

Implementing health coaching for people with long-term conditions: a scoping review

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ABSTRACT

Introduction. The rising global burden of chronic diseases has compelled healthcare practitioners to bolster their role in supporting individuals with long-term conditions in managing their health and well-being. Demand for health coaching continues to grow, but a limited body of knowledge makes it challenging to develop fit-for-purpose practitioner training. **Aim.** This study aims to examine what is known about how to implement health coaching for people with long-term conditions. **Methods.** Health databases were searched to identify peer-reviewed research articles. Data extraction was undertaken using a tool developed by the authors, and findings were charted, summarised and synthesised. **Results.** Seventy-six studies were included. Health coaching interventions span 17 different long-term conditions, are delivered by various providers (55% dedicated health coaches, 28% nurses) and occur primarily in community and public health settings (78%). Fundamental implementation guidance remains absent. With 69% lacking any named theoretical basis and 62% of studies failing to report training duration, practitioners receive inconsistent preparation for coaching patients with complex needs. **Discussion.** We found conceptual confusion and ambiguity across studies. Advancing the field will require identification of key theories, transferable core components and competency-based training standards. Themes of theorising, tailoring and training recur throughout this review. We offer a conceptual framework that synthesises concepts and bridges theory and practice, thus supporting practitioners to deliver person-centred coaching.

Keywords: chronic conditions, communication skills training, health behaviour change, health coaching, patient adherence, provider-patient communication, self-determination theory, self-management support.

Introduction

The global implications of increasing numbers of people with long-term conditions are inescapable,¹ with costs anticipated to reach ‘US \$47 trillion’ by 2030.² Indeed, 85% of all health loss experienced by New Zealanders (including premature deaths and reduced quality of life) results from long-term conditions.³ Because these conditions cannot be cured, healthcare practitioners (HCPs) need ways to best support patients in self-managing their conditions.¹ Adopting new health-promoting behaviours can enhance well-being and quality of life and reduce health costs.^{4–6} However, many people struggle to make recommended lifestyle changes.⁷ Furthermore, many HCPs find it challenging to support patients in implementing behavioural change plans, reporting a lack of knowledge and skills.⁸

Health coaching (HC)

HC is an intervention that provides self-management support to enable individuals to manage their health and well-being with theoretical roots in motivational interviewing (MI) from counselling,⁹ behaviour change from psychology¹⁰ and, more recently,

WHAT GAP THIS FILLS?

What is already known: Research evidence shows health coaching can be an effective approach to self-management support for people with long-term conditions, yet little is known about how effective coaching interventions are implemented in practice or which core components underpin optimal delivery across diverse conditions and populations.

What this study adds: The reporting of health coaching for long-term conditions is characterised by significant variation in its underpinning principles, processes and practices, with no agreed theoretical or competency framework and limited guidance on tailoring to diverse conditions. This review maps this landscape across 76 studies and offers a synthesising conceptual framework by addressing gaps in theorising, tailoring and training, to support consistent person-centred delivery.

health and wellness coaching from health promotion.¹¹ HC can align with person-centred care by prioritising the development of a collaborative therapeutic relationship, enabling the use of a variety of interpersonal techniques aimed at building the patient's capabilities to make small but significant changes that, over time, can produce long-term benefits to health, function and wellbeing. However, whether this person-centred philosophy is consistently operationalised in practice has not been established.

HC has excellent potential to improve health outcomes and enhance patient satisfaction with care,^{12–14} with interest in HC steadily increasing in recent years.¹⁴ However, systematic reviews show inconsistent effects of HC on physical and mental health outcomes.^{12,13,15} The cause of this variability in outcomes is unclear but may reflect heterogeneity in what is being delivered because the core components that contribute to effectiveness are not known.¹⁶

There has been limited attention to how HC principles and practices should be adapted to meet the needs of people with different conditions and cultural contexts. Although best practice suggests health coaches deliver tailored interventions,¹⁴ how to train practitioners to do this effectively is also unclear.¹⁷ This review addresses that gap by mapping how HC is currently implemented, by whom, with what training and how, to identify the core components needed for a consistent but adaptable approach to delivery. It aims to (1) understand how HC is being used across settings, by whom and with which patient populations; (2) explore the practice of HC for people with long-term conditions, including its theoretical grounding; and (3) report on training undertaken by those providing HC.

Methods

We followed best-practice guidelines for our review (see PRISMA ScR checklist in Supplementary material S1).^{18,19}

The review protocol was developed and refined through team discussion and is available from the author upon request. Table 1 overviews specific questions addressed in this review, adapted from guidelines for standardised reporting of interventions (TIDieR).²⁰

Eligibility criteria

Research articles were included if: (1) participants were over 18 years; (2) participants had at least one long-term health condition²¹ and received person-to-person HC; (3) the article contained information about the type of HCPs delivering the coaching; (4) any description of the attitudes and behaviours of health coaches; (5) any description of components, activities or techniques used in coaching and intervention context such as settings in which the HC occurred; and (6) contained demographics of the clients receiving HC. The review was restricted to English-language publications, given the breadth of the scope and the team's available resources.

Studies were excluded if: (1) the intervention was not provided as part of services from a recognised HCP; (2) the focus of the coaching was solely preventative, not targeted at improving the health and wellbeing of people with long-term conditions; (3) there was no person-to-person interaction (e.g. solely digital health interventions); or (4) there was no information about what the health coach actually did.

Information sources

In conjunction with an experienced librarian, we piloted a range of keywords, settling on the following: 'health coach*.ab' with the limits of years from 2013 to 2023. The timeframe was selected because a preliminary Scopus search showed a marked increase in publications from 2013 onwards. This coincided with increasing interest in educational standards and credentialing.²² We searched EBSCO Health databases (including Medline and CINAHL) and Scopus in August 2023. Supplementary material S2 contains detailed information about the search strategy rationale.

Selection of sources of evidence

Identified records were collated and uploaded to Covidence,²³ and duplicates removed. Titles and abstracts were screened by two independent reviewers against the inclusion criteria. The second author reviewed selected full-text articles and discussed any uncertainty with the first author. The first author regularly reviewed the full-text screening decisions during a weekly meeting, with disagreements resolved through discussion. Reasons for excluding full-text papers were recorded.

Data extraction

The second author extracted all data in relation to the research questions, entered them into a bespoke Excel spreadsheet, and the first author closely reviewed them. Strategies to ensure credibility included pilot testing and

Table 1. Features of HC intervention implementation and context using TIDieR.

TIDieR items	Review questions
Item 1: Name or phrase describing intervention	What was the name of the HC intervention?
Item 2: Why: Rationale/Theory	What kind of theory (if any) informed the design of the HC intervention? What sort of rationale/attitudes inform the way the coach interacts with the client? (e.g. need-supportive, person-centred)
Item 3: What (materials)?	What materials were used by the coaches? What materials were used by participants?
Item 4: What (procedures/processes)?	What HC techniques were used to facilitate behaviour change?
Item 5: Who provided (expertise, disciplinary background, training)?	Who provided the HC? What was their primary job title? What was their disciplinary background? What type and amount of HC training did they have? Who provided the HC training?
Item 6: How (modes of delivery)?	What mode of delivery was used?
Item 7: Where (location)?	Where did the HC take place? (setting, country)
Item 8: When and how much?	How many sessions, over what time, was the HC provided?
Item 9: Tailoring	Was any tailoring or adaptation to the needs of the recipient made (i.e. a personalised approach)?
Item 10: Modifications	Was the delivery of the HC intervention modified from what was planned during the study in any way?
Item 11: Fidelity	Was a protocol for the intervention provided?
Item 12: How well was the protocol actually delivered?	Was the protocol delivered as it was intended?
*Item 13: Who received HC?	What participant characteristics were reported?

*N.B. not in the TIDieR framework.

weekly shared team discussions about the (re)framing of research questions, given the iterative nature of our understanding of core elements. Table 1 provides an overview of the data extracted. When available, we accessed supplementary materials (e.g. protocols) to obtain additional implementation details.

Data analysis

Implementation science distinguishes core (essential) components of complex interventions from adaptable ones; we used this distinction to guide our synthesis.¹⁶ To do this, we synthesised descriptions of what the HC intervention involved and how the coach interacted with their clients. To find a parsimonious way of organising and categorising the data on what the health coaches actually did, we reviewed theoretical concepts from relevant sources to support our retroductive analysis,²⁴ including person-centred care, self-determination theory, motivational interviewing and enablement models.^{25–27} Consequently, we identified three guiding principles reflecting the attitudes of the coach: (1) enable active involvement, (2) build personal skills and capabilities and (3) create a supportive environment. We also identified three core interpersonal practice sets: (1) listening, (2) tailoring and (3) planning.

We returned to the articles looking specifically for evidence of these person-centred principles and practices by asking: (1) Did the coach facilitate active involvement of the client in the behavioural change process? (2) Did the coach aim to build personal skills and capabilities for behavioural change? and (3) Did the coach seek to provide a supportive social environment? If an answer was in the affirmative, then the intervention was deemed to provide an autonomy-supportive environment by meeting the basic psychological needs of the client,²⁶ which we viewed as an indicator of person-centred coaching.

Data presentation

Tabulated data are presented to provide an overview of findings, including study characteristics, intervention characteristics, countries of origin, settings, provider data and training information. See Table 2, Supplementary material S3, S4 and S5.

Results

Fig. 1 presents the PRISMA flow diagram of the study selection process with 76 articles included in the review.

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Supplementary material S3 provides a summary of the included studies, and S4 provides a summary of specific intervention characteristics.

Who received HC interventions?

People with a diverse range of long-term conditions received HC (see Table 2). The most common condition was diabetes (34%, $n = 26$ studies), followed by cancer (22%, $n = 17$). More details are provided in Supplementary material S3.

In what contexts did HC encounters occur?

The countries of origin of studies were: the USA (54%, $n = 41$); Australia (13%, $n = 10$); the UK (5%, $n = 4$); Canada and China had 3 studies each (4%); Finland, Taiwan and Turkey each had 3% ($n = 2$). Two New Zealand studies were included.^{28,29} There was one study each from Brazil, Denmark, Indonesia, Japan, Nigeria and Spain. Most HC encounters occurred in primary health care (54%, $n = 41$) or community settings (28%, $n = 21$). Supplementary material S3 includes country of origin information for each study, and S5b provides information about HC by setting type.

What mode of delivery was used?

Studies commonly used multiple modes of delivery. Three-quarters (76%, $n = 58$) used the telephone to deliver some aspects of a HC intervention, and half of the studies (50%, $n = 38$) contained at least one face-to-face interaction. Other delivery modes included post, email, video conferencing or text message, usually in conjunction with either face-to-face meetings or phone calls. Several studies utilised technology to inform or complement healthcare interactions via fitness trackers (47%, $n = 36$), apps (17%, $n = 13$) and online platforms (12%, $n = 9$). Only a few studies described how using technology influenced the role of the coach or the underlying change processes of the client.

Who provided HC interventions?

Across the 76 studies, two main groups used HC: (1) clinical disciplines (medical, nursing and allied health) and (2) health coaches. The single most common clinical discipline was nursing, mentioned in 23 studies. In the studies where the provider was named as a health coach, 11 of the 49 studies used certified health coaches. Among health coaches, there was a range of professional backgrounds including health promotion, health education, community health work and, occasionally, clinical backgrounds. More information is provided in Supplementary material S5.

How were practitioners trained to facilitate HC interventions?

Across all studies, regardless of provider background, various approaches to training health coaches were reported. Only 20% of studies ($n = 15$) used named external training

providers, with 12 different providers, including organisations providing some certification ($n = 8$) and/or specific skill training in HC ($n = 4$) (see Supplementary material S5). Around half of the studies (51%, $n = 39$) did not provide any information about who facilitated the training. The remaining 22 studies offered their own bespoke training. Most studies (63%, $n = 48$) did not provide any information about training duration; the others revealed a wide range, from 3 h to several weeks.

What knowledge, behaviours, attitudes and skills did HCPs utilise when delivering HC in healthcare settings?

Overall, included studies had limited descriptions of theoretical or conceptual frameworks used to inform either the HC intervention or the training of health coaches. Only a third of the studies (32%, $n = 24$) mentioned one or more behavioural change theories used to inform either the training of coaches or the design of HC interventions. The most cited theories were social cognitive theory/self-efficacy theory (15%, $n = 11$), followed by the transtheoretical model (5%, $n = 4$). Five other behavioural change theories were mentioned in two studies each: self-regulation theory, self-determination theory, information-behavioural-skills and theory of planned behaviour. Supplementary material S5 provides more information about the use of theory in the included studies.

The remaining studies (70%, $n = 53$) did not report any conceptual or theoretical basis for their HC approaches. Most studies (70%, $n = 53$) mentioned person-centred care when describing their intervention, and half (50%, $n = 38$) mentioned incorporating aspects of motivational interviewing into their training or coaching practices.

Three core skill sets utilised by those providing HC were: (1) listening, (2) tailoring and (3) planning. Most studies (60%, $n = 46$) provided evidence of empathetic listening by coaches, 70% ($n = 53$) provided evidence of coaches tailoring their approach to address client issues, and 80% ($n = 61$) provided evidence of behavioural support using goal setting and planning for change. HCPs in 27 studies (35%) used all three skill sets. In 22% of studies ($n = 17$), only one was employed.

Discussion

HC is both an emerging discrete profession and a practice used in health care by various practitioners. Our key findings are: (1) globally there is widespread geographical use of HC for people with various long-term conditions; (2) most HC is delivered in primary care, community or outpatient settings; (3) multiple modes of delivery are being used; (4) HC providers come from diverse disciplinary backgrounds; but (5) there is limited systematic integration of theoretical concepts into HC training and practice. We discuss theorising HC, tailoring HC, and HC training as key

Table 2. Number of studies by condition type.

Long term condition	Subtype	Study ID	Number of included studies	
				Subtype TOTAL
Diabetes	Type 2	Ahn 2018; Azelton 2021; Biber 2023; Browning 2016; Cinar 2014; Delaney 2017; Dillon 2016; Edwards 2022; Fazio 2019; Hadden 2020; Huang 2023; Hurst 2021; Liddy 2015; Martin 2021; McGloin 2015; McLeod 2020; Milani 2021; Onyechi 2016; Sharma 2016; Sullivan 2019; Thom 2015; Young 2020	22	
	Type 1	Magalhães 2018	1	
	Type 1 and 2	Fortmann 2020; Macdonald 2021; Panattoni 2017	3	
				26
Cancer	Prostate	Algotar 2021; Handley 2022; Matthew 2022; Obro 2022	4	
	Endometrial	Bell 2021	1	
	Breast	Lynch 2019; Nápoles 2019; Suzuki 2020	3	
	Colorectal	Hawkes 2013	1	
	Breast and colorectal	Hardcastle 2023	1	
	All types	Dennett 2021; Dolan 2022; Eakin 2020; Eisele 2023; Gell 2020; Oswald 2023; Sohl 2023	7	
				17
Respiratory	Chronic obstructive pulmonary disease (COPD)	Benzo 2016; Benzo 2018; Benzo 2022; Coultas 2016; Coventry 2019; Jolly 2018; Rehman 2017; Tülüce 2018; Wang 2018	9	
	Asthma	Rasulnia 2018	1	
	Interstitial lung disease	Duke 2023	1	
				11
Neurological	Stroke	Lin 2022	1	
	Traumatic brain injury	Madrigal 2017	1	
	Other physical disabilities	Rimmer 2022; Stretton 2013	2	
				4
Cardiovascular	Coronary artery disease (CAD)	Duscha 2018	1	
	Heart failure	Ong 2016; Shoemaker 2017; Zuraida 2022	3	
				4
Visceral	Liver disease	Lai 2021	1	
	Kidney Disease	Lin 2021; Low 2019	2	
	Irritable bowel syndrome	McDonald 2018	1	
				4
HIV		Carey 2020; Ramsey 2021	2	2
Multiple conditions	Two or more chronic conditions	Burger 2019; Dufour 2015; Karhula 2015; Moreno-Chico 2021; Mustonen 2020; Panagioti 2018; Park 2014; Roy 2020		8
				76

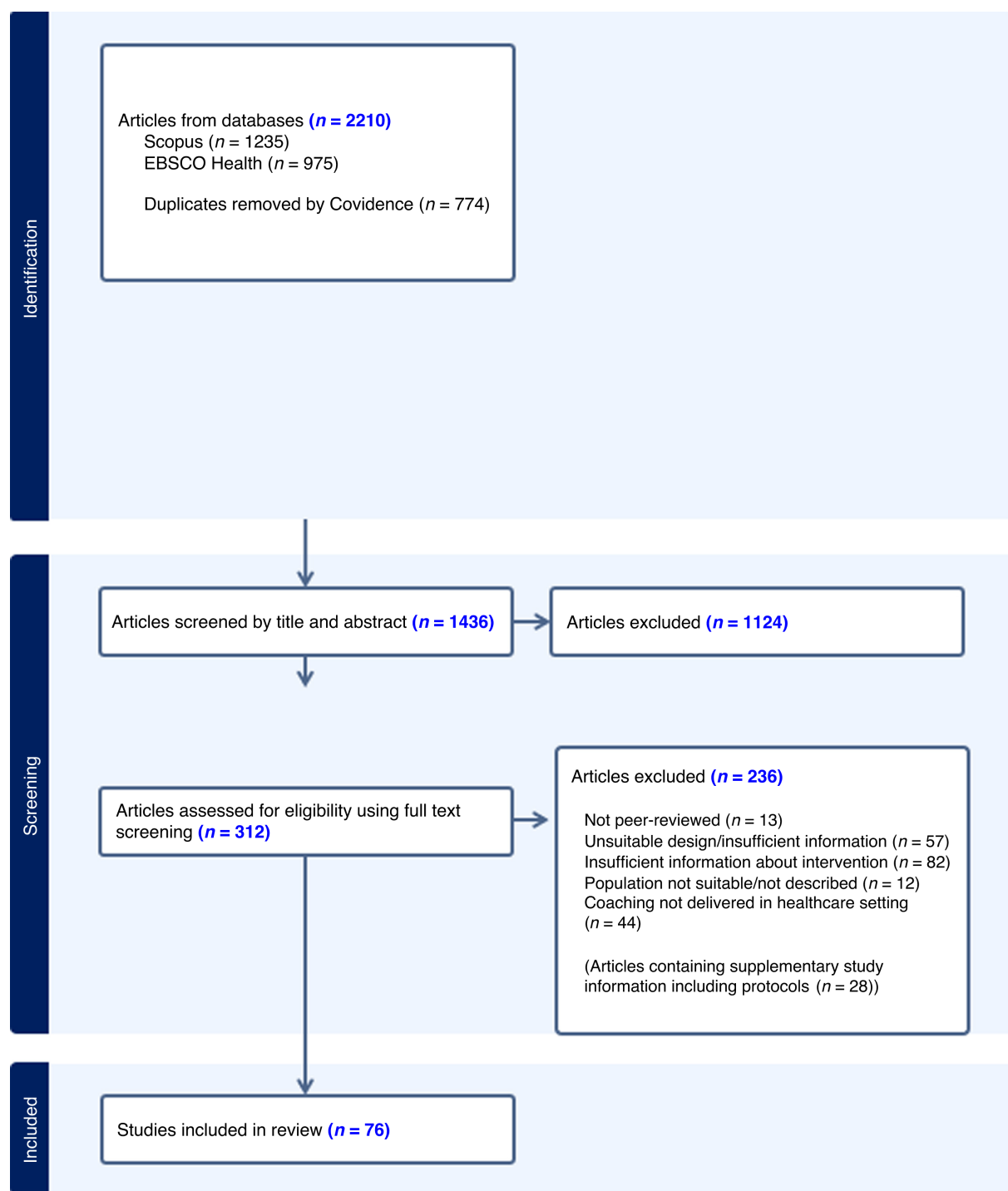


Fig. 1. PRISMA flow diagram of the screening process.

considerations for advancing the value of HC for people with long-term conditions.

Theorising HC

Person-centred care is a cornerstone of contemporary health care, with broad consensus it represents best

practice in long-term condition management.³⁰ The term ‘person-centred care’ was mentioned frequently in the reviewed studies, but the concept was seldom explained or clearly linked to actual coaching practices. We attempted to assess person-centredness by looking for evidence of coaching that could satisfy basic psychological needs and identified three essential interpersonal practices that

appeared across studies: listening, tailoring and planning. However, only 27 studies (35%) described how their coaches used all three of these core practice sets. This suggests a disconnect between HC as it is theorised and HC as it is practised.

We also found inconsistent use of behaviour change theory to guide HC implementation. Behavioural change theories were mentioned in only 32% of studies. The most commonly referenced, Social Cognitive Theory³¹ and the Transtheoretical Model,³² have conceptual, empirical and practical shortcomings that limit the guidance they can provide on how to support behaviour change in real interactions.^{33,34} In contrast, Self-determination Theory (SDT), although less commonly reported, offers an empirically robust and coherent conceptual basis that emphasises support for psychological needs in practical ways.^{26,35} SDT aligns well with principles and practices adapted from motivational interviewing³⁵ and shows an appreciation of the psychosocial challenges and constraints involved in living with chronic illness.^{36,37} Without agreement on HC's core principles and practices, theoretical frameworks are inevitably applied inconsistently, leaving the field without the shared conceptual foundation needed to guide effective implementation.

To advance the HC knowledge base, we suggest a synthesised framework for organising and theorising the core principles, processes and practices into a coherent structure. Fig. 2 provides a visual overview of core principles and processes, and Table 3 provides further explanation and theorising about how HC can be operationalised in a person-centred way.³⁸

Tailoring HC

We found HC used across a range of countries and long-term conditions, but most studies (80%) were conducted in high-income English-speaking countries. Interest in HC from African, Asian and Latin American countries indicates the importance of identifying core concepts that transfer across different cultural settings, and the need for cultural adaptations during HC delivery, which is underexplored.³⁹ Also unexplored is the use of HC in inpatient settings. This may represent a missed opportunity for patients with complex needs who are at crucial junctures of their health journey, such as after an acute episode or new diagnosis.⁴⁰ In New Zealand, relational models of care are particularly valued,⁴¹ but more research is needed to explore how to deliver culturally responsive HC.

Training for HC

Our review revealed two implementation gaps: (1) inadequate reporting of training details (delivery method, duration, training provider) and (2) high variability in

training dosage and structure (3 h to several weeks). High-quality training of HCPs in behavioural change programs is clearly linked to improved health outcomes for patients,^{42,43} although delivery components can vary widely. At one end, comprehensive standards, such as the US National Board of Health and Wellness Coaching standards, comprise approximately 85 distinct skills required for certification.⁴⁴ At the other end, minimalist approaches focus on fewer skill sets for brief or opportunistic coaching conversations.^{45,46} Brief interactive training focused on four core coaching skills (i.e. ask open discovery questions, listen more, reflect on practice and support specific goal setting) produced significant gains in knowledge, skills and confidence retained at 6–10 weeks,⁴⁵ whereas a more detailed 2-day course with 700 staff found that 54% were still using what they learned 5 years later.⁴⁷ Sustainability challenges likely stem from inadequate guidance on transferring coaching skills to specific clinical contexts and a lack of ongoing implementation support, including personalised feedback,⁴⁶ refresher sessions and peer reflection opportunities.^{45–47} Without funding for robust training and ongoing support, HC risks being delivered inconsistently, limiting its potential to improve outcomes for New Zealanders⁴³ among others with long-term conditions.

We found 55% of practitioners were non-clinically trained 'health coaches' and 45% were clinically trained health practitioners. This finding is consistent with Almulhim and colleagues' review of HC for people with diabetes, which found that 40% of providers were non-clinically trained.¹² It reflects a global trend of employing non-clinical practitioners to provide behavioural support for people living with long-term health conditions.^{14,48,49} This workforce composition for HC reflects dual policy approaches in this field, which support clinicians to incorporate HC into routine clinical care^{30,47} and introduce dedicated health coach roles.^{14,48} For example, in New Zealand, the introduction of shared models of care, including the Integrated Primary Mental Health and Addictions programs, has led to 498 non-clinically trained health coaches currently working in primary care settings.⁵⁰

Workforce training needs to consider differing needs of both clinically and non-clinically trained practitioners. Directive interaction styles can be in tension with the autonomy-supportive principles of HC.²⁶ Clinically trained practitioners may struggle to adopt a model of shared expertise, and require a mindset shift to allow them to utilise new ways of working collaboratively.²⁹ In contrast, non-clinical coaches who often embrace collaboration may lack a comprehensive understanding of the healthcare system, the client's health condition and treatment options.⁴⁴ One review compared outcomes in relation to provider type and found no differences,¹² suggesting workforce

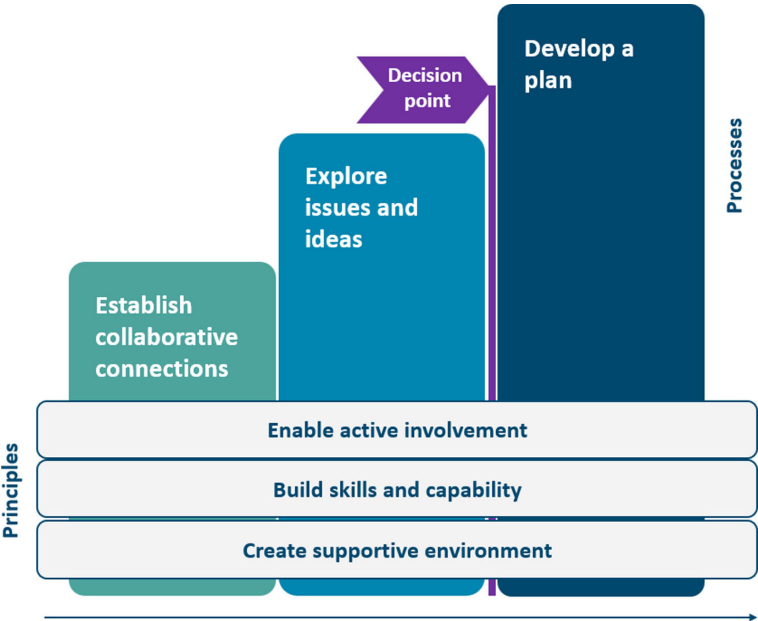


Fig. 2. Principles and processes of health coaching.

Table 3. Implementing person-centred coaching.

Core components		Implementing person-centred coaching
Principles	Enable active involvement	Create an autonomy-supportive environment by meeting the client's need for relatedness, autonomy and competence
	Build person skills and capability	
	Create a supportive environment	
Processes	Create collaborative connections (relational process)	Select and apply appropriate techniques to facilitate core change processes
	Explore issues (motivational processes)	
	Clarify decision point (decisional processes)	
	Develop a plan (volitional processes)	
Practices	Listening practices	Listen well
	Tailoring practices	Tailor carefully
	Planning practices	Plan specifically

Health coaching works best when:

The **coach** creates a positive connection by listening carefully, so the **client** can feel heard and understood (Relatedness needs)

The **coach** explores issues by asking the client what they already know and what matters to them, so the **client** can be ready to engage in the change process (Autonomy needs)

The **coach** supports **the client** to identify their own plan for change and identify strategies to overcome barriers to change, so **the client** can feel capable and confident that they can implement desired changes (Competence needs)

training needs to be responsive to each group’s specific strengths and limitations.

Strengths and limitations

Insufficient detail regarding implementation processes, training content, core practices and contextual factors hindered a comprehensive analysis, and the heterogeneity of outcomes complicated cross-study comparisons. Nonetheless, this review offers the most extensive mapping of

HC implementation across long-term conditions to date. Future research would benefit from consistent frameworks for reporting interventions, such as the Template for Intervention Description and Replication^{22,28} to facilitate evaluation across diverse settings.

Implications

The HC field requires: (1) standardised terminology and shared conceptual frameworks to address the conceptual

disorganisation; (2) competency-based training standards; (3) training that addresses the distinct preparation needs of clinically trained versus non-clinically trained health coaches; and (4) clear guidelines for adapting HC approaches to patient characteristics, condition complexity and specific contexts. Addressing these priorities requires a shift from asking whether HC works to understanding how to implement it effectively across diverse contexts. The framework for HC proposed here, comprising person-centred principles, processes of change and core practice sets, provides a conceptual foundation for testing across diverse populations, providers and settings.

Conclusion

Despite significant recent growth in research, HC remains a field lacking a shared conceptual foundation, limiting guidance available for workforce training and development. Drawing on the most extensive mapping of HC implementation for people with long-term conditions to date, this review identifies three priorities for advancing the field: (1) theorising to establish a shared conceptual foundation such as the framework proposed here; (2) tailoring to define core, transferable elements of practice alongside context-specific and culturally responsive adaptation; and (3) establishing training standards based on best-practice competency frameworks. Conceptual frameworks must be applicable across diverse cultural and geographical settings. Progress on these fronts would enable the preparation of health coaches capable of effectively supporting people with long-term conditions to achieve improved health and well-being.

Supplementary material

Supplementary material can be accessed from the article page online.

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