychological symptoms in a pilot RCT with breast cancer patients. They

found improvement in QoL, psychological symptoms, and reduction in distress after the 12-week program—for the coaching group compared to the control group (Park et al., 2012).

Considering the importance of self-efficacy for behavior change, health coaching has been shown to improve people's engagement, attitudes, and self-efficacy for changing specific health behaviors, such as those related to diabetes management, exercise, nutrition, medication adherence, pain management, and communication with providers. Some of the studies that were cited in the above section include measures for self-efficacy as predictors or moderators of the behavioral indicators of coaching impact. For example, Cinar and Schou (2014) discuss oral care self-efficacy for patients with type 2 diabetes, using a sample randomized to a health coaching or health education group. They found that self-efficacy improved for the health coaching group, and is associated with improved glycemic control (Cinar & Schou, 2014). A 12-week program of in-person wellness coaching for employees was shown to improve a range of health behaviors, as well as eating self-efficacy and goal setting skills (Clark et al., 2016).

In the study by Wolever and colleagues, patients with type 2 diabetes were randomized to a group for Integrative health coaching and a control group. After 6 months of coaching in 14 sessions, the health coaching group showed an increase in patients' engagement in their care (measured by the Patient Activation Scale) and decreased perceived barriers to medication adherence (Wolever et al., 2010). Working with cancer patients with significant pain others have found that coaching is associated with increased self-efficacy for communication with providers; pain control self-efficacy was related to a decrease in pain severity, however they did not find evidence for an effect of coaching (Jerant et al., 2010).

Summary

This section has illustrated the rapidly expanding field of health coaching and the studies which explore its effectiveness. The review has the goal of illustrating the main conditions and outcomes of interest during the past decade. The overall conclusion can be that health coaching interventions are generally effective and promising as the field expands, though not all studies show reliable impacts of health coaching.

Another takeaway from the literature is the diversity of the field. The different coaching interventions employ a wide range of theoretical frameworks and approaches, modalities of delivery, length, and frequency of the engagement, as well as follow-up data collection time points. For example, several studies are showing sustainability of coaching effect over longer periods of time as illustrated by one systematic review (Dejonghe et al., 2017); however, such study designs are rare as they are more expensive and difficult to carry out in terms of recruitment and attrition of participants. Delivery modalities vary significantly and often include more than one type. Telephone and virtual coaching is becoming more prominent

and accepted in all types of coaching (Geissler et al., 2014), especially during the SARS-CoV-2 pandemic when face-to-face contact between providers and clients was reduced significantly for all healthcare professionals. Some programs successfully employ telephone coaching (Miller et al., 2018; Sherifali et al., 2019). In a recent systematic review of pharmacist coaching, the conclusion was that coaching delivered face-to-face, through the telephone or electronically has a positive impact on health and behaviors; however, more studies are needed in order to adequately compare the different modalities (Singh et al., 2020b).

In the impetus to illustrate effectiveness, current research prioritizes randomized control trials. Health coaching has reached the stage at which several meta-analyses have been published, which include between 10–22 published RCTs—for example on coaching for type 2 diabetes (Pirbaglou et al., 2018), cardiovascular risk (An & Song, 2020), and COPD (Long et al., 2019). The field has few qualitative or mixed-methods studies which aim to understand the experiences of coaches or coachees, for exceptions see (DeJesus et al., 2018b; Denneson et al., 2019; Goble et al., 2017; McQueen et al., 2020). In the recent compendium on health coaching which covered publications between 2016–2018, out of the 104 peer-reviewed articles included, only five employed qualitative data collection methods such as focus groups or interviews (and only three were fully qualitative) (Sforzo et al., 2020). When qualitative methods are employed in health coaching research, it is usually for program evaluation. However, they can contribute more broadly, to the understanding of the coaching process and relationship, the phenomenology of health and illness, experiences of inequalities and power hierarchies in the healthcare system, the contextual and cultural meanings of health, illness and of coaching itself. Qualitative methodologies need to be further integrated into health coaching research and informed by the extensive literature and discussions in qualitative health research (Braun & Clarke, 2019), to learn directly from practitioners and recipients of coaching about the process and results of coaching.

My point is not that we should be aiming for the unification of coaching approaches, modalities, theoretical frameworks, or study methodologies and designs; rather exploration of all dimensions of health coaching is encouraged, and the accumulation of studies would allow for clearer conclusions about the outcomes of coaching and characteristics of the coaching engagements which are associated with health-promoting results.

Health Coaching Theoretical Frameworks and Approaches

Health coaching is informed by multiple theoretical frameworks with practitioners and researchers contributing to advancing relevant models and their implications for coaching practice. As evident by the brief literature overview in the above section, health coaching aims for lifestyle change and thus is often informed by behavior change theories, either explicitly or implicitly. This theoretical orientation to behavior change theory is included in the definition of health coaching (Wolever et al.,

2013); which has also been the base for several recent reviews (Sforzo et al., 2018, 2020). While in the initial stages of health coaching research the focus was on clinically and behaviorally relevant outcomes without explicit discussion of theoretical frameworks, more recent publications are explicit about the theoretical frameworks which inform the study design and/or the coaching practice. More recent reviews of the coaching literature, for example in Type 2 diabetes, spell out the theoretical frameworks which inform the coaching intervention in the studies included in the systematic review and meta-analysis (Pirbaglou et al., 2018). This review concludes that coaching training and interventions are based on frameworks such as patient-centered communication, motivational interviewing, PRECEDE_PROCEED, social cognitive theory and self-efficacy, the transtheoretical model and cognitive behavioral therapy constructs. Health coaching has also been influenced by other conceptual frameworks such as adult development, self-determination theory, positive psychology, and coaching psychology (Passmore & Lai, 2019).

More specifically, the empirical studies cited in this chapter have been informed for example by social cognitive theory (Annesi et al., 2016), the taxonomy of behavior change techniques (Godino et al., 2016), self-determination theory (Bezner et al., 2018; Denneson et al., 2019), the self-efficacy construct (Cinar & Schou, 2014; Clark et al., 2016), the self-help model and community-based participatory research (Kim et al., 2015), acceptance and commitment therapy (Hawkes et al., 2014) and the transtheoretical model of change (Bezner et al., 2018).

Health coaching practice and research design could benefit from additional interdisciplinary conversations, for example with current developments in behavioral change science (see chapter: "Health in Coaching"). Much work in this area is being conducted in health psychology such as that on integrative theories and theory-informed behavior change techniques (Bohlen et al., 2020), as well as critiques of widely employed models (Sniehotta et al., 2014). For example, a recent publication reported a detailed thematic analysis of theory-based coaching techniques using the behavior change techniques taxonomy (Ryan et al., 2020). The concepts of the behavior intention gap and implementation intentions have also been applied successfully to coaching (Greif, 2018); see also chapter: "Motivation, Volition, and Implementation".

Health coaching can be informed by coaching models more broadly, as well as by the idea of shifting to different models, depending on the situation and need (Kauffman & Hodgetts, 2016). Of relevance are models of health coaching informed by narrative theory and implemented in different ways in healthcare and patient coaching. These emphasize meaning-making through narrative, including constructing meanings of health and illness, and the relational construction of meaning (Drake, 2017; Stelter, 2015); see also chapter: "Meaning as a Theme in Coaching". Such frameworks are of interest in current times when the public health landscape has changed dramatically during the SARS-CoV-2 pandemic, we are reflecting deeply on the meaning of this crisis, and our awareness of multiple contributions to our health has increased (see the section below).

Coaching Professionals, Certification, and Competencies

Health coaches aim to help patients prevent or manage chronic conditions in a collaborative way. Their competencies and knowledge are thus different from those of other professionals in healthcare, as well as from those of coaches in other contexts (Wolever et al., 2017). As stated by the authors, most other health professions emphasize treating and teaching clients and patients, and there is an assumption that the provider is the one who teaches the patient. On the other hand, health coaching is a patient and relationship-centered engagement, which is focused on the clients' agenda, goals, strengths, and existing resources and how to identify and harness them for improving health. The content of the session is directed mainly by the client's preferences and concerns.

At the same time, health coaching can be different from other areas of coaching such as executive coaching, since information provision and education about the disease could be necessary at times. This aspect of health coaching is included in the definition of health coaching we cited at the beginning of the chapter (Wolever et al., 2013). This means that health coaches need to have knowledge about the disease and aspects of its treatment, and at the same time have the skills to provide that information in ways that are relationship centered and support client motivation and self-efficacy. Health coaches can work independently, and more and more often are becoming part of integrated medical teams, particularly in primary care (Gastala et al., 2018). Being part of an integrated medical team speaks for the need for specific competencies related both to knowledge and teamwork in healthcare. Additionally, the coaching clients whom health coaching professionals work with might be more vulnerable due to their chronic conditions, compared to clients in organizations (Wolever et al., 2017). In summary, professional boards for health coaches need to take the specifics of the profession into account when identifying competencies, accrediting programs, and certifying health coaches.

The training and certification of health coaching is a widely discussed topic, and agencies across the globe have been actively involved in identifying standards for knowledge and competencies for coaches working in healthcare. Several international and national professional organizations identify coaching competencies (for example, The Association for Coaching (AC), International Coaching Federation (ICF), European Mentoring and Coaching Council (EMCC), and some such as the National Board for Health and Wellness Coaching (NBHWC) specify health coaching specific competencies.

A recent systematic review (Singh et al., 2020a) aimed to identify the core "skills, knowledge, attitudes, and attributes associated with health coaching", as well as to discuss how they map onto general coaching competencies identified by international coaching organizations (specifically EMCC and ICF). The review identified 18 publications that fit the inclusion criteria over the period of 1950–2018 and nine

competencies for health coaches, which are proposed in the literature.[1] Many of these were found to overlap with competencies identified by EMCC and ICF, while four are specific to health coaching. One of the specific competencies is "demonstrates team and leadership skills to optimize healthcare," which speaks to the context in which health coaches work and could be part of an interdisciplinary team.

NBHWC in the United States implemented a collaborative interdisciplinary process over several years to develop a job description,[2] standards, and certification for health coaches (Jordan et al., 2015; Wolever et al., 2016). They created training and education standards for health coaches, and procedures for accrediting health and wellness coaching programs (NBHWC, 2020). Requirements for national certification of health coaches include completion of an accredited program, as well as the National Board Certification Examination, which is in coordination with the National Board of Medical Examiners (NBME, 2020). Additionally, based on the advocacy from this organization, since January 1, 2020, the American Medical Association has approved a new Category III Current Procedural Terminology (CPT) Billing Codes for health and wellness coaching, which sets the ground for reimbursement of coaching services by insurers. This has been a significant accomplishment for the recognition of health coaching and potential access to and wider utilization of coaching in healthcare.

The Changing Landscape of Health and Health Coaching

Health coaching emerged as a practice at a time in which chronic diseases dominated the health landscape, many of them preventable and treatable with behavioral changes. We are now living in a time that has palpably brought to our attention the risk of infectious disease on a global scale. For years healthcare systems have been dealing with antibiotic-resistant bacteria the threat of which is increasing. Several outbreaks of coronavirus epidemics are evident since the early 2000s (SARS-CoV, MERS-CoV) and most recently the novel SARS-CoV-2 pandemic

[1] Competencies for health coaches base on a systematic review (Singh et al., 2020a): communicates effectively for the delivery of patient centered care; demonstrates team and leadership skills to optimize healthcare; demonstrates an understanding of relevant, fundamental, and evidence-based knowledge and undertakes lifelong learning to improve professional practice; demonstrates tolerance and respect for individuals and groups from diverse backgrounds; demonstrates professional behavior and accountability; demonstrates the ability to utilize empathy when communicating with patients; demonstrates confidence; identifies areas for development to improve competency; works systematically and coordinates activities.

[2] The job description for health coaching from NBHWC is: "Health and Wellness Coaches are professionals from diverse backgrounds and education who work with individuals and groups in a client-centered process to facilitate and empower the client to achieve self-determined goals related to health and wellness. Successful coaching takes place when coaches apply clearly defined knowledge and skills so that clients mobilize internal strengths and external resources for sustainable change."

caused high morbidity and mortality and wreaked havoc in health systems globally. It has had severe consequences for all people and institutions and has evoked reflections about who we are, what we are doing, how we are all connected, and what is of utmost importance.

The field of health coaching can also take this time as an opportunity to appreciate its accomplishments and reflect on its future; as well as what on what its role could be in the transformed global landscape of health, illness, and healthcare. Coaching researchers and practitioners have reflected on the potential for coaching to support people at the time of the pandemic crisis, so far, particularly as it relates to mental health (Williams & Palmer, 2020) or health provider burnout (Institute of Coaching, 2020).

The Covid-19 pandemic does not eclipse the importance of chronic diseases; on the contrary, it has illuminated what happens when chronic and infectious diseases intersect, what a significant risk factor chronic diseases are for susceptibility to infectious diseases. Morbidity and mortality data are showing that people with accompanying chronic conditions such as hypertension, obesity, and diabetes are more susceptible to contracting and having more severe progression of COVID-19. Health coaching's role increases when we realize the importance of preventing and reducing chronic disease, in order to reduce the additional risks of novel infectious diseases. Additionally, as the example of COVID-19 shows, social behavioral strategies are crucial in preventing transmission and serious illness. Behavioral science offers theory-informed approaches to preventive behavior change to reduce virus transmission and adhere to public health measures, through changing attitudes, beliefs, and motivations, which health coaches are very familiar with (West et al., 2020); see also chapter: "Health in Coaching".

Most importantly, the SARS-CoV-2 pandemic has exposed as well as exacerbated the health inequalities associated with chronic conditions and has illuminated their social and economic determinants, as well as started a discussion about what we can learn from these insights, to improve health and reduce inequalities in the future (Coates et al., 2020). The SARS-CoV-2 pandemic and its severe cases have disproportionally affected racial and ethnic minorities, those living in difficult socioeconomic circumstances, who are more vulnerable to infection and have had higher mortality rates. Research and practice in health coaching have occasionally addressed health inequalities especially in the past several years (Schultz et al., 2020; Thom et al., 2018), for example through implementing programs in impoverished neighborhoods (Gootjes et al., 2019), or illustrating that participating in coaching can reduce inequalities in coronary heart disease risk factors (Jelinek et al., 2014). The events happening before our eyes compel us to ask how coaching's role can be further expanded and implemented in a way that is accessible and beneficial for all. One step toward affordability has been the approval of billing codes in the US, which however will take time to be applied, and will then be helpful only to those with health insurance. Thus, there is a clear need to consider ways that coaching can be provided through social programs.

Another question is how the heightened awareness of health and structural inequalities brought about by the pandemic expand the purpose of health coaching

and what that means for the content of coaching practice and conversations. Jordan has illustrated how coaching conversations with vulnerable populations need to focus attention on safe housing, healthcare access, education, and safety (Jordan, 2013). She also underscores that coaching supports participants' self-efficacy and internal resources to cope with the environmental stressors and economic impoverishment in their daily lives. At the same time, these individual resources can have only partial relevance in overcoming structural inequalities which illustrates the limitations of an individual empowerment and behavior change model. The situation compels health coaching to consider how it can be instrumental in reducing health disparities caused by structural inequalities and in influencing ineffective or unjust policies.

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