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## “I Don’t See Myself as a Medical Assistant Anymore”: Learning to Become a Health Coach, in our Own Voices

Rachel Willard-Grace

*University of California, San Francisco, willardr@fcm.ucsf.edu*

Adriana Najmabadi

*University of California, San Francisco, najmabadia@fcm.ucsf.edu*

Christina Araujo

*University of California, San Francisco, araujoc@fcm.ucsf.edu*

Dalia Canizalez

*University of California, San Francisco, canizalezc@fcm.ucsf.edu*

Denise DeVore

*University of California, San Francisco, devorej@fcm.ucsf.edu*

*See next page for additional authors*

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**Cover Page Footnote**

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**Authors**

Rachel Willard-Grace, Adriana Najmabadi, Christina Araujo, Dalia Canizalez, Denise DeVore, Camille Prado, Amireh Ghorob, and Thomas Bodenheimer

# I Don't See Myself as a Medical Assistant Anymore

## Learning to Become a Health Coach, in Our Own Voices

Rachel Willard-Grace, Adriana Najmabadi, Christina Araujo, Dalia Canizalez, Denise DeVore, Camille Prado, Amireh Ghorob, and Thomas Bodenheimer

*University of California, San Francisco, USA*

### Background

Health coaching is a process that empowers patients to manage their health and collaborate as active participants in their healthcare. There is growing evidence that health coaching improves health outcomes, and an increasing number of healthcare organizations are adopting the model (Chen et al., 2010; Ivey et al., 2012; Nelson, Pitaro, Tzellas, & Lum, 2010; Ruggiero et al., 2010). However, little is known about the process of learning to become a health coach, a role that requires a dramatically new perspective and set of skills. We engaged in practitioner research and conducted a self-study of our experiences adopting this new model. We believe that our experience sheds light on the process of transformative learning and may help to guide organizations that seek to integrate this model into their practices.

The health coaching model challenges traditional healthcare approaches, which excel at "rescuing" patients by telling them how to manage their health (Bennett, Coleman, Parry, Bodenheimer, & Chen, 2010; Ghorob, 2013). In contrast, health coaching is a tailored approach that addresses contributors to chronic disease in the individual. Influences on health include social determinants such as poverty, as well as behavioral barriers to medication adherence, physical activity, and eating choices. Health coaching requires engaging patients "where they are" to: (a) understand their motivation and barriers to being healthy; (b) equip them with the

MA health coaching provides a viable means of providing robust self-management support despite resource limitations.

knowledge and skills to advocate for themselves within the medical encounter and in their lives; and (c) to collaborate with them to develop and follow up on "action plans" to improve their health (Bodenheimer & Abramowitz, 2010; Bennett et al., 2010; Bodenheimer & Laing, 2007).

Many members of the healthcare team have been suggested to act as health coaches, including clinicians, nurses (Hayes & Kalmakis, 2007), health educators (Bodenheimer &

Abramowitz, 2010; Heisler, Vijan, Makki, & Piette, 2010), medical assistants (AHRQ, n.d.; Bodenheimer & Abramowitz, 2010; Chen et al., 2010; Gensichen et al., 2009; Ivey et al., 2012; Nelson et al., 2010; Ruggiero et al., 2010), and other patients living with the same condition (Gilmer, Philis-Tsimikas, & Walker, 2007; Heisler et al., 2010; Thom et al., 2013; Thompson, Horton, & Flores, 2007). Of these, medical assistants (MAs) represent a uniquely untapped resource for self-management support. As one of the fastest growing allied health professions (Bureau of Labor Statistics, 2010), the MA workforce is more ethnically and linguistically diverse than other medical professions and more likely to be culturally and linguistically concordant with patient populations (Chapman, Marks, & Chan, 2010). Moreover, qualitative researchers have found that MAs often conceptualize their role as patient liaisons, cultural brokers, and “workers who care,” roles that segue naturally into health coaching (Taché & Hill-Sakurai, 2010). Within strained “safety net” primary care clinics that care for vulnerable populations (e.g., people who are uninsured, low income, or experiencing homelessness), MA health coaching provides a viable means of providing robust self-management support despite resource limitations.

From 2010-2013, the University of California, San Francisco’s (UCSF) Center for Excellence in Primary Care conducted a randomized control trial of MA health coaching in two clinics within the primary care safety net of San Francisco (Willard-Grace et al., 2013). Three of the authors of this manuscript (Najmabadi, Araujo, and Canizalez) were MAs selected for the health coaching positions for this study. As new health coaches, we underwent extensive training and mentoring in recognition of the dramatically new role that we would play in patient care. We attended 40 hours of training over six weeks, using a curriculum developed by the study team. The curriculum included instruction in using active listening and non-judgmental communication; helping with self-management skills for diabetes, hypertension, and hyperlipidemia; providing social and emotional support; assisting with lifestyle change; facilitating medication understanding and adherence; and navigating clinic and community resources. A description of the curriculum can be found at <http://familymedicine.medschool.ucsf.edu/cepc/>.

Within our new role as health coaches, we interacted with patients at least monthly and met at least quarterly over the course of 12 months. We had three types of interactions with patients: medical visits, individual visits, and phone calls. Medical visits were visits between a patient and their clinician, and consisted of three segments: pre-visit, visit, and post-visit (Bodenheimer et al., 2007). During the pre-visit, we met with the patient to review medications, identify the issues of greatest concern to the patient, and review lab numbers. We then stayed in the exam room during the medical visit to take notes about the care plan and clinician recommendations. In addition, we sometimes acted as a patient advocate: helping the patient remember his/her questions and concerns; sharing opportunities for praise, such as actions that the patient was taking to care for his/her health; or alerting the clinician to issues identified during the pre-visit, such as medication not being taken as prescribed.

After the medical visit, we met with the patient for a post-visit. The post-visit was used to “close the loop” with the patient about the care plan, ensuring that the patient could describe the care plan and recommendations in his/her own words, and asking whether the patient agreed with the plan. In the event that a care plan was not feasible or acceptable to a patient, we helped to explore barriers or drew the clinician into a discussion about alternatives. As health coaches, we

were responsible for facilitating navigation of other resources such as diagnostic imaging or referrals to specialists, making follow up appointments, or facilitating introductions to behaviorists or other clinic resources. We also assisted the patient in making action plans to increase physical activity, improve healthy eating, reduce stress, or improve medication adherence (Handley et al., 2006).

In addition to taking part in medical visits between the patient and the clinician, we met with the patient individually and made follow-up phone calls between visits with the clinician. These visits and calls were used to: (a) create new action plans or address barriers to carrying out action plans; (b) assess patient knowledge and share information about target conditions or medications; (c) provide emotional support; and (d) assist with navigation of health and community resources.

While increasing evidence points to the effectiveness of the health coaching model (Chen et al., 2010; Ivey et al., 2012; Nelson et al., 2010; Ruggiero et al., 2010), little is known about the process of learning the role of a health coach. Health coaching is a radical departure from traditional medicine. Health coaches must assume new roles and are challenged to "unlearn" many of the implicit rules of traditional medicine. We undertook this self-study because we believe that there are vital lessons to be gleaned from our experience that may guide future coaches, their trainers, and sites seeking to integrate coaching into their practices.

## Methods

This study relied on participatory methodologies in which the "subjects" of research also shaped the research questions, took part in analysis and interpretation of the data, and collaborated as co-authors in the writing of this manuscript (Israel, Eng, Schultz, & Parker, 2012; Kondon, Pain, & Kesby, 2007).

Three health coaches (Najmabadi, Araujo, and Canizalez) and one health coach trainer for the study (Ghorob), took part in a focus group in November 2012. The three health coaches had previously received diplomas from MA schools. All three were women under the age of 40. The MAs' time in practice at the start of the project ranged from three months to 11 years. The health coach trainer had conducted health coach trainings for more than 1,000 people across the United States and Canada over a three-year period prior to the study. Other members of the research team helped design the discussion guide and take notes. The focus group explored what it was like to become a health coach, what it felt like to take on a new role, how interactions with patients changed, and how becoming health coaches affected personal lives.

An audio recording of the focus group was transcribed. Using participatory methods, all of the participants of the focus group and other members of the research took part in data analysis and identification of codes and themes.



Figure 1. Participatory methods such as card sorting and idea "carousel" used for data analysis. Copyright 2012 by UCSF Center for Excellence in Primary Care. Photographer: Sarah Syer, PA-C. Reprinted with permission.

## Outcomes/Results

Several themes emerged from this study.

*Theme 1: Learning to become a health coach required embracing a radically new role and “unlearning” ways of thinking that were part of the old role.*

As new health coaches, we found it challenging at first to let go of our old role as an MA and adapt to our new health coach role. The expectations placed on us as health coaches were profoundly different than those placed on us as MAs, and we had significantly more freedom. For example, as MAs, we were taught that we should not engage patients in conversation because we were under constant time pressure to move people in and out of exam rooms quickly. Similarly, as MAs, we were discouraged from providing information to patients or seeing ourselves as the people who could help patients:

Well [for] me, being an MA for 10-plus years, and then going into [being] a health coach, even though they gave me all this training, it’s totally opposite of what you’re taught....it’s not [like being an] MA at all.... I mean, it was drastic -- a drastic change from being an MA.

When I started the health coaching...I didn’t think I would have enough time with this patient because I was also used to a fast-paced clinic where we just had to get the patient in and out, in and out. And we had no real time to communicate with them, to actually sit down with them, to actually explain A1C (a measure of diabetes control), hypertension, hyperlipidemia. So when I heard about health coaching, I’m like: Really? We can help these patients? We can actually sit down and do medication reconciliation?



*Figure 2.* Health coach reviews medications with patient prior to visit. Copyright 2012 by UCSF Center for Excellence in Primary Care. Photographer: Sarah Syer, PA-C. Reprinted with permission.

Our new role as health coaches required asking questions of patients rather than telling them what they should do, listening without judgment, and connecting with patients in a way that was never expected of us before. One of the most fundamental challenges was learning a method that we call “ask-tell-ask.” Rather than simply telling patients what to do, we asked patients what they knew and what they had experienced. We shared information only when they did not know it. For example, as MAs, we would tell patients that they needed to eat better and take all of their medications regardless of what they thought of it. As a health coach we asked questions such as, “What is it that you like about being active?” or “What makes it hard for you to take your medications?” We knew that we had become adept at “ask-tell-ask” when we would hear ourselves asking more instead of telling. This was indeed a light bulb moment!

Our new role as health coaches required asking questions of patients rather than telling them what they should do, listening without judgment, and connecting with patients in a way that was never expected of us before.

I remember with the training what was really overwhelming for me was “Ask-tell-ask.” So I was really used to telling because, of course, coming from clinic, that’s what you

do...I was really overwhelmed, 'cause that was really hard for me to ask. I was just wanting to tell. Tell, tell, tell, you know. You shouldn't do -- You shouldn't eat that. It's unhealthy. You should exercise more. You should do this. You should take your medications. So, like I said, a light bulb moment was when I was actually hearing myself [asking] more in a visit.

*Theme 2: Training to become a health coach was “intrusive” because it required emotional vulnerability and reflection on our body language, behavior, and feelings.*

The process of training to become a health coach went beyond learning new knowledge or skills. As prospective health coaches, we were challenged to think deeply about what our body language and choice of words conveyed to patients. We were asked to examine our own judgments and assumptions, and to become aware of how these would manifest in our interactions. Our trainer (Ghorob) observed that the training process was “intrusive:”

I think all three of [the health coaches] went through this—having to change the way they connect with people. And I was, like, very harsh, like very particular and picking out very specific behaviors and facial expressions and mannerisms. I mean...I kind of messed with their heads. I'm digging into who they are as people....You know the content, and you know how to close the loop. Yeah, but look at your face when you're doing it.... What are you doing with all those papers as you're shuffling them? I'm digging into deep mannerisms...just who they are as people. It's like, I was intrusive.

Developing self-reflectiveness required a number of unusual training activities. For example, as trainees, we took part in simulated visits that were videotaped, and we reviewed the videotapes with our trainer. Role play followed by constructive feedback was a central feature of training exercises. These activities required a significant amount of emotional vulnerability on our part, as we were asked to think critically about our own mannerisms and expressions, and to accept candid feedback from others. At the time, these were stressful exercises. Later, however, we felt that these were vital aspects of our training:

I couldn't even sleep the night before [the videotaping activity]. We didn't even have lunch....Yeah. It was scary.

But [the videotaping exercise] was really helpful. Really helpful. I mean, after I think we went through the feedback with [the trainer], and she pointed out: What could you have done differently? Or what do you think you were doing there? For me it really helped. Because now I kind of think about that, too, when I'm actually coaching. In my mind, I'm kind of like: Wait. How's my posture? Am I facing the patient? And what's my body language? Am I looking at them? My facial expressions? So I think if we wouldn't have had that, I mean, we would have never known what to work on, even though it was really hard.

*Theme 3: As health coaches, we met patients “where they were” and strove to build a relationship of trust.*



The relationship that we developed with patients began with meeting patients “where they were,” and earning their trust. As health coaches, we invested time in getting to know our patients and what was of greatest importance to them. Investment in this foundational connection allowed patients to share sensitive information with us, such as barriers to their health. Once a strong connection was made, we were better able to support the patient in addressing their chronic conditions:

I started off knowing—getting to know her first without talking about her numbers but really connecting to her, wanting to know how she felt, because nobody had ever asked her....When I had built that connection, she started trusting me more, and once she started trusting me, we started talking about her health and the importance of medication and how important it is to see her provider and that I was going to be there with her.



*Figure 3.* Health coach creating an action plan with a patient. Copyright 2012 by UCSF Center for Excellence in Primary Care. Photographer: Sarah Syer, PA-C. Reprinted with permission.

Sometimes, meeting patients “where they were” took unconventional forms. For example, one of us helped a patient learn how to count change. Within the traditional medical paradigm in which we were trained, this education was not relevant to her health. However, this learning experience was very important to her, and therefore, it was essential to us. Notably, investing time in patients and meeting them where they were enabled us to connect with patients who were previously disengaged from the health care system. People who were previously unwilling to take medications or attend their medical visits became active participants in their care during our work together.

Meeting patients where they were meant that we needed to understand and prioritize the issues of greatest concern to the patient before attempting to assert our own agenda. We asked permission to talk about sensitive topics or to add our concerns to the agenda, ensuring that the patient was

in control and remained an active decision maker in their visit. We helped the patient select health-related goals that were important to them and develop plans to work toward those goals. As health coaches, we recognized that so-called “non-medical” issues such as eviction or family fighting could have a profound influence on well-being, so we did not dismiss patient concerns as being irrelevant to their health. In fact, providing emotional support to our patients and listening to their fears and concerns was a vital part of promoting their well-being:

You might have a really good plan of what the individual visit might have, but if they come in with some other issues...[you have to] attend to what’s going on with them and help them with that.

By definition, meeting patients where they are required tailoring our approach to create a connection with each patient. We had to understand individual patient needs and approach each patient differently:

What kind of patient am I dealing with? Because you can’t health coach the patients all the same. It won’t work. Everybody’s different. So one way with one patient might not work with another one, but you just kind of feel it out.

*Theme 4: As health coaches, we focused on patients’ needs more than the clinician’s needs.*

Prior to becoming health coaches, our work as MAs revolved primarily around the needs of clinicians. Our focus was to make sure that the clinicians had patients in the exam room ready to be seen on time. We felt as if we were robots of the clinic and were constantly overwhelmed and stressed. As MAs, we observed that patients were often confused, but we did not see ourselves as the people who could help them. In contrast, as health coaches we focused on the patient's needs rather than the clinician’s needs, and we knew that we had the tools to help them take control of their health:

What’s different is that being a health coach is more patient-centered than being doctor or clinic-centered, you can say. Because when you’re an MA, you’re worried about flow. You have to have to have the doctor on time, and you have to go from one patient to another. You know, just boom, boom—you’re in quick—you’re doing things quickly so the doctor doesn’t fall behind. When you’re a health coach, you actually have the time to do things with patients....[and] we have to better utilize the time...so it can benefit the patient the most.



*Figure 4.* Health coach meeting with patient and clinician for medical visit. Copyright 2012 by UCSF Center for Excellence in Primary Care. Photographer: Sarah Syer, PA-C. Reprinted with permission.

As health coaches, we actively solicited the patient's concerns and ensured that their primary concerns were addressed. Within the medical encounter, we advocated for our patients and empowered them to speak up for themselves. We praised them for successes in front of their clinician to highlight their strengths and achievements.

Being patient-centered also meant that we did not dismiss patients as being “non-compliant” when they did not do what we asked them to do. Rather, we recognized that there are many barriers to health, and we worked with patients to help identify and overcome those barriers. Sometimes, that meant acting as an advocate for our patients and helping articulate their concerns in such a way that the clinician could better assist them. For example, one of our patients had a high hemoglobin A1C (a measure of diabetes control) and would not return our calls or come in for visits:

I was having a hard time having her come in to even medical visits...And one time I happened to catch her....And then I noticed that she had a little plastic from her hearing aid coming out. I'm like: “Can you hear me okay?” She goes: “No. I've had this hearing aid for maybe five years, and it's not working as well as it used to.”...I told her: “Well, you know, have you ever talked to the doctor about [it]?” Her doctor didn't even know about this, which is weird. She'd probably been seeing him for a year or two, and he had no idea...And she kept coming in more and more and more to come see me. But at this time her A1C was out of control. The doctor wanted her to start insulin. And she's like: “I don't want to. We could do this. I could bring it down.” So we worked together. We were to the point where she didn't have to take insulin....After, like, a few times of her coming in, she goes: “I'm so glad that I finally got to talk to you because the reason I would never answer your calls is because I couldn't hear.”...So with her hearing aid and her A1C down, she was good.

*Theme 5: Health coaching was emotionally intensive, and we as health coaches needed robust emotional and instrumental support as we assumed this new role.*

In our role as health coaches, we needed support and guidance from our team. Beyond helping us gain the necessary skills to do our work, our trainer found herself trying to build systems of emotional support for us to combat “compassion fatigue” and feelings of isolation. Because we allocated a significant amount of energy to empathizing with and advocating for our patients, we needed to find our own sources of emotional renewal and support. Our trainer observed that:

I underestimated the amount of emotional support that coaches really need to do this work—ongoing emotional support—because they are giving so much of themselves to other people that you need some techniques or strategies or something to replenish that inside of you.

Being part of a “community of learning” was important to all of us, as we were able to share our experiences and learn from each other. Sometimes, this was simply a matter of talking informally and realizing that we were not alone in our experiences:

I mean, we learned to kind of tell each other our experiences and help each other out with that. I'd be like: Oh, I'm feeling that, too. And I was like: Okay, I'm glad I'm not the only one.

In this project, two of the three health coaches were located at one site, and the third health coach was located at a different site. As we compared our experiences, we found that the health coaches located together were able to feel significant support by sharing their experiences with each other on a daily basis:

I believe that having several health coaches in one practice or wherever they're going, it's good benefit to have because they feed off each other. They make themselves better. I mean, I'm pretty sure if they're going through the same thing, they talk to each other, and I think that's a very good benefit to have.

Within this project, we also took part in “mentoring sessions” in which we met with our trainer, other health coaches, or physicians on the study team in order to discuss difficult cases and share best practices. Regular mentoring sessions provided a safe forum to discuss the shared journey of health coaching, to empathize about challenges, and to feel supported by our community:

We had mentoring sessions...[where] we would bring our difficult cases. So we'd say, like: I have this patient [and] I don't know what to do....And we just kind of bounced ideas off of each other. I think if we wouldn't have done that, it would have been really difficult, and we would have felt like we had no support.

In addition to preventing us from feeling isolated in our work, mentoring sessions served the practical purpose of building our knowledge base and our professional resources:

I would have to say to the mentoring sessions, there were...some [medical] things that we weren't too knowledgeable about....And we would have mentoring sessions with [the physicians on the team], and they would explain that to us so we would be able to explain back to the patients.

Through our training and work as health coaches, we learned to challenge ourselves, take on new roles, and truly connect with patients.

*Theme 6: Becoming a health coach affected both our personal and professional lives, and it shaped our career goals.*

Through our training and work as health coaches, we learned to challenge ourselves, take on new roles, and truly connect with patients. We learned that we have the tools and experience to help patients in a way that even clinicians often cannot help. This gave us greater confidence and delight in our work. We experienced significant professional growth. For example, after a few months, we felt comfortable in speaking up to clinicians, other staff, and patients without being intimidated. We also

facilitated various training sessions using the health coaching skills that we were taught:

I've learned so much. I've learned...more confidence. I was one not to have a lot of confidence before or even engage in a lot of conversation with people, but now I feel I can do that more. Actually myself opening up to people as well. I wasn't as open. It was so many things that [changed] for the better. It's helped me grow overall.

Becoming a health coach impacted our personal lives. Skills learned in this professional role positively transferred to other roles, improving our family relationships:

I've noticed that I've opened up actually more with my family...And they know it. They're like: Wait a minute. You never texted me these type of things, or you never told me this...Like, just for instance. We're going -- me and my daughter are having a girls' night out. We're going out tonight to do a movie thing, me and her. And she's like: Wow!...You know, it's just trying to implement things at my house that I know it's going to make me open up more in an emotional level that I can bring into work. And that has changed me.

As we considered our next career steps at the end of this project, we realized that the experience of working with patients as a health coach had shaped our career aspirations and our perception of our role. The process of becoming a health coach was foundational to the way we saw healthcare and the relationship of medical professionals to the patients that we serve:

I don't see myself as an MA anymore. [Another health coach shakes her head.] I don't want to go back to that sterility. I don't. I want to keep doing what I'm doing and provide the service in this support system to patients and help them better take care of their health.

I think there's so much more that we could offer, as health coaches. [Another health coach nods]...I did an externship not too long ago for phlebotomy. And...they gave me an evaluation at the end. They're like: You were spending too much time with those patients. [Laughs] It was because I was trying to give them that comfort. You know, I'm drawing their blood. I'm poking at them. They're terrified. And I will talk to them, and: How's your day? And blah-blah-blah. And by the time they knew it, I had already drawn their blood, and they're like: Wow, you did it already?...I mean, being in, like, phlebotomy or MAs, they train you to be cold, to be the quick, fast-paced. They want you to be that way, and I couldn't.

Our training as MAs taught us to be hurried and robotic. The process was not focused on developing an emotional connection or open communication with our patients. In fact, engaging in conversation with patients raised concerns that we would not be able to exit the conversation quickly in order to keep up with our duties. However, our experience as health coaches showed us that we have unique skills to offer to patients.

In summary, becoming a health coach required “unlearning” a model that we had been taught as MAs, including the unspoken rule that MAs are primarily concerned with the provider's needs rather than the patient's needs. Our new role required not only learning new skills but also becoming highly aware of our own body language, behaviors, and feelings. Assuming the new role as health coaches, we were given the freedom and time to get to know patients more deeply, meet them “where they were,” and build a relationship of trust with them. Our connection with patients and understanding of their barriers enabled us to be successful at helping patients more effectively manage their chronic illnesses. As health coaches, we found that it was important to us to find support in each other. Finally, becoming a health coach had a profound impact on our personal lives by building our confidence and helping us open up on an emotional level, not only with our patients but with our families.

## **Discussion**

Learning to become a health coach was a transformative process, far more so than any member of the project team anticipated. The lessons that we learned about the role of a health coach and the process of assuming that role may be useful to other clinics that are seeking to create similar positions, to MAs who have the opportunity to work as health coaches, and to clinicians/providers who work with health coaches. As the medical community increasingly seeks to become “patient-centered,” the lessons that we learned may also be applicable to many other health care professionals who are seeking to transform their own roles.

For our cohort of fledgling health coaches, the transformation into health coaches required a number of key steps. We underwent intensive training that included not only didactic learning, but also participation in simulations and actual practice, receiving intensive feedback from our trainer and peers (including patients trained in coaching techniques), and providing feedback to others. The learning process did not end with the start of our duties, as our trainer conducted observations of our sessions with patients and led mentoring sessions in which we learned from each other as we encountered challenges. We developed a learning community in which we observed and provided feedback to each other, and we took time to debrief with each other and

provide emotional support through the role. We also taught other new health coaches using the skills that we were developing. Finally, we took time to reflect on our experiences through the focus group and analysis described in this paper. Each of these steps helped to further our learning and transformation, and we would strongly recommend that other organizations interested in health coaching consider similar steps.

As a rising workforce in primary care (Bureau of Labor Statistics, 2010), MAs are becoming increasingly tapped to provide health coaching support (Chen et al., 2010; Ivey et al., 2012; Nelson et al., 2010; Ruggiero et al., 2010). However, this is the first study that we are aware of that examines the learning experiences of MAs as they become health coaches.

Our experience suggests that learning the skills required to become a health coach is not a simple training task, and that this learning process challenges deeply engrained habits in healthcare. For example, while research has shown the value of collaborative decision making, developing tailored action plans, and asking patients to “teach back” instructions, these activities are rarely performed in medical encounters, where didactic, technical explanations still prevail (Ghorob, 2013). To introduce these practices runs counter to prevailing culture and personal habit, and it requires self-reflection and courage.

Our self-study sheds light on the potential and challenges of transformative learning. Inasmuch as the goal of education is not only to instill new knowledge and skills, it is also to empower people to become active and confident participants in their societies (Freire, Bergman Ramos, & Macedo, 1970; Israel et al., 2012). Our experiences elucidate both the challenges and potential of this awakening. Becoming self-reflective is an emotional process that requires individual courage and the support of a community of like-minded people.

Participatory action learning is an iterative process in which what we learn is applied to our practice and we continue to study and improve upon it (Zuber-Skerritt, 2001). Within primary care, we use the language of quality improvement or Plan-Do-Study-Act (PDSA) to describe this continual process of learning, application, reflection and study, and applying new insights to our practice (Institute for Healthcare Improvement, 2013). Because our experience occurred within the context of a research study that has now ended, the next cycle of application and study must occur in a broader context. Although we are no longer working together as a team, our experience has connected us as part of a learning community that helps to support each other as we seek to bring patient-centered care to the organizations of which we are now a part. One of us is launching a health coaching program in a new clinic, and another has taken on a leadership role within a larger health system, where we can apply our lessons learned in these new settings. We have periodically come together since our project ended to deliver training sessions, design potential new programs, and share our experiences with other healthcare professionals.

While research has shown the value of collaborative decision making, developing tailored action plans, and asking patients to “teach back” instructions, these activities are rarely performed in medical encounters, where didactic, technical explanations still prevail.

The process of conducting this study and writing this manuscript helped to crystalize our experiences and made clear to us the importance that these experiences have to us in our personal and professional growth. Thus, we would also recommend that organizations seeking a transformative learning experience consider a structured experience of self-reflection in which participants can share their personal narratives and identify common themes within their experiences.

In some way, transformative education can create new challenges. We have grown into confident, effective health coaches who are keenly aware of our potential. This knowledge makes it hard to return to a system that remains untransformed, where MAs are expected to perform routine functions with little meaningful patient interaction. Yet at the same time, our journey has the potential of exerting ripple effects on the world around us. Clinicians and clinic leadership at our sites are developing new types of positions at our clinics that would better utilize our skills, research teams are calling on us to help design new programs, and we are sharing our newfound skills with MAs and other healthcare professionals with whom we work.

### **Conclusions**

Being a health coach is a transformative experience and an ongoing learning process. Unlike our past role as MAs, being a health coach required us to focus on patients' needs more than the clinician's needs, which sometimes entailed advocating for the patient. In order to build trust, we had to meet patients "where they are," and our new role required more emotional engagement with our patients than we were accustomed to in our previous role. Learning this new role was challenging, and it required us to be aware of and reflect on changes in our body language, behavior, and feelings. Organizations training health coaches should be aware of the dramatic shift in perspective that this new role requires and be prepared to provide support to help MAs as they move into this new role. Such support should include extensive training that not only imparts skills, but reinforces them through continued feedback, creates a learning community among people assuming the new roles, and structures opportunities for reflection and emotional support through the journey - at once challenging and exciting.



*Figure 5.* Center for Excellence in Primary Care staff photo. Copyright 2012 by UCSF Center for Excellence in Primary Care. Photographer: Sarah Syer, PA-C. Reprinted with permission.



*Rachel Willard-Grace works at the Center for Excellence in Primary Care (the CEPC) at the University of California, San Francisco as the project manager of a randomized control trial of health coaching in the primary care setting. She has a Master's degree in Public Health from the University of North Carolina, Chapel Hill. Prior to joining the CEPC, Rachel was the executive director of a free clinic and worked as a public health researcher with an interest in organizational culture and change.*

*Adriana Najmabadi works at the Division of Internal Medicine (DGIM) at the University of California, San Francisco. She is a health coach who specializes in engaging with patients with uncontrolled diabetes, high blood pressure, and high cholesterol. Prior to becoming a health coach, Adriana worked in a biotech company for six years as a manufacturing technician and eight years at United Airlines as a customer relations agent. Adriana would like to pursue in a career as a registered nurse specializing in Diabetes education.*

*Christina Araujo started out as a medical assistant in Marin Community Clinic in 2009. She worked mostly in adult medicine and enjoyed talking to diabetic patients about healthier eating habits. This is what attracted her to the health coach position at University of California, San Francisco, which she started in 2011. She helped 110 patients who had diabetes, hyperlipidemia, and hypertension for 12 months. She found this position to be very rewarding, and has learned so much from each patient. She is now at Sutter health as a medical assistant but hopes to reach out to many of her patients again to continue to health coach them. As she does this, she continues her studies to become a Family Nurse Practitioner and teaches others the beauty of health coaching.*

*Dalia Canizalez is a medical assistant health coach working at a public health clinic serving a diverse, largely low income population in the Bayview area of San Francisco. She specializes in engaging with patients with uncontrolled diabetes, high blood pressure, and high cholesterol. Prior to becoming a health coach, Dalia had 12 years of experience working as a medical assistant in private practices.*

*Denise DeVore has a Bachelor's degree in Psychology from the University of California, Davis, and has worked on clinical research studies at the University of California, San Francisco since 2010. She has experience recruiting, conducting interviews with patients, and gathering data in safety net clinics. She is also bilingual in Spanish.*

*Camille Prado has a Bachelor's degree in Biological Sciences from the University of California, Davis and is bilingual in Spanish. She has worked for University of California, San Francisco's Community and Family Medicine Department in clinical research for a little over a year.*

*Amireh Ghorob is the Director of Training at the Center for Excellence in Primary Care at the University of California, San Francisco. In her current role, Amireh has developed curriculum for practice facilitation, health coaching, panel management, and complex care management. She utilizes this material to coach staff in primary care clinics at UCSF, in the San Francisco safety net, the Great Los Angeles VA, and in clinics throughout the nation to transform their model of care to a team-based, population-focused model she has coined "Share the Care."*

*Thomas Bodenheimer, MD is a general internist who practiced primary care medicine for 32 years. He is currently on the faculty of the Department of Family and Community Medicine, University of California, San Francisco.*

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