Physical

A C T I V I T Y

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Health and Wellness Coaching: Providers and Practice—A Commentary on Sforzo and Colleagues (2018)

Abstract: *The field of health and wellness coaching holds great promise for making health behavior change interventions available to more individuals. We assert that the health and wellness literature should recognize the potential of lay persons to provide health coaching and lay person health coach studies should be included in the compendium compiled by Sforzo and colleagues. Limiting the field to current health professionals decreases the number of potential coaches unnecessarily. The compendium will be an excellent resource for researchers to compile the existing data to determine the effectiveness of coaching, what aspects of coaching are effective, for what conditions coaching is effective, and what outcomes coaching improves. We provide commentary that researchers exploring health coaching should recognize the importance of physical activity in improving outcomes for a number of different populations and should health behaviors as outcomes in health coaching intervention studies.*

Keywords: health and wellness coaching; physical activity; health behavior change; exercise

The influence of lifestyle behaviors on chronic disease, morbidity, and mortality is widely recognized.^{1,2}

Although many types of health care professionals receive training on how to help patients change their behaviors, a number of factors limit patients' access to this service. For example, a nationwide primary care physician shortage limits individuals' ability to find a local

potential providers, and coaching appointments allow for a defined time for using evidence-based strategies to target behavior change.

Sforzo and colleagues⁵ should be commended for their ambition to tackle the challenge of compiling and reviewing the current literature on health and wellness coaching (HWC). As they note, there is a critical need to

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provider with whom they can develop an ongoing relationship and discuss lifestyle factors, particularly in rural areas.³ Doctors are also experiencing economic pressure to see as many patients as possible and increasing documentation burdens, limiting the time they have available for behavioral counseling.⁴ Health coaches may be ideal additions to a patient's medical team; the profession requires less training, broadening the number of

determine the evidence base for HWC as the field grows. Wisely, the authors used a definition of HWC agreed upon by experts to establish inclusion into the compendium. However, 1 of 5 key aspects of HWC as they define it is that a coach be a "trained health care professional." Yet, there is no included definition of a health care professional: What professions does this include? Must their training involve patient care? Must they be licensed to practice some

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form of health care? Does this include professions that are considered “health care providers” in one state, yet they do not have the same title distinction in another state (eg, massage therapists in Washington are considered health care providers; however, in South Carolina licensed massage therapists with the same or higher level of education do not have that title of “health care provider”). In addition to this lack of specificity, a prerequisite for health coaches to be previously trained health care professionals is concerning. Restricting the field to only established health care professionals seemingly limits the field of potential coaches unnecessarily.

The HWC literature presents inconsistent messages about the requirement for coaches to first be health care professionals. One of the cited papers for determining the HWC definition in the review notes that

While the specific professional background of health and wellness coaches is diverse, there is an emerging consensus in the literature that coaching be provided by health professionals (currently a diverse range is represented) who, further, have specific training in coaching processes and not only expertise in the knowledge base of their profession.⁶

However, no citations are offered, and no further description is provided regarding the reasons for this consensus. This definition also appears to conflict with the requirements for credentialing, which allow applications from those who simply have a bachelor's degree in a health-related field and helping professionals without health-related degrees who have health-related work experience, and allow the opportunity for those not meeting the minimum requirements to petition for application.⁷ Sforzo and colleagues⁵ themselves acknowledge challenges with this aspect of the definition by including studies in the compendium that used “well-trained peers or medical assistants” as coaches; adding that “This was deemed acceptable

in the spirit of not excluding articles describing a HWC process our expert reviewers otherwise deemed appropriate.”

One of the key advantages of the HWC profession is to broaden the number of providers available for health behavior coaching. Why limit the number of possible potential coaches? Lay people and peers may be able to provide health coaching services in rural areas with minimal other medical services. The fact that these individuals are not health care professionals may actually make them more effective in forming connections with the patient and effecting change. Public health researchers have demonstrated the value of recruiting members of a community in order to deliver public health messages. Promotoras de Salud, Spanish-speaking Latino individuals trained as community health workers, have demonstrated improved health-related outcomes and reduction of risk factors through the delivery of health promotion and disease prevention programs to their community.⁸ This model has been demonstrated in health coaching as well; a randomized controlled trial found that a HWC intervention using African American peers and medical assistants delivering coaching to African Americans with uncontrolled hypertension effectively lowered systolic blood pressure at 6 months (although did not decrease 4-year coronary heart disease risk).⁹ Other non-health professionals may also provide unique perspectives to promote change (eg, religious leaders, teachers).

Health coaches absolutely need training and experience. Outstanding work has been done by the National Consortium for Credentialing Health and Wellness Coaches to clarify national standards for the use of the term health and wellness coach and to develop requirements for training, education, and certification.⁷ As the compendium demonstrates, there is significant diversity among HWC models in the literature and in practice, making it difficult to determine the efficacy of HWC. These standards will be critical for

helping referring providers and patients ensure that a coach has received appropriate training and conducts evidence-based HWC practice. The need for training and experience should not preclude non-health care professionals from becoming health coaches. Perhaps an addition to the standards could be made in order to provide sufficient clinical health experience for lay people that health care professionals are already expected to have.

As these lay person and peer coach models have been investigated frequently in the literature, the compendium would benefit from including all studies meeting the other definitional requirements of health coaching where the coaches are professionals and nonprofessionals. This would provide a more comprehensive view of the HWC literature; in a recent systematic review of the HWC literature, only 50% of trials used health care providers for coaches; 14% used peers; 11% used behavioral health providers (eg, social workers), and another 23% used other nonprofessionals who did not qualify as “peers.”¹⁰ These additional manuscripts would make the compendium an even richer resource, offering more empirical data evaluating the practice of HWC. Broadening the compendium to include non-health care providers would also eliminate the need for subjective judgments on inclusion by the expert reviewers and allow for an empirical comparison of professional and nonprofessional coaches. Some initial work in this area has found no clear differences in outcomes for coaching provided by health care professionals compared to non-professionals.¹⁰ Further analyses using studies with non-health care professional coaches could also set the stage for the development of standards for training of lay person and peer coaches.

As Sforzo and colleagues⁵ point out, there is a critical need for high-quality research in the field of HWC given the growth of the profession and the associated literature. The compilation of this literature into a compendium is an excellent step enabling the field to make conclusions regarding the current state of

the evidence and driving future work. The compendium allows us to explore more specific questions of interest within the literature, for example, there is a clear gap in the HWC literature in the area of physical activity. From compendium A, of the 150 papers, only 40 are listed as providing positive changes exercise behavior. An additional 4 studies report a nonsignificant finding increased exercise behavior from HWC. None of the 40 articles reported a negative finding for exercise behavior. There does appear to be 1 article that is not included in the improvement of exercise behavior. Item 96 does not have a "Y+" in the exercise behavior column in the compendium; however, the title of the article indicates that exercise behavior did improve and showed a treatment effect even at 15-month follow-up.¹¹ If only 41 articles of the 150, 27.33%, are measuring exercise behavior in any way, then it appears there may be a significant area for HWC interventions for future studies.

When considering that low cardiorespiratory fitness is a predictor of morbidity and mortality¹²⁻¹⁴ and that physical activity can improve outcomes for patients with chronic disease,¹⁵⁻¹⁷ it is surprising the lack of HWC interventions implementing coaching around physical activity. On review of compendium A, a majority (78.05%, $n = 32$) of the interventions focus on either wellness (24.39%, $n = 10$), obesity (34.14%, $n = 14$), or general health (19.51%, $n = 8$). While physical activity is an appropriate intervention, an opportunity is missed when reviewing the lack of literature for HWC for physical activity and the other listed conditions.

There are no interventions for exercise in chronic fatigue or fibromyalgia populations. Physical activity has been shown to be beneficial for those with chronic fatigue¹⁸ and with fibromyalgia^{19,20} by ameliorating condition symptoms. However, HWC to improve physical activity may be difficult with these populations as those with the conditions may avoid exercise for fear of worsening symptoms.²¹ Those with these conditions appear to benefit

from physical activity and with no interventions listed for these populations, those looking to provide HWC for individuals with either fibromyalgia or chronic fatigue could fill a gap in the literature by including physical activity as part of the intervention.

Compendium A lists a total of 3 articles (7.31%) that focus on cancer and include physical activity as one of the measurement outcomes. All 3 of the interventions report an increase of physical activity at the conclusion of the intervention. Physical activity has been shown to improve quality of life,^{22,23} cognitive function,^{24,25} fatigue,²⁶ and reduce the risk of death^{27,28} for those with cancer. Therefore, HWC interventions for cancer survivors would benefit from including physical activity.

Finally, compendium A includes only 13 studies (31.7%) in populations with cardiometabolic conditions: 1 cholesterol study (2.44%), 2 (4.88%) hypertension studies, 4 (9.76%) heart disease studies, and 6 (14.63%) studies investigating diabetes. All these conditions appear to be underrepresented considering the benefits of physical activity for patients with these chronic diseases. Physical activity has been associated with an increase high-density lipoprotein (HDL) cholesterol, decreased triglycerides, and decreased non-HDL.^{29,30} Hypertension has also been improved through physical activity, including lowering of both systolic and diastolic measures.³¹ The recent narrative review compiled 27 random control trials, results indicated moderate-to-vigorous physical activity led to the greatest reduction of blood pressure compared with resistance training.³¹ In both primary and secondary prevention, high levels of cardiorespiratory fitness along with regular physical activity can reduce coronary heart disease.¹⁶ Furthermore, body mass index has been found to be inversely associated with mortality for patients with high fitness levels and known or suspected coronary heart disease.³²⁻³⁴ Finally, physical activity and structured exercise can be profoundly

beneficial for patients with diabetes. Avery et al³⁵ report in their meta-analysis that behavioral interventions specifically targeting physical activity can improve physical activity behavior and reduce HbA1c levels for patients with diabetes. Moreover, Yang and colleagues³⁶ report that both aerobic and resistance training can help improve glycemic control for patients with type 2 diabetes and that they type of activity may be less important than simply becoming active; patient preference for type of activity may be of the greatest importance when behavioral counseling for increasing physical activity is part of an intervention.

With the preponderance of literature surrounding the benefits of physical activity for patients with these cardiometabolic disorders, it is surprising the paucity of literature listed for HWC in the compendium. It is possible that many of the included HWC interventions did include coaching on physical activity but did not measure this behavior as an outcome, instead using a more distal outcome like HbA1c or blood pressure. Measuring behavior change in studies assessing HWC is critical to determine whether coaching is working to bring about change in health-related outcomes through the hypothesized mechanism: change in behaviors. Consistent measurement of behaviors also enables meta-analytic analyses to determine the effectiveness of HWC on specific behaviors. A recent systematic review found a small, positive, statistically significant effect of HWC on physical activity measured as a continuous variable in steps or minutes compared with an inactive control; when compared with active controls, the estimate was not significant.¹⁰ There was no difference between groups in studies that measured physical activity as reaching or exceeding some threshold. More well-designed research is needed to determine the effect of coaching on physical activity. Future directions suggest more HWC interventions specifically with the goal of increasing exercise behavior to improve health outcomes for patients in the listed populations.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Informed Consent

Not applicable, because this article does not contain any studies with human or animal subjects.

Trial Registration

Not applicable, because this article does not contain any clinical trials. **AJLM**

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