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The Role of the Health Coach in a Global Pandemic

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Abstract

Background: While medical teams were perplexed about the novel SARS-CoV-2 infection, transmission and impairment of organ systems and immune function, viral infections spread worldwide. Complex intersectional issues of co-morbidities coupled with marginalized, diverse ethnic/racial populations emerged as significant risks to contracting severe COVID-19.
Objective: Since a healthy lifestyle is fundamental for lowering risk to chronic diseases, public health initiatives to manage this and future pandemics should include strategies that assist individuals to improve health status through targeted behavior changes. This conceptual paper builds a case for certified professional health coaches as primary actors in future preventive strategies, with expanded skills in addressing social determinants of health and "next generational" cultural competencies.
Methods: This concept paper primarily synthesizes fast-tracked research in 2020 regarding the demographic impact of COVID-19, specifically those groups suffering the highest morbidity and mortality rates. Exploring these intersectional issues through a conceptual lens provides strategies for certified health coaches to contribute their expertise in behavioral change within the larger contextual settings of racial/ethnic disparities and social inequities.
Results: As the co-morbidities and other chronic conditions related to COVID-19 among individuals and families in low-income communities are worsened by dual forces (lifestyle/behavioral choices and ingrained structural inequities), adding the support of certified health coaches to build trust, provide more convenient access to address vaccine hesitancy, and dispell falsehoods, is an effective means for advancing health and wellbeing. Group coaching and one-on-one coaching can work in tandem with public health initiatives for reducing chronic disease burden and addressing social determinants of health (SDoH). Skills are identified in coaching SDoH with expanded cultural competencies for health coaches.
Conclusion: Certified professional health coaches can make a positive impact on general risk reduction of chronic diseases within ethnic/racial minorities, thereby supporting population health in facing future contagions with greater health resilience.

Keywords

health coaching, global pandemic, chronic disease epidemic, marginalized communities, vaccine hesitancy, cultural competence

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While the world fixed its attention on front line health care personnel at the onset of this global viral pandemic, the pandemic cast a harsh light exposing underlying social ills in American society. This conceptual paper advances an expanded role for certified health coaches to address both health inequities and social disparities in this and future health crises.

In Spring 2020 the emergency response to acute infection of the SARS-CoV-2 virus received widespread attention for the ways in which emergency health care personnel are both at risk and heroically responsive. At the time of this writing, the Coronavirus Resource Center at Johns Hopkins University reports 165,115,305 global cases and 3,422,079 global deaths.[1] The challenge of dealing with a fast-spreading infectious disease caused by a novel coronavirus perplexed health agencies around

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the world. Doctors and researchers had very little information about its aggressive nature or means of transmission.

Risk of Older Age

From December 2019 to January 2020, it grew apparent during the first brutal waves of viral infections that older people were at most risk.[62] The first reports from Wuhan China's Center for Disease Control and Prevention confirmed that older adults had a much higher fatality ratio, especially those living in denser urban settings.[2] The more rapid spread of SARS-CoV-2 infections in older people was theorized to be due to the impact of the "biological age clock," inducing slower viral alert signaling cells, and resulting in worse inflammatory cytokine storms.[3] Higher mortality tallies were cited in January in older males in Italy.[4] By February 2020 alarming reports in the UK confirmed the same.[5]

Chronic Disease at Any Age

As the virus spread to other nations, it was not just old age but certain co-morbidities prevalent in older adults that were increasingly viewed as the major contributor to widespread loss of life in the daily ICU death tallies.[6] Independent risk factors linked with higher mortality included male sex, lower lung functional capacity, history of chronic obstructive pulmonary disease, hypercholesterolemia, and type 2 diabetes.[6] Upon closer analysis during the ensuing weeks as death counts climbed to the tens of thousands, it became clearer that concurrent chronic diseases complicated both treatment and survival for elderly and younger patients alike.[7] People over 70 with comorbidities and declining immune systems had higher death rates, but so did those under 70 with comorbidities.[7] For the U.S., a nation where chronic disease rates have climbed as high as one in four adults,[60] the impact of COVID-19 was devastatingly high, resulting in 23 percent of the world's recorded cases occurring among just 4 percent of the world's population, although deaths-per-100,000 ranked considerably lower.[8–11]

Racial and Ethnic Health Inequities

The next groundswell of analytic papers exploring who succumbed and who survived dealt with a complex intersectionality of factors: race/ethnicity, chronic disease and health/wealth inequities. By midsummer 2020 clear evidence mounted that there was a disproportionate risk to racial and ethnic minorities.[12,13] The disproportionate impact of COVID-19 was evident in both urban and rural areas among non-English speaking communities and minority groups.[14] Not only did minorities cope with barriers to health care but with increased burden of chronic disease and compounded effects of structural discrimination.[15] A higher prevalence of chronic disease for racial and ethnic minorities (specifically Black, Hispanic, Pacific Islander, Native American) is reported for obesity, Type 1 and Type 2 Diabetes mellitus, hypertensive disease, and a history of lower respiratory disease such as chronic obstructive pulmonary disease or asthma.[16,17,61] A growing body of research on racial and ethnic health disparities shed light on research violations in protecting human subjects, delayed treatment for severe illness, fewer diagnoses compared to whites of comparable age, along with lower quality care, and inadequate access to care.[16,18,19] The combined impact of these health-related injustices is perhaps most registered as mistrust among marginalized patient populations.[65–67]

A report from *Kaiser Health News* (KHN) (in conjunction with *The Guardian)* revealed how the COVID-19 deaths of 3,600 health care workers, many in the New York boroughs, are tied to inequities linked to race/ethnicity and lower economic status.[20] The KHN report finds that those lower-paid workers in settings such as nursing homes, were forced to deal with a lack of personal protective gear (PPE), and ongoing mask shortages, even when these were distributed to larger medical centers. Delays in COVID tests and inconsistent messaging about safety and risks led to an infection rate that tripled what the general public contracted. In addition, the KHN report discovered that many of these deaths were preventable.

Underscoring this investigative report is another that examined medical claims data of 467,773 patients diagnosed with COVID-19 from April to August 2020.[7] The findings revealed higher rates of mortality existed for individuals with developmental or intellectual disabilities. The report surmised that there is greater prevalence of multi-morbidities in this population, possibly due to higher transmission rates for group homes and employment in low-wage essential working services.[7]

Discoveries of higher COVID-19 death rates for minorities in the U.S. was in lockstep with the summer of 2020 national protests over police killings of unarmed African Americans. National conversations called for a moral reckoning about unrelenting social injustice. In the U.S., Blacks, Hispanics/Latinx, Pacific Islanders, Indigenous and Native Americans were dying at two to three times the rate of whites, with documented higher rates of chronic diseases such as obesity, Type 1 and Type 2 Diabetes mellitus, hypertensive disease, and lower respiratory disease.[21] For many Americans, this was not news, but the most recent exposure of a 250-year scourge of injustice starting with the onset of slavery, continuing with reconstruction era (Jim Crow) lynching, discrimination, economic impoverishment,

land theft, discriminatory hiring practices, lower wages, barriers to education, and politically and socially entrenched structural racism.[22,23]

From Pandemic to Syndemic

As doctors, anthropologists and thought leaders reflect upon the tsunami of biomedical, social, economic and political forces that swept through U.S. society in the past year, some suggest that this current pandemic is more accurately a *syndemic*, a confluence of critical problems and diseases.[24–26] The term syndemic was conceived by medical anthropologist Merrill Singer[27] to refer to a concurring cluster of diseases or contagions coinciding with adverse social, environmental, and historically inequitable conditions. The thinking here is that the SARS-CoV-2 viral transmission was particularly devastating because the U.S. landscape upon which it landed already had an ongoing epidemic of noncommunicable diseases (heart disease hypertension, obesity, diabetes, chronic respiratory illness, and certain cancers) that took a disproportionate toll on Black, Indigenous, and people of color (BIPOC). Additionally, a politically divisive climate in the U.S., where objective truth, factual data and science were undermined led to a quagmire of disinformation and resistance to public health efforts.

From Triage to Long-term Strategies

As an RN and medical anthropologist in the National Medical Reserve Corps,[63] I served as a case investigator and contract tracer in a COVID-19 hot zone, an immigrant neighborhood of Guatemalan and Honduran families in California beginning in spring 2020 along with performing PCR testing. I then became a vaccinator when the first shipments of mRNA vaccine arrived in December. Now our medical/nursing team is obtaining genomic samples from folks with active breakthrough COVID-19 infections three weeks post-vaccinations. This front-line work has allowed me to witness firsthand the fears and hesitancy among marginalized and underserved communities of color. I have had to employ my skills as a National Board Certified Health & Wellness Coach on many occasions. Table 1 is a list of the coaching strategies we employed to address the multiple risk factors and physical and psycho-social challenges encountered in this ongoing effort.

As the numbers of vaccinated residents reach a threshold for more widespread immunity, public and community health officials have time to revisit pre-pandemic initiatives that support individuals and families in adopting healthier lifestyles of better diet, more exercise, improved sleep, managed stress and supportive relationships. However, making lifestyle change is difficult for most of us. The behavioral change process is confusing and cyclic in nature, rather than linear, with stages that require specific interventional strategies.[28,29] Individuals worldwide need support with evidence-based behavior change methodologies that aim to prevent diabetes, hypertension, hyperlipidemia, heart disease, cancer and other chronic disorders.[30,31] This is where the supportive alliance of health coaches who excel in the process of behavior change can serve population health.

Setting Standards for the Health Coaching Profession

The profession of health coaching has made great strides in the past twelve years with a growing body of research that examines its effectiveness in eliciting and sustaining healthy behavior changes.[32–37] About 150 data-supported studies are listed in the *Compendium of the Health and Wellness Coaching Literature*.[31] Health coaching to reduce the burden of chronic disease is gaining acceptance among primary care providers.[41–44] The profession did not always have a clear definition of health and wellness coaching or agreed upon competencies, but it took great strides once a large stakeholder group came together in 2007 to create a standard definition of health and wellness coaching, identify the competencies and tasks, and establish standards for training and education.[38] The NBHWC definition:

> Health and Wellness Coaches partner with clients seeking self-directed, lasting changes, aligned with their values, which promote health and wellness and, thereby, enhance well- being. In the course of their work health and wellness coaches display unconditional positive regard for their clients and a belief in their capacity for change, and honoring that each client is an expert on his or her life, while ensuring that all interactions are respectful and non-judgmental.[68]

To earn the NBC-HWC (National Board Certified Health & Wellness Coach) credential, individuals must complete an approved program where they must successfully pass a practical skills evaluation and then take a written knowledge examination that covers the published competencies, and commit to continuing education.[39] The National Board of Health & Wellness Coaching is working to secure CPT codes and Medicare reimbursement for health coaches in supervised clinical settings.[63,64]

As of this writing, over 5000 national board certified health and wellness coaches (NBC-HWC) now exist in the U.S., and other nations are adopting similar competencies, code of ethics and standards for professional

Table 1. Risk Factors and Coaching Strategies.

Targeted Risk Factor	Possible health/wellness coaching strategies
Older Age	Discuss ways to improve sleep, benefits of functional fitness training, regular health care appointments, hydration, healthy diet; elicit family/friends for social engagement; ask about home environment measures for safety and fall-prevention.
Lower Respiratory conditions (chronic asthma, COPD)	Determine health literacy regarding improved functional respiratory capacity; Facilitate learning about pollutants, irritants, chemicals, smoking, avoiding respiratory infections; supportive information dissemination (with permission) on triggers for symptom onset; support for finding resources for smoking cessation; assist in learning relaxation breathing techniques.
Obesity, cardiometabolic conditions	Facilitate learning as desired for metabolic syndrome, hyperlipidemia, hyperinsulinemia, elevated blood glucose levels; supportive heathy lifestyle actions for reducing elevated risks for chronic disease; tracking action plan for healthy weight, heart-healthy eating plan, physical activity and exercise; support client's discussion with health care providers regarding target biometrics (healthy waist circumference, hemoglobin A1c, BP, lipids, HDl, BMI, as desired, with permission)
Type 2 Diabetes	Co-create plan for healthy weight management and healthy food intake; offer supportive coaching discussion regarding healthful eating styles, enhanced physical activity; facilitate learning of risk reducing behaviors and signs of high and low blood glucose levels; coordinate with diabetic educators and health care team as desired by client.
Hypertension	Offer general wellness planning in alignment with medical provider goals for client; assist with behavior change for dietary modifications or salt intake as prescribed by doctor; coaching support for adhering to medical appointments and medication regimen.
Chronic Immune Dysfunction	Support action steps as recommended by health care team for reducing chronic inflammation; discuss knowledge of diets low in refined sugars and starch; ways to improve rest and recovery.
Vaccine hesitancy	Facilitate health literacy to reduce myths and misinformation regarding vaccine safety and effectiveness; practice motivational interviewing techniques to listen with support while avoiding "sustain talk" regarding fears; discuss risk of super-spreader events, using elicit-provide-elicit format for sharing information; dispel disinformation from Internet-based sensationalist headlines, "clickbait" falsehoods.
Disabilities (physical and developmental/ intellectual)	Elicit personal goals that are tied to values and strengths; facilitate learning regarding social-political advocacy for greater access to resources and social networks of support; identify strengths and widen perspectives on capabilities.
"Long" COVID	Facilitate learning about healthy sleep hygiene and rest, recuperation and restorative practices (i.e., meditation, breathwork, Tai Chi, yoga, modified yoga, enjoyable physical activity); discuss spiritual support for meaning and purpose with pastors, clergy, religious community, peer groups; support client's search to find credible resources and medical experts to manage fatigue or chronic anxiety.
Loneliness, Social Isolation	Discuss typical days and support growth in emotional wellbeing and self-efficacy with small steps to enhance social connections; support client's exploration of daily practices of self-care holistic practices; help client build connection to community resources and social networks.

conduct.[45] Many health coaches are nonclinical professionals from a variety of backgrounds in physical fitness, nutrition consulting, health education, fitness, human resources, and wellness programming. A growing faction have licensure as health care professionals, of which the largest group are nurse coaches, defined as a nursing role that is described as "skilled, purposeful, results-oriented and structured client interaction" provided by the American Holistic Nurse Credentialing Corporation (AHNCC) for the purpose of promoting achievement of client goals.[40]

Expanding the Tools, Embracing New Strategies

The current challenge brought to light in this pandemic for any health practitioner, educator or coach is to build rapport and trust among marginalized folks who have suffered poorer quality care or outright neglect within conventional medical systems, and whose problems are confounded by an economic need to not shelter in place but rather to interact freely with the public, in lower waged jobs in essential services, taking public

transportation, and living in higher density dwellings. Health coaching is uniquely situated to bridge this schism of trust through its commitment to offering unconditional positive regard, holding clients as agents of self-autonomy and experts in their own lives, and believing in the clients' capacity for change, while keeping all interactions respectful and nonjudgmental. However, the demands of this pandemic point out how more is needed from health coaches.

The new strategy proposed in this conceptual paper is for health coaches to expand their tools and their reach, and play a more pivotal role in the following three ways:

- *Recruit representative coaches*. More BIPOC health coaches are needed. The first step is not only recruiting and training interested students who represent diverse ethnic and racial backgrounds, but providing funding support.
  - A few grants are becoming available to support such an effort. One potential source of funding is the ADAPT Trailblazers Grant[46] for those are from underserved communities or who wish to work with marginalized populations, available September 2021 from Kresser Institute.[46]
  - The CARES Act offers temporary student federal loan relief.[47]
  - Another possible funder for those seeking higher education support is the RWJF Health Policy Research Scholarship for students from underrepresented backgrounds or marginalized communities seeking to reduce health disparities.[48]
  - Attempts to train bicultural/bilingual medical assistants and community workers in coaching skills have shown uneven results. Positive changes in self-care (but not lowered A1c) among diabetic patients was reported in a RCT of bicultural/bilingual medical assistants who offered telephone and clinic-based coaching for low income racial/ethnic minority populations.[73] Lessons could be gleaned from Project DULCE which utilized culturally oriented, self-empowerment training led by peers, along with a diabetes nurse management program, and resulted in lowered hospital costs and improved clinical outcomes for medically indigent populations. The delivery mode again was telephone based, and although this was not a coaching program, the peer-led training utilized several aspects of a coach-approach mindset.[74] The main point here is that the culturally-oriented program delivered by lay individuals operating on a level playing field provided significant benefit to a high-risk diverse group through telephonic and/or internet-based coaching.
- *Offer "next generation" cultural competency training*. Health care professionals have long recognized that cultural beliefs, values, customs and patterns of human behavior should influence how health care is delivered and evaluated. Advocates call for diversity and cultural competence training to be woven into the strategic plans of organizations.[49] Ongoing analysis of diversity training for health care finds mixed results with attitude change.[50] Criticisms of tokenism (representation without inclusion) and formulaic responses to minorities can be riddled with stereotypes (i.e., an ethnic group is devoutly religious, or another respects all elders) while linguistic, contextual and cultural barriers continue to play a large role even when translators are available. The Georgetown University National Center for Cultural Competence recognizes that their established assessments for cultural and linguistic competence now requires an update in the face of rising national awareness of racial/ethnic issues.[51]

  Next generational cultural competency is the term I use to describe leading edge thinking from diverse authors and educators that has been generated since the Black Lives Matter (BLM) movement, police killings of unarmed minorities, and a growing national awareness that centuries-old legacies of racism and injustice must end now. This moral reckoning requires an overhaul of outmoded diversity trainings and stale cultural competency assessments that have stopped short of demanding deep-seated inquiries into ways most of us unconsciously engage in implicit bias, participate in white power systems, and prop up systemic structural racism. Additional training and education of health coaches in next generational cultural competency training should be developed to more effectively engage with and support individuals and families throughout underserved communities of color, especially BIPOC who may experience marginalization and exclusion from mainstream preventive health endeavors. Ideas that contribute to this next generational cultural competency thinking are described in Table 2.

- *Include social determinants of health (SDoH) coaching skills*. While addressing SDoH is normally the purview of public health, epidemiology and social work, it would be worthwhile to expand the tools in the health coach's toolkit to include skills in coaching SDoH. It is time to adopt a wider perspective to reverse longstanding health inequities.[52] The coach approach provides a respectful, peer-like conversation that evokes versus admonishes, refrains from giving advice or lecturing, and leads with empathy, while building rapport and tracking progress. Expanding the coaching dialog to actively support an individual's struggle with the harsh realities of securing employment, education, food, housing and safety may

Table 2. Next-Generational Cultural Competence for Health Coaches.

Assess your personal cultural effectiveness with valid tools (i.e., National Center for Cultural Competence measures growth toward self-identified competency goals)
Examine unconscious bias and judgmental assumptions
Make an audit of personal privileges and subjugations
Become aware of historical racial/ethnic injustices in health care
Learn more about clients' cultural backgrounds
Find out about terms: white power, structural racism, Blackness, wokeness
Practice inclusive language and messaging
Elicit with different perspectives with openness curiosity, sensitivity
Learn to hold difficult cross-racial dialogue
Develop skills in emotional self-regulation when actively listening to stories of trauma or injustice; find ways to process guilt, fragility or internalized superiority
Learn to center BIPOC voices from the margins as a new practice
Get involved in racial/ethnic justice organizations
Recruit and train health coaches from underrepresented groups
Develop skill in affirming the lived experiences of victims of racism and discrimination
Hear feedback nondefensively; sincerely apologize, offer to make amends
Seek out friendships with those who look different than you
Commit to learning how to be an ally, read, listen to diverse voices
Engage in a lifelong process of learning and growth; practice self-compassion while doing so.
Inspiration for these ideas is extended to Ibram X. Kendri (How to Be an Anti-Racist), Michelle Alexander (The New Jim Crow), Isabelle Wilkerson (Caste, The Origins of Our Discontent), Robin DiAngela (White Fragility).

require more training and demonstrated skills by the coach in regulating emotions, maintaining boundaries, and holding space for vulnerable disclosures, especially during times of widespread anxieties about serious airborne viral infections. It would be beyond the health coaching scope of practice to include tasks that are under the purview of social work, such as, reducing food insecurity or securing housing or employment, but that is not what I am suggesting here.

The role that is uniquely situated for coaches is that of facilitating an evocative discussion to increase the client's self-awareness regarding these issues, then proceeding with specific self-efficacy work of translating failure to learning, identifying inspirational people, reflecting strengths and competencies, and "test driving" a fledgling skill. My grant-supported ethnographic field study of coaching homeless and street-dwelling adults in San Francisco found that listening to the coachee's story with openness and curiosity, *not* through the filters of frustration and burnout that many social and public health agency workers unfortunately acquire,[71] made a significant difference in connecting people with supportive community resources that they had previously ignored, dismissed or rejected.

Coaches are skilled in expanding the conversation to better understand the complex adaptive systems by which "under-resourced" individuals and families cope and manage. In coaching parlance, the coach holds the client as resourceful and not needing fixing, which may seem at odds with the dominant thinking in the social support field. The lengthier coaching dialog flushes out nuanced capacities that are unorthodox and inventive. The coach's gaze of empowerment and encouragement is a reversal of the dehumanizing and detached medical gaze described by Foucault,[72] which is all too familiar for the disenfranchised. While it takes much more time in deep listening, the coaching gaze and dialog translates to a deeper sense of support and encouragement. Therefore, the final result is not so much about fixing these inequities—that would be an insurmountable and unrealistic challenge for health coaches—but to assist in co-creating client-directed, short-term and long-term nonconformist strategies that are centered in the realities people of limited means face every day. One example from the study: Resolving widespread food insecurity is a social work and public health objective, but a coach-facilitated brainstorming session with a homeless couple transformed a local food bank with non-perishable foods into a discounted farmer's market with fresh produce. Of course, this is in no way a substitute for well-funded local and federal assistance programs such as Medicaid and Children's Health Insurance, SNAP (food stamps), education grants and housing credits, but it can be an enormously powerful experience for those receiving coaching.

The mode of coaching delivery in this ethnographic study was not successful via telephone or text messaging, but only through face-to-face contact at point of services (tents outside Social Security offices, churches, check cashing sites, local hangouts, monthly service fairs for street-dwelling individuals and the working-poor families) Group coaching and one-on-one coaching can work in tandem with public health initiatives for reducing chronic disease burden and address social determinants of health (SDoH).

Another option is to create internship sites for newly graduated health coaches at community health centers, chiefly the 501(c)3 non-profit community-based Federally Qualified Health Center (FQHC) that offer comprehensive medical, dental, mental health and specialty healthcare services. Health coaches could also offer services to public housing units, attracting residents through group activities such as healthy food preparation classes or stretching, balance and dance exercise classes.

Table 3 offers concepts for this expanded set of skills.

Table 3. Coaching the Social Determinants of Health (SDoH).

Build a more complete health coaching plan that includes non-medical SDoH factors
Generate a comprehensive updated list of local resources and introduce yourself
Facilitate in-session experimentation with role play for expressing self-advocacy
Grow adept at disseminating information with permission when required
Identify specific community networks that address cross-cultural support
Create a multi-dimensional SDoH wellness wheel to explore client's level of satisfaction in each dimension:
-*Housing*: Explore tenants' rights, address housing instability and security, discover value-oriented efforts to revalue residences
-*Food*: Strengthen access to foods that support healthy eating; reduce food insecurity, advocate for local farmers markets and elimination of food deserts
-*Employment*: Support efforts to rise above poverty, address fairness in workplace, explore job training, find recourse for discrimination issues
-*Education*: Promote high School enrollment, retention, and graduation, explore grants for higher education; facilitate literacy training, explore support for early childhood education and development
-*Social and Community*: Facilitate expansion into positive social networks and strengthen sense of belonging, explore civic participation in groups that work to reduce incarceration and discrimination.
-*Neighborhood and Built Environment*: Engage with local leadership to reduce crime and violence; facilitate reduction of risk and injury, incarceration and recidivism, participate in neighborhood watch, for crime-free residency, safe well-lighted walkways and transit; identify recreational, play settings, promote green spaces, community gardens.
- *Health & Health Care*: Facilitate access to quality primary care and improve health literacy
Support client autonomy to narrow the focus and implement small steps with accountable tracking
Facilitate learning about how to coordinate with public health, community agencies, and social support services as desired by client

As Horton indicated in his editorial in The Lancet,[24] the crushing new realities of this syndemic requires that our approach must extend beyond the biomedical response of vaccines and booster shots. We are dealing with a divided public that is skeptical, hesitant and prey to the click-bait falsehoods of digital media. Again, my field experience put a spotlight on this stark reality. When I was assigned with a medical/nursing team to deliver the first Pfizer vaccines to a staff of low-wage earners at a skilled nursing facility (SNF) devoted to frail elderly on public support, I ran headfirst into vaccine resistance. The staff were among the lowest wage earners in health care, either Black, Hispanic or Filipino, most with limited education. What appeared to be a biomedical "miracle" to the health practitioners was viewed as dangerous by much of the staff, with comments such as, "I heard they didn't test this on anybody but white people," "This is like poison, right?" "I don't want it. There's really no such thing as COVID." "I heard that about these Black men that doctors gave diseases to on purpose." While a range of fears were expressed, by the end of an eight-hour shift, I noted that there seemed to be three different categories of nursing home staff who resisted the vaccine on that day:

1. Those who did not trust the safety of the vaccine and stated that there was either not enough testing or approval.
2. Those who did not believe that the vaccine was necessary, that the pandemic was "made up," and that they didn't know anybody who was really sick.
3. Those who believed they could take care of themselves and had special at-home or traditional folk remedies that made them resistant to disease.

Acknowledging these fears and concerns was the first task of the medical/nursing teams in place that day. Health coaching skills in motivational interviewing, rolling with resistance, honoring emotions, active listening, extending empathy, not resisting or denying but instead, affirming the lived experiences—these coaching skills were called upon in order to keep the lines of engagement open. These are coach-approach skills that should be learned by all healthcare personnel. It took a full eight-hour shift to convince some of the more influential staff leaders to finally roll up their sleeves and receive the vaccination.

But a vaccine is not enough to resolve the onslaught of fears and falsehoods that have been spawned in the past few years. For a successful coaching session to occur, coaches must bridge cultural differences through the use of effective communication that is sensitive and responsive. Ethical and professional conduct should include a commitment to cultural competence, which is the process of becoming aware of one's own biases and prejudices, then pursuing a higher level of knowledge, understanding, respect and acceptance of the client's culture.

There are too many racial/ethnic groups for a full discussion of what that entails in this article, however, some examples include:

- Ethnic groups with higher religiosity might relate to use of prayer more than mindfulness meditation as a means for stress reduction.
- Individuals identifying as gay, queer, gender nonconforming or nonbinary are more inclined to feel marginalized by conventional health care so the

coach should seek additional resources that are attuned and supportive to their communities. BIPOC folks have for too long had their educational agendas shaped by dominant white systems, therefore, the coaching dialog should be sensitive and relevant to the fears, concerns, roles, expectations and learning styles of the clients.
- Older generations among Chinese, Japanese and other Asian societies may not express negative emotions in favor of interpersonal harmony, therefore, coaches need to delicately inquire about personal concerns that are diverse from the family group.
- The coach should examine their own use of words that, while unintentional, are perceived as disparaging for people with mental or physical disabilities (i.e., that's so *lame,* you're acting *bipolar,* it all falls on *deaf ears*). Respectful and direct communication is a hallmark of competent, supportive coaching.

In brief, the coach's stance should be to establish rapport and trust within the coaching relationship that works to dismantle disparities, not unknowingly reinforce then, and provide culturally tailored dialog that improves health outcomes, while affirming client autonomy and connection with meaningful cultural lifeways.

Even though the behavioral change for health improvement requires dedicated effort over several weeks to years, the long-range benefits from adopting healthful lifestyles should be considered an ongoing complementary health care strategy to reducing widespread risk of chronic diseases such as obesity, type 2 diabetes, hypertension and chronic respiratory disease. In addition, the client-focused, non-directive, supportive and empathetic coaching dialog may prove an effective approach for supporting individuals who cope with the anxiety of prolonged social isolation, the perplexing condition of long-COVID,[53] and vaccine hesitancy,[54] often related to past injustices suffered within marginalized and oppressed communities of color. Both individual (one-on-one) coaching tailored to the specific agendas and needs of individuals and affordable, high-efficiency models of group coaching are proposed as locally designed strategies that could collaborate with public health initiates to improve the social determinants of health.

Summary of Challenges for Health Coaches

In viral pandemics as well as chronic disease epidemics, the certified professional health coach must operate on three fronts:

1. facilitating individual behavior change
2. advocating for improved social conditions (social determinants of health)
3. actively engage with next-generation thinking on cultural competence for underserved minority groups

For the first challenge involving one-on-one work with individuals, health coaches make a difference by working with a client-oriented agenda to co-create health and wellness goals that are based on the individuals' risk profiles, health history, current health status, preferences, needs and interests. They partner with their clients to create wellness plans that articulate actions steps for self-directed, sustainable health goals that are specific, measurable, achievable, relevant and time-bound. For under-resourced individuals and families, health coaches need to "switch hats" more often and provide more information as consultants at times, employing the information-sharing technique of Elicit-Provide-Elicit to assure that people have a meaningful grasp of the content and can track accountability and progress.[55–57]

These individualized approaches are far greater than the one-size-fits-all approach for health or wellness programs that has undermined the health needs of diverse groups. For example, people of Southeast Asian origin and Native Americans have twice the risk of developing type 2 diabetes. Higher rates of hypertensive disease are experienced by both African Americans and Blacks in Sub-Saharan Africa, with significantly higher rates among younger ages in low-income countries.[58] Tailoring preventive health strategies for these groups should include better management of normal HgbA1c levels, striving for regular exercise, maintaining heart-healthy diets, and facilitated learning about mindfulness and stress-relieving relaxation.

For the second challenge that addresses improving social conditions, the health coach serves as an advocate and resource, helping the individual (or several individuals in group coaching sessions) develop skills in negotiating improved living conditions in a myriad of ways.[55] The full spectrum of social determinants of health (economic stability, education, safe social context, housing and built environment, accessible health care) could be addressed in efficient, theme-oriented group coaching workshops, where insights and lessons are leveraged through coaching leaders in a step-by-step approach.[59] Community-oriented group coaching facilitates an increased awareness of rights, practices, and self-efficacy for participants, while sharing support for building competencies, confidence and connections improved in league with regional public health initiatives.

Possible themes for group coaching that address social determinants of health include advocating for access to fresh produce in poorer neighborhoods; providing safe walkways and well-lighted parks for physical

activity; supporting local leadership that develops affordable housing; helping adolescents complete secondary education; fighting environmental toxic dumping in low-income areas; and bringing law enforcement and community representatives together where new solutions for restorative justice and reparations could emerge.

The third challenge referred to as "next generation cultural competence" goes beyond early diversity training taught to health professionals in past decades. Next generation thinking builds upon the recent moral reckoning of racial/ethnic injustices, and the calls for new engagement with next generational cultural competence (see Table 2). Schools and training programs could consider opportunities to bring health coaching to sliding-scale community clinics, as done by the Functional Medicine Coaching Academy, or offer pro bono coaching to student and community centers.

Future Research Considerations

Future research might examine emerging data about intersectionality issues presented in this paper in the face of ongoing challenges from emerging viral variants. From a medical-anthropological viewpoint, transmission of the primary virus and its variants persists in four primary ways: 1) among patients with comorbidities, compromised physical health, immune dysfunction, and chronic inflammation; 2) among marginalized racial and ethnic minorities whose lived experiences include lower wage jobs in unprotected situations (meat processing plants, delivery and food handling, sanitation, home health caretakers), high density dwellings, reliance on public transportation and experience a lower health literacy; 3) among non-vaccinated individuals as evidenced by a recent spike and spread of coronavirus and Delta variants among communities with lower vaccination rates;[69,70] and 4) among individuals who prescribe to conspiracy theories, and display a willful denial of precautionary measures to stop transmission (social distancing, mask wearing). As we gain insight on the ways in which this virus mutates and more importantly, resurfaces, there is a critical role for health coaches to influence healthier behaviors among these three groups. There are also opportunities for health coaches to work in concert with medical teams to support individuals who struggle with extended symptoms of fatigue and brain fog observed in long-COVID.[53]

Additional future research should be directed toward ways to increase the communication and negotiation skills of health coaches in novel community-oriented formats, such as group coaching that combines local public health agents with health coaches in BIPOC neighborhoods at risk. An example of this is under consideration in a new immigrant neighborhood in Norther California. Initial plans are considering an incentive to be offered for 6-8 individuals to engage in 8 weeks of group coaching, in sessions lasting 2 hours, scheduled twice a month. Initial plans are for people to receive at least 32 hours of coaching. Settings for the pilot program might include a local worksite, community center, recreational gym, nonprofit resource center or local library branch. Each group session would present a working theme, ranging from issues of equity, inclusion, healthy lifestyle, vaccine hesitancy, health literacy, or healthcare access. The combination of the supportive dialog facilitated by certified professional health coaches together with committed local public health agents could build bridges to healthier communities and strive to reverse historical legacies of mistrust and inadequate treatment and care.

Summary

This conceptual paper concludes the following:

- Aggravating the problems of SARS-CoV-2 viral pandemic is an ongoing epidemic of noncommunicable disease, coupled with racial and ethnic injustices and longstanding health/wealth disparities, plus a political divisive atmosphere that undermined factual science and public health initiatives. The totality of these biological, social, political, and cultural forces qualifies this pandemic as a syndemic, requiring a multifaceted, multilayered comprehensive approach that goes beyond widespread vaccinations for population immunity.
- By establishing supportive coaching relationships with individuals and families who are most at risk, certified professional health coaches can facilitate behavior change and mindset shifts toward healthier choices and activities, thereby reducing the risk of preventable, chronic diseases largely dependent upon lifestyle factors. However, additional skills are recommended.
- While health coaches often place the responsibility of behavior change squarely on the shoulders of the individual, the grave disparities and inequities laid bare by the pandemic require an expanded coach-approach that optimizes and supports the social determinants of health.
- Health coaches, like everyone in the health professions, should undergo a candid and straightforward appraisal of their cultural competencies. This intense time of moral reckoning over racial/ethnic injustices and discriminations requires that we each undergo a deep-seated examination of implicit and unconscious bias, and strive to learn next generational cultural competencies in order to more fully support the

health and well-being of diverse and marginalized populations.
- The client-focused, non-directive, supportive and empathetic coaching dialog may prove an effective approach for supporting individuals who cope with the anxiety of prolonged social isolation, the perplexing condition of long-haul COVID, and vaccine hesitancy, often related to past injustices suffered within marginalized and oppressed communities of color. Both individual (one-on-one) coaching tailored to the specific agendas and needs of individuals and affordable, high-efficiency models of group coaching are proposed as locally designed strategies that could collaborate with public health initiatives to improve individual and population health.

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