



## Proactive Health Support

*Exploring Face-to-Face Start-Up Sessions Between Participants and Registered Nurses at the Onset of Telephone-Based Self-Management Support*

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# Proactive Health Support: Exploring Face-to-Face Start-Up Sessions Between Participants and Registered Nurses at the Onset of Telephone-Based Self-Management Support

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## Abstract

Proactive Health Support (PaHS) is a large-scale intervention in Denmark carried out by registered nurses (RNs) who provide self-management support to people at risk of hospital admission to enhance their health, coping, and quality of life. PaHS is initiated with a face-to-face session followed by telephone conversations. We aimed to explore the start-up sessions, including if and how the relationship between participants and RNs developed at the onset of PaHS. We used an ethnographic design including observations and informal interviews. Data were analyzed using a phenomenological–hermeneutical approach. The study showed that contexts such as hospitals and RNs legitimized the intervention. Face-to-face communication contributed to credibility, just as the same RN throughout the intervention ensured continuity. We conclude that start-up sessions before telephone-based self-management support enable a trust-based relationship between participants and RNs. Continuous contact with the same RNs throughout the session promoted participation in the intervention.

## Keywords

start-up sessions, telephone-based self-management intervention, ethnographic design, participant observation, nurse–patient relationship, trust, Denmark

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## Introduction

The number of people with multiple and chronic diseases is increasing due to aging populations, medical progress, and lifestyle-related conditions (WHO, 2015). Indeed, multimorbid and older patients have been found to have frequent contact with the health care system (Flarup et al., 2014; Ronksley et al., 2016). Hospital readmissions are especially common among elderly patients, and risk factors include a multifaceted and dynamic combination of sociodemographic and health-related conditions (Pedersen et al., 2017).

Several studies have examined the effect of case management (CM) or self-management support (SMS) on elderly patients with chronic diseases (Edgren et al., 2016; Harter et al., 2016; Newman et al., 2004; Reinius et al., 2013). Some interventions have been found to decrease hospital readmission (Althaus et al., 2011), reduce mortality rates (Dorr et al., 2008; Harter et al., 2016), and positively influence patients' quality of life (Dennis et al., 2013), although other studies

could not confirm these findings (Boult et al., 2011; Gravelle et al., 2007; Metzelthin et al., 2013). Although a comprehensive review of interventions supporting self-management of people with long-term conditions revealed varying and minor effects on hospital readmissions and mortality (Taylor et al., 2014), a systematic review found some evidence that self-management interventions could reduce health service utilization (Panagioti et al., 2014) and unplanned hospital

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admissions in adults with chronic obstructive pulmonary disease (COPD) and asthma (Purdy et al., 2013).

SMS studies have focused on individual goal setting and the partnership between patients and health professionals (Bodenheimer et al., 2002; Lorig et al., 2001), peer education to increase patients' knowledge about their disease (Barlow et al., 2002), and group interventions to achieve the patients' goals (Barlow et al., 2005). Other studies emphasized the need for coaching to enhance patients' self-efficacy and self-confidence to develop coping strategies that support significant life changes (Lindner et al., 2003; Thorne & Paterson, 2001). The latter is the coaching approach that is followed in Proactive Health Support (PaHS), in which the overall aim is to reduce the number of preventable hospital admissions as well as enhance patients' quality of life and self-management.

PaHS is a large-scale telephone-based self-management intervention in Denmark carried out by registered nurses (RNs) who coach and support persons at risk of hospitalization to enhance their health, coping abilities, and quality of life and ultimately to prevent hospitalization. PaHS includes a face-to-face start-up session with an RN to build a relationship with the participants before the telephone-based self-management intervention (Benthien et al., 2020). Existing studies have described the effect of one-to-one telephone-based management support, but only one CM study explicated an initial information meeting between participants and RNs before the intervention commenced (Reinius et al., 2013). Furthermore, the content and aim of the information meeting were sparsely described, and it is unclear what characterized the setting, how the meeting proceeded, and whether the same RN conducted the following telephone-based intervention (Reinius et al., 2013).

An initial face-to-face meeting is presumably valuable in telephone-based self-management interventions, particularly in building a long-term relationship between participants and RNs so that participants acquire new competencies to cope with their conditions. Several studies have described the importance of trust in developing relationships in health care (Calnan et al., 2006; Grob et al., 2017; Lee & Lin, 2010, 2011; Robinson, 2016; Skirbekk et al., 2011; Thorne et al., 2000). Trust between health care providers and patients is a global relational phenomenon that is constructed through reciprocal interaction (Calnan et al., 2006; Robinson, 2016; Thorne & Robinson, 1988) based on loyalty, caring, competency, honesty, and confidentiality (Hall, 2006). In particular, the influence of trust on symptom improvements and health outcomes in the context of chronic illness is significant due to patients' long-term and increased dependency on health care providers (Lee & Lin, 2010, 2011; Robinson, 2016). In a complex intervention such as PaHS, trust is a prerequisite for developing a relationship between participants and RNs as a foundation for an equal dialogue. To our knowledge, no studies have described relationship development before a telephone-based self-management intervention. Thus, the aim of this study was to explore the start-up sessions,

including if and how the relationship between participants and RNs developed prior to the commencement of PaHS.

## Method

### Design

A focused ethnographic research design (Alvesson & Kärreman, 2011; Cruz & Higginbottom, 2013; Knoblauch, 2005) was chosen, which included participant observations of the start-up sessions ( $n = 22$ ). Focused ethnography was utilized, as the study focused on situated, problem-focused, and context-specific situations, such as actions, interactions, and collaboration. This design is considered applicable to delineated phenomena in a specific environment in which the number of participants involved in the situation is limited (Cruz & Higginbottom, 2013; Knoblauch, 2005). Data were collected at designated PaHS services in all five Danish regions.

### Recruitment and Sample Strategy

Invitation letters with information about the intervention and the research project were sent to potential participants identified in the PaHS prediction model (an algorithm that identifies participants based on their risk of hospital admission). Inclusion criteria were persons with a hospital contact within the last year caused by one or more of the following diagnoses—heart diseases, connective tissue diseases, pulmonary diseases, or diabetes—and one or more unplanned hospital contact within 12 months. Participants with cognitive impairment, terminal illness, substance abuse, uncontrolled psychiatric illness, hearing impairment, or difficulties with the Danish language were excluded (Benthien et al., 2020). If the participants provided consent to participate in the intervention, they were contacted by telephone and informed by RNs about the research project and the possibility that a researcher would participate in the start-up session. When the participants attended the start-up sessions, they met the RNs for the first time. After the participants and the RNs greeted each other without the presence of the researcher, the participants were asked for permission to allow the researcher to participate in the session. No participants rejected.

### Participants

The start-up sessions were primarily conducted in meeting rooms at hospitals or health centers. The participants in the start-up sessions included eight women and 14 men (age range: 53–80 years). Four participants were excluded: two did not meet inclusion criteria, and two did not want to participate in the following telephone-based intervention. A total of 13 PaHS RNs, all women, conducted the sessions. The RNs had a minimum of 2 years of clinical experience and were recruited based on their varied competencies obtained from the Danish health care system.

## Procedures

After the start-up-sessions, 16 participants and 12 RNs were followed through informal interviews to obtain different perspectives of the sessions. The informal interviews were conducted either with the participant or with the RN and were not scheduled. They were often agreed upon spontaneously at the completion of the start-up session, either because the researcher sought to elaborate on the participant's perspective on some of the themes that had been brought up during the start-up interview or because the RN asked the researcher to follow and guide the participant when leaving the facility. Between each start-up session, the researcher had the opportunity to elaborate on the RN's considerations and understandings of the conversations. The start-up sessions and informal interviews were recorded with supplementary field notes and a logbook and transcribed verbatim.

## Observations

Besides paying attention to how the parties were placed in the room, we coded observations of facial expressions, eye contact, body movements and body postures, tone of voice, and breaks and inconsistencies between spoken and body language. In the informal interviews, we used supplementary queries derived from observations of the questions and answers throughout the conversation to elaborate our understanding of the participants to compare it with the RNs' perspective.

## Analysis

The transcribed data, field notes, and coding nonverbal communication were linked, compared, and analyzed using a phenomenological–hermeneutical approach to understand the entirety and connection of the participants and RNs' experiences, perceptions, and behavior to interpret the units of meanings (Brinkmann & Kvale, 2015; Lindseth & Norberg, 2004). The analysis was divided into four levels: units of meaning, meaning condensation, subthemes, and main themes. Five steps were included in the analyses. (a) Data were transcribed, read, and reread to gain an understanding of the entirety. Notes were taken as initial ideas for codes and later discussed and compared. (b) Text was divided into natural sentences based on “what is said and expressed” without making any interpretations. (c) Units of meaning were reformulated to a meaning condensation based on the interpretation of the original sentence. (d) The subthemes generated through meaning condensation were based on the research questions (see below). (e) The text was examined and linked to the main themes and later described through critical interpretation (Brinkmann & Kvale, 2015; Lindseth & Norberg, 2004). NVivo software was used for coding (NVivo 12 Pro).

The research questions were as follows:

**Research Question 1:** How does the participant experience the invitation to participate in the project?

**Research Question 2:** How are participants' experiences included in the conversation?

**Research Question 3:** What characterizes the interaction between the participant and the nurse?

**Research Question 4:** What conditions are conducive to the development of the relationship between the parties, and what barriers are seen?

## The Intervention

PaHS is a self-management intervention initiated and financed by the Danish Government. The PaHS research program is linked to the intervention and comprises five work packages (Benthien et al., 2020). The intervention and research program are described in Table 1.

## Ethics

The research project was approved by the Regional Committee on Health Research Ethics (SJ-677). Participation in the study was based on oral and written informed consent. The RNs emphasized that the participants could withdraw their consent at any time. In some of the start-up sessions, the participants became emotional and started to cry when they discussed sensitive topics with the RNs. This meant that the researcher at times withdrew from the setting and was careful to handle the observation and the subsequent informal interviews in a careful and respectful manner. All data were anonymized.

## Findings

Based on the analysis, the following three themes were identified: the role of the context in the start-up sessions, the importance of initial face-to-face communication, and continuity as a ground for building a relationship. Each theme contains related subthemes.

### *The Role of the Context in the Start-Up Sessions*

The analyses demonstrated that the context for the start-up sessions played an important role in the way the participants perceived the meaning of the intervention and the research project. In this case, context refers to the location/setting, the intervention and research project, and the RN. The start-up session was typically held in a health care context, such as hospitals or health centers, which seemed to make the participants feeling obliged to participate in the research project. The participants had an underlying expectation of contributing to research, and they did not seem to fully understand that they had to participate in an intervention in which they themselves would be in focus. As such, the dual scope of both a research project and an intervention and the role of the

**Table 1.** The Intervention and Research Components (Benthien et al., 2020).

PaHS—Intervention and context	
Structure	Initial face-to-face session with the same RN who will conduct the entire intervention Telephone-based follow-up sessions 6–9 months of such sessions
Tools	Development of one or more individualized self-management strategies Assessment of the risk of hospitalization at each session
RN's roles	Caregiver Coach Health care professional
Education/training	Person-centered coach Mentor guidance (ongoing) Peer supervision (ongoing)
Content	Knowledge about disease and treatment Needs assessment and relationship building Coping and strategies Self-help Need for health care services
The five work packages in the PaHS Research Program	
1.	Development phase
2.	Determination of the effects of the intervention and development of a PaHS prediction model (i.e., algorithm) that identifies participants based on their risk of hospital admission
3.	Determination of cost-effectiveness
4.	Intervention development and organizational implementation
5.	Identification of the participants' perspectives on the intervention, including whether and how the development of a relationship between the participants and RNs helped to strengthen the participants' competencies and allowed them to achieve a better quality of life, coping skills, and an ability to develop self-management strategies. The participants' experiences with the intervention and what they find important and meaningful were also gathered. This article paper reports parts of this work package

Note. RN = registered nurse; PaHS = Proactive Health Support.

RN seemed to confuse the participants in the beginning of the sessions, as exemplified by this participant's question: "So, we don't have to show up here [at the hospital] several times, and you won't examine me?" This quote demonstrates how the context seemed to influence the participants' perceptions of frequenting a hospital and their expectations of participating in a research project.

*The context and the RNs legitimize the intervention.* The participants expressed numerous experiences from hospital admissions related to their multiple diseases and from being a patient, and most had experienced failures and adverse events. Despite these experiences, the participants expressed that the first phone call with the RN had given them the courage to show up. At the start-up session, the participants gradually demonstrated trust by telling their life stories and sharing their health and concerns with the RN. In one session in which an RN had listened to a participant who had been diagnosed with cancer, the RN asked him how he thought he could benefit from her support. The participant (male, 67) put it this way:

It helps to sit here with you and talk about it and to feel that someone wants to talk about it . . . Well, I'm really happy that you care to listen to me. I don't know what I was expecting, but I think it feels good to talk with you.

The participants openly indicated that it was important to them that health care professionals listened and took their problems seriously. They expressed how comfortable they felt with the RNs, and some of them were in tears, seemingly because it was a different and positive experience for them to talk to RNs who demonstrated interest and engagement and had time for the conversation. The initial confusion seemed to be linked to the participants' preconception of hospital contexts and the clinical roles that RNs normally adopt in such a context. However, this confusion changed during the start-up session, where the context served as a well-known and safe environment in which the participants' and RNs' roles evolved during the course of the session. As such, the context seemed to legitimize the intervention by providing a familiar foundation for developing a relationship based on trust between both parties.

### *The Importance of Initial Face-to-Face Communication*

Communication is a comprehensive concept, and it is a prerequisite and a gateway for building a relationship between the RN and the participant during the start-up session. Observations showed that the RNs were aware of how they communicated, and they stressed that the start-up sessions were essential because they were their only opportunity to meet the participants face-to-face. One woman (72) spoke tearfully about her experiences of daily pain. When she talked about how the pain influenced her mood in her daily life, the RN responded as follows: "If you are in pain every day or many days during a week, it will affect you . . . not only physically, but also mentally. It eats on you, and you can easily have episodes of crying." In this situation, the RN showed that she understood the participant's symptoms and feelings. She seemed to sense the participants' suffering and pain and showed her understanding by responding in a caring way.

Another woman (67) felt guilty, ashamed, and lonely because her husband was suffering from cancer. In her response, the RN seemed aware of the participant's feelings and offered the following consolation: "It's a huge burden you have to carry while you're really sick yourself. I think we should talk about the feelings you might have and that you in no way should feel guilt or shame." In this case, the RN acknowledged the participant's feelings by expressing that she genuinely sought to understand the complexity of the participant's situation. This demonstrates that the RNs invited the participants to express their feelings and to bring matters that were relevant to them into the conversation.

*Clarity in the conversations.* The relationship development between the RN and the participant depended on how transparent the RN was in conveying information about the intervention. This concerned clarification of the content of the intervention and research project, as well as the roles of RNs and participants during the intervention. This was significant because they were going to collaborate with each other over a long period. In their endeavor to create clarity, the RNs used repetition and mirroring in their communication with the participants. One participant said, "I have no energy at all. I am so tired." The RN replied, "You are so tired?" Several of the RNs mirrored what they observed. For example, "I can see that you're smiling with your eyes," or another asked, "Are you okay now? I can see that you're sitting in a strained position." The RNs often mirrored the participants when they seemed emotional. Clarity was also evident when the RNs repeated, summarized, and pinpointed the main points of what they had been talking about. This is exemplified in the statement one RN made to a male participant (65):

If I should sum up now, you would like to focus on your anxiety that may lead to a depression . . . is that correctly understood? . . .

It is my experience that you can prevent a lot just by talking about your anxiety.

It seemed as if the RNs' way of creating clarity in the conversation contributed to credibility and the participants feeling comfortable with the RNs. When the RNs repeated, mirrored, and summarized what they heard in the sessions, it motivated the participants to share their private, and at times sensitive, stories. At the same time, clarity contributed to the participants' expectations related to the subsequent telephone contacts with the RNs.

*Communication "on track."* At times, communication was challenged by the participant's ability to focus and reflect on the subjects that were discussed. In this case, the RNs led the participants back on track or stopped them and challenged their comprehension of the subject. Some also challenged and confronted the participants' points of view. In one situation, a talkative woman (78) told the RN that she discussed her diabetes with her son. The RN noticed that the participant did not fully attend to her diabetes and blood sugar measurement. The RN asked, "What is your knowledge about the food you can eat and when you have to take your medicine?" [Short break; RN continued with a wink in her eyes]. "Where do you get your knowledge from?"

When the RNs challenged the participants' perspectives on the way they managed their health in their daily lives or how often they consulted their doctors, it often triggered the participants to reflect on their personal situations. In such cases, the conversations changed, and the participants seemed more present and focused on what they would like to gain from the intervention. However, some participants did not reflect on the topics of the conversation, either because they seemed unable to do so or because the question surprised them. In one conversation, a male participant (81) told the RN that he did not talk to his son about being lonely. The RN responded, "What do you think he [the son] would say if you told him that you really don't feel well?" This seemed to be an unexpected question that made the participant thoughtful. Such situations placed demands on the RNs' ability to communicate, and they were careful about the way in which they challenged the participants' comprehensions. Some RNs seemed hesitant to challenge the participants. If the participants spoke aimlessly and lost the thread of the conversation and the RN did not stop them, it seemed to lead to a missed opportunity for the participant to start a reflection.

### *Continuity as a Ground for Building a Relationship*

The analysis showed that continuity was essential for building a relationship between the participants and RNs. The fact that the same RN would contact the participants on the phone proved to be of great importance for their participation in the

start-up session and their later consent to continue the intervention. Observations demonstrated that the RNs often asked the participants “What do you want to talk about at our first phone call?” In this assessment, the RNs sought to identify the participants’ motivation and willingness to participate in the further intervention as well as the extent of the participants’ ability to self-care to predict how they could continually support them.

The participants reported that they had previously had the same general practitioner, but the system had changed, and they now tended to meet with different health care professionals in the course of their treatment. One woman (53) who had mental health problems seemed to have a great need for permanent health care professionals:

I have been unfortunate with doctors over the last years. They have stopped their practice and I meet a new one every time [visiting the clinic]. It’s hard when you have been through a lot . . . , because you always have to tell your story all over again. It’s exhausting.

Some participants had experienced episodes in which they were only able to talk about one symptom or disease, and they were not used to talking about their problems with a single person. The prospect of having to work closely with the RN for an extended period of time caused these participants to openly report their entire life histories.

The participants expressed that there was a lack of coordination and continuity throughout their many contacts with the health care system, and they seemed to miss long-term personal contact with the health care system. When the RNs asked the participants who they thought coordinated their multiple diseases, some of them had difficulties answering the question. It seemed that the PaHS RNs did not seek to coordinate the participants’ contacts with the health care system. However, they supported the participants in considering whether the intervention could be beneficial in terms of obtaining an overview of their conditions and treatments. Our observations showed that the RNs often asked the participants questions such as “How do you express your needs” [to health care professionals] or “are you good at making demands?” One of the RNs asked, “What can I do to help you stay in such a good condition as you obviously are?” Here, the RN acknowledged the participant and his ability to maintain good health. At the same time, the RNs seemed aware of their role in creating a relationship for their continuing collaboration with the participants as a foundation for preventing further health problems.

*Interrelationship as a way to maintain continuity.* The start-up sessions began with the RN asking the participant about the subject they had talked about on the telephone when they made the appointment. We observed that the participants felt recognized and appreciated when the RN referred to the initial phone call and to issues the participants had brought up

themselves. One RN asked a participant whether she wanted to talk about the pain she had expressed in their phone conversation, and the participant responded, “[. . .] but there is nothing I can do about it, or is there?” The RN replied that together they might find something that could alleviate the participant’s pain. The participants noticed and seemed positive about the RN’s recollection of what they had talked about, particularly when the RN repeatedly said that there was no topic that was “too small or too stupid to talk about.” The RNs emphasized that they wanted to ensure that they talked about what the participants thought was important and relevant to them. This led one woman (78) to laughingly exclaim, “Will I have unlimited talk time, then?” The RN replied with a smile on her face: “No you don’t, but I will manage that.”

This shows that humor was used in building a relationship that could influence the development of continuity in the intervention. The RNs tended to use humor when they challenged the participants’ point of views, whereas the participants used humor to lighten the conversation about their problems. Some participants seemed to use humor as a way to handle communication when they struggled to find words, whereas some used it to create a good chemistry. The RNs often answered with a wink in the eye to reflect the playful tone of the participants. It seemed crucial for the RNs to reflect their humor for the development of the relationship because it enabled a sense of cohesion and shared experience.

## Discussion

This study explored the start-up sessions, including if and how the relationship between the participants and RNs developed prior to the commencement of PaHS. Context, communication, and continuity were important in creating reciprocal trust as a basis for developing a relationship between the participants and RNs. The RNs, hospitals, and health centers legitimized the role of the RNs, the intervention, and the research project. Through face-to-face communication, the RNs openly displayed that they were present and transparent. The RN was the same person throughout the intervention to ensure continuity, which seemed to be crucial for the participants and for obtaining their consent to the following telephone-based intervention.

Numerous self-management intervention programs have been introduced targeting elderly and frail patients to decrease illness, reduce health service utilization, and reduce the incidence of hospitalization (Lindner et al., 2003; Newman et al., 2004). SMS interventions promote face-to-face interaction with the participants through training, goal setting, group or individual education, or coaching (Barlow et al., 2002; Lindner et al., 2003; Lorig et al., 2001; Thorne & Paterson, 2001). However, no studies have described the interactions between health professionals and participants during the face-to-face interaction before a telephone-based

intervention. Our study provided in-depth insight into the characteristics of start-up sessions with RNs and participants in such an intervention. We found it essential for both parties to meet face-to-face to develop a trust-based relationship before the telephone-based self-management intervention. At the beginning of the start-up session, we discovered that the participants were curious yet confused about participating in both an intervention and a research project. Through the start-up sessions, the context legitimized the role of the RNs and the research project, and therefore the sessions influenced the participants' trust. When the RNs were present and showed interest in the participants' stories, the participants demonstrated "mandates of trust" (Skirbekk et al., 2011). In other words, the participants had conditional trust in the RNs. In addition, if the RNs displayed sincere attention and trust in the participants by expressing understanding and acknowledging how stressful it was to live with the illnesses, the participants reciprocated this trust and showed "open mandates of trust" (Skirbekk et al., 2011), indicating that the participants' trust was no longer limited (Robinson, 2016; Skirbekk et al., 2011).

The RNs' communication focused on developing a relationship with the participants, presumably because they would meet face-to-face only once. The RNs seemed genuinely interested in getting to know the participants, their situations, and how they coped with daily life. As such, PaHS seemed dissimilar to the "information meeting" in the telephone-based intervention in Reinius et al.'s (2013) study, which was characterized by a set and scheduled program. Instead, in our study, the interaction was characterized by encouragement and motivation for the participants to discover, on their own terms, what health issues they felt most compelled to act upon. Thus, PaHS did not seem to be a strictly goal-oriented dialogue (Reinius et al., 2013). Rather, it focused on participants' own versions of their medical stories and daily lives about their health problems and coping strategies. This supports the notion that trust is constructed through interpersonal interaction (Calnan et al., 2006).

In our study, the participants and RNs were able to clarify their understandings by using clarifying questions and mirroring. If the RNs observed changes in the participants' behavior, they took stock of the situation and acted upon it immediately. If the participants expressed sadness, anxiety, or depression, the RNs showed that they were present and engaged. As such, the physical meeting provided a unique opportunity to create a respectful interaction between both parties. We observed that the RNs acknowledged the participants' efforts and strategies to find solutions to their daily problems. This is in contrast to a study that found that some patients were met with disregard from professionals for their competencies and distinctive coping strategies, and that patients often have a more advanced understanding than health professionals of their diseases (Thorne et al., 2000). However, the RNs also challenged the participants by encouraging them to

elaborate on their situations or to reflect on their health issues and coping abilities. When the RNs challenged the participants, some of them answered with playful voices as if they wanted to minimize their problems. The RNs often responded with a playful tone as a way of alleviating their directive speech. Thus, both parties seemed to inject a note of humor into the conversation.

The participants' interest in the intervention developed through the session and was correlated with the RNs' communication skills and the mutual chemistry between the parties. Consistent with another study (Grob et al., 2017), we found that the participants welcomed the RNs' interest in them as individuals, which was contrary to their previous experiences, in which they felt they were "just another number." In our study, start-up sessions were essential for developing a relationship in the subsequent telephone-based intervention, and it was important that the RNs were present and emphasized an equal dialogue with the participants. As such, the RNs created a frame of credibility and trust as a foundation for building a relationship.

### **Strength and Limitations**

The strength of this study is the in-depth exploration of the development of a relationship between RNs and participants. However, we cannot conclusively state how the participants experienced the intervention and how this affected their long-term relationships with the RNs, and that is a limitation of this study. This issue will be explored in further research.

### **Conclusion**

We conclude that start-up sessions in telephone-based SMS have the potential to help create a trust-based relationship between participants and RNs. The context for the start-up sessions legitimized both the intervention and the research project. RNs were present and acknowledged the participant's issues while challenging them to make improvements. Moreover, it is crucial for the participants' engagement in the intervention that they had continuous contact with the same RN, who was competent and established a relationship by reflecting on the participants' situations, experiences, and emotions, including humor.

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