

Integrating Chronic Care and Business
Strategies in the Safety Net:

A PRACTICE COACHING MANUAL

Written by Katie Coleman, Marjorie Pearson, and Shinyi Wu
Edited by Cindy Brach

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Table of Contents

Acknowledgments.....	3
CHAPTER 1: INTRODUCTION	5
CHAPTER 2: WHAT IS PRACTICE COACHING?.....	9
Why Practice Coaching?	10
What Roles Do Practice Coaches Play?.....	11
What Do Practice Coaches Do?	11
How Is Practice Coaching Structured?	13
Who Serves as a Practice Coach?	14
Which Practices Benefit From Coaching?.....	14
Does Practice Coaching Work?.....	15
What Makes a Good Practice Coach?	16
How Much Does Coaching Cost?	18
How Does Coaching Compare to Participating in a Collaborative?	18
Successful Coaching Case Study #1.....	20
Successful Coaching Case Study #2.....	21
CHAPTER 3: AN APPROACH TO PRACTICE COACHING	22
In a Nutshell	23
PHASE I: Laying the Foundation for Success	24
PHASE II: Active Practice Coaching.....	27
Suggested Modifications to our Practice Coaching Approach	35
REFERENCES.....	37
APPENDIX OF MEETING AGENDAS AND TOOLS	41
EXAMPLE: Practice Team Orientation Call Agenda.....	42
EXAMPLE: Practice Team Site Visit Preparation Call	43
EXAMPLE: Assessment Day Agenda	44
TOOL: Clinic Observation Assessment	45
EXAMPLE: Learning Session Agenda	47
TOOL: The “Change Your Practice” Menu	49
TOOL: Getting Started Logistics	51
TOOL: Tell Us What You Think!.....	54

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Darren A. DeWalt, MD, MPH | Assistant Professor of Medicine, University of North Carolina
at Chapel Hill, Quality Improvement Consultant, Improving Performance in Practice

Peter Margolis, MD, PhD | Professor of Pediatrics, Cincinnati Children's Hospital Medical
Center, Center for Health Care Quality, Quality Improvement Director, Improving
Performance in Practice

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Marjie Harbrecht, MD | Medical/Executive Director, Colorado Clinical Guidelines Collaborative

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CHAPTER 1

Introduction

CHAPTER 1: Introduction

Welcome! Most likely, if you're reading this you are interested in improving health care quality through practice coaching. This practice coaching manual aims to help effectively and efficiently improve clinical quality in an ambulatory setting by providing:

- AN OVERVIEW of what practice coaching is and how a variety of settings have used it to improve care.
- A SUMMARY of important characteristics and skills to look for when recruiting or training a practice coach.
- A DESCRIPTION of a time-limited practice coaching intervention that includes a series of activities, companion agendas, and tools.

This practice coaching manual accompanies a comprehensive Web-based toolkit, [“Integrating Chronic Care and Business Strategies in the Safety Net.”](#) The toolkit outlines a sequence of steps that practice teams can use to efficiently improve clinical quality along the lines of the Chronic Care Model. It also includes presentations, assessments, data tracking sheets, and sample action plans for use by teams as they transform their care. The toolkit and this practice coaching manual work together and refer to each other. We know that clinical teams often need help and support to effectively improve care, and we believe practice coaching may be useful to them as they do this work. This manual provides instructions and materials needed to support those using [“Integrating Chronic Care and Business Strategies in the Safety Net”](#) to transform care.

The development of these two resources grew out of a desire to help primary care teams improve clinical quality efficiently and effectively. Both are based on the Chronic Care Model (CCM), an evidence-based framework that has helped hundreds of clinical practices transform their daily care. The Chronic Care Model (CCM) is designed to help practices improve patient health outcomes through changing the routine delivery of ambulatory care. The Model calls for a number of interrelated system changes, including a combination of effective team care and planned interactions; self-management support bolstered by more effective use of community resources; integrated decision support; and patient registries and other supportive information technology.

Most often, the CCM has been implemented through Breakthrough Series (BTS) Collaboratives, an organized quality improvement approach that brings together practices from a variety of organizations four times a year to learn from leaders and colleagues about improving care. In between these learning sessions, teams return to their practices and try out new ways of delivering care through small, short-cycle changes called Plan-Do-Study-Act (PDSA) cycles. The practices that have participated in BTS Collaboratives to learn the CCM improved the care they provided for patients and improved patient health outcomes.¹⁻⁸

In our 10 years of experience with BTS Collaboratives, we have seen that they are often expensive to organize and require practices to take time out from providing patient care to attend learning sessions. Often the practices that are willing and able to do this are more highly motivated and well-supported than others. We sensed a need for a less time- and resource-intensive intervention that would:

- Make the tools and concepts taught in the Collaboratives available to more practices, and
- More closely integrate the business strategies necessary to sustain clinical change in the long term.

The manual is created primarily based on our practice coaching experience during the AHRQ-funded pilot project “Integrating Chronic Care and Business Strategies in the Safety-Net.” It captures our coaches’ approach to the teams, lessons learned from our experience, and feedback from the teams. It is supplemented by a literature review and interviews with leaders from other national coaching initiatives.

CHAPTER 2 reviews the many forms that practice coaching can take and summarizes coaching as it is depicted in the literature and by leaders in the field.

CHAPTER 3 provides step-by-step instruction for those interested in replicating the 10-month AHRQ pilot coaching intervention. Sample agendas and tools are available in the Appendix. This coaching model is being evaluated as part of a randomized trial.

THIS PRACTICE COACHING MANUAL IS DESIGNED FOR:

- Clinic or hospital leaders who want to use coaching to initiate or spread improvement efforts from one site to others;

- Quality improvement coaches, improvement leaders, and anyone else interested in new ideas about how to facilitate practice improvement; and
- Public health departments, multistakeholder collaboratives, and medical associations or other organizations interested in improving clinical quality in medical practices.

This practice coaching manual and the companion toolkit are meant to provide the tools and structure for coaches to use in helping teams in a wide variety of settings improve clinical quality. Of course, modifications and tailoring for the specific context where you work may be appropriate. However, many of the tools in the companion toolkit are copyrighted and cannot be modified unless the original authors grant permission. As this is an emerging coaching model, we would love to hear from you about your experience using this manual and toolkit. We can be reached at www.improvingchroniccare.org under “About Us.” Good luck!

CHAPTER 2

What is practice coaching?

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In 2006, the Agency for Healthcare Research and Quality funded a project to develop, test, and disseminate a package of tools to facilitate the effective and financially viable implementation of the Chronic Care Model (CCM) in safety net organizations. The RAND Corporation, Group Health’s MacColl Institute for Healthcare Innovation, and the California Health Care Safety Net Institute participated in the project. A key premise of our effort was that primary care practices may need more help than a toolkit alone can provide, yet they may be unable to attend a year-long Breakthrough Series style collaborative. This intervention was designed to provide low-intensity in-person, hands-on guidance to successfully implement the CCM. We conceptualized such assistance as helping, advising, and enabling and used terms such as “coaching” and “facilitation” when talking about it.

To better understand how such help might be structured, we looked at the literature on coaching and facilitation and talked with nine practice coaching leaders from a variety of organizations. In this chapter, we summarize key lessons learned from the literature and our interviews with coaching practitioners, as well as our own experience with practice coaching.

Why Practice Coaching?

There are a number of reasons that primary care organizations might want to look to coaches when embarking on a program of practice improvement:

- Primary care practices often lack in-house expertise or experience to successfully identify and initiate needed changes. Coaches can bring expertise on specific topics and approaches, and tools to facilitate implementation.
- Practice transformation is a complex undertaking, involving fundamental change to how a practice operates. Coaches have experience in how to help practices sequence and manage change.
- Primary care practices have difficulty making time for quality improvement in the face of the competing demands of day-to-day practice. The presence of a coach lends structure, dedicated time, and focus to quality improvement efforts.

“External initiatives like pay-for-performance and public reporting may help to generate interest in improving care, but in the crush of the current practice environment,

mounting an initiative to redesign care is almost impossible without support.” - Northwest Physicians Network

What Roles Do Practice Coaches Play?

Coaches perform multiple functions.⁹ Coaches can serve as:

- Facilitators who help practices achieve their improvement goals.
- Conveners who bring groups of staff members together to work through an issue.
- Agenda setters and task masters who help practices prioritize their change activities and keep them on track.
- Skill builders who train practices in quality improvement processes and assist them in developing proficiency in the techniques used in the CCM.
- Knowledge brokers who know about external resources and tools and save practices from engaging in extensive searches for information or reinventing the wheel.
- Sounding boards who give practices a reality check and provide feedback.
- Problem-solvers who can help practices identify and surmount a stumbling block.
- Change agents who promote adoption of specific evidence-based practices.

“Coaches offer a structure, time, and place for practices to solve their own problems.” - Humboldt Del Norte Foundation, a Robert Wood Jonson Aligning Forces for Quality participant

What Do Practice Coaches Do?

Coaches can play a role in setting the stage at the outset of the transformation process. For example, coaches can:

- Help to prepare the organizational infrastructure for quality improvement implementation through such activities as advising on team-building, improving communication,¹⁰ facilitating meetings,¹¹ and helping to develop leadership skills.¹²
- Communicate the vision for change through activities such as presenting best practices¹³⁻¹⁵ and sharing what other organizations have done.

- Help people to better understand how their practice compares to the ideal and where there is room for improvement by observing and delineating practice operations, assessing needs, and gathering baseline data, as well as guiding discussions of the current practice and opportunities for change.^{16, 17}

Coaches can also engage in very concrete tasks during the implementation period.

Coaches can:

- Help practitioners to plan change by encouraging them to set goals,¹⁸ suggesting ideas or providing menus of possible strategies or innovations,^{16, 17} and helping them choose among such options and create a plan.¹⁵⁻¹⁷
- Enable practitioners to execute changes by providing tools,^{13, 14, 16, 17, 19} guiding them through rapid-cycle tests of change,^{11, 13, 14, 18} and assisting when obstacles arise.¹¹
- Aid practices in customizing processes to fit their own situation and incorporating the changes into their day-to-day routines, so as to increase the likelihood that the changes will be sustained.^{20, 21}
- Provide direct technical support with health information technology (HIT) implementation and development of registries and reminders systems.¹⁵
- Help practitioners to collect and use measurement data,²² assess the effectiveness of changes made^{16, 17} and sometimes even undertake activities such as conducting chart audits.¹⁵⁻¹⁷

Motivation, education, and consultation are at the core of coaching.

- Motivational coaching addresses the amount of effort that group members collectively put into the task, especially by enhancing the conviction and confidence they bring to the work²³ through encouragement, reassurance, permission, and nudges.²⁴
- Educational coaching addresses the knowledge and skills that members bring to bear on the group's work.²³ Educational coaching can take the form of information sharing, skills training, and role feedback.²⁴
- Consultative coaching fosters use of performance strategies that are especially well-aligned with and appropriate to the task.²³ Consultative coaching may include rapid response to needs and requests; interactive problem solving,^{17, 24} and suggestions for change concepts or resources.

Most coaching involves a mix of these functions, but the emphasis placed on any one function changes over the course of the coaching process.^{9, 23} A motivational focus, for example, may be needed before education or consultation can be effective.

A frequent challenge for coaches is to maintain clarity about what they do and do not do. Coaching leaders have observed that there is a danger of “scope creep,” whereby coaches are pulled into work unrelated to the project at hand. In most cases this occurred because the coaches themselves were not clear on their role or because they wanted to be perceived as a helpful and valuable resource. “Scope creep” was best managed through clarification of roles at the outset of the project, frequent reevaluations of project status and open, clear communication with both the practice team and their leadership about the role of the coach and the expectations of the teams.

“Presenting accurate, timely data on a provider’s panel of patients is a powerful way to create a willingness to change.” - Colorado Clinical Guidelines Collaborative

How Is Practice Coaching Structured?

Coaching approaches and methods vary in many respects, including:

- Duration (e.g., from a few months to a number of years).
- Intensity, ranging from time-intensive, comprehensive practice management and clinical quality improvement efforts involving frequent communication with sites (e.g., ongoing facilitation provided through practice-based research networks) to brief and narrowly focused efforts (e.g., a preventive care effort launched with one group meeting and minimal follow-up).
- Proximity, ranging from onsite coaching, with a coach dedicated to a single site or set of sites (e.g., academic research institute coaches integrated into university-affiliated practices) to long-distance coaching, using telephone and e-mail to continue work between in-person meetings (e.g., coaches in large systems such as the Veterans Affairs (VA) health system).

Coaching also can be:

- A team activity, whereby two or more coaches bring complementary skills to interactions with the practice (e.g., specialized expertise in improvement methods versus the clinical problem area).

- Scripted, using a consistent curriculum for practice coaches to use with sites (e.g., Improving Performance in Practice).
- Prescriptive of the changes that the practices should make (e.g., top-down promotion of highly defined best practices).
- Practice driven, allowing the structure - and to some degree the content - of the program to be decided largely by the site (e.g., STEP-UP¹⁶).

Most coaching leaders acknowledged a tension between wanting to be reliable and consistent in their approach to teams while recognizing that one key advantage of coaching is the ability to tailor the implementation of a quality improvement initiative to needs and strengths of each practice. Learning which elements of an intervention work and are generalizable and which can and should be customized at the site level is an area where much more needs to be known.

Who Serves as a Practice Coach?

While coaching can be done by a member of the practice, the predominant model found in the literature is to use a coach external to the practice. In the coaching interventions that we studied, an entity outside the practice arranged and paid for the coaching. Practice coaching is a service available for purchase. A variety of different types of individuals have served as coaches. These include:

- Researchers with expertise on evidence-based practice and implementation (e.g., practice facilitators for the VA Quality Enhancement Research Initiative (QUERI) program).²⁴⁻²⁷
- Professional improvement advisors, broadly trained in quality improvement methods (e.g., faculty at the Institute for Healthcare Improvement).
- Specially trained individuals with bachelor's or master's degrees and some previous health care experience or training (e.g., practice enhancement assistants trained by practice-based research networks).

Which Practices Benefit From Coaching?

It is difficult to predict which practices will be most likely to succeed. Coaches generally see that practices with engaged leaders and long-term quality improvement goals are more likely

to embrace the changes coaches nurture. On the other hand, programs using coaches may want to target practices unlikely to be able to engage in quality improvement on their own. These include practices that:

- Are not part of or supported by a larger system.
- Cannot attend quality improvement collaboratives.
- Require additional motivation or contain pockets of resistance or inertia that block spread of the CCM.

“You don’t always know which practices are going to do well. There may be practices that you think are least likely to change, but if you can crack the nut, they are often the ones that make transformational change.” - STEP-UP

Does Practice Coaching Work?

Although there are few evaluations of practice coaching, it is perceived to be valuable. Many have come to view primary care practices as complex adaptive systems, each with unique histories, people, relationships, values, rules, influences, and problems.^{28, 29} Since one predefined approach cannot possibly fit all these unique systems, quality improvement implementation requires extensive customization. This customization, in turn, necessitates understanding the context and opportunities for change³⁰ and facilitating a process of learning and reflection that helps practices adapt to and plan change.³¹ Coaching is key to this process.

Emerging evidence suggests that this tailoring to the practice’s unique context may increase the likelihood of sustainability by helping to better incorporate quality improvement changes into the day-to-day routines of the practice.^{20, 21} Studies have shown that coaching has led to increases in evidence-based care of diabetics, preventive services, and screenings.^{15, 32, 33}

Evaluation of our practice coaching intervention, which was designed to foster adoption of the CCM and use of the “Integrating Chronic Care and Business Strategies in the Safety Net” toolkit, has led to the following conclusions:

1. Coaching is a necessary bridge to the toolkit. The coaches help providers and staff navigate the toolkit. By answering questions and helping people locate specific tools, the coaches save staff and provider time.

2. Coaching motivates and prompts people to make changes. The coaches encourage providers and staff to test small changes in their work routines, which providers and staff may not have been able to do on their own. The participants believed these changes would not have happened without coaching.
3. Coaching extends the horizons of the teams. The coaches provided outside experience and shared information from other clinics. These examples allowed the providers and staff to learn from changes that have been effective elsewhere, resulting in greater motivation in implementing the CCM.
4. Coaching has a positive effect on team building. Although some physicians and their supporting staff worked well together prior to the project, others commented that coaching helped them to build a better team through regular meetings and staff empowerment.
5. Coaching is an emotional bond. The coaches' commitment and positive attitudes in motivating and encouraging participants were appreciated. This emotional bond was noted to be a key factor in the success of the coaching intervention.

What Makes a Good Practice Coach?

For those practices interested in hiring their own practice coach, below are some characteristics to consider, including a list of core competencies and a proposed scope of work. Because this area has not been empirically examined in the context of ambulatory care, we rely on our own experience and our conversations with national leaders to suggest what makes a good practice coach.

Characteristics

In our experience and that of others in the coaching world, certain characteristics and personality traits of the coach are tremendously important. Because of the interpersonal nature of the coaching relationship, respect for others, superior communication skills, and open-mindedness are characteristics deemed most crucial. Other characteristics mentioned by experienced program leaders as important for a potential coach include empathy, creativity, passion for the job, and respect for the real-life barriers in practice. They also need to have a thick skin and avoid internalizing things. Being a “people-person” was considered very important (e.g., being able to get along well with people and being good at

reading people and understanding who is in power). Teaching skills also were emphasized, as was the ability to read between the lines and elicit underlying issues in a nonthreatening way.

Those quality improvement leaders who have experience serving as practice coaches spoke about some of the challenges of working with different types of people on different teams. The executive director of one quality improvement effort said, “Coaches must have a variety of approaches at their fingertips to connect with different teams. And, you need lots of different tools in your toolbox to connect with different types of staff - from those with a high school education to highly trained providers. A coach has to work well with all of them.”

In many cases, the coach is the face of the quality improvement program for the practice teams. Being able to keep teams engaged in what is often very challenging improvement work is not easy. As one coach put it, “You have to have a thick skin. There is no way around it. You’ll be treated like dirt, and you can’t take it personally.” Sometimes the frustration of the team gets directed at the coach, so being able to maintain good relationships while continuing to promote improvement is key.

Core Competencies

In addition to the interpersonal skills and emotional intelligence of coaches that may enable them to function well in a practice, some skills and content knowledge are needed. Although all our interviewees agreed that these skills were important, there was some debate as to which were essential and which were nice to have. If you are fortunate enough to have a number of coaches that will work together on your initiative, then the group as a whole could possess these skills. Each coach individually may be able to provide specialized knowledge in areas where they are more familiar. If you only are able to hire one coach, seeking out external sources of support in areas where that person may not be as strong would be helpful.

Skills and knowledge a coach should possess or be able to connect with include:

- Familiarity with data systems, including registries.
- Ability to understand and explain data reports in different ways to different stakeholders.
- Some clinical understanding and credibility.
- Knowledge of, and experience with, the Chronic Care Model.
- Knowledge of, and experience with, the Model for Improvement.

- Understanding of performance reporting and measurement.
- General quality improvement methods.
- Group facilitation skills.
- Project management skills.
- Knowledge of practice management and/or financial aspects of the practice.
- Experience with and understanding of the outpatient clinical setting.

There was considerable debate about how important it is for the coach to be clinically trained, such as a registered nurse, physician assistant, nurse practitioner, medical doctor, or doctor of osteopathy. Some thought it was essential that the coach be a clinician to provide credibility and to act as a resource with whom the practicing physician could discuss clinical issues in improvement. Others thought having a clinician coach may be a detriment because of an overemphasis on the clinical aspects of care. These respondents stressed the wide variety of skill sets needed to care for patients and emphasized how a coach needs to be able to value and speak to each role. In the end there are pros and cons to having a clinician coach. Likely it is important for the coach to have some clinical credibility and to be able to access a provider to come in and talk to the clinicians on an “as-needed” basis.

How Much Does Coaching Cost?

There is little information about the costs of coaching, which of course varies with the intensity of coaching, the qualifications of the coach, and the duration of the coaching. Our 10-month practice coaching of two clinic sites cost approximately \$41,000 (in 2007 dollars), which included time spent in coach training, coaching, and travel to sites. Practice coaching has been shown to be cost-effective by reducing inappropriate testing and treatment costs and increasing practice efficiency.³⁴

How Does Coaching Compare to Participating in a Collaborative?

More than 1,500 physician practices have participated in CCM collaboratives. Collaboratives can be thought of as group coaching sessions, where several practices are all trained in CCM implementation at the same time. There is real value in bringing together groups of practices. Teams benefit when they get together to interact, share lessons learned, feel some camaraderie with colleagues undergoing similar transformation, and develop ongoing networks.

Coaching, however, may be uniquely beneficial in these ways:

- Coaches can see and evaluate practice resources firsthand and tailor advice accordingly.
- Bringing coaches to the practice can enable more staff to participate in the practice improvement sessions.
- Through shorter educational sessions, conducted during a lunch break or after work hours, coaching can be delivered without requiring the closing of the practice.

Coaching has also been used as a supplement to collaborative learning sessions, blending the best that both methods have to offer.

“Some material is better presented in the collaboratives and some is better presented in the coaching framework. We’re trying to capitalize on doing them both together.” - Prescription for Pennsylvania Coach

Clearly the field of practice coaching is still evolving, and it may be that even as our knowledge base grows, different models will work better in different settings. The next chapter provides a detailed description of the practice coaching intervention developed to be used in tandem with the “Integrating Chronic Care and Business Strategies in the Safety Net” toolkit, available at www.ahrq.gov and www.improvingchroniccare.org.

Successful Coaching Case Study #1

Coaching Preventive Care Improvement in Primary Care Practices³⁴⁻³⁶

Who was coached? Fifty-four physicians and allied health staff in 22 primary care practices in Ontario, Canada.

Who were the coaches? Three “prevention facilitators,” all nurses with community nursing degrees and previous facilitation experience. They received 30 weeks of training in outpatient medical systems and management, preventive improvement, performance reporting, and facilitation techniques. Each coach was assigned to up to eight practices (with up to six physicians per practice) within a geographic area.

How was the coaching structured? The coaches worked out of their homes and traveled by car to the practice locations for onsite visits. During the 18 months of the intervention, they made 33 visits to each practice and spent 1 hour and 40 minutes per visit, on average. Between visits, they corresponded regularly with each practice through e-mail and telephone calls.

What roles did coaches play? The coaches served as *educators*, providing evidence on best preventive practices; *motivators*, using audit and feedback as well as opinion leader strategies; *consultants*, offering specific improvement tools and strategies such as reminder systems; *team conveners* and *consensus builders*; and *chart auditors*.

What did coaches do? They presented baseline performance data; facilitated the meetings in which the practices set performance goals, developed prevention plans, and developed and adapted strategies and tools to implement these plans; and conducted chart audits to provide performance data to monitor success.

Successful Coaching Case Study #2

Coaching Local Development of Interventions To Improve Depression Recognition and Treatment in Substance Abuse Clinics²⁷

Who was coached? Clinicians and administrators at two outpatient substance abuse disorder clinics of the U.S. Department of Veterans Affairs (VA).

Who were the coaches? The facilitators, in this case, were researchers from the VA's Center for Mental Healthcare and Outcomes Research, including the project's principal investigator (PI), (a PhD with a background in sociology) and the project coordinator.

How was the coaching structured? This facilitation used onsite visits, conference calls, site-specific diagnostic data, expert consultation, and provision of implementation strategies and tools to help the local teams design and launch the site-specific interventions to further adoption of guideline-based practices for recognizing and treating depression. The PI spent 16 hours per week and the project coordinator 30 to 40 hours on these diagnostic and design guidance activities.

What roles did coaches play? The coaches acted as *observers* of local practice, *collectors* and *providers* of data and tools, *educators* on guideline-recommended practices, and *builders* of local expertise in quality improvement.

What did coaches do? They used formative evaluation and local teams (called "Development Panels") to facilitate the development of the interventions. In the formative evaluation, the coaches used clinic observation and key informant interviews to diagnose the key facilitators of, barriers to, and influences on depression recognition and treatment in these clinics. Specific diagnostic activities of the coaches included (1) an initial visit to each clinic by the PI to review materials on policies and procedures and to meet with clinical directors, (2) a three-day visit to each clinic three months later to conduct formal and informal observations of program operations and to interview program staff (10 to 14 staff members at each site) and patients (five or six), and (3) an analysis and presentation of this information in tables that summarized problems and offered potential solutions and tools. Over the next 5 months, the coaches used conference call meetings to guide the local Development Panels (consisting of the clinical director, a physician, a counselor, and a nurse or other staff member involved in depression screening) in designing the intervention specifics for their clinic.

CHAPTER 3
**An approach to
practice coaching**

CHAPTER 3: An approach to practice coaching

In this chapter we describe the approach used by two coaches as they worked together with nine randomly selected primary care teams to improve quality of care. Feedback from the teams and reflections on how to alter and improve the intervention are also included. The described approach illustrates how the principles described in Chapter 2 were put into action. The goal of coaching was to lay the foundation for implementation of the CCM. This was done by tutoring practices in the CCM and quality improvement methods and acquainting them with the toolkit, which they could continue to use to guide their improvement activities after coaching ended. The tools and steps below provide a template for a practice coaching intervention, but organizations can and should adapt the pace and content of the work to fit their needs.

In a Nutshell

Who was coached? Nine randomly selected primary care teams at two public hospital outpatient clinics located in California, USA. Both clinics were designated Federally Qualified Health Centers, serving disproportionately low-income and uninsured residents.

Who were the coaches? Two quality improvement professionals external to the public hospital systems with expertise in teaching the Chronic Care Model and Model for Improvement and leading teams through quality improvement initiatives efficiently. Two coaches were used because of their complementary skill sets. One acted as the regular point of contact with teams. The other provided specific technical assistance around topics including selecting and monitoring performance measures, integrating self-management support into the routine visit, and developing and using registries.

How was coaching structured? The coaching intervention was low intensity. The out-of-town coaches made two site visits and communicated with practices by phone two to three times a month and by e-mail on a weekly basis. Practices submitted monthly reports to coaches. Coaches spent a total of 10 months working with the clinical organizations, six months of which was spent directly working with practices.

What roles did coaches play? The coaches served as motivators, content experts, and team facilitators. The practices were expected to take the ownership of their quality improvement

initiative. Coaches acted as resources providing a broad outline of areas to address but letting the team decide sequencing and level of effort expended.

What did coaches do? Coaches taught the CCM and Model for Improvement cycles, organized teams and team meetings, worked with leadership to reduce barriers to accomplishing the work, guided the selection of clinical measures, reviewed monthly reports, helped prioritize changes, introduced tools from the toolkit, provided examples from other settings, and acted as a resource and motivator.

Practice coaching was divided into two phases:

- Phase I: Laying the Foundation for Success (4 months)
- Phase II: Active Practice Coaching (6 months)

PHASE I: Laying the Foundation for Success

The first phase of coaching took about four months and focused on laying the foundation for working with the practice teams. During this time, the coaches had three primary responsibilities:

1. **INTRODUCING** themselves to leadership of the organization and explaining the program and its goals, benefits, and requirements.
2. **LEARNING** about the organizational context of each site, including the system barriers and facilitators of quality improvement.
3. **GETTING ACQUAINTED** with the members of each team and generating momentum for the start of the project.

There were three major activities conducted in this phase.

ACTIVITY 1: Form Coaching Team

Your organization or initiative may have an existing group of coaches or quality improvement staff available to it, or you may be considering hiring a coach. For this quality improvement initiative, we sought coaches with experience implementing the Chronic Care Model, including population-based care using registries, self-management support, and planned care.

Coaches also should have some content knowledge about the business side of a medical practice, including operational and financial functions. We wanted individuals who would flexibly fit with a practice as well. While one person may have all these skills, we were lucky enough to have access to two coaches who together had a variety of expertise and perspectives.

ACTIVITY 2: Get Acquainted With Leadership

The coaches first contacted both the executive or middle-level leadership that initiated the quality improvement effort, as well as the local leadership ultimately responsible for implementing the work.

The primary goal of these informal conversations was for the coaches and leaders to get acquainted and discuss expectations and initial thoughts about the initiative. The following questions can be helpful conversation starters: What are you expecting to achieve during this initiative? What do you think will be the biggest barriers to success? What are you expecting to receive from us?

During these conversations, leaders were asked to provide insight into how the goals of the project would be best achieved at their site and what additional staff members should be contacted. These conversations began to develop what should be a solid and trusted working relationship between the site leadership and the coaches. The meetings also:

- Ensured that important stakeholders were brought in early, enhancing buy-in and creating the opportunity to address major problems or misconceptions early.
- Opened lines of communication directly between leaders and coaches.
- Enabled coaches to outline some of the basic requirements for successful participation, including the ability to generate population-based clinical data for monthly reports.
- Provided valuable information for coaches as they went on to develop their tactical approach; for example, when and with whom to schedule meetings for maximum attendance.
- Enabled coaches to integrate their effort with other existing system initiatives, minimizing unnecessary duplication of effort.

- Provided the executive and local leadership with enough information to be able to present the initiative to their own clinical teams. Having local leaders, rather than the coaches, motivate and introduce their teams to the effort from the very beginning sets the tone that this quality improvement work is owned by sites. The role of the coach is to support those local leaders and the teams' efforts as they move forward.

ACTIVITY 3: Orient the Practice Team to the Work

After the coaches talked with the site leadership, they introduced the effort in detail to the local practice team undertaking the quality improvement initiative. All the stakeholders who would be involved in the effort from front desk staff to physician leaders were invited to participate in this project introduction.

The more staff participating in this call, the better. For many of the practice team members, this may be the first that they have heard that they are expected to participate in a new way of working. For this reason, every effort should be made for local leadership to introduce the program. Local leaders can frame the importance of the project, provide an overview of their expectations, and offer resources to support the team.

An agenda of the phone call where the coaches and local leadership introduced the program to the practice team is in the Appendix. Note that half of the agenda is devoted to introductions and time for questions and answers. All attendees should be given a chance to participate, regardless of their position in the organization. Setting this example early can facilitate later team development.

After orienting the team undertaking the quality improvement effort, it is important for the coaches to stay in close communication with them. To build and sustain momentum, not more than three or four weeks should elapse between the time of these introductory conversations and the onsite launch of the initiative. While an effort to speak with each member of the participating practice team should be made during Phase I, do not be surprised to meet new team members during Phase II, active practice coaching. There is no substitute for an in-person orientation to get people engaged.

PHASE II: Active Practice Coaching

The second phase of the project was active practice coaching and lasted about six months. The six month design was an attempt to provide inexpensive and time-limited technical assistance to help teams get started. We know that six months of technical assistance is short compared to other quality improvement initiatives, and it may be insufficient for teams with little or no prior experience with quality improvement. This phase consisted of five activities.

ACTIVITY 1: Introduce Prework and Prepare Practice Team for Site Visit

As with the practice team orientation call, all members of the team and the practice leadership should participate in this meeting to introduce prework and prepare the practice team for the first site visit. In this AHRQ pilot, we conducted this call about three weeks before the learning session, allowing the site time to complete those elements of the prework that had to be done before we arrived: the clinical assessment, the financial assessment, and the Assessment of Chronic Illness Care (ACIC). Participants included the medical director of the site, administrative director of the site, physicians, nurses, medical assistants, front desk staff, and ancillary clinical staff, including dietitians and nurse care managers.

The primary purpose of this call was to discuss the plan for the upcoming site visit and to introduce the prework to the teams. However, it is likely that some new staff will participate, so it may help to conduct a brief refresher of the project and allow time for questions and answers about the general aims of the program before jumping in. Reminding the team that this is just a refresher and they can talk with other team members or leaders or e-mail questions may help keep this portion of the agenda short. For a sample agenda of the practice team site visit preparation call, see the Appendix.

You'll notice in the companion toolkit that one of the first steps for teams when they are working to improve quality is to select measures that are important to them. Data gathered during prework is primarily for the teams' use during the learning session to decide what areas of care they first want to improve. In addition, the data provide a baseline to measure progress, an important tool for engaging senior leaders. Finally, the data provide the coaches with some insight into the needs of the teams with whom they are working. Introduce teams to the prework assessments. Examples of each of the prework assessments are available in "Integrating Chronic Care and Business Strategies in the Safety-Net" toolkit. They include:

- **Clinical Assessment:** Clinics start on their quality improvement journeys by selecting and measuring the outcomes for a subpopulation of patients. In the case of our initiative, the sites worked with diabetic patients, so the clinical assessment provided a baseline of clinical quality for each team's diabetic population. It is to be filled out to the extent possible through automated data. If a clinic does not have automated data, a small chart review may be necessary. Each team is expected to complete this assessment before the coaches arrive for the learning session. A copy of this assessment, called *Quantitative Monthly Diabetes Report Template*, is available in Key Change 2.3 in the toolkit.
- **Financial Assessment:** In our experience, the financial functions and performance of a practice are often fairly far removed from the daily clinical practices. In order to capitalize on possible reimbursement and cost-saving opportunities, sites can complete a financial assessment before the coaches arrive for the learning session. If multiple provider teams within one site are being coached, only one financial assessment is needed. A copy of this assessment, called *Finance Collaborative Prewrite*, is available in Key Change 2.1 in the toolkit.
- **Assessment of Chronic Illness Care:** This survey assesses how well teams are set up to deliver high-quality chronic illness care according to the elements of the Chronic Care Model. This survey is to be completed by each individual of the clinical team before the coaches arrive for the learning session. A copy of this survey, called *Assessment of Chronic Illness Care*, and a companion *Scoring Guide* are available in Key Change 2.1 in the toolkit.

This short prework call also provided an important opportunity to prepare the teams for what to expect during the coaches' first site visit. Be sure to allot time to discuss:

- **Completing the administrative process assessment:** This fun, poster-sized assessment assesses how well administrative processes such as answering phones and rooming patients are working. This tool is a poster-sized template that can be printed and hung on the wall. All staff and even patients are invited to place a checkmark in the box that corresponds to their perception of the processes. This assessment is completed during the coaches' first visit. A copy of this assessment, called *Primary Care Practice: Know Your Processes*, is available in Key Change 2.1 in the toolkit.
- **Conducting the observational assessment:** The observational assessment is designed to give coaches a sense of how the practice works with patients. During the assessment, coaches will spend a couple hours looking at the practice supports for

high-quality chronic illness care: how clinical information systems and decision support are used; whether planned visits, self-management support, and linkage to community resources are conducted; and how leadership supports the team.

- **Developing the agenda for the learning session.** Before conducting this call, you should have a good sense of how you plan to structure the learning session. For more information about the learning session, see Activity 2 below. It may be helpful to share your vision and a proposed agenda for how you expect the day to go. This gives teams something to look forward to and prepare for.
- **Reaching coaches with questions.** It is likely the teams will have questions between this meeting and the first site visit about how to complete the prework, what to expect during the learning session, or other topics. Be sure to talk explicitly about how teams can reach you effectively, be it phone or e-mail.

ACTIVITY 2: Conduct the Observational Assessment (1/2 day) + Learning Session (1/2 day)

Because the coaches did not live in the same U.S. cities as the teams they were coaching, they conducted the observational assessment and the learning session as part of the same trip. The observation assessment was conducted the afternoon of one day, and the learning session was conducted the following morning. Finding a meeting time with the team for an hour one day and then for a full morning the following was challenging. Breaking up these two functions may facilitate scheduling.

OBSERVATIONAL ASSESSMENT

Clinical observation can be a valuable way for coaches to get a sense of how the clinic functions on an average day. In observing the flow of patients with a fresh eye, the coaches were able to identify areas where enhanced chronic illness care, such as self-management support, could be integrated with the existing operations and staffing. Using an organized observational tool helped to focus our observations in the midst of a very busy setting.

- The day began with a one-hour meeting with the team. During this meeting the coaches discussed expectations, collected prework, and administered another tool: *Know Your Process* (Key Change 2.1 in the toolkit). You will find the *Assessment Day Agenda* in the Appendix.
- Coaches then observed the practices, using a standard tool to guide their observations. A copy of the Clinical Observation Assessment tool is provided in the Appendix.
- The coaches gathered the information from all assessments, including their observations, and organized it to be useful for the teams to use in setting their improvement agenda.

LEARNING SESSION

The learning session served as the big project kickoff; it was the first time the coaches met with all the teams and the site leadership face to face. The expressed purpose of the learning session was to provide an orientation to the Chronic Care Model and Model for Improvement and to help the teams get started making small-cycle changes. However, the meeting also served as a way to generate momentum for the project, and as a fun introduction to redesigning clinical care. An agenda for the learning session is in the Appendix.

The coaches attempted to keep the learning session interactive, dynamic, and useful. All the baseline assessment data were presented conversationally, with coaches briefly presenting the results of the assessments and then leading the teams through a discussion about the results. Feedback sometimes got heated. Redirecting pointed questions back to the team by asking, “What do others think?” helped to diffuse energetic responses. It also set the tone that the coach is there not to fix all the practices’ problems externally, but to support the team to fix their own problems. In addition, didactic presentations were kept short and substantial time was allotted for the teams to figure out how to get started doing small cycles of change. Coaches attempted to model teamwork by encouraging shy participants to speak up and share opinions. Specific content covered in the learning session is presented below.

- **Teaching the Chronic Care Model.** The Chronic Care Model is the organizing framework around which this toolkit and coaching intervention were designed. The CCM is an evidence-based model that can help teams provide proactive, population-based care. For more on the Chronic Care Model, see the companion toolkit Key Change 1.2, *Chronic Care Model Primer*. Videos and PowerPoint presentations of the Model should be short, specific, and interactive. Additional examples of presentations are available at www.improvingchroniccare.org.
- **Reviewing Assessment of Chronic Illness Care.** By the time of the learning session, the coaches should have received all the ACIC surveys back from the team members who completed them as part of the prework. To score the ACIC, see the companion toolkit Key Change 2.1, *Assessment of Chronic Illness Care*. Presenting these scores back to the group in aggregate or as blinded individual surveys gives the team members a chance to identify and discuss areas of strength and opportunities for improvement. Practices may feel discouraged when they realize how many elements of the CCM they do not currently address. Coaches familiar with quality improvement methodologies know that teams do best when they start with small changes. Reassure

teams that they can make progress without addressing every element of the CCM at once. As the day progresses, teams will have a chance to discuss where they might be able to achieve early successes.

- **Model for Improvement.** Like the Chronic Care Model, the Model for Improvement is an important organizing framework for this intervention. If the Chronic Care Model is what the teams are going to work on, then the Model for Improvement is how the teams are going to do the work. Plan-Do-Study-Act cycles are the key component of the Model for Improvement, and there are many creative ways to present this content, including games. For more information on the Model for Improvement, see the companion toolkit Key Change 1.2, *A Model for Accelerating Improvement*. Don't be concerned if not everyone "gets it" all at once. This is just an introduction; these concepts are best learned by doing.
- **Observational Assessment Results and Group Discussion.** During this time, coaches present qualitative feedback to the teams about what they observed during their observational assessment. A good approach is providing an overview of what you observed the teams doing well and then identifying areas where easy enhancements could be made to better address patient needs. For example, if patients are routed through some sort of nurse- or medical assistant-led checkout process before leaving the office, perhaps goal setting or action planning could be integrated. This exercise is most helpful when coaches can point out potential solutions simultaneously with potential areas for improvement.
- **Where to Start.** After learning about the concepts behind the Chronic Care Model, teams often wonder how to get started. Here, the coaches introduced a menu of starter ideas, areas that the team might like to address first. This was not a prescriptive list, but it was meant to start discussion. This was the most valuable and important aspect of the learning session: the time teams had together to brainstorm Plan-Do-Study-Act (PDSA) cycles and how they would make the program run. You can find the "Change Your Practice Menu" of starter ideas and the "Getting Started Logistics" tools in the Appendix.
- **The Toolkit.** The companion toolkit provides a sequenced approach to help teams improve care. It also provides content and tools for almost any related topic of interest from selecting a registry to trying out planned visits. During this session, coaches provided an interactive overview of the toolkit with a special emphasis on its approach to the business case for improved care. The toolkit is available to teams free of charge online at both www.improvingchroniccare.org and www.ahrq.gov. Team

members can use any of the tools or review content on the Web without printing out a heavy binder.

- **Monthly Reporting.** Coaches also briefly introduced the monthly reports teams were required to submit to them. Key Change 2.3 of the *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit provides examples of the Quantitative Monthly Diabetes Report Template and the Narrative Monthly Report Template that the teams completed. These monthly reports serve several functions. They provide a tangible deliverable and an opportunity for the teams to ask questions of the coaches in a systematic way. The reports also provide a template for the teams to look at changes in health process and outcome measures as a result of their work. They also demonstrate evidence of improvement to be used to engage leadership or other teams in spread.
- **Planning Future Team Meetings.** In order for teams to successfully make changes in how they deliver care, regular time needs to be set aside for the team to gather together. This can take the shape of a weekly one-hour meeting or a series of short, daily huddles. Either way, it is important to establish a time to share what has been learned, develop new ideas to test, and maintain momentum. Because trying to get started on a new initiative in the midst of a very busy clinical schedule can be challenging, the time set aside by the coaches must be more than just didactic presentations. It must be value-added planning time for the teams as well.
- **Evaluation.** In the spirit of continuous quality improvement, the coaches asked the teams to evaluate them after the learning session. The evaluation form, “Tell Us What You Think,” can be found in the Appendix.

ACTIVITY 3: Coaching Through Regular Team Meetings

After the learning session, teams start trying to improve care using PDSA cycles. The coaches participated by phone in the team’s regular weekly or biweekly meetings, though in-person participation could also work. The expectation was that a team leader would facilitate the meetings, but the coaches were available before the meeting to brainstorm an agenda, during the meeting to provide suggestions and ideas, and after the meeting to reflect on how to best move the project along. The team leader can be anyone on the team who is able and interested in convening team meetings, maintaining momentum for the initiative, and overseeing the implementation of change ideas. Some teams have one person who acts as the team leader, such as the medical director of the practice or the office manager. Other groups

rotate team leadership among team members. For more information about leadership, see Key Change 1.1 in the toolkit, *Organize your lead quality improvement team*.

Coaching through these regular meetings, as opposed to establishing separate meetings either individually or as a group, has many advantages. First, since the teams are already meeting, coach participation is efficient. If the teams have questions, especially at the beginning as they work on PDSAs, they can get coaching help and ideas right way. Participating in team meetings also enables the coaches to see how the project is progressing. If, for example, key members of the team are not attending, the coaches can talk with leaders who may be able to encourage attendance.

Initially, the coaches provided substantial guidance, but over time, the meetings shifted to be led and managed much more independently. From the beginning, an important goal was for the teams to own the meetings and to perceive the coaches as a support but not an active “implementer” or team member. Coaches do not and cannot know the local politics and organizational context as well as the team members do, and they are only available to the teams for a limited time.

The coaches also provided ad hoc support to individual members of the teams through e-mails and phone calls. Often this involved providing a link to a specific tool or a recommendation for a speaker or training on a topic of interest. Sometimes, the coach acted as a listening ear when people felt frustrated or unable to move forward. The coaches took on various roles throughout the six-month active coaching phase of the project: observer, trainer, meeting participant, report-reviewer, and ad hoc resource. These roles changed as the needs of the teams changed.

Having clear, well-communicated boundaries about what is and is not the job of the coach is important. Coaches should:

- Be in a position of offering ideas, not imposing what they want to get done.
- Help the teams actually implement what they learn.
- Set up systems for the benefit of the clinic and its staff, not the organizing group, the coaches, or even the leadership.

Finally, there is only so much a coach can do. To be successful, coaching has to be sufficiently supported and matched by good leadership, sufficient resources, and a clear idea of the desired outcomes. Some organizations and teams are just not ready or able to make good use of a coaching resource.

ACTIVITY 4: Communicating With Leadership

In addition to participating in team meetings via phone, or occasionally in person, coaches also worked with local and executive leadership, communicating about the project, highlighting challenges and successes, and helping leaders think about how they could contribute to the success of the effort. Sometimes this meant drawing attention to resistant staff or broken systems that impeded the ability of the team to move forward; other times it was encouraging leaders to ask and follow up with the teams about their work.

ACTIVITY 5: Closing Out Coaching

Our intervention was deliberately low-intensity and lasted six months, though certainly you could continue coaching if interest or funding were available. In preparation for the last team call, teams were asked to discuss two things: first, reflect on the initiative and how it affected their relationships both with patients and coworkers, and two, think through how the effort would be sustained after the coaching component ended. During the meeting, the teams presented on these topics and the coaches reminded the teams about available resources, including the companion toolkit.

Suggested Modifications to our Practice Coaching Approach

The aforementioned coaching intervention was evaluated as part of AHRQ's "Integrating Chronic Care and Business Strategies in the Safety Net" project. RAND assessed the implementation of the intervention through site visits to the two participating medical centers and interviews with key informants. Below we offer the following suggestions for modifying the practice coaching intervention.

1. Coaching should include more face-to-face interactions. Due to the ease of communication and discussion, the pilot site participants believed that they would benefit from more frequent in-person contact with the coaches. Although for the most part the telephone calls and e-mail functioned well, some participants felt their enthusiasm was dampened when the coaches could not be reached.
2. An internal coach might be added. The participants felt that sometimes the external coaches' advice was too general and not applicable to their particular organizational setting. In one site, a physician who had prior experience using the Chronic Care Model was consulted by others about how to implement specific changes. Hence, many participants suggested that an internal coach who knows their system better and is more

readily available could complement an external coach. It was also noted that an internal coach should be given sufficient time and clear responsibility, so as not to cause antipathy among other staff members.

3. Coaching intensity may need to be greater at the beginning. The meeting and coaching time allotted was perceived to be insufficient for participants to learn, ask questions, and exchange information. The participants commented that they needed more help at the beginning and suggested greater intensity of coaching until they became self-sufficient. It was also suggested that everyone in the practice who plays a role in CCM implementation should be invited to the first in-person coaching meeting. Some recommended that the coaches provide a more specific timeline for changes.
4. Coaches should be more proactive and creative in introducing the toolkit. The interviewees suggested that coaches be more proactive in introducing the toolkit. The learning session could allot more time to reviewing the toolkit to increase users' understanding of its contents. One participant suggested that the coaches could create scenarios to demonstrate how and when to use the toolkit. Others suggested that the coaches remind them to use the toolkit.
5. Continue coaching for a longer period of time. We designed the coaching intervention to get the practice team started in CCM implementation, but the coaching was perceived to be worth continuing beyond the six-month timeframe.

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Appendix of Meeting Agendas and Tools

EXAMPLE: Practice Team Orientation Call Agenda

INTEGRATING CHRONIC CARE & BUSINESS STRATEGIES IN THE SAFETY NET

Practice Name:

Date:

Time:

Dial-in Number:

Conference Code:

PARTICIPANTS: Coaches, medical director of ambulatory care, medical director of the site, administrative director of the site, physician, nurse, medical assistant, front desk staff, local trusted stakeholder

AGENDA

Opening Remarks	Key Medical and Administrative Leadership e.g., Medical Director of Site, Medical Director of Ambulatory Care Administrative Director of the Site	<i>10 minutes</i>
Introductions	All	<i>10 minutes</i>
Overview	Coaches	<i>15 minutes</i>
Questions & Answers	All	<i>20 minutes</i>
Next Steps	Coaches	<i>5 minutes</i>

EXAMPLE: Practice Team Site Visit Preparation Call

INTEGRATING CHRONIC CARE & BUSINESS STRATEGIES IN THE SAFETY NET

Clinic Name:
Date:
Time:
Dial-in Number:
Conference Code:

PARTICIPANTS: Coaches, medical director of the site, administrative director of the site, physician, nurse, medical assistant, front desk staff

AGENDA

Introductions	All	<i>10 minutes</i>
Overview	Coaches	<i>5 minutes</i>
Remaining Questions About Project Aims	All	<i>10 minutes</i>
Pework Overview	Coaches	<i>20 minutes</i>
Clinical data		
Financial data		
Assessment of Chronic Illness Care		
Administrative Process		
What to expect during the observational assessment	Coaches	<i>5 minutes</i>
What to expect during the learning session	Coaches	<i>5 minutes</i>
Continued communication	All	<i>5 minutes</i>

EXAMPLE: Assessment Day Agenda

INTEGRATING CHRONIC CARE & BUSINESS STRATEGIES IN THE SAFETY NET

Clinic Name:
Date:
Time:
Dial-in Number:
Conference Code:

PARTICIPANTS: physicians, nurses, medical assistants, administrators, coaches, anyone else the team deemed to be part of their work (e.g., Certified Diabetes Educators, nutritionist, front desk clerk)

TEAM MEETING

1:00 - 2:00

Introductions	All	<i>1:00 - 1:10</i>
Overview & What To Expect	Coaches	<i>1:10 - 1:40</i>
Remaining Questions	All	<i>1:40 - 1:55</i>
Collect prework, complete "Know Your Process"	Coaches	<i>1:55 - 2:00</i>

PRACTICE OBSERVATION

2:00 - 4:30

Patient perspective

1. Observe patients - How long does a patient spend waiting for his or her appointment?
Does the check-in process work smoothly? Is patient information available in the waiting room at appropriate reading levels and in appropriate languages?

Practice perspective

1. Talk to team members.
2. Observe office practice (Tool: see below, Clinical Observation Assessment).

TOOL: Clinic Observation Assessment

<p>Self-Management Support</p> <p>ASK! “How do you support patients to manage their _____ on their own?”</p> <p>What you’re looking for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Emphasize the patient's central role. <input type="checkbox"/> Use effective self-management support strategies that include assessment, goal-setting, action planning, problem solving, and followup. <input type="checkbox"/> Organize resources to support SMS. 	<p>Delivery System Design</p> <p>ASK! “Who is in charge of _____?” “Do you bring your patients regularly for planned visits?”</p> <p>OBSERVE! Is a case manager part of the team? Is care provided in a culturally competent way?</p> <p>What you’re looking for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Define roles and distribute tasks among team members. <input type="checkbox"/> Use planned interactions to support evidence-based care. <input type="checkbox"/> Provide clinical case management services. <input type="checkbox"/> Ensure regular followup. <input type="checkbox"/> Give care that patients understand and that fits their culture.
<p>Decision Support</p> <p>ASK! “How do you get your information about clinical guidelines?”</p> <p>OBSERVE! Are guideline-based patient materials available?</p> <p>What you’re looking for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Embed evidence-based guidelines into daily clinical practice. <input type="checkbox"/> Integrate specialist expertise and primary care. <input type="checkbox"/> Use proven provider education methods. <input type="checkbox"/> Share guidelines and information with patients. 	<p>Clinical Information System</p> <p>ASK! “Do you have a patient registry that is useful in providing clinical information at the point of care?” “How do you monitor your performance?”</p> <p>What you’re looking for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Provide reminders for providers and patients. <input type="checkbox"/> Identify relevant patient subpopulations for proactive care. <input type="checkbox"/> Facilitate individual patient care planning. <input type="checkbox"/> Share information with providers and patients. <input type="checkbox"/> Monitor performance of team and system.

Community Resources and Policies	Health Care Organization
<p>ASK! “What community agencies do you all find particularly useful for your patients?”</p> <p>OBSERVE! Is there a sense that the team members are aware of other resources in the community? Is information about referrals to other organizations readily available?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Encourage patients to participate in effective programs. <input type="checkbox"/> Form partnerships with community organizations to support or develop programs. <input type="checkbox"/> Advocate for policies to improve care. 	<p>OBSERVE! Are senior managers engaged with this project? Are they supportive of the teams? How does the organization handle problems?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Visibly support improvement at all levels, starting with senior leaders. <input type="checkbox"/> Promote effective improvement strategies aimed at comprehensive system change. <input type="checkbox"/> Encourage open and systematic handling of problems. <input type="checkbox"/> Provide incentives based on quality of care. <input type="checkbox"/> Develop agreements for care coordination.

EXAMPLE: Learning Session Agenda

INTEGRATING CHRONIC CARE & BUSINESS STRATEGIES IN THE SAFETY NET

Clinic Name:
Date:
Time:
Dial-in Number :
Conference Code:

PARTICIPANTS: Coaches, medical director of the site, administrative director of the site, physicians, nurses, medical assistants, front desk staff

GOALS:

1. Review data.
2. Learn about the Chronic Care Model, PDSAs, Business Redesign tools.
3. Identify what changes you want to make.
4. Plan how to start.
5. Build team confidence.

Reflections on where we are

1:00 - 2:55

Coach	Present the Chronic Care Model (Tool: Key Change 1.2, Chronic Care Model Primer)	1:00 - 1:30
Coaches	Review ACIC Scores & discussion (Tool: Key Change 2.1, Assessment of Chronic Illness Care)	1:30 - 1:50
Coach	Review “Know your Process” & group discussion (Tool: Key Change 2.1, Primary Care Practice Know Your Processes)	1:50- 2:10
Coach	Present Model for Improvement (Tool: Key Change 1.2, A Model for Accelerating Improvement)	2:10 - 2:40
All	Review themes from observational assessment & group discussion	2:40 - 2:55

Break 2:55-3:10

Where To Start 3:15 - 4:50

Coach Present “menu” concept of where they might start
What’s missing? Anything from the data/presentations
that wasn’t covered?
(Tool: see below, The “Change Your Practice” Menu) 3:15 - 3:40

Team Breakout Decide where to start & what you will track monthly
List as many PDSAs as you can
(Tool: see below, Getting Started Logistics) 3:40 - 4:30

Coach Present business redesign elements from the toolkit
& introduce the toolkit as a resource 3:40 - 4:30

Introduce monthly report template
*(Tool: Key Change 2.3, Quantitative Monthly
Diabetes Report Template and the Narrative Monthly
Report Template)* 4:30 - 4:50

Wrap-Up & Next Steps 4:50 - 5:00

Coaches Thank you & last minute comments

Teams Complete Coach Evaluation
(Tool: see below, Tell Us What You Think!)

TOOL: The “Change Your Practice” Menu

Below are some ideas to begin testing in your practice. These are not meant to be an exhaustive list. You may have other ideas not on this menu. So please do not feel constrained by this menu. It is meant to stimulate thought.

DELIVERY SYSTEM DESIGN

- Conduct team meeting or huddle tomorrow.
- Assign roles and responsibilities for the care of chronically ill patients.
- Call patient and conduct a planned visit.

SELF-MANAGEMENT SUPPORT FOR PATIENTS

- Set goal and create action plan at next patient visit.
- Refer patient to self-management program in community.

DECISION SUPPORT

- Use registry data as reminders.
- Use care coordination agreement with a specialist.
- Create patient care guidelines wallet card for patient use.

CLINICAL INFORMATION

- Design process for getting patient information into registry.
- Use registry population report at team meeting to plan care for patients in the following month.
- Use a patient summary of information from last visit to drive care at current visit.

COMMUNITY RESOURCES

- Contact DOH, ADA, or other patient organizations for patient resources.
- Connect patients with resources.
- Discuss potential partnering with outside organizations to create needed services.

PROCESS EFFICIENCIES

- Develop checklist of all the patient information needed at the time of the visit and brainstorm ways to ensure you get all the info you need before the visit.
- Create a process map of a visit from the perspective of a patient.

REVENUE OPTIMIZATION

- Review your coding practices by provider. Are you fully capturing the work you're doing?
- Review your copay and self-pay policies to ensure that you collect your portion of the cash up front.

TOOL: Getting Started Logistics

1. WHO WILL BE ON OUR TEAM?

Physician	_____
Nurse / MA	_____
Nurse/ MA	_____
CDE?	_____
Data guru?	_____
Office manager?	_____
Others?	_____

2. WHAT IS OUR AIM?

To improve chronic illness care for patients in the most effective, safe, and efficient way using the Chronic Care Model and business strategies and facilitated by the toolkit and practice coaches.

3. WHAT MEASURES WILL WE LOOK AT TO KNOW IF WE'RE IMPROVING? *(select no more than 6-8 of the options below, a mix of process and outcome measures)*

PROCESS MEASURES

- % of patients with documented self-management support goal
- % of patients with 2 HbA1cs in the last year
- % of patients with retinal exam
- % of patients with foot exam
- % of patients who are current smokers
- % of patients with influenza vaccination
- % of patients with pneumococcal vaccination
- % of patients with depression screen in the last 12 months
- % of patients with annual dental exam
- % of patients 18 to <70 not on ACE/ARB with Microalb Screen in last 12 months*
- % of patients 55 & older on ACE/ARB*

- % of patients 40 & older on statins*
- % of patients 30 & older taking aspirin*

OUTCOME MEASURES

- % of patients with HbA1c < 7
- % of patients with BP < 130/80
- % of patients with LDL < 100

** indicates measures requiring a customized denominator. All other measures will use your panel of diabetic patients as the denominator.*

4. WHAT DATA WILL WE NEED FOR THOSE MEASURES? HOW WILL WE COLLECT THESE?

Most of the measures can be captured from electronic sources, though they may not be completely accurate. The following measures often are not captured electronically so may require designated data entry.

- Blood pressure
- Monofilament foot testing
- Self-management support
- Smoking status
- Depression screening
- Patients on aspirin
- Annual dental exam

5. HOW OFTEN/WHEN WILL WE MEET?

- Individually or as a group
- Daily huddles or weekly meetings

6. PLAN-DO-STUDY-ACT CYCLES TO GET STARTED WITH:

Description of change	Responsibility	OCT	NOV	DEC

TOOL: Tell Us What You Think!

Date

PART 1: Circle the number of the statement you most agree with.

THE TRAINERS ...

Were helpful:

1	2	3	4	5
<i>not at all</i>	<i>a little</i>	<i>sort of</i>	<i>mostly</i>	<i>totally</i>

Knew the topic:

1	2	3	4	5
<i>not at all</i>	<i>a little</i>	<i>sort of</i>	<i>mostly</i>	<i>totally</i>

Gave us what we needed to get started:

1	2	3	4	5
<i>not at all</i>	<i>a little</i>	<i>sort of</i>	<i>mostly</i>	<i>totally</i>

Communicated clearly:

1	2	3	4	5
<i>not at all</i>	<i>a little</i>	<i>sort of</i>	<i>mostly</i>	<i>totally</i>

PART 2: Write any additional comments that may help the trainers improve.

Things I liked:

Things I didn't like:

Other recommendations/comments: