Health Coaching by Behavior Analysts in Practice: How and Why

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Abstract

Approximately half of the U. S. population is living with a chronic disease that could be prevented or abated by lifestyle changes. We have a behavior problem of great social significance that requires carefully designed interventions that produce meaningful changes in behavior, ideally by drawing from the extensive basic and applied research literature in behavior analysis. But to truly address this problem, we will need many more behavior analysts in practice, given the scope of what is facing us. At least for now, behavior analysts who want to practice in the broad field of behavioral health need to establish and maintain professional credentials in new areas of practice. In this paper we describe how BACB certificants can obtain certification as a Health Coach and why it might be fruitful to do so. Specifically, we define the emerging practice area of health coaching, identify some similarities and differences in professional competencies in health coaching as compared to behavior analysis, describe the necessary steps for behavior analysts in practice to become certified health coaches, and suggest ways in which behavior analysts can meaningfully contribute to the practice of health coaching. We conclude with suggestions for how to establish behavior-analytic services focused on health coaching.

*Keywords*: health coaching, wellness coaching, behavioral health, fitness, applied behavior analysis
Health Coaching by Behavior Analysts in Practice: How and Why

Despite what some have been led to believe, or would at least like to believe, health and wellness are largely matters of what we do and what we do not do. Being healthy is behaving healthy. The good news is that although we cannot control all aspects of our health and well-being, our lifestyle plays a large role. Improving health, then, is largely a matter of changing behavior. This, too, is good news, because there is a robust science and practice of behavior change at our disposal. And it is desperately needed.

For example, according to recent estimates, approximately 40% of adults and 18.5% of children and adolescents in the United States are obese (e.g., Fryar, Kruszan-Moran, Gu, & Ogden, 2018; Hales, Carroll, Fryar, & Ogden, 2017). Obesity rates have more than doubled since 1980, and some bleak projections estimate that 51% or more of the population will be obese by 2030 (Finkelstein et al., 2012). Even more, research suggests that young adults are increasingly being diagnosed with type 2 diabetes (Mayers-Davis et al., 2017) and the cancers most associated with obesity (Sung, Siegel, Rosenberg, & Jemal, 2019). The costs related to obesity are estimated at $147 billion (Finkelstein, Trogdon, Cohen, & Dietz, 2009), and some project the costs will top $956 billion in the near future (Wang, Beydoun, Liang, Caballero, & Kumanyika, 2008). Weight is largely a product of two behavioral factors: eating and physical activity (J. O. Hill & Peters, 1998). Unfortunately, many people engage in too much of the former and not enough of the latter.

1 Some people burn calories more readily than others and some people are more adversely influenced by an obesogenic environment (Bouchard, 2010). However, the dramatic increases in obesity rates have occurred much too quickly to be explained by our genes (Bouchard, 2010; J. O. Hill & Peters, 1998; J. O. Hill, Wyatt, Reed, & Peters, 2003). It is also true that some individuals have health conditions, such as metabolic disorders, that distort the typical calorie equation, or take medications that can lead to weight gain. Additionally, the way our metabolism works to burn and store calories (as fat) seems to change as a consequence of our weight, particularly when one gains or loses weight (Rosenbaum, Hirsch, Gallagher, & Leibel, 2008). However, weight still remains a function of calories consumed and calories burned, even if the amount of calories burned changes based on various factors.
It is difficult to quantify how many people do or do not eat a healthy diet, but some estimates suggest that relatively few people in the United States are eating what they should in the amounts that they should. The average diet in the United States contains too much sodium and too many calories from fats, saturated fats, added sugars, and refined grains (U. S. Department of Health and Human Services, 2017). For example, approximately 90% of Americans eat more than the recommended amount of sodium, and dietary fat consumption has increased considerably since 1980 (U. S. Department of Health and Human Services, 2017). For most children and adolescents, dietary fats and added sugars compose approximately 40% of their diet (Reedy & Krebs-Smith, 2010). To be healthier, people need to eat healthier.

In terms of physical activity, adults should engage in at least 150-300 min per week of moderate physical activity, or 75-150 min per week of vigorous physical activity, but approximately 78% of American adults do not (U.S. Department of Health and Human Services, 2018). Children and adolescents need to move even more and should engage in at least 60 min of moderate-to-vigorous physical activity (MVPA) per day, but approximately 80% of American children do not (U.S. Department of Health and Human Services, 2018). Importantly, physical activity has health benefits beyond weight management, and physical inactivity poses health risks beyond weight gain. Currently, physical inactivity is considered the fourth leading risk factor for mortality, worldwide (Lee et al., 2012). To be healthier, people need to move more.

Of course, the health problems facing the world are not limited to diet and exercise. According to the 2016 National Survey on Drug Use and Health, more than 50 million people smoke cigarettes, roughly 65 million people binge drink, over 16 million engage in regular heavy alcohol consumption, and almost 29 million use illicit drugs (Substance Abuse and Mental Health Services Administration, 2017). Relatively few adults and children sleep enough
(Gradisar, Gardner, & Dohnt, 2011; Liu et al., 2016; Stranges, Tigbe, Gómez-Olivé, Thorogood, & Kandala, 2012). Few people living with chronic health conditions adhere to prescribed medical regimens, including lifestyle behavior-change recommendations. An estimated 92% of adults in the United States do not access the recommended preventive health care services identified as most likely to improve health (Borsky et al., 2018). Approximately 15% of the U.S. population does not see a physician in a calendar year (National Center for Health Statistics, 2016). According to one estimate, almost 65% of U.S. adults do not receive regular dental care, and only about half of U.S. children do (Nasseh & Vujicic, 2016). The list goes on.

All of this to say that we have serious behavior problems to address. And many people are concerned, in the United States and around the world. In the United States, we spend an enormous amount of time, money, and other resources attempting to prevent and abate the many health problems caused by unhealthy lifestyles. Approximately half of the U.S. population is living with a chronic disease that could be prevented or abated by lifestyle changes (U.S. Department of Health and Human Services, 2017; U.S. Department of Health and Human Services, 2018). For behavior analysts, this should all sound familiar. There are behavior problems of great social significance that require carefully designed interventions that can be shown to produce meaningful changes in behavior, ideally by drawing from the extensive basic and applied behavior-analysis research literature. This is essentially the definition of applied behavior analysis (ABA; e.g., Baer, Wolf, & Risley, 1968; Baer, Wolf, & Risley, 1987). Health behavior, or lack thereof, is a problem that behavior analysts can address.

But to address problems of this scope, there will need to be many more behavior analysts in practice. Approximately 90% of children and adults in the United States eat something other than a healthy diet, and approximately 80% do not engage in enough physical activity. As a
consequence, as much as 50% of the population may be well on the way to being obese by 2030. Now consider this: right now, most of the thriving field of behavior-analytic practice is driven by the services provided to children diagnosed with autism spectrum disorder (ASD). The most recent estimates are that 1 in 59 children in the United States are diagnosed with ASD (Baio et al., 2018), which equates to less than 2% of the population. This means that the large and ever-growing numbers of behavior analysts in practice (conservatively estimated at 35,445 as of this writing; see https://www.bacb.com/bacb-certificant-data) can be attributed, in large part, to the need to solve a problem diagnosed in only 2% of the population. And the field cannot even keep up with this demand. Imagine how many behavior analysts in practice are needed to address a problem affecting 80% or 90% of the population, which is the scope of the obesity “epidemic,” as it has been justly called. It is worth noting that the epidemic includes individuals diagnosed with ASD (A. P. Hill, Zuckerman, & Fombonne, 2015) and with intellectual and developmental disabilities (IDD), and is even more prevalent in those populations (Hsieh, Rimmer, & Heller, 2013; Rimmer, Yamaki, Davis Lowry, Wang, & Vogel, 2010; Segal et al., 2016). Behavior analysts who provide services to those populations might want to consider expanding their services into the behavioral health area as an adjunct to, rather than a replacement of, their early intervention services.

Where are all those behavior analysts in (health) practice? Most of them are not yet here, and those who are work with those aforementioned serious problems—ASD, IDD—where there is great need. One important reason more behavior analysts work in autism agencies than in behavioral-health agencies is that the autism agencies are hiring them and behavioral-health agencies (e.g., hospitals, health clinics) are not. In truth, most behavioral-health agencies do not even know that they should. Without a job market it is hard to have a workforce—hire them and
they will come. Currently, the credentials offered by the Behavior Analyst Certification Board (BACB®) are among those recognized by the parties providing and paying for services for individuals diagnosed with ASD. Not so in the broader health field. At least for now, behavior analysts who want to practice in the broader health field need to establish and maintain professional credentials in new areas of practice (see Normand & Kohn, 2013 for a discussion).

In this paper we will describe how BACB certificants can obtain professional credentials relevant to behavioral health and why it might be fruitful to do so. Behavioral health is a broad term that encompasses many things, including, by some definitions, what behavior analysts already do in the realms of ASD and IDD. We will use the term here to refer to practice outside of those areas, especially the design and delivery of interventions to encourage lifestyle changes that abate chronic diseases. Specifically, we will define an emerging practice area (health coaching) in behavioral health that has direct relevance to behavior analysis, identify some similarities and differences in professional competencies in health coaching as compared to behavior analysis, describe the necessary steps for behavior analysts in practice to become certified health coaches, and suggest ways in which behavior analysts can meaningfully contribute to the practice of health coaching. We will conclude with suggestions for how to establish behavior-analytic services focused on health coaching.

**What is Health Coaching?**

Health coaching, sometimes called wellness coaching, is a relatively new field that covers a range of activities related to promoting health and wellness on an individual-by-individual basis. There is no consensus definition of health coaching, though most definitions share a number of common elements (e.g., Butterworth, Linden, & McClay, 2007; Chapman, Lesch, & Baun, 2007; Johnson, Saba, Wolf, Gardner, & Thom, 2018; Kivelä, Elo, Kyngäs, & Kääriäinen,
2014; Olsen & Nesbitt, 2010; Palmer, Tubbs, & Whybrow, 2003). For present purposes, we will work from the description provided by the American Council on Exercise (ACE), which is the most prominent organization certifying exercise professionals and health coaches:

The certified Health Coach is an advanced fitness professional responsible for working independently and with other professionals to help a wide variety of individuals and groups adopt structured behavior-change programs that focus on lifestyle and weight management through physical activity, nutrition, and education necessary to improve and maintain health, fitness, weight, body composition, and metabolism.

In general terms, then, health coaches educate people about healthy lifestyles and help people to make healthy lifestyle changes. In more specific behavioral terms, they provide task clarification (stimulus discrimination training; what is healthy behavior and what is unhealthy behavior), help set goals (identify and define the specific behaviors to change and by how much), and arrange antecedents and consequences that are intended to evoke or reinforce behavior change. This general description is obviously consistent with behavior-analytic practice, though the methods employed by health coaches can sometimes differ from those employed by behavior analysts.

Health coaches work in a variety of settings, such as doctor’s offices, gyms, and private practice. No matter the specific setting, health coaches work one-on-one with people who want to be healthier. They aim to provide individualized help to their clients to help them change in light of their unique circumstances, beyond what, for example, the person’s primary physician can do. This aspect of health coaching also squares nicely with behavior-analytic practice. However, it often is the case that health coaches rely on self-reports of behavior in lieu of direct observation and some, sometimes much, patient contact occurs via phone or internet (Kivelä et al., 2014). These are obviously important deviations from what constitutes best practice for
applied behavior analysts, but these deviations are not codified, meaning that one certainly could make direct observation in the “real world” part-and-parcel of their health coaching.

In terms of professional scope of practice, health coaches are not necessarily the ones to determine what needs to be changed. Indeed, health coaches are not supposed to diagnose any medical condition or prescribe any specific medical treatment (Lipscomb, 2006). The American Council on Exercise, for example, specifically states that the following actions, among several others, are outside the scope of practice for an ACE Certified Health Coach: nutrition prescription and meal planning, exercise prescription, diagnosis of medical ailments (Matthews, Bryant, Skinner, & Green, 2019, p. 13).2 Physicians, physical therapists, nutritionists, and other medical professionals are the ones who should determine the kinds of behavior that warrant change. This is not unlike the role of many behavior analysts in practice who work as part of an inter-disciplinary team and are charged with devising and implementing behavior intervention plans based on goals identified by or in collaboration with others, such as parents, teachers, school psychologists, and other school personnel. A health coach is not necessarily a medical expert but, in our estimation, they should be a behavior-change expert, which is why the BCBA seems an especially relevant professional credential.

Of course, behavior analysts and health coaches alike might develop competencies in areas that fall outside their scope of practice. For behavior analysts, licensure laws in some states restrict the practice of behavior analysts beyond what the BACB specifies. For example, in New York state, licensed behavior analysts must restrict their practice to individuals diagnosed with ASD or related disorders, no matter their competence in other areas unless they hold professional credentials in those other areas. However, they must then practice not as

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2 Similar to the scope of practice guidelines for BACB certificants, Health Coaches also are supposed to refrain from engaging in activities that are considered counseling or therapy.
licensed behavior analysts but as a professional wearing a different hat. The case is similar for certified Health Coaches; it is possible to be certified as a health coach and, say, as a personal fitness trainer. As a certified personal fitness trainer, you could make exercise recommendations but you would have to do so wearing that hat rather than the hat of a certified health coach. As a health coach, your role is not to prescribe what needs to change, it is to help the prescribed change happen.

**Health Coaching and Applied Behavior Analysis**

Health coaching, at least currently, seems more usefully considered an arena for practice rather than a kind of practice, per se. Health coaching encompasses a range of activities (Johnson et al., 2018), and the activities commonly practiced by behavior analysts fit well within this range (see also Finn & Watson, 2017). Several reviews of the efficacy of health coaching interventions suggest that the effects are promising, if not variable (Dejonghe, Becker, Froboese, & Schaller, 2017; Kivelä et al., 2014; Lindner, Menzies, Kelly, Taylor, & Shearer, 2003; Olsen & Nesbitt, 2010; Wolever et al., 2013). Unfortunately, it is difficult to draw conclusions about overall efficacy because of the important methodological limitations that characterize many studies to date (Olsen & Nesbitt, 2010; Wolever et al., 2013). Most published evaluations of health coaching include varying definitions of coaching practices, employ non-randomized group designs, report high rates of participant attrition, and, perhaps most importantly, do not involve direct measures of health behavior. It is in this milieu that behavior analysts might make a substantive contribution.

Applied behavior analysis has produced an array of technologies ready to be deployed in the service of health coaching. It also constitutes an approach to understanding health behavior that is rooted in a strong conceptual and basic-research literature, combined with a robust applied
research tradition of the kind that would be of service to the emerging field of health coaching (Finn & Watson, 2017). ABA is characterized by operational definitions of target behaviors, repeated direct observation of those behaviors across time, and a focus on individual behavior change evaluated using within-subject research designs (e.g., Baer et al., 1968; Baer et al., 1987; Cooper, Heron, & Heward, 2014). This approach makes it possible to develop interventions tailored to the needs of each individual and to evaluate the effectiveness of those interventions on a case-by-case basis.

The ABA literature already contains many examples of research that directly informs practices that would be subsumed under the guise of health coaching. From a behavior-analytic standpoint, the bulk of what health coaches do, or at least should do, is captured by the tried-and-true technologies of task clarification, goal-setting, behavioral skills training, and contingency management (e.g., incentives). There is a wealth of research in the applied behavior analysis literature from which to draw, though a comprehensive discussion of that literature is beyond the scope of this paper (see Allen & Hine, 2015; Dallery, Defulio, & Meredith, 2015; Hausman & Kahng, 2015; Normand, Dallery, & Ong, 2015 for reviews). Task clarification, goal-setting, and feedback have been used across a variety of populations, settings, and target behaviors to improve performance, including physical activity (e.g., Donaldson & Normand, 2009; Normand, 2008). Similarly, Behavioral Skills Training has been established as a robust intervention to teach a variety of skills to a variety of people, including exercise and sport performance (e.g., Moore & Quintero, 2019). Contingency Management interventions have been developed to treat some of society’s most intractable problems, such as smoking and other drug abuse (Higgins, Silverman, & Heil, 2007; Stitzer & Petry, 2006), as well as obesity (Jeffery, 2012). There are a number of behavior-analytic tools ready to be used in the service of health coaching.
Health Coaching Competencies and Credentials

Recognizing your scope of competence is essential to any practicing professional; because certain activities might fall within your professional scope of practice does not necessarily mean you are competent to perform them (Brodhead, Quigley, & Wilczynski, 2018). Moving into new practice areas requires one to become competent in the characteristic practices of those areas, both ethically and practically (see LeBlanc, Heinicke, & Baker, 2012; Normand & Kohn, 2013). This requires contacting the relevant professional literature and becoming part of professional groups that are relevant to health coaching (LeBlanc et al., 2012). To successfully practice as a health-coach and to meaningfully contribute to the evidence-base for health-coaching strategies, behavior analysts will need to learn basic concepts and principles of diet, fitness, exercise, and they will need to become familiar with standard health-coaching strategies and the evidence, or lack thereof, supporting them. Behavior analysts should read what their new colleagues read, see and hear what they see and hear, and be able to talk like they talk. Table 1 provides a list of relevant non-behavior-analytic journals related to health coaching, and Table 2 provides a list of relevant professional organizations for those interested in health-coaching research and practice. These lists are not exhaustive but should serve as a good starting point for the interested reader.

There are no specific professional credentials required to practice as a health coach, though this is likely to change in coming years. For now, almost anybody can hang up a shingle and call themselves a health coach, and so much the worse for potential consumers, we fear. As other fields already have recognized, this makes it important for those in health coaching who do have reputable professional credentials to make those credentials obvious to the consumer (e.g., Lipscomb, 2006). Currently, most health coaches appear to have educational backgrounds in the
medical or allied health fields, with many being nurses or mental health professionals, including psychologists (Butterworth et al., 2007). Credentials are available for several professions related to health coaching, including Health Educators, Personal Fitness Trainers and Nutrition Specialists, but certification also is available from several organizations for Health Coaches, specifically. As of now the American Council on Exercise (ACE) is the only such organization accredited by the National Commission for Certifying Agencies (NCCA), which is the accreditation body of the Institute for Credentialing Excellence. (This is the same body that accredits the BACB.) One of the NCCA accreditation requirements is that the certification program develop a job analysis that identifies the specific skills related to the certification.

The skills of a health coach identified in the ACE job analysis overlap considerably with those of a Board Certified Behavior Analyst (BCBA), with some exceptions and, of course, some important additions. Both ACE (https://acewebcontent.azureedge.net/assets/certification/pdfs/HC-Exam-Content-Outline.pdf) and the BACB (https://www.bacb.com/wp-content/uploads/2017/09/170113-BCBA-BCaBA-task-list-5th-ed-.pdf) describe performance domains and specific tasks relevant to their respective practices. ACE divides the various Performance Domains into Task Statements, which are further categorized as Knowledge and Skill statements. Similarly, the BACB provides a Task List that is organized by topics categorized as either Foundations or Applications, which are comparable, with some exceptions, to the Knowledge and Skill categories used by ACE.

Table 3 provides examples of performance domains and task statements for health coaches (identified by ACE) compared with corresponding task domains for behavior analysts in

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3 These related professional credentials, and the accompanying education, might be beneficial for behavior analysts in health-related practice. These other certifications, except for personal fitness training, require specific educational backgrounds (i.e., degrees in related fields such as nutrition or biomedical sciences) and more formal practical training experiences and, thus, are beyond the scope of this paper.
practice (identified by the BACB). The most obvious overlaps pertain to the development, implementation, and monitoring of interventions designed to change health behavior. The specific ACE knowledge and skill statements were not included due to space considerations, but they reveal even more direct areas of overlap with the BACB task list. There is considerable overlap between the ACE Professional Conduct and Legal Responsibility statements and the BACB Professional and Ethical Compliance Code, as well. Put simply, BACB certificants should already have many of the competencies and skills needed to be certified as a Health Coach. Moreover, the similarities in the required competencies help establish the relevance of applied behavior analysis to the field of health coaching.

There are also many items on the ACE task list that are beyond the typical range of behavior-change topics taught to behavior analysts, and most of these are related to health-specific topics (e.g., diet and exercise) and the health-coaching research literature. Additionally, there are a number of ACE Knowledge and Skill items that are not part of the BACB Task List but that would be beneficial to behavior analysts in any kind of practice. Most critically, the ACE task list makes clear that effective interviewing techniques (e.g., motivational interviewing, active listening) are important. Such interviewing techniques are important both for gathering relevant information and for building rapport. Behavior analysts in any area of practice would be well-served to develop interview skills. Process can matter as much or more than content (Chadwell, Sikorski, Roberts, & Allen, 2018).

In the ACE task analysis, the knowledge pertaining to theories and models of behavior change and the related skills involving the design and implementation of behavior-change plans do include, but also cover much more than, behavior-analytic theories, models, and practice (e.g., Cooper et al., 2014). As such, behavior analysts will need to become familiar with a broader
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range of theories and models related to behavior change, and they will need to contact a research literature beyond just applied behavior analysis. This does not mean that these models, theories, and practices should supplant behavior-analytic practices, unless empirical evidence clearly suggests so, but it does mean that behavior analysts need to know what other health coaches know. The most straightforward way to do this, at least initially, is to complete an exam preparation course offered by the various certifying organizations, such as the online study program provided by ACE ("Choose your Health Coach Study Program," n. d.).

Behavior analysts practicing as Health Coaches will undoubtedly encounter behavior-change strategies that are not empirically-supported and that do not qualify as the kinds of practices sanctioned by the BACB (e.g., Behavior Analyst Certification Board, 2014, Sections 1.01, 4.01). This is not qualitatively different from what most behavior analysts encounter in any other settings, such as practicing as a member of an Individualized Education Program (IEP) team composed of professionals with a range of academic and professional backgrounds. The responsibilities of the behavior analyst, at least if they are credentialed by the BACB, is to not recommend or use unsupported practices (Behavior Analyst Certification Board, 2014, Section 1.01) and, ideally, the behavior analyst would engage the other parties in discussion about appropriate behavior-change strategies. If agreeable empirically-supported strategies cannot be identified, the behavior analyst should not be involved in implementing the questionable practices, but they probably will not be able to proscribe them. In terms of health coaching, it is not the case that the health coach is obligated to engage in any specific set of strategies in any particular circumstance. If anything, the BACB guidelines are considerably more prescriptive than those of, say, the ACE Health Coaching Performance Domains. It is likely that, at least in
most circumstances, the BACB *Professional and Ethical Compliance Codes* can be followed without issue.

**Putting Behavior Analysis into (Health) Practice**

Behavior analysts wanting to pursue a career in behavioral health will need to be willing to work in unfamiliar and varied settings and, ultimately, to forge the way by starting their own health-coaching agencies. Be flexible and be entrepreneurial. We suggest that behavior analysts first work in existing facilities or agencies to gain skills, experience, and credibility, and then put all of that to work in more behavior-analytic work environments. Behavior analysts who start their own health coaching agencies not only provide work for themselves, but they potentially provide work for other behavior analysts. They create the workplace for a workforce.

At least initially, many of the job opportunities might be on a part-time basis. Some health coaching jobs are advertised as part-time positions, and even the entrepreneur who starts a health-coaching agency will likely find that it takes a while to develop a full-time client base. This might well be a good thing, as it means that behavior analysts can serve multiple masters, at least at the beginning. Providing ABA services for, say, young children diagnosed with ASD can provide a solid income and meaningful clinical experiences while you develop your skills and your business in the area of behavioral health. Moreover, as mentioned earlier, many individuals diagnosed with ASD or IDD also would benefit from health coaching services, meaning such services might be developed as a useful adjunct to other ABA services.

The U. S. Bureau of Labor Statistics does not report statistics on “Health Coach” as a job title, which is not surprising given how recently the field emerged (and it is worth noting that “Behavior Analyst” is not a listed job title, either). Still, most jobs in the healthcare industry are growing faster than average because of the aforementioned rise in chronic diseases related in
large part to lifestyle, and because of our aging population and the health needs associated therewith. As of this writing, the estimated salary for a full-time health-coach is approximately $45,000-$48,000, with a range generally between $35,000 and $54,999 (e.g., "Health Coach Salaries," 2019). That salary range is relatively wide and likely not very representative, especially given the variety of settings in which health coaches are employed and the various sources of revenue available—particularly if one establishes their own health-coaching consulting agency to work across settings with multiple employees. Still, many hospitals and medical offices are beginning to advertise positions that have Health Coach as the specific job title, and a number of health insurance companies indicate that they provide or pay for health coaching services, though this is not a universal feature of all health insurance plans. Currently, major providers such as AETNA ("Benefits Overview," 2019), Cigna ("Cigna Health and Wellness Programs and Services," n. d.), and Humana ("Personal Health Coaching," n. d.) provide coverage. Of course, private pay also is an option.

**Summary**

Behavior analysts in practice are well positioned to help address many of the serious health problems facing society, as most of those health problems are behavior problems that require behavior change. However, it is unlikely that many behavior analysts will, after working many years to complete formal educational and professional requirements in behavior analysis, return to school to earn degrees in the health sciences. Fortunately, there are credentials available that require little additional education to attain but that place those holding them in the domain of the behavioral-health professionals. More importantly, the years of training in behavior analysis, in our opinion, is really what the doctor ordered. There are many professionals who know what people should do to be healthier, but there are relatively few who
know how to get people to do those things. Behavior analysts in practice know how to get people to get important things done.

The field of health coaching is just emerging and much work remains to shape it into an organized and, most importantly, an effective professional practice. It seems to us that behavior analysts are exceptionally well-positioned to get in on the ground floor and make some useful contributions to the development of best-practices in the field, much like has been done in the realm of ASD. Doing so could help the field of health coaching, and the clients thereby served, as well as help the field of behavior analysis by extending the reach of our science and expanding the job market for practice. The more behavior analysts who become certified as Health Coaches, the more influence behavior analysis can have on that emerging field. But to be clear, we are not proposing this as a one-way street, as the more informed behavior analysts are about the health problems to be solved and the strategies being proposed to solve them, the stronger behavior-analytic science and practice can be. At the end of the day, in order to be healthy, people need to behave healthy. Currently they are not, but behavior analysts can help change that.
References


Table 1

*List of Relevant Professional and Scientific Journals (alphabetical)*

<table>
<thead>
<tr>
<th>Journal Name</th>
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<tbody>
<tr>
<td>American Journal of Lifestyle Medicine</td>
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<td>Annals of Behavioral Medicine</td>
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<td>Behavioral Medicine</td>
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<tr>
<td>British Journal of Health Psychology</td>
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<td>Coaching: An International Journal of Theory, Research and Practice</td>
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<td>European Journal of Health Psychology</td>
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<td>Families, Systems, and Health</td>
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<td>Medicine &amp; Science in Sports &amp; Exercise</td>
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Rehabilitation Psychology
Society for Behavioral Medicine Outlook (newsletter)
Sport, Exercise, and Performance Psychology
Translational Behavior Medicine: Practice, Policy, Research
Table 2

*List of Relevant Professional Organizations (alphabetical)*

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<th>Organization</th>
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<td>American College of Sports Medicine</td>
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<td>American Council on Exercise</td>
<td><a href="https://www.acefitness.org">https://www.acefitness.org</a></td>
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<td>Health, Sport, and Fitness Special Interest Group (Association for Behavior</td>
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<td>National Academy of Sports Medicine</td>
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<td>National Council on Strength and Fitness</td>
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<td>Society of Behavioral Medicine</td>
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Table 3

Comparison of selected ACE performance domains and task statements for Health Coaches with BACB task domains for BCBAs.

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<tr>
<th>ACE Performance Domain</th>
<th>ACE Task Statement</th>
<th>BACB Task Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Coaching Behavior Change</td>
<td>Facilitate client-directed behavior change using evidence-based coaching strategies to promote healthful lifestyle choices.</td>
<td>A. Philosophical Underpinnings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. Concepts and Principles</td>
</tr>
<tr>
<td>II. Conducting Assessments and Developing Plans</td>
<td>Design individualized plans based on interviews, screenings, assessment data, and goals in order to progress clients toward healthful lifestyle management.</td>
<td>B. Concepts and Principles</td>
</tr>
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<td>F. Behavior Assessment</td>
</tr>
<tr>
<td>III. Implementing and Adjusting Individualized Plans</td>
<td>Implement individualized plans using evidence-based coaching practices in order to progress clients toward healthful lifestyle and behavior change.</td>
<td>G. Behavior-Change Procedures</td>
</tr>
<tr>
<td></td>
<td>Evaluate plan effectiveness in collaboration with clients to monitor outcomes and support progress toward goals.</td>
<td>H. Selecting and Implementing Interventions</td>
</tr>
<tr>
<td>III. Implementing and Adjusting Individualized Plans</td>
<td>Collaborate with clients to adjust plans based on ongoing evaluations in order to promote adherence, personal responsibility, and success.</td>
<td>C. Measurement, Data Display, and Interpretation</td>
</tr>
</tbody>
</table>