Active Roles for Older Adults in Navigating Care Transitions: Lessons Learned from the Care Transitions Intervention

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Abstract: Older persons suffer from complex and chronic health conditions that require ongoing self-care activities as well as management by health care professionals. Older adults commonly receive care in multiple settings (hospital, skilled nursing facility, ambulatory clinic, home) necessitating transitions between settings of care. Multiple strategies have been proposed to aid care coordination between settings of care. However, most rely upon changing the way in which roles for health professionals are structured or function and do not acknowledge the significant role patients and family caregivers play in navigating their transitions. An alternative approach, health coaching, seeks to impart the skills and confidence needed for patients to assure their needs are met, and thus enacts a patient-centered approach to problems in care coordination. Here, we use an intervention with proven efficacy (The Care Transitions Intervention) to explore transition coaching as a specific form of health coaching used to empower older adults in navigating care transitions; we discuss the mechanisms and techniques involved in enacting an empowerment-based intervention; and finally, we discuss the approaches and contextual issues involved in training selected members of the existing health care workforce in a transition coaching model.

Keywords: Care transitions, care coordination, health coaching.

INTRODUCTION

Older persons frequently suffer from complex and chronic health conditions that require ongoing self-care activities as well as management by health care professionals. Older adults commonly receive care in multiple settings, necessitating transitions between settings of care. These transitions have been related to problems in patient safety and to high costs of care. At this juncture, the problems associated with care transitions are relatively well-understood, but few effective strategies have been designed to address them. In this paper, we use an intervention with proven efficacy (The Care Transitions Intervention) as a starting point for exploring transition coaching as a means of empowering older adults in navigating care transitions. We then discuss the specific mechanisms and techniques involved in enacting an empowerment-based intervention and in training healthcare providers in a transition-coaching model.

The Problem of Care Transitions

The term 'care transitions' refers to the multiple transfers patients make between care settings during an episode of illness [1]. For example, in the course of an acute exacerbation of an acute or chronic illness, a patient may receive care at an inpatient hospital setting, followed by treatment at a skilled nursing facility, at which point he or she may return home and receive services from a visiting nurse or a primary care physician in an outpatient setting. Each of these shifts between settings constitutes a care transition. Due to the fragmentation and lack of coordination in the current U.S. health care context, care transitions represent critical and problematic junctures in the course of illness management that raise vulnerability to confusion with regard to care instructions, lack of appropriate follow up, and medication errors [2-4]. For older adults, who often experience multiple chronic conditions, the potential for poor transition-related outcomes is amplified [5].

A typical scenario that exemplifies this vulnerability is as follows: an older man who takes multiple medications, including a blood thinner to prevent a future stroke, experiences a fall that results in a fractured hip and is hospitalized for surgical repair. The medical professionals at the hospital are unaware that he is taking a blood thinner, much less his current dose. He is sent home on a new prescription for what turns out to be the same blood thinner. The older man is not aware that this newly prescribed medication duplicates one of his prior medications when he returns home and is instructed to resume his previous medications. Four days later he is subsequently re-hospitalized for uncontrolled bleeding. This is but one example of many scenarios that can occur during care transitions.

One in five Medicare beneficiaries are re-hospitalized within 30 days, costing our nation over $17 billion annually [6]. The primary pathways to this cost burden include unnecessary hospital readmissions due to medication errors, patient confusion about and subsequent failure to follow up on care instructions and the management of multiple chronic conditions. As a result, leading national health care quality improvement organizations have identified transitions out of the hospital as a priority area in need of action. These organizations include The Joint Commission, the Centers for

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Medicare and Medicaid Services and their accompanying Quality Improvement Organizations, the Institute for Healthcare Improvement, the Institute of Medicine, National Quality Forum, the Medicare Payment Advisory Committee, the American Board of Internal Medicine Foundation, the National Transitions of Care Coalition, the American College of Physicians, the Society for General Medicine, and the Society for Hospital Medicine [7, 8].

Approaches to Enhancing Transitional Care

Recognition of the costs and impact of poorly-executed care transitions has led to a call for improved transitional care. A recent position statement from the American Geriatrics Society defines transitional care as follows:

> a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs [9].

Strategies to improve transitional care take diverse forms, but are generally based on two distinct approaches, which we distinguish as 'system-level' and 'patient-level'. System-level approaches are structural, or macro, in focus and seek to improve transitional care by enhancing the coordination and communication between health care providers and settings. This category comprises initiatives such as those that seek to improve the efficacy of discharge planning, enhance communication between hospitalists and primary care physicians or encourage the use of electronic medical records to enable more ready transfer of information between settings. Alternately, another set of strategies to improve transitional care is more explicitly focused at the level of the patient and often in creating changes in patient behavior. These include many patient-education and health coaching models [10-13].

Prior studies have demonstrated reductions in re-hospitalization rates for older chronically ill adults and patients with specific conditions, such as congestive heart failure, through advanced practice nurse- and pharmacist-led interventions [10, 14-16]. However, by and large, these models involve health care professionals intervening to assess, provide patient education, identify problems, or solve problems. In reality, health care professionals may not be available to complete these transition-related tasks and thus by default, this responsibility often falls upon the patient and family caregivers, who constitute the only common thread across settings of care [17]. For this reason, it is critical that patients and family caregivers have the skills needed to gainuse? specific health-care strategies that make them more effective at getting their needs met during care transitions. Health coaching is one means of achieving that goal.

HEALTH COACHING IN THE CONTEXT OF TRANSITIONAL CARE

Defining Health Coaching

Health coaching is a heterogeneous term that has been defined as "the practice of health education and health promotion within a coaching context, to enhance the well-being of individuals and to facilitate the achievement of their health-related goals" [18] and it is executed by facilitating a learning process for and with patients. Health coaching has been used to refer to a wide variety of programs and models with goals such as: 1) helping patients manage a specific condition (such as diabetes); 2) helping patients navigate a process (such as cancer treatment); 3) helping patients be more informed and engaged in their health care (communication and information focus); and/or 4) helping patients achieve specific health or wellness goals (such as smoking cessation) [19-23]. These goals may be achieved using approaches such as self-management skills training, patient education, and/or counseling/coaching-specific techniques that explicitly encourage patient activation and empowerment. For the purposes of this article, we will confine our focus to the narrower, but extremely vulnerable context in which a person with complex care needs is transferring across one or more health care settings. In this context, health coaching may be referred to as transition coaching [24].

Differentiating Health Coaching from other Models

Health coaching has become increasingly used in the context of chronic illness management and the term has been widely applied to programs and approaches that may vary greatly in their core assumptions about the patient's role in health care. Health coaching interventions guided by patient self-identified personal health goals seek to achieve these goals and to foster a higher level of patient activation in the health care context [25]. These types of programs are based on the understanding that older adults who are more involved in their health care are not only better prepared to manage their condition, but also more likely to be able to effectively navigate the discontinuities associated with care transitions [24, 26]. Because of the loose usage and broad application of the term 'health coaching', we offer the following operational definition. Health coaching in the context of transitional care can be defined as a means of assisting patients to gain the knowledge, skills, tools, and confidence to become active participants in coordinating care and managing their conditions toward the achievement of self-identified health goals.

The Role of Process and Content in Coaching: Parallel and Reinforcing Structures

In the context of transitional care, the key factor differentiating coaching from similar case management and disease management models is that in coaching, the interpersonal process aspects of the coach-patient interaction become *as important* as the content of the interaction. True coaching models are focused on the process and content of the patient-

coach interaction; whereas many disease management and case management interventions are implicitly focused on content (task completion or information transmission) [27-29]. As such, many patient-education and self-management models seek to alter patients' behavior, skills base, and knowledge base, but may do so in ways that repeat the traditional model of practitioner dominance and patience passivity. Thus, while the patient may receive the information or be instructed to perform discreet tasks, the dynamic of passivity and disempowerment has been reinforced by the style of interaction. In contrast, health coaches seek to not only impart new skills and knowledge, but also to explicitly promote and model patients' taking a more active role in health care setting. Part of how this is accomplished is by modeling and facilitating patient engagement in the coaching session. By doing so, patients gain experience and confidence asserting a more active role in health care interactions, beginning with the coaching session itself. Thus, the content and process of the coaching session are parallel and reinforce one another. Below we provide two vignettes to highlight this distinction. Vignette A depicts an intervention model that is focused primarily on task completion, with a secondary focus on patient education. Vignette B depicts a coaching intervention model, which shares these goals, but has the additional goal of helping the patient take a more active role in his health care.

Vignette A

An intervention is designed to reduce medication errors after discharge from the hospital. A health care provider makes a visit to the patient's home during the first few days following discharge. When she arrives at the patient's home, she discovers that the patient is confused about what medications he should be taking and that he isn't comfortable calling his doctor to clarify the issue. The health care provider collects the patient's discharge instructionsand gathers the patient's medication bottles. She then reconciles the patient's prior and new medication lists by comparing them and calling the patient's doctor to clarify dosage changes and to ask whether the patient can resume taking medications that are not on the discharge instructions. She creates an updated medication list for the patient and reviews how to take any new medications and side effects.

Vignette B

A coaching intervention is designed to reduce medication errors after discharge from the hospital. A Transition Coach makes a visit to the patient's home during the first few days following discharge. When the coach arrives at the patient's home, she discovers that the patient is confused about what medications he should be taking and that he isn't comfortable calling his doctor to clarify the issue. Upon eliciting the patient's concerns, she discovers that his goal is to return to his attendance at the nearby senior center and participate in a pottery class. Because the focus of the coach is to empower the patient (process component of the intervention) as well as complete a medication reconciliation (content component of the intervention), she proceeds as follows. First, the coach lets the patient know that understanding and properly taking his medications is an important part of getting back to his normal activities. She then asks the patient to gather his medication bottles and any discharge paperwork from the hospital, and she asks the patient to share with her what he has been taking and how he has been taking it. This open-ended form of questioning gives the patient permission to be transparent with respect to what he is actually taking rather than asking in a manner that only elicits socially desirable responses. As the patient tells the coach about each of his medications, together they compare his old medications to the discharge instructions, and it becomes clear where there are discrepancies, such as dosage changes or prior medications that are not on the discharge list. As these issues arise, the coach asks the patient to write down each of these questions in his own words. The coach also has the patient create a correct medication list as they review each medication. Once they have reviewed all of the medications, the coach and patient role play making a phone call to the doctor to ask those questions. After several times practicing what to say, the patient feels more comfortable and confident about asking his questions, but he is still a bit hesitant. The coach offers to sit by as the patient makes the phone call. The patient calls the doctor's office and is directed to the nurse, who answers most of his questions and says she will call back to clarify the remaining question later in the day. The doctor's office calls back in the afternoon to clarify the remaining question and the patient writes the answer down on his new medication list.

Comparison of these two vignettes reveals that in both scenarios, the intended content-related goal (medication reconciliation) occurs. However, the process by which the two scenarios reach that end point is distinctly different. In both cases, the medications are reconciled and we can argue that the patient has been helped, but only in the second scenario has the patient been empowered and supported to take a more active role in his health. In the second scenario the patient has not only overcome the immediate challenges associated with his hospitalization, but he is also prepared for future challenges because of the manner in which the coach has modeled behavior for dealing with common transition-related problems. Only in the second scenario has the patient engaged in the active learning that will make it more likely that in the future (when no health care professionals may be present to help), he will be able to reconcile his medications; successfully formulate questions for his doctor and get them answered; and get his needs met in a health care interaction. Only in the second scenario has the patient learned new skills for interacting with the health care system in addition to learning skills for managing his medications better. Because the coaching scenario stresses patient engagement, while the first scenario reinforces passivity, the process-related outcomes differ greatly between the two scenarios.

Key Distinctions Among Health Care Roles: Do-er, Teacher and Coach

Below, we explore this distinction more closely in the context of health care roles commonly encountered in transitional care, such as patient education, nursing or case management. Coaching differs from other health care roles on five dimensions: 1) paradigm; 2) goal; 3) primary focus; 4) ownership of the agenda; and 5) level of patient engagement. In order to better understand the distinctions, please refer to Table **1**, where we refer to the primary health care roles in the context of three primary meta-categories: the "Do-er" (traditional case management models or other health care

Table 1. How Does Coaching Differ from Other Health Care Roles?

	Do-er	*Teacher*	*Coach*
Paradigm	**Do-ing**	**Teaching**	**Facilitating**
Goal	Task completion	Information & skill transfer	--Patient engagement & empowerment --Information & skill transfer
Primary Focus	Content --Task completion	Content --Assessment --Information/skill transfer	Process of coaching --Patient-centeredness of the interaction (built around patient's goals) --Modeling patient engagement in the coach-patient interaction Content --Information/skill transfer
Ownership of the Agenda	The Do-er	The Teacher	The Patient
Level of Patient Engagement	Low	Medium	High

professional roles, etc.), the "Teacher" (most patient education models), and the "Coach".

Before describing each role in terms of the five dimensions, we would like to acknowledge that each of these roles serves a critical and important purpose in the health care system and in getting patients' need met. Do-ers, Teachers and Coaches are all needed in order for health care delivery to be most effective. However, in terms of the transitional care context, because of the fragmentation of care and the likelihood that older adults with complex care needs will experience multiple care transitions over the course of an illness, it is essential that older adults feel prepared to negotiate these transitions with confidence. For this reason, it is essential to add coaching to the repertoire of usual care if we hope to help older adults take a more active role in their health, improve outcomes, and decrease costs associated with poor care transfers.

A provider functioning in the Do-er role is working within the paradigm of doing, usually enacted as a form of care provision, such as nursing or case management. We refer to this as the "Do-er" role in order to highlight the distinction between doing and other forms of patient interactions without confusing these issues with specific job titles. For the Do-er, the goal of a patient-provider interaction is related to task completion, such as provision of discharge instructions or changing a dressing on a wound. The primary focus for the Do-er is at the level of content, rather than process, and the Do-er decides what is important, and thus owns the agenda for the interaction. In this scenario, patient engagement is relatively low, as the patient is the object of the doing, and therefore more of a recipient than a participant in the caring interaction.

In contrast, a provider functioning in the Teacher role is working within the paradigm of teaching, often enacted as a form of disease management or patient education programming. For the Teacher, the goal of the patient-provider interaction is information and/or skill transfer. An example of a goal for a Teacher might be to teach a patient how to monitor her blood glucose levels. Like the Do-er, the primary focus of the Teacher is at the level of content, but in this case the content comprises assessment and information/skill transfer. In this case, the Teacher owns the agenda and introduces it to the patient in the context of important information and skills that the patient needs to learn. In this scenario, the level of patient engagement is more moderate because the patient is a participant, rather than just recipient, in the interaction.

Finally, a provider functioning as a coach is working within a facilitation paradigm. To facilitate means "to make easier" and in this paradigm, coaches seek to make the process of care transitions easier for patients by transferring not just 'hard' skills, such as medication reconciliation or disease management protocols, but also 'soft' skills, such as communication and interaction skills. In the Coach role, the goals of the Teacher (information and skill transfer) are built upon by adding the goal of fostering patient engagement and empowerment.

This goal is carried out by modeling an active patient role in the patient-provider interaction and by engaging in a means of information and skills transfer that is bi-directional, iterative, and patient-centered. In the Coach role, the primary focus of the patient-provider interaction is shared, encompassing the process of the interaction itself as well as the actual content of the intervention. Thus the Coach role requires dual attention on the part of the coach. Ownership of the agenda is shared. Rather than introducing the provider's agenda, the coach elicits the patient's agenda by discovering the patient's health goals, and organizes the visit around those goals. In the Coach role, the level of patient engagement is high, for several reasons. First, patients are more engaged because the agenda is immediately and obviously relevant to the patient. Second, patients are more engaged because the patient is an active participant in all activities. For instance, the coach uses role plays to practice new communication strategies; the coach uses open-ended questions to elicit richer responses from patients; and knowledge and

skill transfer is based on the patient's stated goals and demonstrated skills.

We now re-visit the vignettes to illustrate how the roles apply to the examples provided in the vignettes. In vignette A, the provider is functioning in the Do-er and Teacher roles, telling and/or showing the patient what to do, organizing the medications, and making the call to the doctor on behalf of the patient. In this scenario, the provider completes the medication reconciliation, answers the patient's questions about what medications he should be taking, and informs the patient about new medications and side effects. In the Doing and Teaching paradigms, this would constitute a successfully-completed intervention because the designated tasks were completed in a manner consistent with the goals and foci associated with the Do-er and Teacher Roles. However, this example does not constitute successful coaching insofar as patient has not necessarily received the transfer of activation skills necessary to support him if he is faced with another care transition. In Vignette A, the patient is a passive recipient of information and he has not necessarily learned the skills to reconcile his medications nor to call his doctor should he be hospitalized again. Because the provider does not elicit the patient's goals nor tailor the intervention goals to the patient's goals, it is unclear whether the patient deems the intervention content relevant or not. Only in the Vignette B has the patient become an active partner in the session. Thus, while a coaching model and a case management model might share the goal of facilitating a smooth transition home from the hospital and both models might achieve this goal, they would go about it in different ways, and as a result, have different outcomes in terms of patient engagement and activation.

Terms such as patient activation and empowerment abound in the heath literature to describe intervention models aimed to help older adults navigate the health care system or manage complex health conditions. However, the definition and enactment of these concepts varies widely. The work of Hibbard, *et al*. provides an operational definition of activation in which those who are activated believe they have an important role in managing their care; know how to manage their condition; have the skills to do so; collaborate with their health care providers; maintain their health functioning; and access appropriate care [30]. In a systematic thematic analysis of the term 'empowerment' in the field of healthcare, Aujoulat, *et al*. assert that the key components of an empowerment-based intervention are as follows: "empowering interventions were found to be necessarily patient-centered and based on principles of experiential learning. Moreover, empowerment was said to occur within a continuous and self-involving relationship which facilitates self-reflection and the expression of emotions, preferences, fears, personal goals, etc." [31]. However, even with a firm understanding of the concepts of activation or empowerment, it is often difficult to decipher *how* such models work to enhance empowerment. Below, we provide specific examples of how patient engagement is enhanced in the context of a specific intervention, the Care Transitions Intervention.

Lessons Learned from the Design and Implementation of a Transition Coaching Model

The remainder of this paper will be devoted to lessons learned in designing and implementing a transitional care coaching intervention that explicitly relies upon an activation approach. We reference the pitfalls and wisdom gained from our experience developing and disseminating the Care Transitions Intervention to demonstrate effective means of helping older adults adopt more a more active role in their health care. We begin by discussing the intervention model, exploring the specific mechanisms through which patient engagement is elicited, and finally, by examining the implications for training the existing health care workforce in health coaching models.

The Care Transitions Intervention was implemented and tested in 2000-2003 [5, 24-26], and has been widely disseminated nationally and internationally. The intervention offers a low-cost, low-intensity approach to improving transitional care and lowering the costs associated with poor transitions. For 350 chronically ill older adults with an initial hospitalization, the intervention nets an average net costs savings of $300,000 over a 12-month period [26]. Costs associated with the intervention include the salary, mileage, and cell phone for the Transition Coach, estimated at $70,000+ US Dollars annually [24, 26]. The efficacy of the intervention has been previously demonstrated in a series of research studies as well as in the demand for dissemination [5, 24, 26]. Interestingly, the effects of the intervention become stronger over time, suggesting that patients have not just learned how to manage one transition, but how to manage interactions with the health care system more generally [25]. Below, we provide an overview of the core conceptual basis of the intervention, followed by a detailed discussion of the means through which its goal of increased patient engagement is achieved. A more comprehensive presentation of the genesis and design of the model can be found in prior publications [17, 32].

The Care Transitions Intervention is designed to encourage older patients and their caregivers to assert a more active role in their care during care transitions. The aims of the intervention are to improve care transitions by improving patient knowledge, self-management skills and engagement. The structure of the intervention involves 5 contacts with a Transition Coach over a thirty-day period: a hospital visit before discharge; a one-hour home visit occurring within 72-hours of discharge; and three follow-up phone calls. The intervention is based on four conceptual domains, or 'pillars' that prior work suggests are essential to promoting smooth care transitions: medication self-management, follow-up with a Primary Care Provider (PCP) or Specialist, use of a patient-centered record, and knowledge of 'red flags', or warning signs about ones condition. The four pillars make up the topics, or content, around which Transition Coaching takes place. Finally, the intervention is carried out *via* two mechanisms used to enhance activation and help patients take on a more active role: Transition Coaching and the use of a Personal Health Record (PHR).

The intervention uses two main tools to achieve its goals of helping patients become more active and confident in managing their health: a PHR and a series of contacts with a Transition Coach. The PHR is a simple, portable booklet designed to be patient-owned and patient-friendly (see Fig. **1**). In contrast to many health care documents provided to patients, this PHR is portable, readable (large font), and has ample room for patients to write questions and update their

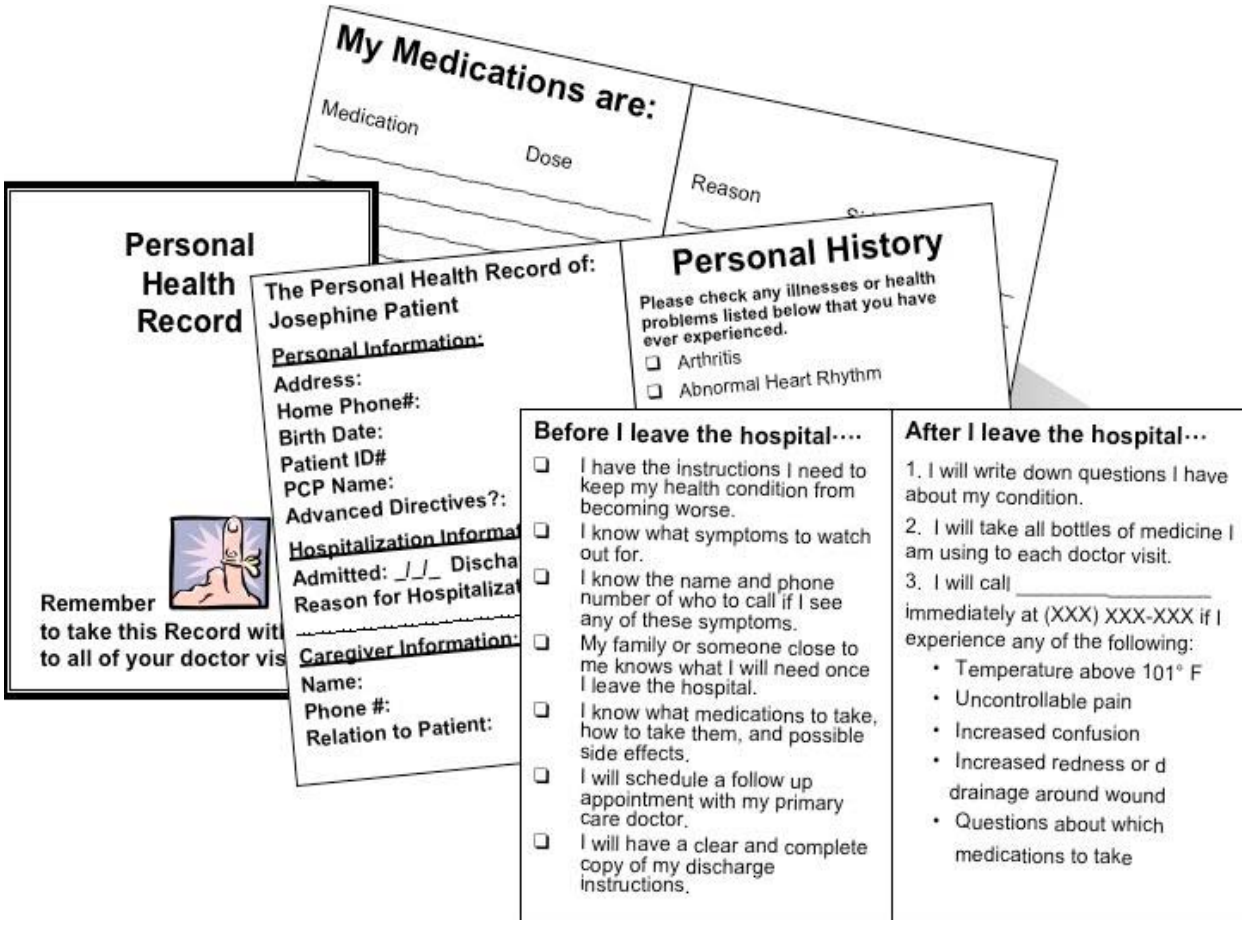

Fig. (1). Lessons learned from the design and implementation of a transition coaching model.

medications. The PHR contains a brief medical history, a space for the patient to write warning signs related to her condition, a patient-generated medication and allergy list, a structured checklist of critical activities after discharge, and space for patient questions and concerns. Rather than being comprehensive, the PHR was designed to contain only essential information that is important to the patient. In this way, the document is patient-centered and user-friendly, which encourages patient engagement. The PHR is owned and managed by the patient. The second mechanism used to encourage patients to take a more active role in their health is the use of a Transition Coach. The Transition Coach is a facilitator who prepares patients for what to expect throughout their care transition; coaches patients *how* to get their needs met; and coaches patients in the use of the PHR. The professional background of Transition Coaches varies and may include those with backgrounds in nursing, social work, case management, as well as laypersons. More important than disciplinary background is a commitment and ability to adopt a coaching role and to foster empowerment and confidence in the patient [25, 26].

As mentioned previously, effective coaching works by adopting a method of interaction that parallels the message being conveyed to the patient. Thus, rather than simply telling the patient information that we hope will enable him to be more active in his health care interactions and take better charge of his health, the patient is practicing these new skills in the coaching session, with the coach. This approach, which constitutes a form of active, experiential learning, requires careful facilitation and a greater initial time investment on the part of the coach, but ultimately results in greater confidence and competence on the part of patients. This is accomplished by eliciting the patient's goals and questions at the start of the coaching session and building the session around these issues rather than the provider's agenda; by the coach adopting a 'hands-off' approach; by using role play to practice new skills; and by the use of specific communication skills that encourage patient participation and elaboration.

The coaching session begins with the coach asking the patient to identify one health goal for the next 30 days. Eliciting the health goal creates patient buy-in and lets the patient know that this health care interaction is being constructed around the patient's agenda. As the coaching session progresses, the goal becomes a touchstone for the patient and coach to revisit as relevant. Throughout the coaching session, the coach encourages the patient to be the 'do-er' by metaphorically and literally putting materials and control into the patient's hands. For example, rather than completing these tasks for the patient, the coach would encourage the patient to gather his or her medication bottles and paperwork, write in the PHR, and call the doctor's office. Patient ownership of the content of the intervention is also reinforced in more subtle ways, such as encouraging patients to identify medications in a manner that is meaningful to them (i.e. writing "blood sugar" next to the name of their Diabetes

medication on the medication list, if this is how the patient remembers the purpose of the medication). Role play techniques are used to practice asking questions or communicating more effectively with one's physicians. Role play allows patients an opportunity to practice making a phone call or asking questions in a supportive environment. Finally, excellent coaches adopt a communication style that fosters patient participation through the use of open-ended questions and the employment of active listening skills.

Implications for Training the Current Healthcare Workforce

To date, the Care Transitions Program has trained over a thousand health care providers to be Transition Coaches, including individuals from nursing, social work, emergency medicine and allied health fields. We have witnessed individuals from a wide variety of professional backgrounds demonstrate model fidelity and go on to be effective coaches within their respective organizations. The training program includes a menu of options, built around a one to one-and-a-half day face-to-face training, followed by structured shadowing, supervision and field learning. Further information on the training program can be obtained through the Care Transitions Program's website [32].

As noted above, a key factor underlying the success of the Care Transitions Intervention and differentiating it from other models is its use of the coaching role to help patients become more active participants in their health care. Our experience training health care providers to be coaches has uncovered a variety of challenges inherent in training an existing healthcare workforce in coaching models. One of the challenges is a by-product of the fact that the term 'heath coaching' has been widely and somewhat indiscriminately applied: many health care providers characterize their work as coaching and believe they are coaching, even when their approach and execution fall squarely into the Doer and Teacher role categories. Thus, the concept of role shift and deprogramming (or un-learning old skills) is central to the process of training health coaches.

The coaching program described above sounds simple, but it contradicts underlying paradigms and notions of caring that have been strongly reinforced in many health care providers' training. As a result, efforts to engage in the role shift from 'doing' to coaching often elicit significant confusion, discomfort and resistance on the part of coaches-in-training. This discomfort is compounded by the sense of being de-skilled in the use of new communication skills, being confused about how to facilitate a patient-centered interaction and by the challenges involved in reducing large amounts of accumulated professional knowledge into more patient-friendly doses of information. Many coaches-in-training have a long occupational history of being Do-ers or Teachers and slide into these roles by default and experience difficulty resisting the urge to manage paperwork and medications, write in the PHR, make phone calls for the patients, and generally take control of the interaction. With proper shadowing and feedback, these behaviors gradually diminish and are replaced with coaching behaviors. The transition period to adopting a Coach role takes approximately 2 months' time.

We have discovered that the most effective means of training coaches follows the same principles employed in the coach-patient interaction: reliance upon experiential learning modalities. Our initial training efforts involved a combination of didactic approaches, discussion of case studies and role plays. However, coaches-in-training were quick to revert to established roles, focusing on the content domains (the four pillars) of the intervention and engaging in the familiar behaviors of assessment and task completion. Many coaches-in-training believed they were already coaching in their current roles, when in fact, most were providing patient education using a provider-centered model. In order to illustrate this distinction and help coaches assess their own behavior and communication styles more clearly, the training program evolved to rely heavily upon role play and group feedback activities. Finally, the training program was? developed to include a simulation training module, in which the coach and a standardized patient actor enact a home visit. In simulation trainings, patient actors provide prompts that challenge coaches-in-training to use coaching skills. The simulated coaching sessions are videotaped and coaches are provided with a DVD recording of their performance. Structured review of the DVDs allows coaches-in-training to observe and critique their performance in terms of their strengths and weaknesses and the impact of their interaction style on patient engagement. Reliance upon experiential learning modalities and the integration of role play and simulation experiences has been essential in facilitating the role shift necessary to ensure model fidelity, support effective coaching and ultimately help patients become active partners in their health care.

CONCLUSION

The Institute of Medicine recently released a landmark report highlighting the fact the American health care workforce is ill prepared to meeting the burgeoning demands of the rapidly expanding older population [33]. The transition-oriented health coaching model makes two important contributions for lessening the disparity between workforce supply and population demands. First, a wide variety of individuals have been trained for the role of the transition coach. Although social workers and nurses represent a significant percentage of coaches trained, we have learned that emergency medical technicians, pharmacy technicians and nursing assistants can also function effectively in this new role. Second, by empowering patients and families to assert a more active role in their care, it reduces the amount of direct care and oversight needed from those professionals who are in relative short supply, namely nurses and social workers. Important next steps in subsequent research and translation will likely include the use of web-based teaching platforms to support widespread training of coaches and exploring the potential role of telehealth or remote communication technologies in activating patients in less populated regions of our country. Although to date the focus of the Care Transitions Intervention has been on transitions across health care settings in the context of either an acute illness or a chronicillness exacerbation, the model may also hold promise for other types of transitions. Future dissemination efforts may also focus more explicitly on the integration of transition coach training into existing professional curricula.

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