THE EXPERIENCES, RESPONSIBILITIES, AND RECOMMENDATIONS OF THE REGISTERED NURSE HEALTH COACH IN ALBERTA

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Bachelor of Nursing, University of Lethbridge, 2023

A thesis submitted
in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

Faculty of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

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Date of Defense: January 20, 2023

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ABSTRACT

The Center for Disease Control (CDC) reports that almost half of the adult population are living with at least one chronic disease and 70% of healthcare costs involve the care of individuals with long term chronic conditions. The Registered Nurse Health Coach (RNHC) is well positioned to partner with these individuals to enhance primary healthcare delivery and improve health outcomes. This thesis includes a literature review on the current evidence on the RNHC role and a study guided by the following broad question: *what are the experiences, roles, and recommendations of the Registered Nurse Health Coach in Alberta?* A qualitative descriptive study design was utilized to examine the RNHC experiences in the Alberta primary healthcare setting and explore the opportunities and challenges experienced by the RNHC. Limited research exists in Canada on the role of the RNHC. Findings from this study suggested that the RNHC role supports individuals achieve their healthcare needs through specialized skills and a unique approach to health. This approach helps RNHCs create partnerships with clients that empowers individuals to positively influence their own health. The RNHC participants from this study discussed how these partnerships and experiences with clients reignited their passion and pride as Registered Nurses practicing as health coaches. It is expected the findings will contribute to the current understanding of the RNHC role within the Alberta primary care context. This knowledge will inform future research, healthcare teams, and Registered Nurses in the Alberta Primary Care Network (PCN) of the role of RNHCs.

ACKNOWLEDGEMENTS

With sincere appreciation, I would like to thank my supervisor along with my supervisory committee, Dr. Tracy Oosterbroek, Dr. Paige Pope, and Dr. Sienna Caspar. Their support and guidance throughout my graduate studies has been invaluable in my professional and personal growth as not only a Registered Nurse.

Next, I would like to thank all the Registered Nurse Health Coaches who participated in this study. Your participation has highlighted the instrumental role Registered Nurses have in primary healthcare and without you, this thesis would not exist. Thank you for sharing with me your experiences. I admire your determination and dedication to the profession as you pave the way for future Registered Nurse Health Coaches.

To my parents, I am thankful for your unconditional support and guidance you've given me throughout the years. Thank you for the gift of education you've always valued for me and for your example of hard work and determination. For that, I am eternally thankful.

To my husband, Spencer. Thank you for your remarkable support, encouragement, and patience as I worked to complete this project. I truly could not have done it without you. Thank you being you and believing in me.

Lastly, to all the incredible mentors I have had the privilege to learn from throughout my nursing career – instructors, preceptors, co-workers, and students. Thank you for sharing your passions with me. Your pursuit for life-long learning has inspired me more than you know and continues to be my motivator for growth.

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LIST OF ABBREVIATIONS

RNHC	Registered Nurse Health Coach
RN	Registered Nurse
PHC	Primary Health Care
PCN	Primary Care Network
CARNA	College and Association of Registered Nurses of Alberta

CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

ABSTRACT

Introduction: The Center for Disease Control (CDC) reports that almost half of the adult population are living with at least one chronic disease and 70% of healthcare costs involve the care of individuals with long term chronic conditions. It is suggested that Registered Nurse Health Coaches (RNHC) are well positioned to facilitate partnerships and enhance primary healthcare delivery within interprofessional teams (Smolowitz et al., 2015).

Method: This study is guided by the following broad question: *what are the experiences, roles, and recommendations of the Registered Nurse Health Coach in Alberta?* A qualitative descriptive study design was utilized to examine the RNHC experiences in the Alberta primary healthcare setting and explore the opportunities and challenges experienced by the RNHC. Seven RNs were recruited who are currently practicing in Alberta in the role of the RNHC. One-on-one semi-structured interviews were carried out by the researcher with each participant.

Results: The results of this study will contribute to the current understanding of the role of the RNHC within the Alberta primary care context. Furthermore, an understanding was gained about the experiences and challenges experienced by the RNHC while in practice. The benefits to the participant include participating in professional development activities and research as required by regulating professional bodies for annual Alberta RN registration.

Implications: There is an opportunity for Registered Nurse Health Coach (RNHC) to enhance primary healthcare delivery within interprofessional teams through health promotion and disease prevention strategies in a patient centered approach (Caldwell, Gray, & Wolever, 2013; Goble, Knight, Burke, Carawan, & Wolever, 2017; Kreitzer, 2015; Smolowitz et al., 2015). This knowledge will be disseminated to inform future RNHCs of the challenges and opportunities that

should be considered when integrating into primary health care (PHC) teams. Additionally, this study will inform future studies aimed at examining how the RNHC can contribute to the improvement of quality of care in PHC clinics as well as patient outcomes within these clinics.

Conclusion: The findings from the proposed research project will be disseminated to inform employers, healthcare teams, and Registered Nurses in the Alberta Primary Care Network of the role of RNHCs. Additionally, these teams will be informed of the experiences of RNHC's including the opportunities, challenges, and recommendations for implementation. The study findings may also inform future research into how RNHC can further leverage the success of existing Alberta Primary Care Networks.

INTRODUCTION

The delivery of high-quality and effective primary care is essential to improve health outcomes for all individuals but is complicated by the rising incidence of chronic disease (Vincent & Sanchez Birkhead, 2013). The Center for Disease Control (CDC) report that almost half of the world's population are living with at least one chronic disease and 70% of healthcare costs involve the care of individuals with long term chronic conditions (Gulino Schaub, Luck, & Dossey, 2012; Newman, Varnam, & McDowell, 2013). Registered Nurse Health Coaches (RNHC)s are professionals who engage in professional interactions with clients to enhance their wellbeing and facilitate the achievement of health-related goals (Palmer, Tubbs, & Whybrow, 2003; Vincent & Sanchez Birkhead, 2013). Recognition of the nurse coach role as an expanded role within nursing and began to appear in the literature after the International Council of Nurses partnered with The Honor Society of Nursing, Sigma Theta Tau International to release the document, *Coaching in Nursing: An Introduction* (2009) (Gulino Schaub et al., 2012). This emerging role in healthcare enhances health promotion and disease prevention strategies (Goble et al., 2017; Kreitzer, 2015) in a patient centered approach (Caldwell et al., 2013). Additionally, it is suggested that the primary healthcare (PHC) setting is most optimal for health coaching because it provides essential healthcare services to individuals from diverse socioeconomic groups and geographic regions (Smolowitz et al., 2015). In the PHC setting, the RNHC is an RN that engages in evidence-based health coaching strategies to collaborate with clients. This collaboration results in active client participation towards health behavior changes and self-management, resulting in improved health outcomes and lowered health risks (Delaney & Bark, 2019; M. H. Huffman, 2014).

Since inception and recognition from the International Council of Nurses in 2009, there are limited examples of RNHC implementation in the literature (Donner & Wheeler, 2009; Gulino Schaub et al., 2012). There is growing evidence showing that Registered Nurses are equipped for health coaching roles (Vincent & Sanchez Birkhead, 2013) but lack of consensus on the practices, strategies, and delivery methods necessary for consistent and competent RNHC implementation (Wolever et al., 2013). Additionally, the need for RNHC studies with well-specified methodologies and design are lacking (McElligott, Eckardt, Motgomery Dossey, Luck, & Eckardt, 2018; Olsen & Nesbitt, 2010). Well-specified methodologies would not only improve the understanding of existing RNHC studies' results, but also allow for greater transferability to practice. Despite this, it is suggested that RNHCs are well positioned to facilitate partnerships and enhance primary healthcare delivery within interprofessional teams (Luck, 2010; Smolowitz et al., 2015).

Primary Healthcare in Alberta

Since the inception of the Primary Care Network (PCN) in Alberta in 2003, Registered Nurses have taken a more active role in primary health care. The PCN includes forty provincial health organizations, resulting in improved patient healthcare outcomes, especially related to the prevention, management, and treatment of chronic disease (Hutchison, Levesque, Strumpf, & Coyle, 2011; Ludwick, 2011; Oelke, Besner, & Carter, 2014). PCN services address five objectives: access to primary care services; management of primary care services; prevention, health promotion, chronic disease and complex care; coordination of services across the continuum of care; and facilitation of team-based care (Oelke et al., 2014). Ludwick (2011) posits that PCN's have facilitated a reduction in emergency department wait times, improvements in integration among local private and public health service providers, and an

increased overall patient satisfaction with healthcare. These improvements could be attributed to better patient attachment to family doctors and therefore, better use of health promotion and disease prevention screening (Ludwick, 2011). Additionally, PCNs have not only improved access to PHC services, but also the coordination and integration of care for patients, focusing on patient engagement and self-management (Hutchison et al., 2011).

Research Problem

Since the inception of the 2005 Primary Care Network (PCN) in Alberta, RNs have taken a more active role in primary care but little is known how the RN practicing in the RNHC role would integrate into the existing Alberta primary healthcare system (Hutchison et al., 2011). Little is known in general about the RN practicing in the Alberta PCN (Anderson, St. Hilaire, & Flinter, 2012; Olsen & Nesbitt, 2010). Prior to PCN initiatives, 13% of Alberta RNs practiced in the community setting or similar settings to primary care (Oelke et al., 2014). Although this number has grown, current literature on the role of the RN in Alberta primary care remains poorly understood and few Canadian studies clearly identify the role of the primary care RN employed in specific patient settings (Ammi, Ambrose, Hogg, & Wong, 2017; Hutchison et al., 2011; Oelke et al., 2014). Furthermore, RNs in primary care have received little attention from employers and government organizations, despite their increasing role and the evidence to suggest that RNs should be more prevalent in primary care based on their education and training (Ammi et al., 2017).

Nonetheless, it has been suggested that the primary care setting is ideal to implement the role of the RNHC. In the PHC setting, there is a focus on collaborative healthcare efforts and patient engagement, fostering an ideal environment to understand the effectiveness of the RNHC (Jeon & Benavente, 2016). There is an opportunity to further leverage the success of the existing PCN

through the role of the RNHC (Anderson et al., 2012). The RNHC has the potential to improve existing primary care services though using their full RN scope obtained through their education and training, facilitating improved patient communication and care within healthcare services (Anderson et al., 2012). Additionally, it is suggested that RNs working in their full scope of practice through roles like the RNHC, patients experience higher rates of satisfaction and increased knowledge in their condition and treatment (Oelke et al., 2014).

The role of the RNHC new to the context of Alberta primary care. Currently, there is no data or reporting evidence available to suggest there are RNHC employed in Alberta. Additionally, Smolowitz et al. (2015) suggests that it is essential that the role of the RNHC is defined within the context of a healthcare team so that the RN is optimized to improve health outcomes for individuals, communities, and populations. Finally, the role of the Registered Nurse in Primary Health Care in Alberta needs to be clarified as collaboration within primary health care teams is necessary for successful RNHC implementation (Anderson et al., 2012; Olsen & Nesbitt, 2010)

Purpose

The purpose of this literature review is to determine the *role of the Registered Nurse Health Coach and how they impact individual health outcomes in the primary care setting*. Registered Nurse Health Coaching is patient-centered and the RNHC partners with the individual to increase their self-efficacy through health education and health promotion in a coaching context (M. H. Huffman, 2007; Luck, 2010; Olsen & Nesbitt, 2010; Palmer et al., 2003). The coaching context is what separates RNHC from traditional methods of health promotion and health teaching in nursing. *Coaching* is a collaborative relationship where the RNHC uses skills of questioning and active listening to guide and support the individual to explore how they want to take control of their health, including strategies for disease management and prevention (Donner

& Wheeler, 2009; Luck, 2010). This collaborative relationship promotes trust, openness, and increased empowerment for the individual (Donner & Wheeler, 2009; Vincent & Sanchez Birkhead, 2013). *Primary healthcare* is an inclusive term encompassing activities including episodic first-contact care, comprehensive care sustained over time, and delivery of health promotion strategies (Hutchison et al., 2011).

METHODOLOGY

Search Strategy

A comprehensive search of the existing literature was conducted in April 2020 using the following online databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Google Scholar. Key search terms for all databases included: *registered nurse health coaching; health coaching; wellness coaching; nurse coach; primary healthcare nursing; health coach.* Boolean operators (AND, OR) were applied to combine search terms/keywords to expand results and focus the search.

Inclusion criteria included: published in the English language, studies that utilized nurses/Registered Nurses as a health coach; publication date between January 1, 2000 and present. I included a 10-year span within my search criteria as I felt that this would give me an adequate range of research while keeping in mind the newness of the RNHC role to the field of health coaching (Vincent & Sanchez Birkhead, 2013). Exclusion criteria included: grey literature; organizational statements and expert opinion; studies that utilized non-nursing professions as the coach; and duplicate articles across databases.

Initially, the search process resulted in 189 articles. All references were imported and stored using the Endnote reference manager. Articles were reviewed for relevancy by reading the abstract and skimming the article. Articles were then individually removed that did not meet

inclusion criteria. Manual reference checking of the remaining 31 articles was conducted in order to locate articles not included in initial electronic data base search. This process yielded an additional 25 articles for a total of 55 articles that met inclusion and exclusion criteria. Of the remaining articles, an additional 15 articles were removed based on inclusion or exclusion criteria. From this process, 40 articles were selected to review: 20 non-research articles; 9 qualitative studies; 2 quantitative studies; 7 systematic reviews/literature reviews; and 2 electronic nursing textbooks.

SYNTHESIS OF LITERATURE AND RESULTS

Data from the selected articles was systematically extracted and synthesized using the Evaluation of Evidence Tool (adapted from the SPIDER tool) (Cook, Smith, & Booth, 2012) to promote clarity and ensure consistency of the literature being reviewed (see Table 1). Articles were dated from 2001-2019. This time span could be related to the early emersion and growth of the role of the RNHC. From the review of the articles (see Appendix A), the three predominant themes emerged: *theoretical foundations (sub-themes: theories of coaching, integrative health coaching framework, and holistic nurse coaching frameworks); nurse coach background (sub-themes: nurse coach training and nurse coach seminal work); and role of the nurse coach (sub-themes: chronic disease management and implementation strategies)* (see Table 2).

Table 1. *Evaluation of Evidence Tool* (adapted from the SPIDER tool (Cook et al., 2012)

Evaluation of Evidence Tool							
Author & Year	Phenomenon Of Interest (Purpose)	Methodology	Conceptual Framework	Setting	Sample	Analysis	Findings

Table 2. *Major Themes of Literature Review*

Theoretical Foundations	Nurse Coach Background	Role of the Nurse Coach

Theories of Coaching Integrative Health Coaching Framework Holistic Nurse Coaching Frameworks	Nurse Coach Seminal Work Nurse Coach Education	Chronic Disease Management Implementation Strategies

Theoretical Foundations

Numerous authors found that while Registered Nurse Health Coaching (RNHC) continues to evolve, the theoretical underpinnings emerged from previous work in psychology, behavioral sciences and behavioral change theory, coaching principles, integrative and functional medicine, and holistic nursing theory (S. W. Butterworth, A. Linden, & W. McClay, 2007; Caldwell et al., 2013; Frey & Ratliff, 2018; Gulino Schaub et al., 2012; Smith et al., 2013). This previous philosophical work has influenced the development of existing RNHC frameworks. Moreover, limitations and dissatisfaction in current health education practices have influenced the uptake of coaching principles by Registered Nurses to better assist individuals to achieve their health related goals (Love, 2011).

Theories of Coaching

Coaching theories that have been traditionally recognized in sport, have crossover with nursing in methods and application (S. Butterworth, A. Linden, & W. McClay, 2007; Donner & Wheeler, 2009; Hughes, 2003; Palmer et al., 2003). These authors suggest that coaching is a professional relationship that requires advanced skills in questioning techniques, effective listening, and providing feedback to promote learning, self-awareness, and action. A coach must have the ability to clarify an individual's core values and sense of purpose, identify gaps between the client's vision and reality, and encourage and motivate the client to achieve their goals (Donner & Wheeler, 2009). Additionally, coaching takes the full context of a person's life into

consideration including external environment and social and economic resources and presupposes the client's inner resources (Wolever & Dreusicke, 2016). The process of coaching directs the client to examine what they perceive are issues, discover his or her own personal ambivalence, and take responsibility to create effective health behavior changes (M. H. Huffman, 2010; Hughes, 2003). Coaching principles are more effective than traditional health education models of "telling" the individual what to do to stay healthy as coaching works to activate the individuals own motivation for change through collaboration with the RNHC (M. Huffman, 2009). Hayes and Kalmakis (2007) add that traditional health-education strategies for behavior change that rely on persuasion or coercion have not been effective and that coaching methods effect change through collaboration with the client. Huffman (2009; 2010) introduced evidenced based coaching strategies for collaboration that prioritize 1) active listening; 2) working with the client's agenda; 3) identifying the client's beliefs and values; 4) eliciting change talk; 5) recognizing the client's change readiness.

Integrative Health Coaching Framework

Six authors described the Integrative Health Coaching (IHC) Framework as a branch of coaching, emerging in the health coaching field (Caldwell et al., 2013; Frey & Ratliff, 2018; Goble et al., 2017; Gulino Schaub et al., 2012; Smith et al., 2013; Wolever et al., 2011). Caldwell et al. (2013) reports that since development of IHC in 2002, the client asserts sustainable behavioral change in a systematic, collaborative, and solution-focused process to health-related goal achievement. IHC provides a process model for the RNHC to guide clients through the following stages: preparation for change, action, and integration of learning (Smith et al., 2013). Frey and Ratliff (2018) and Smith et al. (2013) suggest that IHC's incorporate both traditional coaching principles and the nursing process to guide clients to maintain forward

momentum while ensuring flexibly within the process as they work towards their goals. Gulino Schaub et al. (2012) suggest that the IHC framework creates a clinically relevant model for nursing practice, recognizing that health imbalances arise from environmental factors, diet, physical activity, stress, trauma, genetic predisposition, and an individual's own attitudes, values, and beliefs.

Wolever et al. (2011) interviewed six IHC coaches whom provided care to 350 patients within a single primary medical center. These authors concluded that the IHC framework provided a structure for IHCs to assist clients in defining personal health goals, holding them accountable for their progress. Trust was formed between IHC coach and client as IHC is centered on understanding client's values, sense of purpose, and personal vision for health rather than diagnosis and treatment of symptoms. The IHCs reported that understanding a patient's vision for health was a challenge of the role, as this process can requires a significant time commitment to allow clients to create or discover strategies for change uniquely fitted to their situation.

Conversely, Goble et al. (2017) described the client's experience with IHC. Participants received individual telephone-based coaching for participant determined health related goals including arthritis, asthma, cardiovascular disease, cancer, back injury, depression, diabetes, menopause, sleep, stress, and obesity. Results of this study showed that client's reported perceived improved health and wellbeing from engagement with the IHC, and that *self-awareness* was the key skill cultivated to promote goal-directed action. These authors also reported that a central theme to participants' IHC experience was an increased sense of empowerment to engage in self-defined processes of change.

Holistic Nurse Coaching Frameworks

Holistic Nurse Coaching Frameworks is identified in seven of the selected articles. Holistic Nurse Coaching Framework is defined by skilled, purposeful, results-oriented, and structured relationship-centered interactions with clients provided by the RN for the purpose of promoting health and wellbeing of the *whole person* (Delaney & Bark, 2019). The *whole person* encompasses an individual's mind-body-spirit-emotion-environment and recognizes that biological, psychological, social, cultural, and energetic components of individuals have an effect on health and wellbeing (Delaney & Bark, 2019). Holistic nurse coaches collaborate with the client as active partners in the healing process of the whole person (Love, 2011; Luck, 2010). Multiple authors mention the Theory of Integral Nursing (TINC) (Keegan & Dossey, 1988), a holistic framework for nurses to address health promotion and prevention (B. Dossey, 2015; Gulino Schaub et al., 2012; McElligott et al., 2018). TINC encompasses holistic nursing theory that views the individual as a *whole person*, whose health is being affected by internal and external factors (McElligott et al., 2018).

Holistic Nurse Coaching is defined by a unique set of standards of practice and values. These standards of practice and values imply that holistic nurses coaching is uniquely different from other professional health and wellness coaches (Erickson et al., 2016). Although it is proposed that RNHC is embedded in Holistic Nurse Coaching principles, it may not always be clear where role delineation lies. This perhaps reiterates the need to determine the role of the RNHC in a primary health care setting.

Nurse Coach Background

Examination of RNHC background education and training is critical to ensure effective primary healthcare delivery (Anderson et al., 2012). Additionally, the existing literature related to the RNHC reflects nurse coaching interventions and draw from previous work from prominent

nurse scholars and theorists. This seminal work has not only influenced the foundations of RNHC practice, but also how RNHCs build on their existing background knowledge (Luck, 2010).

Nurse Coach Seminal Work

Although RNHC is still emerging, several authors mention the influence of early work from prominent nursing theorists and scholars. Florence Nightingale's (1820-1910) integral work on identifying the diverse nature of individual and population-based health sets the foundation for RNHC philosophies (B. Dossey, 2015; Gulino Schaub et al., 2012; Luck, 2010). Nightingale introduced the concepts of environmental (clean air, water, food, housing) and social determinants (poverty, education, family relationships, employment) of health. She suggested that these environmental and social determinants impact individual health and wellness on many levels.

Betty Neuman and Dorthea Orem, are also mentioned as early contributors to RNHC practice, both describing interventions that empower individuals to obtain desired health goals (B. Dossey, 2015; Gulino Schaub et al., 2012; Luck, 2010; Old, 2012; Vincent & Sanchez Birkhead, 2013). Neuman (1970) designed a nursing conceptual model to expand understanding of client variables beyond the medical model; viewing the individual as a complex system, constantly seeking to maintain balance between internal and external environments. To help attain this balance, she developed a nursing assessment tool to assist patients to self-discover patient-identified behaviors inhibiting or improving their quality of life and overall health (B. Dossey, 2015; Old, 2012). Orem's Self-Care Model of Nursing Practice (1959-2001) viewed the nurse-patient relationship as collaborative and that the promotion of health, wellbeing, and self-care was based

on an individual's capabilities. Additionally, she suggested that self-care was key in maintaining health (B. Dossey, 2015; Gulino Schaub et al., 2012).

The work of Miller and Rollnick's (1990) Motivational Interviewing (MI) techniques were mentioned as having early influence on RNHC theory (M. Huffman, 2010a). MI is a technique that recognizes that the assessment of an individual's ambivalence to change and readiness to change is important when initiating health behavior changes. Health coaching requires conversations within a specific framework to guide individuals to discover his or her own ambivalence to health behavior change (M. H. Huffman, 2010). It is also reported that the term, *health coaching*, is often used interchangeably with motivational interviewing within the healthcare community (M. H. Huffman, 2010). Furthermore, there are many similarities when comparing the descriptions of both MI and RNHC. MI proposes a new framework for individual health behavior change and suggests that we must transcend traditional methods of health teaching and "telling a patient what to do" (M. Huffman, 2014). Similarly, RNHC principles suggest that traditional health education models of "telling" the individual what to do are not effective as they do not activate the individuals own motivation for change (M. Huffman, 2009). These similarities may speak to the evidence to support that MI principles provide evidence-based interventions that enhance patient activation and self-management of health behaviors.

Nurse Coaching Education

Thirteen of the studies reviewed concluded that Registered Nurse background and training is critical to the effectiveness of health coaching. Gulino Schaub et al. (2012) propose that the education and professional background of the RN enhances and supports the health and wellness coach role. Among these are: interpreting and monitoring lab test results, assessing the effects and implications of medication administration, utilization of health assessment tools, initiating

and monitoring plans of care, and recognizing and addressing general health issues in clients with diverse health needs. Professional nurse coaching is a systematic and skilled process grounded in evidence-based nursing practice (Frey & Ratliff, 2018; Gulino Schaub et al., 2012; M. H. Huffman, 2014). The nursing profession is also primarily responsible for health teaching and education, placing them in key position to lead health coaching in healthcare (Vincent & Sanchez Birkhead, 2013). Furthermore, the Registered Nurse is adaptive to changes in healthcare landscape and evidence based practice and is well-suited to introduce new and innovate ways to promote health and wellbeing (Vincent & Sanchez Birkhead, 2013). It is reflected in the literature that there is a wide variation of RNHC training and scope of practice. However, Donner and Wheeler (2009) and Smith et al. (2013) argue that although there are presently limited examples of health coaching by nurses in the literature, nursing education provides a background of rigorous evidenced based practice is critical for this emerging role. Many health disciplines have begun to offer health coaching ranging from credentialed health professionals to untrained individuals and there are currently no standards for being a health coach (S. Butterworth et al., 2007). Despite this, nursing has taken a leadership position in the field by setting standards through their scope of practice in the RNHC role (Delaney & Bark, 2019).

As the role of the RNHC grows, it is imperative for the Registered Nurse to practice to the full scope of their education and training and continue seek out opportunities for continued competence to define RNHC practice and improve healthcare delivery (Anderson et al., 2012; Luck, Dossey, & Schaub, 2011). There are numerous continuing education opportunities for RNHCs in the USA. Among these are, The National Consortium for Credentialing Health and Wellness Coaches (U.S.A.) (Goble et al., 2017; Wolever et al., 2013); the Integrative Nurse

Coach Certificate Program (U.S.A.) (Frey & Ratliff, 2018); Duke University's Integrative Health Coaching Training (U.S.A.) (Smith et al., 2013); the Health and Wellness Nurse Coaching Certification through the American Nurses Association (U.S.A.) (Erickson et al., 2016); and the Virtual Integrated Practice Program for trained nurse coaches, aimed to improve delivery of primary care (U.S.A.) (Minnick, Catrambone, Halstead, Rothschild, & Lapidos, 2008). These programs provide opportunities to further educate Registered Nurses in the RNHC role. However, consistency among education and training standards, RNHC role definition, and evidenced based RNHC strategies is critical to guide effective practice (M. H. Huffman, 2014; Minnick et al., 2008). Additionally, all of these programs are located in the U.S. and based on the role of the Registered Nurse is the US. The literature search did not yield evidence regarding RNHC continuing education programs in Canada or any other countries.

Role of the Nurse Coach

As the role of RNHC continues to develop, an important ongoing question involves how the RNHC influences health and wellness of individual patients. RNHCs collaborate with individuals to help clients to gain the knowledge, skills, and tools to be active participants in their health needs (Delaney & Bark, 2019; Hughes, 2003; Newman et al., 2013). Themes in the literature regarding the role of the nurse coach described that RNHCs can particularly influence health behavior changes for individuals with chronic disease. These individual health behavior changes were executed through various evidence-based implementation techniques.

Chronic Disease Management

Eleven of the articles reviewed described the emergence of the nurse coach role in response to the chronic disease epidemic. Articles were dated from 2007-2016. There is growing evidence affirming that chronic disease can be reduced through behavior changes and improved health and

that lifestyle behaviors not only influence the development of these chronic conditions, but also affects the progression and severity of disease (Caldwell et al., 2013; Holland, Greenberg, Tidwell, & Newcomer, 2003; Love, 2011; Olsen & Nesbitt, 2010; Smith et al., 2013; Vincent & Sanchez Birkhead, 2013). The articles reviewed primarily mentioned chronic disease and lifestyle behavior management in general context. However there were articles that described cardiovascular disease management and diabetes mellitus type II specifically (Vincent & Sanchez Birkhead, 2013) and nurse coaching for chronic disease management in group-visit format (Jeon & Benavente, 2016). Nurse coaching enhances self-care and self- management behaviors for both individuals with chronic disease as well as their family members whom support the individual, overall improving compliance with chronic disease management (S. Butterworth et al., 2007; M. Huffman, 2009). Lastly, 70% of healthcare costs involve the care of individuals with long term chronic conditions (Gulino Schaub et al., 2012; Newman et al., 2013). Two articles suggested that RNHCs have the potential to alleviate the financial burden associated with chronic disease by collaborating with individuals with chronic disease (Lanese, Dey, Srivastava, & Figler, 2011a, 2011b). Healthcare cost saving associated with RNHC implementation is partially predicted on the rising demand on primary healthcare services and associated cost (Lanese et al., 2011b).

Implementation Strategies

Butterworth, Linden, McClay, and Leo (2006) quantitatively evaluated the impact of motivational interviewing-based health coaching's impact on physical and mental health status. The study included 276 participants who self-selected to participate in either a three-month health coaching intervention or control group. Although the treatment group showed significant improvement in both physical (p = .035) and mental (p = 0.0001) health status compared to

controls, there are significant methodological limitations in the study, including selection bias related to participants self-selecting groups without researchers knowing their baseline health Additionally, because of this bias and because practitioners were not exclusively Registered Nurses, this study may not be generalizable across all participants, settings, and outcomes for RNHC implementation technique evidence (Linden, Adams, & Roberts, 2005). Holland, Greenberg, L, and Newcomer (2003)'s randomized controlled trial aimed to link participants with existing community and self-directed programming to improve disease prevention strategies and self-management of chronic illness. Nurse coach team provided the following interventions: disability prevention strategies, patient education on chronic-disease self-management, fitness programming, health-action plan development, and general health coaching to the treatment group (control group received no intervention). Health action plans were developed to encourage participant participation and empowerment by engaging clients to take charge of managing and adopting healthy lifestyles through self-identified needs. At the beginning of the study and after one year, 500 participants from each group received a health questionnaire and in-person assessment of health status. These authors had not yet concluded the study at the date of publication but discussed previous studies from which the project was developed that found nurse coaching to be promising in disability prevention and health management as a community resource (Holland, Greenberg, L, et al., 2003).

The Integrative Health and Wellness Assessment (IHWA) short form assessment tool (B. M. Dossey, Luck, & Schaub, 2011) is a quantitative study tool used to assess the effectiveness of health behavior nurse coach interventions for practice (McElligott et al., 2018). These authors concluded that the IHWA tool (2011) was successful to generate reflection and discussion between client and nurse coach, however further modification of the tool was necessary to create

a tool that encompassed all components of the nurse coaching process. Moreover, there is a need for evidence based instruments derived from nursing theory to advance and solidify the role of the RNHC (McElligott et al., 2018).

Motivational Interviewing (MI) was discussed in ten articles. As previously mentioned, MI has been described as a goal-oriented, client-centered counseling style for eliciting behavior change by exploring an individual's motivation and ambivalence to change (S. W. Butterworth et al., 2007; M. H. Huffman, 2007; M.H. Huffman, 2010; M. H. Huffman, 2014). Behavioral change theories like MI have been integrated in nurse coaching theories because they address the complex interactions of motivations, ambivalence, cues to action, perceptions of benefits or consequences, environmental and cultural influences, self-efficacy, and readiness to change that influences transformative health behaviors (S. Butterworth et al., 2007). In their literature review on nurse coaching, Hayes and Kalmakis (2007) concluded that MI requires empathy and therefore is an effective technique for building client rapport. Despite these findings, there are gaps in the literature surrounding nurse coach intervention techniques and more empirical work is necessary (Delaney & Bark, 2019; Wolever & Dreusicke, 2016). It is suggested that the prominence of MI in nurse coach literature is due to the large body of current evidence validating the benefits of MI for patients in studies who were able to increase their physical activity, lower blood lipid levels, improve blood glucose levels, improve diet consumption of fruits and vegetables, improve chronic heart failure, increase preventative screenings, lose weight, and improve diabetes management (S. W. Butterworth et al., 2007). It is also suggested that current health coaching evidence lacks description of valid assessment tools that provide consistent intervention delivery like the motivational interviewing skill code and Motivational Interviewing Treatment Integrity (S. W. Butterworth et al., 2007). In an integrative review on health

coaching, it was concluded that MI is congruent with definitions of health coaching as both enhance self-awareness, motivation, accountability, and confidence by recognizing the patients is the expert of their own personal life situation and should direct change (Olsen & Nesbitt, 2010).

Despite these findings, there is a lack of consistency on RNHC interventions. Of the forty articles included in this literature review there is a lack of consensus on the practices, strategies, and delivery methods are necessary for consistent and competent implementation (Wolever et al., 2013). RNHC studies with defined methodologies and rigorous designs are needed to strengthen the evidence surrounding the RNHC's role for implementing change. Well-specified methodologies would not only improve the understanding and evaluation of RNHC study outcomes, but also allow for greater transferability to practice.

Discussion

Primary Health Care Context

Little is known about the role of the Registered Nurse within the Primary Healthcare context therefore, evidence to support how the RNHC will fit into primary healthcare is unclear (Anderson et al., 2012). Currently in Alberta, Primary Care Network (PCN) programs are comprised of multidisciplinary teams of nurses, pharmacists, dieticians, social workers, and other professionals to deliver programs (Ludwick, 2011; Oelke et al., 2014). Current literature on the role of the RN in Alberta primary care remains poorly understood and few Canadian studies clearly identify the role of the RN employed in specific geographic or patient groups within the PCN (Ammi et al., 2017; Hutchison et al., 2011; Oelke et al., 2014). In addition, role ambiguity and variance in RN practice across PCNs exists, presenting poor understanding of the RN role in primary care itself and creating a barrier to multidisciplinary collaboration. Oelke et al. (2014)

posits that this could be explained because prior to PCN initiatives, few RNs (13%) practiced in the primary healthcare setting.

Despite this, as the body of literature grows supporting the notion that nurse coaches can play a critical role in the delivery of primary health initiatives, it could be suggested that this role could be effective in other primary care settings (Minnick et al., 2008; Oelke et al., 2014). RNHCs may improve coordination of patient care within multidisciplinary healthcare teams by identifying how all team members can communicate and collaborate to assist the patient in achieving their determined health care goals (Minnick et al., 2008; Smolowitz et al., 2015).

Multidisciplinary Collaboration

Currently in Alberta Primary Care Network (PCN) programs little consideration has been given to the practice of Canadian RN's within the primary care setting, and the limited, existing literature suggests that the RN role is poorly understood within multidisciplinary primary care teams (Oelke et al., 2014). Despite this, research has shown positive patient outcomes including higher rates of satisfaction, higher rates of treatment compliance, and increased knowledge of their condition and treatment where integration of nurses in the primary care setting as been done (Anderson et al., 2012; Byrne et al., 2020; Keleher, Parker, Abdulwadud, & Francis, 2009).

Moreover, one objective for Primary healthcare in Canada is the expansion of team-based approaches to clinical care with a greater emphasis on patient engagement, self-management, and self-care (Hutchison et al., 2011). Team-based, high-quality care is accomplished when healthcare providers collaborate and the advantages of this collaboration are: expanded access to care, effective and efficient delivery of services, supportive environments, and improved patient satisfaction (Schottenfeld et al., 2016). Multidisciplinary collaboration remains a priority in RNHC and primary healthcare models and nurse coaches must actively partner with physicians

and other healthcare providers to provide leadership within multidisciplinary teams to transform healthcare (Luck, 2010; Oelke et al., 2014). RNs are best suited for this role, as they possess the skills and knowledge necessary for complex care coordination within these primary care teams (Anderson et al., 2012; Ladden et al., 2013; McMurray & Cooper, 2017). It is suggested that nurse coaches are best suited to provide this leadership to mobilize teams towards achieving patient care objectives (Donner & Wheeler, 2009). Holland, et al.'s (2003) random controlled trial included multidisciplinary health coaching teams led by nurse coaches as part of their methods. In Olsen, et al.'s (2010) integrative review on health coaching, authors recommend that collaborative primary healthcare teams are essential for effective health coaching programs.

Jeon & Benavente (2016) (Jeon & Benavente, 2016) also describe that health coaches are the liaison between patients and their families with physicians, clinical staff, and other healthcare departments. Donner & Wheeler (2009) (Donner & Wheeler, 2009) support this notion by highlighting the increasing emphasis on effective interprofessional practice to provide comprehensive care in nurse coaching models as greater understanding on RNHC emerges. However, these authors highlight that more knowledge about teams involving the RNHC is required to ensure the readiness of interprofessional teams to be created and sustained.

Healthcare Funding

There is a growing body of research that explores the healthcare costs of funding primary care initiatives like RNHC programs (Hutchison et al., 2011; Jeon & Benavente, 2016; Lanese et al., 2011a, 2011b; Ludwick, 2011). As part of Alberta's Primary Healthcare Reform and creation of PCN programs in 2003, it was decided that PCN's would receive just over 130 million dollars per year from public sources (Ludwick, 2011). In the 2017 audit of the Alberta PCN program, the auditor general reported that the Department of Health expected to pay the PCNs a total of

$240 million in 2017-2018 and has provided over $1.5 billion in direct funding to PCNs since the program began (Health, 2017). Nationally, between 2000 and 2006, the Canadian Primary Health Care Transition Fund (PHCTF) contributed $800 million towards primary health care reform in Canadian provinces and territories (Carter, Riverin, Levesque, Gariepy, & Quesnel-Vallee, 2016). It was also discussed that the goal of primary healthcare reform is to reduce overall costs while improving healthcare quality, medical outcomes, and patient satisfaction (Lanese et al., 2011a, 2011b). Their pilot study concluded that the financial impact of adding a nurse coach did not initially result in monetary profit, but the return on investment period began the following year and profits grew in the third year (Lanese et al., 2011a). Jeon and Benavente (2016) highlight the financial challenges in private primary care practices, emphasizing the lack of evidence on both, the financial cost of implementing nurse coaching programs and billing practices involving nurse coaches in primary healthcare clinics. They also claim that in response to initial hiring costs associated with the addition of nurse coach staff, may cause physicians to hire health professionals who could be paid less than Registered Nurses, despite the evidence that Registered Nurses are best suited for the role (Jeon & Benavente, 2016). Even though RN's or Nurse Practitioners may be better qualified, medical assistants or physician's assistants were frequently hired because of lower cost expenses (Jeon & Benavente, 2016) There were no articles specifically addressing the RNHC or nurse coaching in the Alberta or Canadian primary care practice context.

SUMMARY OF LITERATURE REVIEWED

There is growing evidence on the definition of RNHC emerging from seminal work and theoretical frameworks on nurse coaching. Conceptual clarity on the role of the RNHC, especially related to nurse coaching implementation and intervention is required (McElligott et

al., 2018; Minnick et al., 2008; Vincent & Sanchez Birkhead, 2013; Wolever et al., 2013). There is also a need for evidence-based assessment and management tools derived from nursing theory to advance and solidify the role of the RNHC (McElligott et al., 2018).

Despite evidence showing that RN's are equipped for health coaching roles (Vincent & Sanchez Birkhead, 2013), there is limited literature studying RN's in this role. Future research using specific and rigorous methodology is needed to support existing findings. In the articles reviewed, a consensus on the practices, strategies, and delivery methods necessary for consistent and competent RNHC implementation was not evident (Wolever et al., 2013). RNHC studies with defined methodologies and rigorous designs are needed to strengthen the evidence surrounding the RNHC's role for implementing change. More research is needed to first clarify the role of the RNHC to guide processes of standardization in education and training (Erickson et al., 2016).

Although coaching principles are not new to nursing, there is currently no standardized training and certification for RNHC (Smith et al., 2013). Additionally, all of the programs were based on the American Registered Nurse practice and the literature search did not produce evidence regarding RNHC training programs in Canada or any other countries. Retrospectively, this could be related to the limitation that articles in this review unintendedly produced articles exclusively based in the North American setting.

Lastly, little is known about the role of the Registered Nurse in Primary Care in Alberta, and there is limited research documenting the importance of collaboration within primary health care teams for successful health coaching implementation (Anderson et al., 2012; Olsen & Nesbitt, 2010). Additionally, existing literature suggests that the RN role is poorly understood and under-utilized in primary care but there is evidence to support claims that team-based approaches

improve patient engagement, self-management, and self-care (Hutchison et al., 2011; Oelke et al., 2014). As a result, future research is needed around multidisciplinary collaboration within teams with RNHCs. More understanding is needed about teams involving the RNHC to ensure the readiness of interprofessional teams to create and sustain integration of the role (Donner & Wheeler, 2009). There is lack of knowledge surrounding the unique role of the RNHC within the multidisciplinary team to provide leadership and complex care coordination to produce and sustain successful patient outcomes. Furthermore, additional research exploring the RNHC's experiences within primary healthcare would lend to greater understanding of the role itself, increased awareness of multidisciplinary collaboration dynamics, and greater ability to provide effective patient care. Wolever and Dreusicke (2016) state that at this time, the most powerful mechanism of action in nurse coaching will happen through empirical work.

CONCLUSION

The purpose of this literature review was to examine the body of literature related to the Registered Nurse Health Coach (RNHC) role in the primary healthcare settings to facilitate effective health outcomes for individuals. Facilitating effective and high-quality care to improve health outcomes for all individuals has been complicated by the rise in chronic disease and subsequent strain on existing primary healthcare services in Canada (Anderson et al., 2012; Vincent & Sanchez Birkhead, 2013). RNHCs are professionals who can enhance existing health promotion and disease prevention strategies within primary healthcare (Smolowitz et al., 2015). The RNHC engages in evidence-based health coaching strategies to collaborate with individuals in a patient centered, collaborative approach to facilitate the achievement of health related goals (Delaney & Bark, 2019; Palmer et al., 2003). To date, there are limited Canadian studies on

RNHC in any healthcare setting. More research is needed to increase the state of knowledge surrounding RNHC for this emerging role to find a legitimate place in our healthcare system.

CHAPTER TWO: THE EXPERIENCES, ROLE, AND RECOMMENDATIONS OF THE RNHC

ABSTRACT

Background: Registered Nurse Health Coaching (RNHC) has been identified as an effective strategy to motivate individual behavior aimed at engaging and empowering patients to be actively involved in decision making processes related to healthcare choices and decisions. The purpose of this study was to gain deeper understanding of the experiences, role, and recommendations of the Registered Nurse Health Coaches in Alberta.

Methods: A qualitative descriptive research design was used, and seven participants were recruited through purposeful snowball sampling strategies. From the seven Registered Nurse Health Coach participants, semi-structured interviews were completed.

Results: From the seven semi-structured interviews, three themes emerged from the interview data to support a greater understanding of the experiences, roles, and recommendations of RNHCs practicing in Alberta. The themes that emerged are: (a) *the RNHC toolbox*; (b) *the RNHC perspective*; and (c) *RNHC pride.*

Implications: There is an opportunity for Registered Nurse Health Coach (RNHC) to enhance primary healthcare delivery in Alberta. The findings and conclusions from this study offer insight into the roles, responsibilities, and recommendations of Registered Nurse Health Coach's practicing in Alberta. Furthermore, findings from this research project will disseminated to inform healthcare teams, and Registered Nurses in the Alberta Primary Care Network of the role of RNHCs. Finally, these findings offer rationale for the development of future research into how RNHC can further leverage the success of existing Alberta Primary Care Networks.

INTRODUCTION

Registered Nurse Health Coaching (RNHC) has been identified as an effective strategy to motivate individual behavior change as the chronic disease epidemic continues to strain current health care models (Caldwell et al., 2013). This emerging method of healthcare delivery aims at engaging and empowering patients to maintain lifestyle behavior changes while being actively involved in decision making processes related to healthcare choices and decisions (Caldwell et al., 2013; Love, 2011). Registered Nurse's possess the essential skills, such as effective communication, clinical knowledge, and patient advocacy, to facilitate this empowerment process and are the crucial interface between health care services and the individuals seeking increased control over their health and wellbeing (Byrne et al., 2020; Love, 2011). Although Registered Nurse Health Coaching (RNHC) is a natural extension for Registered Nurses (Delaney & Bark, 2019), the role of the RNHC new to the context of Alberta primary care. Additionally, there is currently no data or reporting evidence available to suggest there are RNHC employed in Alberta. Finally, despite the evidence showing that Registered Nurses are equipped for health coaching roles (Vincent & Sanchez Birkhead, 2013), there is limited literature studying the experiences of Registered Nurses in this role.

Literature Review

There is growing evidence on the definition of RNHC emerging from seminal work and theoretical frameworks on nurse coaching. Conceptual clarity on the role of the RNHC, especially related to nurse coaching implementation and intervention is required (McElligott et al., 2018; Minnick et al., 2008; Vincent & Sanchez Birkhead, 2013; Wolever et al., 2013). There is also a need for evidence-based assessment and management tools derived from nursing theory to advance and solidify the role of the RNHC (McElligott et al., 2018).

Despite evidence showing that Registered Nurses are equipped for health coaching roles (Vincent & Sanchez Birkhead, 2013), there is limited literature studying the role of the RNHC. Future research using specific and rigorous methodology is needed to support existing findings. In the articles reviewed, a consensus on the practices, strategies, and delivery methods necessary for consistent and competent RNHC implementation was not evident (Wolever et al., 2013). RNHC studies with defined methodologies and rigorous designs are needed to strengthen the evidence surrounding the RNHC's role for implementing change. More research is needed to first clarify the role of the RNHC to guide processes of standardization in education and training (Erickson et al., 2016).

Although coaching principles are not new to nursing, there are currently no standardized training and certification for RNHCs (Smith et al., 2013). Additionally, all programs are based on the American Registered Nurse practice and the literature search did not produce evidence regarding RNHC training programs in Canada or any other countries. Retrospectively, this could be related to the limitation that articles in this review unintendedly produced articles exclusively based in the North American setting.

Lastly, little is known about the role of the Registered Nurse in Primary Care in Alberta, and there is limited research documenting the importance of collaboration within primary health care teams for successful health coaching implementation (Anderson et al., 2012; Olsen & Nesbitt, 2010). Additionally, existing literature suggests that the RN role is poorly understood and under-utilized in primary care but there is evidence to support claims that team-based approaches improve patient engagement, self-management, and self-care (Hutchison et al., 2011; Oelke et al., 2014). As a result, future research is needed around multidisciplinary collaboration within teams with RNHCs. More understanding is needed about teams involving the RNHC to ensure

the readiness of interprofessional teams to create and sustain integration of the role (Donner & Wheeler, 2009). There is lack of knowledge surrounding the unique role of the RNHC within the multidisciplinary team to provide leadership and complex care coordination to produce and sustain successful patient outcomes. Furthermore, additional research exploring the RNHC's experiences within primary healthcare would lend to greater understanding of the role itself, increased awareness of multidisciplinary collaboration dynamics, and greater ability to provide effective patient care. Wolever and Dreusicke (2016) state that at this time, the most powerful mechanism of action in nurse coaching will happen through empirical work.

Background and Significance

The RNHC has the potential to enhance individual and community health by optimizing the delivery of primary healthcare (Smolowitz et al., 2015; Wolever et al., 2013). The optimization of primary healthcare is necessary in attempt to navigate the existing fragmented services found in the current Canadian healthcare system (Byrne et al., 2020; Pedersen & Hack, 2011). This is particularly detrimental for individuals with complex or chronic health conditions who experience reduced quality of life and increased health complications because of these fragmented services (Byrne et al., 2020). Chronic disease is the leading cause of morbidity and mortality in Canada and globally, the World Health Organization projects that the total annual number of deaths due to chronic disease will increase from 38 million in 2012 to 52 million by 2030 (Roberts, Rao, Bennett, Loukine, & Jayaraman, 2015).

Globally, the chronic disease epidemic has compelled countries to implement care strategies that coordinate and organize functional health services. Healthcare systems are implementing integrative care strategies defined as: coordinated care models that support care across multiple services and providers, with the goal of enhancing patient quality of live and improving system

efficiency (Byrne et al., 2020; McMurray, Ward, Johnston, Yang, & Connor, 2018; Pedersen & Hack, 2011). An integrative care strategy that has been recently introduced in Australia is the nurse navigator role. In 2015, the Queensland government introduced a major initiative in 2015 that positioned nurse navigators throughout various primary care health networks to help patients navigate health services (McMurray & Cooper, 2017). Nurse navigation encompasses coordination of care between healthcare services; creating partnerships that enhance integration and communication within multidisciplinary teams; and improve patient outcomes that encourage evidence-based practice (Byrne et al., 2020; Pedersen & Hack, 2011). Additionally, nurse navigators facilitate system improvement by providing a leadership role and acting as an agent of change within fragmented healthcare systems, assisting patients to manage their health along the care continuum (Byrne et al., 2020; McMurray et al., 2018). Australia's nurse navigation role may serve as a step forward in the evolution of similar nursing models of care within primary health care.

Currently, nurse navigation models of integrative care have considerable overlap with other roles identified in nursing literature such as case manager, care coordinator, patient navigator, and RNHC (McMurray & Cooper, 2017). A similar role called *patient navigator* was first documented in the United States in the 1990s and has since been used in current models of chronic disease management and cancer treatment (McMurray & Cooper, 2017). In Canada, some cancer nurses serve as patient navigators, whose role involves bridging the gap between health services in cancer patients (McMurray & Cooper, 2017; Pedersen & Hack, 2011).

Despite the overlap and similarity of roles, as described in literature, of the nurse navigator, patient navigator, and RNHC, there are specific principles that make RNHC unique. The coaching context is what separates the RNHC from similar roles and incorporates coaching

theories and principles. Coaching principles are more effective than traditional health education models of "telling" the individual what to do to stay healthy as coaching works to activate the individuals own motivation for change through collaboration with the RNHC (M. Huffman, 2009). The process of coaching directs the client to examine what they perceive are issues, discover his or her own personal ambivalence, and take responsibility to create effective health behavior changes (M. H. Huffman, 2010; Hughes, 2003). Like the role of the nurse navigator, the RNHC role is a newer concept to primary health care delivery. Recognition of the nurse coach role as an expanded role within nursing began to appear in the literature after the International Council of Nurses partnered with The Honor Society of Nursing, Sigma Theta Tau International to release the document, *Coaching in Nursing: An Introduction* (2009) (Gulino Schaub et al., 2012).

Alberta Primary Healthcare Context

In Alberta, the Primary Care Network (PCN) was created in 2003 and includes forty health organizations with the goal of improving patient healthcare outcomes, especially in regard to the prevention, management, and treatment of chronic disease (Hutchison et al., 2011; Ludwick, 2011; Oelke et al., 2014). PCN services address five objectives: access to primary care services; management of primary care services; prevention, health promotion, chronic disease and complex care; coordination of services across the continuum of care; and facilitation of team-based care (Oelke et al., 2014). Additionally, PCNs have not only improved access to primary care services, but also the coordination and integration of care for patients, focusing on patient engagement and self-management (Hutchison et al., 2011).

There is an opportunity to further leverage the success of the existing PCN through the role of the Registered Nurse Health Coach (Anderson et al., 2012). Although RNHC is a natural

extension for Registered Nurses (Delaney & Bark, 2019), the role of the RNHC new to the context of Alberta primary care. Currently, there is no data or reporting evidence available to suggest there are RNHC employed in Alberta. Additionally, Smolowitz et al. (2015) suggests that it is essential that the role of the RNHC is defined within the context of a healthcare team so that the RNHC is optimized to improve health outcomes for individuals, communities, and populations. Finally, the role of the Registered Nurse in Primary Health Care in Alberta needs to be clarified as collaboration within primary health care teams is necessary for successful RNHC implementation (Anderson et al., 2012; Olsen & Nesbitt, 2010).

Study Rationale

Although the RNHC role is an emerging practice, the theoretical underpinnings are embedded in nursing theory from two prominent nurse scholars, Betty Neuman and Dorothea Orem (Love, 2011). Orem's (2001) Self Care model of Nursing views the relationship of nurse and patient as interactive, with the promotion of health and wellbeing and self-care based on an individual's own capabilities and motivations. Neuman viewed a person as a complete system responding to internal and external environments. Orem's self-care model and Neuman's assessment tool set the stage for RNHC, which has evolved to an art that nurses use to help patients improve their own health and wellness through empowerment strategies (Vincent & Sanchez Birkhead, 2013). There is an opportunity for the RNHC to enhance primary healthcare delivery through health promotion and disease prevention strategies in a patient centered approach (Caldwell et al., 2013; Goble et al., 2017; Kreitzer, 2015; Smolowitz et al., 2015). The purpose of this study is to *gain an understanding of the experiences, role, and recommendations of the Registered Nurse Health Coach (RNHC) in Alberta.*

Research Questions

Registered Nurse Health Coaching is patient-centered and the RNHC partners with the individual to increase self-efficacy through health education and health promotion in a coaching context (M. H. Huffman, 2007; Luck, 2010; Olsen & Nesbitt, 2010; Palmer et al., 2003). The coaching context is what separates RNHC from traditional methods of health promotion and health teaching in nursing. The findings from the proposed research project will be disseminated to inform employers, healthcare teams, and Registered Nurses in the Alberta Primary Care Network of the role of RNHCs. Additionally, these teams will be informed of the experiences of RNHC's including the opportunities, challenges, and recommendations for implementation. The study findings may also inform future research into how RNHC can further leverage the success of existing Alberta Primary Care Networks.

This study is guided by the following broad question: *what are the experiences, roles, and recommendations of the Registered Nurse Health Coach in Alberta?*

METHODS

Study Design

Qualitative descriptive methodology is the most appropriate fit to gain a deeper understanding of the experiences, roles, and recommendations of the Registered Nurse Health Coach in Alberta. Qualitative descriptive methodology is described as a comprehensive summary of specific events experienced by individuals or groups to describe a phenomenon (Lambert & Lambert, 2012). The process to define and identify the role of the RNHC is new and emerging (Gulino Schaub et al., 2012). Qualitative descriptive research design allows the examination of the RNHC experiences in the Alberta primary healthcare setting and explore the opportunities and challenges experienced by the RNHC. Lastly, qualitative description is valuable to health environments research as it provides intentional responses to questions about how people feel

about particular phenomena in their natural environment (Sandelowski, 2000) (Colorafi & Evans, 2016).

Theoretical Framework

The decision to use the qualitative descriptive methodology for this study was informed by a relativist worldview and belief that that the world has multiple realities and truths, varying from individual to individual, each possessing their own strengths and perspectives (Hirani, Richter, & Salami, 2018). Additionally, a relativist worldview values that an individual's experience shapes their understanding and it is this understanding that gives meaning to their experience (Gottlieb & Gottlieb, 2017). Through a qualitative descriptive approach, each participant's individual experience as a Registered Nurse Health Coach will be explored as they describe their own interpretation of phenomenon. Finally, qualitative descriptive methodology compliments a relativist worldview because it is appropriate for research questions focused on discovering the who, what, and where of experiences while gaining unique insights from participants' experiences as Registered Nurse Health Coaches (Kim, Sefcik, and Bradway (2017).

Ethical Considerations

In qualitative research, nurse researchers need to consider all aspects of potential ethical issues to respect and protect participants, preventing participant harm, and avoiding exploitation or abuse of participants (Orb, Eisenhauer, & Wynaden, 2001).This project received ethical approval from the *Human Participant Research Committee* at the University of Lethbridge (#2021-074) in accord with the University policy and the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2018).

In recruitment of participants meeting selection criteria, a Letter of Invitation to Participate was sent via email outlining the purpose of the study, the rationale of the study, and research

procedures (Appendix A). Participants were informed that they reserve the right to withdraw from the study at any time without harm or consequence. Upon agreeing to participate, written, informed consent was obtained from each of the study participants (see Appendix B). The consent form was explained by the researcher then read and signed by participants upon agreeance. An extra copy of this consent was retained at a convenient location that is mutually agreed upon by each participant. Additionally, all participant's confidentiality was maintained in all sources of data by assigning a pseudonym to protect the identity of the participant. A list of study participants was stored separately form study data. All research data and any related research materials will be stored electronically on a secure password-protected computer. Following data analysis, all data and related research material will be kept for a minimum period (five years) as required by the University of Lethbridge, upon which time will be destroyed by the researcher.

Risks and Benefits

There were minimal anticipated risks associated with the proposed study. Research questions may have the potential to bring up the recollection of unpleasant memories. If at any time throughout the research process the participant was experiencing distress, they would be given the choice to skip a question, ask for the interview to be paused, or withdraw entirely without penalty. Support was provided through Alberta Health Service's free and confidential counseling services through the Shepell-FGI Employee and Family Assistance Program.

Sample and Recruitment

Sandelowski (2000) reports that researchers may choose their sample to represent a combination of pre-selected variables to describe phenomena in Qualitative Descriptive studies. Once I received ethical approval, data collection occurred from August 3rd, 2021, to August

31st, 2021. Registered Nurse Health Coaches working in Alberta were recruited. For the purpose of this study, purposeful snowball sampling was used to recruit participants, beginning with a sample of initial subjects who met eligibility criteria. These participants were then be asked to identify other potential subjects from their professional and social networks who also meet eligibility criteria. Seven Registered Nurse Health Coaches met inclusion criteria and were recruited for data collection.

Recruitment strategies involved contacting via e-mail the following Canadian Registered Nurse organizations: Canadian Nurses Association, College and Association of Registered Nurses of Alberta, The Canadian Institute of Integrative Nursing Development & Education Ltd. (See Appendix C). The recruitment email included my contact information for potential participants to contact me directly. For the purpose of this study, purposeful snowball sampling was used to recruit participants. When I had a participant that agreed to participate in my study who met inclusion criteria, I asked if they would refer anyone to my study. Through snowball sampling, I was able to recruit two of the seven participants for this study.

When individuals contacted me by email or phone, I screened them to see if they met the inclusion criteria to participate in the study. Once individuals were screened and deemed eligible to participate, I sent them the consent for participation (see Appendix B) and explained the purpose and objectives of the research before scheduling a mutually agreed upon interview date and time.

Seven Registered Nurse Health Coaches met inclusion criteria and were recruited for data collection. Inclusion criteria for recruitment of participants included:

1. all RNs who currently work as Registered Nurse Health Coaches in Alberta;
2. have worked as RNHCs for a minimum of 6 months.

Exclusion criteria was:

1. members of the healthcare team who are related to the researcher or express a potential conflict of interested related to participation in the study.

From the seven participants, extensive descriptions of their experiences were collected. Descriptions were diverse in nature, as were their RN backgrounds including acute care, intensive care, public health, and community health nursing. Additionally, while some RNHC's did not have a specific client focus, a few stated specific client niches like athletes, new mothers, families of neonatal intensive care patients, and patients with chronic diseases. Shared characteristics were that of the seven RNHC's recruited, all the participants were female. Finally, six of the seven participants obtained their RNHC training from the Canadian Institute of Integrative Nursing Development & Education.

Data Collection

Data collection and analysis was carried out concurrently throughout the Summer of 2021 and Spring of 2022. Data for this study was collected from participants through semi-structured interviews. Semi-structured interviews are versatile and flexible and enable reciprocity between the interviewer and participant. Additionally, semi-structured interviews enable the interviewer to use pre-determined interview questions, but then improvise follow-up questions based on the participant's responses and individual verbal expression (Kallio, Pietila, Johnson, & Kangasniemi, 2016). Interviews lasted approximately one hour in duration and took place via an online communication platform, Zoom.

Interview Guide

In the semi-structed interviews, an interview guide was used (see Appendix D). The interview guide questions must be clearly worded and open ended to generate answers from

participants and are spontaneous, unique, and in-depth (Kallio et al., 2016). The interview guide offered a focused structure for discussion during the interviews but was not strictly followed. Instead, the interview guide was intended to direct conversation towards the research topic, allow dialogue during the interviews, create the opportunity to change the order of the questions, and allow spontaneous follow-up questions (Galletta, 2013; Kallio et al., 2016). Spontaneous follow-up questions allow the interviewer to ask participants to expand on a particular point that came up in the interview by asking for more information or providing an example of the point (Kallio et al., 2016).

For the purpose of this research project, the interview guide questions focused on the broad research question: *what are the experiences, role, and recommendations of the Registered Nurse Health Coach in Alberta?* Additional questions explored the RNHC's education and training opportunities, the specific role of the RNHC, the opportunities and the challenges experienced within the role, and the recommendations of the RNHC.

Data Analysis

Data analysis was based upon the steps of *thematic analysis* by Braun and Clarke (2006). Thematic analysis is a foundational method of qualitative analysis and is a flexible analytic method to report patterns and themes within data. The first step of thematic analysis is *familiarizing yourself with the data* (Clarke & Braun, 2016). Semi-structured interviews from the seven participants were transcribed verbatim from the audio recordings by the researcher. The transcription process allowed for data immersion, noting the participants' pauses in speech, laugh, sigh, or tone of voice. This helped to capture the true essence of what the participant was saying. Initial analysis of the qualitative data was then completed by reading and re-reading the transcribed interviews, line-by-line to glean meaning from the data based on the participants

descriptions (Kim et al., 2017). Repeated reading of the data is a way to search for meanings and patterns in the data set (Braun & Clarke, 2006; Clarke & Braun, 2016). The second step of thematic analysis is *generating initial codes* (Braun & Clarke, 2006). From the transcribed interviews, significant words, phrases, and sentences, were highlighted to form in-vivo codes (Hilal & Alabri, 2013; Saldaña, 2016). In-vivo codes refers to a word or short phrase from the actual language of participants from the qualitative data. By using words and concepts drawn from the words of participants, researchers are more likely to capture the meaning or essence of the participants' experience (Saldaña, 2016). After in-vivo codes were created, the highlighted words, phrases, and sentences were reviewed and analytic memos were added beside each in-vivo code. This process allowed for reflection on the essence of what each participant was saying. During this phase, codes were collated together in a *thematic map*. This involved copying extracts of data from the transcripts, grouping similar codes together, and looking at repeated words or phrases (Braun & Clarke, 2006). By looking at repeated words or phrases, the *search for themes* was carried out to identify and develop categories from the grouped in-vivo codes and analytic memos (Braun & Clarke, 2006). These categorical themes grouped similar in-vivo codes together to generate further meaning from the qualitative data (Colorafi & Evans, 2016; Saldaña, 2016). As similar in-vivo codes were grouped together, reflective notes were made explaining why similar codes formed categorical themes with similar meaning. The final product of qualitative descriptive approach is the formation of these categorical themes, capturing significant meaning in relation to my research question(s) (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013). The researcher moved back and forth between the data, the in-vivo codes, the categorical themes, and reflective notes throughout the coding process.

Identification of Initial Themes

In Braun and Clark's (2006) phase four of thematic analysis, *reviewing themes,* categorical themes are refined. During this phase, similar themes were combined to form one theme (Clarke & Braun, 2016). Additionally, reflection on the relationship between codes and between themes were completed using field notes, reflective journals, and analytic memos. Braun and Clarke (2006) describe that data should have *internal homogeneity,* meaning that data within themes should unite meaningfully (Braun & Clarke, 2006). As a result, some themes became overarching themes with sub-themes within them. Throughout this process, a reflective journal continued to be utilized to identify themes that most accurately captured the experiences, responsibilities, and recommendations of the RNHC in Alberta.

The final report of the research findings utilized direct quotations from the participants to support each theme. This final analysis and report is consistent with qualitative descriptive methodology. Qualitative descriptive methodology produces a comprehensive summary of specific events experienced by individuals or groups to describe a phenomenon (Lambert & Lambert, 2012). This comprehensive summary will be used to not only inform future research regarding the Registered Nurse Health Coach in Alberta, but also contribute to the current understanding of the role of the RNHC within the Alberta primary care context.

Rigor and Trustworthiness

The value and trustworthiness of qualitative descriptive research lies in the knowledge and descriptive meaning that emerges through methodological processes (Vaismoradi et al., 2013). Researchers must defend all steps of their research procedures to not only meet the purpose of the study, but also to support rigor and trustworthiness within the study (Sandelowski, 2000). Methods to defend all steps taken throughout the qualitative research process included reflexive activities throughout each stage of the research process. Reflexive activities create awareness

surrounding a researcher's values, beliefs, knowledge, and assumptions and how these may and create potential bias (Berger, 2013; Elo et al., 2014; Shenton, 2004). Reflexive activities included field notes, analytic memos, and journaling. These field notes and memos about observations and reflections during all stages of the research process helps identify the potential or actual ways the researcher may both assist and hinder the process of understanding phenomena in qualitative data (Berger, 2013; Vaismoradi et al., 2013). Additional measures to assessing trustworthiness such as credibility, dependability, confirmability, and transferability, will be further discussed (Elo et al., 2014; Kallio et al., 2016; Lincoln & Guba, 1985; Shenton, 2004).

Credibility

Credibility refers to the confidence in the truth of the study and that the findings accurately represent the participants' experience and is the most important measure for validity in qualitative research (Connelly, 2016; Cope, 2014; Lincoln & Guba, 1985). Techniques to demonstrate credibility included: reflective journaling, data triangulation, and member checking (Connelly, 2016; Creswell & Poth, 2018). *Reflective journaling* refers to the field notes and analytic memos taken to disclose the researcher's understanding of personal biases, values, and experiences that he or she brings to the study (Creswell & Poth, 2018). *Data Triangulation* is the process of using multiple sources and methods to draw conclusions and to articulate a certain perspective (Austin et al., 2008; Cope, 2014; Creswell & Poth, 2018). Examples of triangulation for this study included data triangulation from transcribed interviews, field notes, reflective journals, and observations recorded throughout the research process. Finally, *member checking* involves requesting feedback from participants at the completion of data analysis. Participants

reviewed the analyses, interpretations, and conclusion of the data to judge for accuracy (Connelly, 2016; Cope, 2014; Creswell & Poth, 2018).

Dependability

Dependability in the data refers to constancy of other researcher's reaching similar conclusions of the data (Cope, 2014; Kallio et al., 2016). A measure taken to ensure dependability was the interactions between researcher, the researcher's supervisor, and supervisory committee. Discussion of decision trails with the faculty supervisor and debriefings at each stage of the research process confirms that findings are consistent to the data (Connelly, 2016; Cope, 2014). Finally, the interview guide contributes to dependability, allowing for availability of the data collection tool for other researchers (Kallio et al., 2016).

Confirmability

Confirmability refers to the researcher's ability to demonstrate that the data represents the participant's responses and not the researcher's biases or assumptions (Cope, 2014). Confirmability can be demonstrated through reflexive activities, such as field notes, analytic memos, and journaling. Additionally, the field notes throughout the research process maintains an audit trail. An audit trail is a key strategy to enhance confirmability and is a collection of materials and notes used in the research process that documents how conclusions and interpretations were derived from the data by the researcher (Cope, 2014).

Transferability

Transferability is the extent to which findings are applicable and valuable to persons in other settings (Connelly, 2016; Creswell & Poth, 2018; Lincoln & Guba, 1985). The study's transferability is supported through rich, detailed descriptions of the participant's experiences. A description is rich if it provides abundant details of the context, location, and people studied

using strong verbs and direct quotations in the analyses of data (Connelly, 2016; Creswell & Poth, 2018). Direct quotations from participants provided rich descriptions of their experiences and were used to create the final written report.

RESULTS

Registered Nurse Health Coaching (RNHC) is an emerging role within health care (Frey & Ratliff, 2018). The purpose of this study was to *gain an understanding of the experiences, role, and recommendations of the Registered Nurse Health Coach (RNHC) in Alberta.* To explore this, a qualitative descriptive study was carried out to gain a deeper understanding from seven Registered Nurse Health Coaches currently practicing in Alberta. Additionally, the process of identifying the role of the Registered Nurse Health Coach is new and emerging (Gulino Schaub et al., 2012). The RNHC's who participated in this study identified how they utilized specific tools and skills to create partnerships with clients. From the seven qualitative interviews, a deeper insight was gained into how these specific tools and skills defined the role of the RNHC in the coach/client partnership. The RNHC partnership created experiences that shaped each RNHC participants' approach to health. Lastly, this unique approach to health seemed to reignite the participant's passion and pride as Registered Nurses practicing in the RNHC role.

Themes emerged from the interview data to support a greater understanding of the experiences, roles, and recommendations of RNHCs practicing in Alberta. The themes that emerged are: (a) *the RNHC toolbox*; (b) *the RNHC perspective*; and (c) *RNHC pride.* In the theme of *the RNHC toolbox,* the findings suggest that RNHCs partner with clients to utilize their existing knowledge, resources, and strength to better achieve their desired health related goals. This is accomplished through RNHC specific tools and skills, like motivational interviewing, and utilizing the nursing process. Additionally, when health related goals were client driven, rather

than provider driven, the findings suggest that a client had greater success in making health related behavior changes. Next, in the theme *the RNHC perspective,* it is described how the RNHC's experience with a holistic approach to health is at the core of their practice in primary healthcare. Findings suggest that this holistic approach emphasizes health promotion and preventative health, a defining characteristic of the RNHC role. Finally in this theme, RNHC's in this study suggest how integrating this approach into Alberta primary care is integral. In the final theme, *RNHC pride,* RNHCs describe how their experiences as RNHCs have reignited their passion as Registered Nurses in the profession. Additionally, the findings suggest that the empowerment the RNHC felt led them to feeling as if they were utilizing their full RN scope of practice more freely. Finally, while utilizing the RN scope of practice fully, the participants recommended that RNs are the profession best suited for health coaching. These themes and subthemes are presented in Table 1 below.

Table 1: The Experiences, roles, and recommendations of RNHCs

THEME	SUBTHEME
The RNHC Toolbox	Client partnership
	Motivational interviewing
	The nursing process
The RNHC Perspective	Holistic Perspective
	Proactive approach
	Primary healthcare integration
RNHC Pride	Nursing passion
	RNHC scope of practice
	RNs in health coaching

The RNHC Toolbox

Since inception and recognition from the International Council of Nurses in 2009, there are limited examples of RNHC implementation in the literature (Donner & Wheeler, 2009; Gulino Schaub et al., 2012). Within the limited sample of literature, the practice of RNHCs have been described most commonly as professionals who engage in professional interactions with clients to enhance their wellbeing and facilitate the achievement of health-related goals (Gulino Schaub et al., 2012; Palmer et al., 2003; Vincent & Sanchez Birkhead, 2013). This theme explores how RNHC's create partnerships with their clients to achieve health-related goals through specific tools and skills. Additionally, a deeper insight was gained into how RNHCs utilize the nursing process as the foundation to these unique tools and skills.

Client Partnership

Participants interviewed described that client partnership was at the core of Registered Nurse Health Coaching. Participants described that client partnership meant that the RNHC's role is to support clients to make positive health-related changes regardless of their starting point, and regardless of whether *'they're ready to actually make the change' (Jana).* Participants describe that client partnership most importantly is *'client focused and not provider driven' (Desiree)* and avoids 'telling' them what to do. Instead, the approach begins with asking what a client is seeking out in their healthcare experience. For example,

> *'Steer away from being 'I know better than you…'…'start asking them questions… trying to understand where they're coming from and…where are they at… what are they lacking or what are they needing' (Caitlyn).*

Client partnership also means *'honoring and respecting the person…supporting the client's beliefs' (Kristen)* in their health journeys. Kristen spoke more about her experience with client partnerships,

> *'It's very interesting, from my experiences from what I've learned just really getting to know and honor the personal that you are working with and really just trying to understand how they view themselves…as individuals, their own self-care, but also how they view their connection to others, their relationships, the world around them, and really trying to use that perspective and try to integrate it into the healthcare system that we have… It is so rewarding to be able to meet clients where they're at in the community and assist them from there' (Kristen).*

She continued that client partnerships are foundational and are part of the defining the role of the RNHC: *'I kind of define health coaching or nursing coaching as um… supporting and empowering a client to reach their optimal health…helping where you are in your present moment and assisting you in moving forward in reaching your optimal health goals" (Kristen).*

Several participants described that client partnership also recognizes a client's expertise about their own health and that this recognition may encourage the client to uncover other aspects of strength within themselves.

> *'We really work on the premise of the client, the client has the most wisdom about themselves…it's all about them, kind of peel back the onion and open up these layers about themselves that they've never even considered' (Jillian).*
>
> *'I love helping people with their health and love helping people uncover the choices that they already know are within them, so it's that kind of thing too' (Jana).*

Desiree added on that the RNHC facilitates the client use their strengths to recognize their health-related goals:

> '*The beauty of a nurse coach and coaching is that we are able to pull that out so that the client can then recognize that in themselves and really hone in on what they want to change or build on…putting it into their hands so the client, we can offer and bring awareness to what they would like'.*

Additionally, when the RNHC partnered with client to consider their own strengths, clients were not only able to express their health needs, but also the reason 'why' they were seeking health behavior changes.

> *'It's so incredible when you finally get down to their 'why' and really unpacking with them you know, why do they want to make these changes and some of them are just so profound and they're ready to do the work at that point' (Jillian).*

Finally, Paula described that client partnership resulted in client empowerment. This in turn encouraged the client to make continued or additional significant health related improvements.

> *'Connecting to yourself and knowing that you do have the power and you do have the strength and when you see how powerful you are to influence one part of your life, you have the power to change other parts. When you care for yourself, you want to make better choices…tiny changes, you can make a huge impact and you don't even realize it… changing one part or your physical, or emotional or spiritual health completely impacts the rest and enhances and evolves… it's amazing!'.*

Client empowerment was described as the underlying goal of the RNHC and client partnership by Addison,

'Being able to empower other individuals is what my main goal is right? Like finding that power within all of us and being able to pass it on in our communities and it just takes…just takes one match right? (Then) the whole box goes up right? So, that's what I'm hoping to do to…spark!'.

When client partnership occurs, the approach to health behavior changes is client focused rather than provider driven. Participants described that not only did this show respect towards the client, but it also creates initial rapport with the client in supporting their beliefs. This rapport set up the stage for a positive RNHC and client interaction.

Motivational Interviewing

This subtheme describes a primary tool within the RNHC toolbox. Participants interviewed described Motivational Interviewing (MI) as a foundational tool when working with clients to achieve their goals. MI is a technique that recognizes an individual's readiness to change. From there, conversations then guide individuals to discover his or her own ambivalence to make changes, activating a client's self-management of health behaviors (M. Huffman, 2010b, 2014). Additionally, participants described MI as '*a way of asking questions differently' (Jillian)* through open-ended questions. Desiree described that MI helped a client bring awareness through reflection on their current health behaviors.

'Questioning beliefs, bringing awareness to behaviors…getting people to really think about and bring awareness to what their behaviors are or whatever the topic is…it's really a lot of reflective questions to kind of to get them to think on a deeper level' (Desiree).

Another participant suggested that MI was a tool that provided a framework for interacting with clients and asking thought-provoking questions that helped the client uncover their true motivation for seeking health behavior changes.

> *'(Motivational interviewing) is utilizing different things to find ways to interact with people, ask powerful questions, and help client discover and articulate feelings…it's like the power of why so like if you don't have a reason for doing something, you'll probably aimlessly circle around it and if you keep coming back to it there's probably a reason why so maybe you should figure it out' (Jana).*

By uncovering a client's 'why' they were seeking health behavior changes through MI, participants described that they could focus on listening to their client and this in turn increased client compliance.

> *'MI involves active listening in a different way…tune in and really hear the individual for their experiences rather than seeing nurse as expert' (Kristen).*
>
> *'It's a skill and a skill that once you realize you have, it's a powerful skill… you can really make some huge shifts and some huge changes that could be the difference between non-compliance and compliance'(Jana).*

MI seemed to help the RNHC by focusing on *'knowing how to ask a question' (Paula)* rather than necessarily just what questions to ask. These findings seem to suggest that tools like MI are utilized to transcend traditional health teaching methods of 'telling a client what to do'. Rather, activating a client's own motivation for health behavior change is aligned with RNHCing.

The Nursing Process

Fundamental to the RNHC toolbox is *'maintaining the nursing process when assessing the dimensions of health' (Paula)* of the client. The nursing process was developed by Ida Jean Orlando (1958) to guide a systematic approach to critical thinking in nursing practice. It's client-centered and evidence-based approach involves the five sequential steps of assessment, diagnosis, planning, implementation, and evaluation (Toney-Butler & Thayer, 2022). Despite utilizing different tools, participants described that the foundation of RNHC practice is still rooted in the nursing process.

> *'We're using the nursing process, we're putting it through the nursing process; 'that's the biggest under arching and underlying theme is that we are using the nursing process in our work' (Jana).*

Jana continued that that although the RNHC may use other complimentary modalities of coaching not traditionally used in nursing practice, it is the nursing process that grounds these methods in the standards of practice as a Registered Nurse.

> *'If you're using it as a tool and you're able to put it through the nursing process, then you can start to use those complementary modalities as a nurse… so that's one of the biggest things is showing them like… you can do these things, (but) you need to make sure you're doing them as a nurse'.*

Paula described that the nursing process provided framework for the RNHC to confidently assess a client: *'I use the nursing process every session and it's…it's definitely nursing and it's really exciting to be securing in knowing that and feeling confident about that and to see how it does affect my client's health'.*

Participants also described that the nursing process assisted RNHCs in an *'evidenced based approach' (Jillian)* and created accountability to the RN professional boundaries. Jana added on that,

> *'(the nursing process) shows nursing judgment, nursing skills and (helps the nurse) to stay within the scope of practice and know when and who to refer to when something was outside of the RN scope…it's viewing it from a nursing lens'.*

These participants suggested that the nursing process is what separated the RNHC from other health and non-health disciplines in the health-coaching field.

The RNHC Perspective

This theme explores the RNHC's experiences with a unique perspective to health. This unique perspective was described by participants in the first subtheme, holistic perspective. This involves assessing a client's *'mind, body, physical, spiritual, energetic, and environmental' (Caitlyn)* aspects of health. Participants interviewed suggest that it is this that is *'missing from our current healthcare system' (Kristen).* In the second subtheme, proactive approach*,* participants describe how health promotion and prevention is foundational to '*do something better in the healthcare system' (Desiree).* Lastly, participants recommend how we can integrate this approach to primary healthcare in Alberta.

Holistic Approach

The participants interviewed described that a holistic approach to health is integral RNHC practice. It involves *'focusing on the whole person' (Addison).* Caitlyn added that, *'as a nurse coach we look at the mind, body, spirit, environment…it's not just the physical, mental health of the patient…we see all of it – the visible and the non-visible, the energetic and the*

environment and all of that… and how people are all encompassing of that'. Participants continued to define holistic nursing as:

> *'A comprehensive physical, emotion, spiritual, environmental, health perspective…connecting all aspects of health' (Kristen).*
>
> *'RNHCoaching brings everything together to focus on the whole person…providing our nursing care but really just going a little further and…encouraging the patient to explore, grow, health within themselves' (Addison).*
>
> *'Nurse coaching is holistic nursing…whole person nursing (while) using their scope, standards, and the nursing process' (Jana).*

Several participants emphasized that a holistic perspective includes assessing a client's spiritual health and *'connecting with yourself'(Paula).*

> *'Spiritual assessment means (assessing) a connection to yourself, connection to others, connection to nature, and/or higher power…it helps to understand a client's beliefs, values, and ways of knowing…(it involves) connecting the aspects of a client's physical, mental, emotional, social, cultural, spiritual and environmental aspects of health' (Kristen).*
>
> *'I go by 'the Connected Nurse' because… I really want people to connect with themselves and with spiritual care…connecting with yourself, connecting to others – finding the connections in your life… you can make a huge impact and you don't even realize it… changing one part or your physical, or emotional or spiritual health completely impacts the rest and enhances and evolves… it's amazing!' (Paula)*

Finally, Caitlyn described how she assesses a client in a holistic way: *'I begin client engagement with the integrative health and wellness assessment…a multi-statement*

questionnaire addressing mind, body, physical, spiritual, energetic, environmental aspects'. Desiree also described that,*'the holistic assessment questionnaire assesses both mental and physical health'.*

Proactive Approach

In addition to a holistic approach, participants expressed that the RNHC places an emphasis on health promotion and preventative health. Participants described health promotion and preventative health as a '*proactive instead of reactive approach to health' (Desiree).* This proactive approach involves clients being accountable to their own health through health decisions and practices instead of reacting to health problems when they arise and trying to *'fix a problem' (Paula)*. Several participants described what a proactive approach to health means to their practice:

> *'Health promotion is more proactive…it's really getting into the why things are showing up like they do and really hone in on what they want to change or build on' (Desiree).*
>
> *'It's helping people uncover…you know what's going on instead of reacting to it like 10 years down the road' (Jana).*

Participants also pointed out the challenges of a proactive approach as an RNHC*,* especially in Alberta's current healthcare system. Despite our *'reactive vs. proactive healthcare system currently' (Jana)* participants also described '*wanting to do better for patients' (Kristen).*

> *'We over value physical health and disease treatment, not preventative health…we're so focused on fixing the body that we're forgetting about preventing it in the first place…I needed to find a different way' (Paula).*
>
> *'There's a need and what we have doesn't support people and our healthcare system is very reactive not proactive…it's such a helpless feeling and it feels so bad' (Caitlyn).*

'This is why I think our current healthcare system is failing…I see it as healing from the inside out vs. our current healthcare system is form the outside and not even getting into the innards…our current system is very broken which is why I want out of it' (Desiree).

Participants stated that a lack of time was primary barrier for nurses providing a proactive approach in our current healthcare system.

'Our healthcare system is a sick care system if you want to call it that… we are just managing disease…managing symptoms. We unfortunately have come to a place where there isn't time for disease prevention and health promotion' (Jillian).

'Sometimes we get lost being a healthcare provider because of our case loads and the busy-ness and…whether it's acute or primary care, we have a certain amount of time' (Addison).

'TIME, I hear that so much, we don't have the TIME' (Caityln).

Wanting to do better for patients seemed to be a primary motivator for RN's shifting to RNHC practice. Several participants described that the RNHC can support clients in a different way than traditional approaches. This approach includes health promotion practices and a proactive approach to health.

'We're so focused on fixing the body that we're forgetting about preventing it in the first place…we over value physical health, disease treatment, not preventative health – I needed to find a different way' (Addison).

'I've always been into health promotion…it's a big part of who I am and I was looking to pivot…the current system is not equipped to support primary prevention and health promotion' (Desiree).

Jana added that, *'There's gotta be a way where I can work as a nurse and work with doctors and work with people to really start being proactive instead of reactive to everything'.* Addison also described that successful health promotion includes the patient's family and support system: *'(Health promotion practices) supports the individual and their support system, the nurse coach is there to be able to support everybody, not just the patient though this'.*

The emphasis on health promotion practices seemed to be a quality that separated participants' RNHC practice from their past experiences as RN's. The proactive vs. reactive approach to health as an RNHC means *'defining health differently' (Paula)* for many individuals and an opportunity for nurses to '*do something better in the healthcare system' (Desiree).*

Primary Healthcare Integration

The previous subtheme explored how the RNHC places value on a proactive approach. This subtheme explores the recommendations of the RNHC of how to best integrate this role into primary healthcare in Alberta. The Alberta Primary Healthcare Network (PCN) was formed in 2003 and includes forty health organizations aimed at improving and coordinating patient access to primary healthcare. They do this through a network of doctors and other health professionals providing health promotion and the coordination of access to primary healthcare, and health services to Albertans (Alberta Health, 2017).

One participant described how RNHCs could integrate into the existing PCN organizations through physician-led clinics as well as other physician-specialist clinics.

> *'Client's coming in with a health issue that a physician could deal with and then refer to the RNCH to get to the deeper root cause…that's where you could really delve into what people need…it's beyond physical health, it's the emotional, the spiritual, the mental components…RNHCs could do an intake, like a comprehensive health assessment…do*

your nursing assessment and come up with a client driven diagnosis and then figure out where you want to go from there' (Desiree).

Jana described that there's *'lots of overlap'* between the RNHC role and RN's practicing in the PCN. Addison added that there are similarities in her role as a Registered Nurse Behavioral Health Consultant and the RNHC role,

> *'I work with the Primary Care Network right now and this is the probably the closest position I've had to be able to practice my nurse coaching…(however) I don't have full freedom. I'm doing referrals, I'm doing patient teaching, I'm following up in the community, I'm talking about lab results. I'm basically a nurse coaching position but I've been put under this role as an RN Behavioral Health Consultant'.*

Jana also spoke about the similarities between the RNHN and her past role with the PCN as an RN, but that RNHC's go one step further to *'coach them to figure out how they are going to make it work in their own lives'*. She went on to say, '*In my role in the PCN…like they are coaching day in and day out…its promising to me they (the PCN) sees how you can be proactive in healthcare'.* Jana also described that her previous experience working with the PCN led to her current collaboration with a physician in the PCN working as an RNHC consultant. She described her collaboration with a physician specializing in internal medicine.

> *'I convinced her (the physician) that she didn't need a health coach, I convinced her that she needed a nurse coach and we've been working together for four years now and we've done lots in clinics, we've created group programs… I was hired with a mental health focus and chronic disease management focus so you're really helping do that proactive piece or you're helping them take the instruction from the doctor and then live it out in real life'.*

Finally, Jana suggested that the PCN provided an opportune place for RNHCs to integrate on a larger scale.

> '*I think that's where we're going to see a lot of formal positions… that nurses can do nurse coaching… they (doctors) have their nurse in their clinics so it's already happening… I see it definitely showing up in the primary care network'*.

The experiences of participants seemed to highlight similar values between the RNHC role and Alberta PCN initiatives. Despite these similarities, participants still felt that the current healthcare system felt like *'you're just trying to fit into this box, there's no room for growth' (Desiree)*. The RNHC role not only seemed to provide an alternative view on healthcare, but also a way for RNHN's to freely grow their practice in a way that prioritizes health promotion for their clients. This finding seemed to support that working with clients in this way resulted in pride for the RNHC. This pride will be described in the theme category of this chapter.

RNHC Pride

This theme describes the pride that participants experienced as RNHCs. Participants expressed *'pride in representing Registered Nurses and being a part of this community and a part of this profession' (Kristen)*. Participants expressed that stepping into the role of an RNHC has *'reactivated and inspired me to provide patient centered care' (Addison*). Additionally, the findings suggest that the reignited passion RNHCs felt led them to feeling as if they were utilizing their full RN scope of practice more freely. Finally, participants described that RNs have the education and professional experience and background to best support clients in health coaching practices.

Nursing Passion

Participants described that the RNHC role has *"reignited a passion for nursing" (Jana)* and provides *"an opportunity to be inspired" (Addison)*. She goes on to describe that,

> *'RNHCing is bringing back the heart into nursing, providing an environment which allows nurses who are passionate at providing patient care to practice….so this is actually giving me the permission to be like 'that's what we're supposed to be doing, that's what we came into nursing for… I almost feel like a new grad again. We need to be inspired and our spark needs to be re-lit again, we gotta get that extra jolt to remember why we came into this for, right?' (Addison).*

Jillian described that her role as an RNHC has brought both passion and clarity into her career.

> *'Honestly finally after a decade of dabbling in different areas of health and wellness I've found an avenue that I can amalgamate both….my passion and my pride of being a Registered Nurse with this deep desire to promote health and just bring it all together'.*

Participants also expressed that prior to finding the role of the RNHC, they were at a crossroads within the RN profession and *'looking to pivot' (Caitlyn)* while valuing their title as a Registered Nurse.

> *'I think we would all probably agree on is…coming to the program (RNHCing) feeling like we need more, we all need nursing but so many of us are burnt out and fed up from the lack of change…that we came to nursing to do more and we're able to do more….I thought I don't want this for myself anymore and I want a change and I'm seeking growth, seeking the growth that aligns with everything in such a way that I'm like "yeah, I want to do this!' (Caitlyn).*

> *'A lot of nurses were coming into the program completely burnt out wanting to leave the profession and so we're helping them find themselves back to who they want to be as*

nurses' (Jana).

Desiree also described that she wanted to continue carrying her title as a Registered Nurse,

'A nurse really is a part of who I am so I'm not ready to give up that part of my identity And having my license is a big part of that…that credibility piece is really important to me…nursing is who I am at my core'.

Participants also spoke to feeling passion and a *'place of belonging' (Addison)* within the RNHC community.

'*It's a supportive community/network of RNHC's who are passionate, inspired, engaged…I was like 'oh my god theses nurses are speaking my language like "where have I been"?' (Addison).*

'I got shivers and I like literally said to myself, 'I found my people!' (Caitlyn).

'It's really nice to have other nurses that are like minded and are wanting this' (Kristen).

Finally, one participant recommended that reigniting a passion for nursing is beneficial to the profession.

'I think that the more that we can realign with that…the more we would see less burnout and anxiety and depression and we're losing nurses from the workforce like crazy right now and I think a course like this is sometimes a good breather and refresher to remind you like, "what did you come in here for?"' (Addison).

RNHC Scope of Practice

Participants expressed how their reignited passion towards nursing as a profession was partly attributed to feeling as if they were utilizing their full RN scope of practice:

'It excites me to fully work to my full (RN) scope as a health coach' (Kristen).

'RNHC-ing is a stepping stone for RN's to promote greater professional freedom and

practicing to full scope… it's freedom to really express and to show our craft. (Nurse coaching) allows us to do this but it also allows us to do it with the freedom of exercising our own capacity of knowledge and expertise of being able to assess, support, patient teach, and still refer' (Addison).

Several of the participants spoke to feeling more freedom within their RN scope of practice. This freedom seemed to contrast previously feeling stifled within their previous roles in the RN profession.

'It's the freedom to use different modalities and connect with clients in a totally different way that couldn't in public health…as a nurse yeah, that's in my scope and I want to do that. It's like the art behind the science. We all have the scientific background but it's the art of learning how to adapt and flow and really feel out your client and know what going to work and what doesn't and knowing that you have alternative modes of doing the same thing just using things differently to get where you want to go… if every modality was a tube a paint, it's like, "which colors are going to work together and what colors do they even like to use?" so what modalities are going to work for them' (Paula).

'I don't want to feel like I'm making myself sit inside a box to fit inside their puzzle. I want to show up as my very layered, very colorful, very multidimensional self and say…. "I have a lot to offer, can I have some freedom?" within the nurse coaching role there's definitely a lot of room' (Caitlyn).

Frustration was expressed by some participants regarding the RN scope of practice in traditional healthcare settings.

'We're not allowed to do anything; everything has to be like… physician's order, and this order…I don't think as nurses we're utilized to our full capacity and scope' (Addison).

'There's rigidity in acute care practices…there's no room for interpretation of policy and procedure… whereas I have found in independent practice I have policy and procedures but there's a lot more room for interpretation!... it's really cool seeing what you can do as a nurse, like we always say nursing has so many endless possibilities and then it's always kind of like well "as long as you stay within the parameters"…. there's different ways of nursing.' (Jana).

Finally, participants recommended that while utilizing their RN scope of practice more freely, it is also important to *'have an evidence-based approach' (Jillian)* and practice within the scope of practice for Registered Nurses. Desiree said, *'make sure with RNHC-ing you're operating within the RN scope'.* Similarly, Jana stated, *'stay within the scope of practice, know when and who to refer to when something outside the RN scope – it shows nursing judgement and nursing skills'.*

RNs in Health Coaching

In this final subtheme, participants expressed that RN's have the *'advanced knowledge and education, therapeutic communication skills, and evidence-based practice' (Jillian)* that is foundational to the RNHC role. For this reason, participants suggested that RN's are *'well-positioned to be health coaches' (Caitlyn)* in comparison to other health professions for numerous reasons. Addison described that

'*Having an RN background actually provides a more stable foundation opposed to maybe an unregulated body just because we are able to tap into those medical aspects that you need to still be attune to…the assessment skills aids being a nurse coach…being able to navigate through questions…experience working with multidisciplinary teams to refer patients to assist further and continue the goal of patient centered care'.*

Similarly, several participants emphasized that RN's have the background and professional accountability to support clients:

> *'We are professionals, we have a high level of education, we're well equipped to be able to support people…I think that clients do recognize that… it's just that additional layer of accountability, professionalism, understand medications, symptoms… I think for me, like, that's what distinguishes a nurse coach vs. just a health coach…is that I'm a Registered Nurse' (Desiree).*
>
> *'I think that's what is so special is that as nurses we really have that training to really listen in and identify when it is appropriate to counsel…and maybe it might be over our experience and skills and refer to a psychologist or psychiatrist…. It's a whole nother level' (Kristen).*

Jana added that RN's have familiarity with professional ethics,

> *'We have scope and standards, we have ethics, we have things that we focus and follow… we also, it doesn't make us the best at anything we just, are the perfect profession to be doing this type of thing because many of us… I would say 100% of us are coaching even if we don't know we're coaching… I just feel like it's embedded into what you do as a nurse…there's so many health coaches out there who focus on like weight management and weight loss but having to ability to look at labs and having someone who understands the power of a health coach'.*

Paula added that RN's have added familiarity with holistic health:

> *'I want to use my nursing because I want people to know that health is more than just your physical body. Health, as nurses, we need to be addressing the whole person…I*

hope that other health coaches or life coaches would recognize that but I don't know if they would have the background to do that'.

Participants also described their opinion that public trust was an underlying assumption that is associated with RN's that also supports them being well positioned for health coaching.

'There's background with providing patient care- the RNHC role is new and patient's may not understand "what is a health coach?" but they know an RN can provide support, education, resources, and navigation' (Addison).

'There's just a standard there I guess that the public just knows is part of being a nurse' (Desiree).

'I think we are really well positioned…being a trusted profession being already intimately involved in people's lives because of that trust foundation…public trust embedded in the profession who we are as Registered Nurses in our caring profession and that we all come to it to care for people and show up for them in during their biggest need and a lot of times the weakest and most painful worst days of their life…the fact that we're a trusted profession' (Caitlyn).

The participants in this study seemed to feel that the significant factors that favored nurses as health coaches were their clinical background and expertise, their professional accountability embedded in RN practice, and the trust associated with the profession by the public.

DISCUSSION

The purpose of this qualitative descriptive study was to gain a greater understanding of the experiences, roles, and recommendations of RNHCs practicing in Alberta. Seven RNHCs discussed their experiences as RNHCs. From the seven qualitative interviews, a deeper insight was gained into how specific tools and skills shaped the RNHC role for participants, how their

experiences changed their approach to health, and how this approach to health led them to experiencing a reignited passion and pride as Registered Nurses practicing as health coaches.

Participants described how supporting clients by creating partnerships is foundational to the RNHC role. These partnerships are used to make client focused health-related changes. The RNHC uses Motivational Interviewing effectively to guide conversations with clients to bring awareness to their current health behaviors, readiness to change, and health-related goals. Additionally, participants described how the nursing process is foundational to the RNHC role and guides client interactions in a systematic, evidence-based way.

Many of these participants suggested that a holistic approach to health was a core value of the RNHC role. An integrative health assessment of a client's physical, mental, spiritual, emotional, and environmental health seemed to be unique to RNHC practice. Also unique to RNHC practice was the emphasis on health promotion and a proactive approach to health. The RNHCs suggested that this approach was missing from our current healthcare system. Participants made recommendations regarding integration of the RNHC's role within the context of the Alberta PCN.

Finally, the participants in this study described their experiences with a reignited sense of passion towards nursing in the role of the RNHC. They expressed an increase in freedom within their practice that they did not experience in their previous roles as Registered Nurses. A final recommendation by participants in this study was that RNs are well positioned for health coaching. Participants stated that this was attributed both advanced knowledge and education embedded in RN practice, and the pre-existing public trust associated with RNs. Although still an emerging role within health care (Frey & Ratliff, 2018), a deeper understanding of the experiences, roles, and recommendations of the RNHC was gained.

Implications for Nursing Practice

Reducing the strain of chronic disease on our healthcare system is essential. The Center for Disease Control (CDC) report that almost half of the world's population are living with at least one chronic disease and 70% of healthcare costs involve the care of individuals with long term chronic conditions (Gulino Schaub et al., 2012; Newman et al., 2013). Every participant in this study suggested Registered Nurse Health Coaching has the potential to meet these challenges and positively impact future nursing practice. Participants recommended that integration into the existing Alberta Primary Care would be the opportune place to influence positive health changes for both chronic disease management and prevention. Participants suggested that Registered Nurse Health Coaches have the tools and strategies to impact positive health changes on an individual and systems level. Moreover, fragmented health services are an additional barrier for individuals attempting to access primary healthcare (McMurray et al., 2018). RNHC's cannot only assess an individual's unique health goals, but also assist them navigate fragmented primary healthcare services and resources.

The participants of this study also discussed their previous experiences working as Registered Nurses within the Primary Care Network (PCN). They recommended that collaborating with primary care physicians is integral to reach clients and influencing health promotion practices in the role as a RNHC. Participants also spoke about the similarities they experienced between their roles as RN's in the PCN and their current RNHC practice. They described that combining the PCN's resources with RNHC specific skills like motivational interviewing and the holistic health assessment would bring current practice *'one step further'* (*Jana*). RNHC's utilize various coaching skills to empower individuals to have a proactive approach to their health for both chronic disease prevention and management.

Lastly, a strategy that may be beneficial in promoting further learning in Registered Nurse Health Coaching is through leveraging existing learning opportunities and education. Currently in Alberta, there is only one Canadian Nurse Association (2020) accredited course for RNHCs. The Canadian Institute of Integrated Nursing Development & Education (CIINDE) is a comprehensive holistic nurse coach program aimed at providing nurses the opportunity to provide health coaching. Promoting the development of further education courses in health coaching will perhaps influence undergraduate nursing programs in Canada to integrate RNHC training options or theory.

Little research has been conducted on RNHC implementation in general way. Additionally, little is known about the existing role of the Registered Nurse in Primary Care in Alberta (Anderson et al., 2012; Olsen & Nesbitt, 2010). Despite this, participants recommended that Alberta primary care is the most opportune place to integrate the RNHC role. RNHC's can positively impact individual and systemic health within the PCN. Additional recommendations include promoting the RNHC role through further educational opportunities.

Implications for Future Nursing Research

Through this study, I identified the unique experiences and role of the RNHC in Alberta. More research is needed on this unique role. Additionally, more research is needed to further understand how RNHCs can positively impact individual and community health within Alberta primary healthcare. Specifically, I wonder if the formal integration of RNHCs within the Alberta PCN could improve chronic disease management. Additionally, in collaboration with family physicians within the network, can RNHCs be utilized to work with patients within a physician's panel to successfully promote the prevention of chronic disease. Moreover, this study was conducted on a small scale, involving seven Registered Nurse Health Coaches in Alberta. It

would be beneficial to study the utilization of Registered Nurse Health Coaches across Canada to compare findings.

A major theme that emerged from the study was that the RNHC role has reigniting a passion for nursing amongst participants. They expressed how stepping into the role of an RNHC has *'reactivated and inspired me to provide patient centered care' (Addison*). As a result, I recommend that more research be conducted in greater depth on how the RNHC role has seemed to provide a solution to nursing burnout for certain individuals.

Lastly, outside of the current recommendations from the College and Association of Registered Nurses of Alberta (CARNA) and the Alberta Association of Registered Nurses in Private Practice (AARNIPP) there are no guidelines in Alberta specifically for the RNHC, especially for the RNHN entering into private practice. Therefore, it would be beneficial to create a guideline specific to the role of the RNHC in Alberta for both private practice and within publicly funded roles.

Limitations

Purposeful snowball sampling techniques for this proposed study may have limited the study. Furthermore, purposeful snowball sampling may have generated a biased sample unbalanced in demographics because participants were chosen for the study on a first-come first serve basis if they met eligibility criteria. Every participant who agreed to be a part of this study was female, leading to an unintentional exclusion of men. Having a larger sample size of participants may allow for a more in-depth understanding of the RNHC experience, including that of male perspective.

This study was limited to the subjective experiences of RNHC's where six of the seven participants went through the same educational program, the Canadian Institute of Integrative

Nursing Development & Education (CIINDE) program. Currently in Alberta, the CIINDE program is only Canadian Nurse Association (2020) accredited course for RNHCs. Therefore, transferability of these findings may be more limited as the study captured did not capture the experiences of participants from diverse RHNC training backgrounds.

CONCLUSION

The rise in chronic disease has put a significant strain on existing primary healthcare services in Canada (Anderson et al., 2012; Vincent & Sanchez Birkhead, 2013). Facilitating effective and high-quality care to improve health outcomes for all individuals is critical. There is an opportunity for Registered Nurse Health Coach (RNHC) to enhance primary healthcare delivery within interprofessional teams through health promotion and disease prevention strategies in a patient centered approach (Caldwell et al., 2013; Goble et al., 2017; Kreitzer, 2015; Smolowitz et al., 2015). This study contributes to the current understanding of the RNHC within the Alberta primary care context. Furthermore, understanding was gained about the RNHC's experiences and the opportunities and challenges experienced by the RNHC. The findings from this research project will inform employers, healthcare teams, and Registered Nurses in the Alberta Primary Care Network of the role of RNHCs. Additionally, it will offer rationale for the development of future research into how RNHC can further leverage the success of existing Alberta Primary Care Networks. Currently, the role of the RN in Alberta primary care remains poorly understood and few Canadian studies clearly identify the role of the RN employed in specific geographic or patient groups (Ammi et al., 2017; Hutchison et al., 2011; Oelke et al., 2014). It is therefore crucial to enhance knowledge about how RNHC can enhance Alberta primary healthcare delivery.

CHAPTER THREE: GENERAL SUMMARY AND RECOMMENDATIONS

Registered Nurse Health Coaches (RNHC)s are professionals who engage with clients to enhance their wellbeing, facilitate health-related goals, and encourage health promotion and disease prevention (Palmer et al., 2003; Vincent & Sanchez Birkhead, 2013). There is an opportunity for RNHCs to enhance primary healthcare delivery in Canada. This is especially important in a current healthcare system, where the rise of chronic disease has put a significant strain on existing healthcare resources (Anderson et al., 2012; Vincent & Sanchez Birkhead, 2013). In Alberta, primary healthcare initiatives are aimed at improving patient healthcare outcomes, especially in regard to the prevention, management, and treatment of chronic disease (Hutchison et al., 2011; Ludwick, 2011; Oelke et al., 2014). Currently, little is known about the role of the Registered Nurse in Primary Care in Alberta (Anderson et al., 2012; Olsen & Nesbitt, 2010). Despite this, it has been suggested that the primary care setting is ideal to implement the role of the RNHC because of the focus on collaborative healthcare efforts and patient engagement (Jeon & Benavente, 2016).

Registered Nurse Health Coaching

Registered Nurse Health Coaches (RNHC)s are defined as professionals who engage in professional interactions with clients to enhance their wellbeing and facilitate the achievement of health-related goals (Palmer et al., 2003; Vincent & Sanchez Birkhead, 2013). Recognition of the nurse coach role as an expanded role within nursing began to appear in the literature after the International Council of Nurses partnered with The Honor Society of Nursing, Sigma Theta Tau International to release the document, *Coaching in Nursing: An Introduction* (2009) (Gulino Schaub et al., 2012). The coaching context is what makes the RNHC role unique and incorporates coaching theories and principles. Coaching principles are more effective than

traditional health education models of ‘telling’ the individual what to do to stay healthy as coaching works to activate the individuals own motivation for change through collaboration with the RNHC (M. Huffman, 2009). Despite evidence showing that Registered Nurses are equipped for health coaching roles (Vincent & Sanchez Birkhead, 2013), there is limited literature studying Registered Nurses in this role.

The purpose of this study was to *gain an understanding of the experiences, role, and recommendations of the Registered Nurse Health Coach (RNHC) in Alberta.* Seven RNHCs were interviewed in this qualitative descriptive study. From the seven qualitative interviews, a deeper insight was gained about both experiences and opportunities as well as challenges experienced by the RNHC. In this chapter, a summary of the major findings of this study will be discussed. Additionally, the implications for nursing practice and future research will be discussed in relation to the major findings and recommendations from RNHCs whom participated in this study.

DISCUSSION

From the seven qualitative interviews, RNHCs who participated in this study identified the specific tools that were unique to the RNHC role. They described how these tools shaped their interactions and experiences with clients. Furthermore, RNHCs discussed how these interaction and experiences changed their approach to health. A unique approach to health seemed to be foundational to the role of the RNHC and influenced their experiences with a reignited sense of passion and pride as Registered Nurses practicing as health coaches. Three themes emerged from the interview data: (a) *the RNHC toolbox*; (b) *the RNHC perspective*; and (c) *RNHC pride.*

Participants described how specific tools and skills, like motivational interviewing, are unique to the RNHC role in comparison to RN practice. These skills are used to collaborate with clients

to achieve client-driven health related goals. The RNHC begins by asking what a client is seeking in relation to their health goals. Additionally, participants described that utilizing foundational tools like the nursing process also assisted the RNHC to engage in professional interactions with clients and create a framework for the RNHC role.

Participants described how a holistic approach to health involves the physical, mental, emotional, spiritual, and environmental aspects. This holistic approach to health seemed to be the foundation of RNHC principals. Also foundational to the RNHC role, participants described how health promotion and prevention was key to encouraging clients to be accountable to their own health and empowering them through proactive health decisions and strategies. Lastly, RNHC's recommended how their profession could integrate into primary healthcare in Alberta. Participants described their past and current experiences with Primary Care Network where they collaborated with physicians in to reach clients and influence health behavior changes. An unexpected finding of this study is that more participants did not speak more about the potential challenges for the RNHC wanting to integrate into Alberta primary healthcare. Several participants mentioned that *'time'* was a challenge in integrating proactive and preventative healthcare measures in our current primary healthcare setting, but it was unexpected that more potential challenges were not discussed. Participants responses to interview questions were diverse, perhaps influencing the overall discussion of challenges experienced in the RNHC role.

Finally, participants described their experiences with feeling a reactivated passion towards the profession of nursing as a result of entering into the RNHC role. Additionally, the RNHC's in this study described that this reactivated passion also led them to experiencing a sense of pride towards providing patient care. Participants also felt that they were able to utilize their RN scope of practice more freely in comparison to their previous roles as RNs. Practicing at full scope,

participants recommended that this, along with advanced knowledge and education, therapeutic communication skills, and an underlying public trust, made RN's well suited the role.

Implications for Nursing Practice

Reducing the strain of chronic disease on our healthcare system is essential. The Center for Disease Control (CDC) report that almost half of the world's population are living with at least one chronic disease and 70% of healthcare costs involve the care of individuals with long term chronic conditions (Gulino Schaub et al., 2012; Newman et al., 2013). Every participant in this study suggested Registered Nurse Health Coaching has the potential to meet these challenges and positively impact future nursing practice. Participants recommended that integration into the existing Alberta Primary Care would be the opportune place to influence positive health changes for both chronic disease management and prevention. Participants suggested that Registered Nurse Health Coaches have the tools and strategies to impact positive health changes on an individual and systems level. Moreover, fragmented health services are an additional barrier for individuals attempting to access primary healthcare (McMurray et al., 2018). RNHC's can not only assess an individual's unique health goals, but also assist them navigate fragmented primary healthcare services and resources.

The participants of this study also discussed their previous experiences working as Registered Nurses within the Primary Care Network (PCN). They described that collaborating with primary care physicians is integral to reach clients and influencing health promotion practices as Registered Nurse Health Coaches. Participants also spoke about the similarities between their roles as Registered Nurse's in the PCN and RNHC practice. They described that combining the PCN's resources with RNHC specific skills like motivational interviewing and the holistic health assessment would bring current practice *'one step further'* (*Jana*). RNHC's utilize various

coaching skills to empower individuals to have a proactive approach to their health for both chronic disease prevention and management.

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Little research has been conducted on RNHC implementation in general way. Additionally, little is known about the existing role of the Registered Nurse in Primary Care in Alberta (Anderson et al., 2012; Olsen & Nesbitt, 2010). Despite this, participants recommended that Alberta primary care is the most opportune place to integrate the RNHC role. RNHC's can positively impact individual and systemic health within the PCN. Additional recommendations include promoting the RNHC role through further educational opportunities.

Implications for Future Research

Through this study, I identified the unique experiences and role of the RNHC in Alberta. More research is needed on this unique role. Additionally, more research is needed to further understand how RNHCs can positively impact individual and community health within Alberta primary healthcare. Specifically, I wonder if the formal integration of RNHCs within the Alberta PCN could improve chronic disease management. Additionally, in collaboration with family physicians within the network, can RNHCs be utilized to work with patients within a physician's

panel to successfully promote the prevention of chronic disease. Moreover, this study was conducted on a small scale, involving seven Registered Nurse Health Coaches in Alberta. It would be beneficial to study the utilization of Registered Nurse Health Coaches across Canada to compare findings.

A major theme that emerged from the study was that the RNHC role has reigniting a passion for nursing amongst participants. As a result, I recommend that more research be conducted in greater depth on how RNHCing has seemed to provide a solution to nursing burnout for certain individuals.

Lastly, outside of the current recommendations from the College and Association of Registered Nurses of Alberta (CARNA) and the Alberta Association of Registered Nurses in Private Practice (AARNIPP) there are no guidelines in Alberta specifically for the RNHC, especially for the RNHN entering into private practice. Therefore, it would be beneficial to create a guideline specific to the role of the RNHC in Alberta for both private practice and within publicly funded roles.

Dissemination

The dissemination of qualitative research is critical to translate current knowledge to support decision makers, build theory, and influence nursing practice (Toews et al., 2016). Determining appropriate and effective dissemination strategies for knowledge translation is critical. The researcher must determine: a) what should be transferred? b) to whom should research be transferred? c) how should research be transferred? (Grimshaw, Eccles, & Lavis, 2012). The findings from the proposed research project will be disseminated to inform employers, healthcare teams, and Registered Nurses in the Alberta Primary Care Network of the role of RNHCs.

Additionally, these teams will be informed of the experiences of RNHC's including the opportunities, challenges, and recommendations for implementation.

The primary method of dissemination will be providing oral presentation of findings to integrative teams at primary care clinics throughout Alberta. Findings from this study will inform how RNHCs can integrate into these teams and further leverage the success of existing Alberta Primary Care Networks. Additionally, an abstract for oral presentation will be submitted to the *Canadian Nurses Association (CAN) Biennial Convention.* This conference has been selected for its national exposure. The researcher will also engage with the *University of Lethbridge – Faculty of Health Sciences*, specifically the nursing program, to provide oral presentations to third and fourth-year nursing students. These presentations will provide students in the U of L nursing program with information regarding new roles for RN's like the RNHC.

Academic dissemination to influence nursing practice and build theory occur through peer-reviewed publications. The *International Journal of Nursing Studies* (IJNS) and the *Journal of Holistic Nursing* have been selected based on relevance to the topic, national and international readership, and impact factor.

Lastly, public engagement is aimed at engaging the public sector in research findings. A summary of the proposed research study will be shared with the *College and Association of Registered Nurses of Alberta (CARNA)* for possible publication in their magazine that is disseminated to Registered Nurses in Alberta on a quarterly basis. Additionally, a summary will be shared with the *Canadian Nurses Association (CNA)* for publication in their monthly e-newsletter and online membership database, *Canadian Nurse*.

REFLECTION

I started my Masters of Nursing journey at a crossroads in my own nursing career. As an acute care nurse specializing in Pediatrics, I could see how the rise of preventative chronic diseases was affecting even the youngest of our population. I began to wonder how Registered Nurses could play a more active role in the prevention of chronic disease and the promotion of health. Seeking a role that fit this desire, I discovered the role of the Registered Nurse Health Coach. I wanted to understand more about the role from nurses who had already entered into the profession and as a result, the topic of my thesis study came to fruition. I wanted to know not only the experiences of practicing RNHC's but also how they can impact primary healthcare in Alberta. My own understanding of the Registered Nurse's role in primary care was limited therefore I couldn't picture how RNHC's would fit in to the existing healthcare system. As I've mentioned previously in this chapter, currently, little is known about the role of the Registered Nurse in Primary Care in Alberta (Anderson et al., 2012; Olsen & Nesbitt, 2010). Therefore, it is important to understand how roles like the RNHC can support the needs of primary care for all Albertans. After hearing the stories of seven Registered Nurse Health Coaches in Alberta, the findings from this study seem so support that RNHC's not only can integrate into Alberta primary care in a purposeful way, but also support individuals in a unique approach to achieve their healthcare needs.

CONCLUSION

The main findings from this study highlighted that the RNHC role supports individuals to achieve their healthcare needs through empowerment. Empowerment in nursing is an important concept for both nurses and clients alike and is derived from the idea that individuals have the innate power to accomplish their work in a meaningful way (Spence Laschinger, Gilbert, Smith, & Leslie, 2010; Yeh, Wu, & Tung, 2018). It has also been proposed that empowered nurses are

better equipped to empower their patients, having a positive impact on not only health outcomes, but also patient care (Spence Laschinger et al., 2010). This was supported by findings in this study. RNHC's described that their experiences in the RNHC role empowered them to provide the best possible care for their clients. Thus, this study has highlighted that the RNHC role can not only positively influence a client's health, but also enable longevity within the profession through passion as an RNHC.

As chronic disease continues to rise, the demand for efficient and effective healthcare will be at an all-time high. There is an opportunity for the RNHC to enhance primary healthcare delivery in Canada through a specialized skillset, a holistic and proactive approach to health, and the passion for client centered care. Through forming effective client partnerships, the RNHC can empower clients to recognize their own strengths. RNHC's have the perspective and passion to not only navigate our current healthcare challenges, but also improve healthcare for all Albertans.

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