Coaching strategies for enhancing practice transformation

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Abstract

Background. Current research on primary care practice redesign suggests that outside facilitation can be an important source of support for achieving substantial change.

Objectives. To analyse the specific sequence of strategies used by a successful practice facilitator during the American Academy of Family Physicians’ (AAFP) National Demonstration Project (NDP).

Methods. This secondary analysis describes a sequence of strategies used to produce change in family medicine practices attempting to adopt a new model of care. The authors analysed qualitative data generated by one facilitator and six practices by coding facilitator field notes, site visit reports, qualitative summaries, depth interviews and email strings.

Results. The facilitator utilized practice member coaching in addition to consulting, negotiating and connecting approaches. Coaching strategies encouraged: (i) expansive, multi-directional, attentive styles of communication; (ii) solving practical problems together; (iii) modelling facilitative leadership and (iv) encouraging an expanded vision of care. Practice members who received consistent coaching reported internal shifts and new ways of conceptualizing work, not just success at implementing model components. They indicated that their facilitator had helped them think and behave in new ways while helping them achieve benchmarks.

Conclusions. It was once believed that the transition from traditional models of family medicine practice to new models of care meant implementing new technological components, suggesting that outside facilitators should act as technological and care delivery consultants. However, coaches may be especially useful in helpful in practices undertake substantial changes.

Key words: Attitude of health personnel, family practice/methods, models, organizational innovation, primary health care/organization and administration, physician practice patterns/organization and administration, qualitative research.

Introduction

There is an emerging consensus among policymakers, professional organizations, clinicians and payers across many nations that health care requires substantial change (1). In USA, the Patient Centered Medical Home (PCMH) is one of the most popular new models for primary care practice redesign (2,3).
PCMH researchers point to pilot studies utilizing outside facilitators (4,5) which suggest that outside facilitation can act as an important source of support during the ongoing change process (4–7). Such pilots can offer specific guidance about how to utilize facilitation in highly effective ways (4,5,8).

The American Academy of Family Physicians’ (AAFP) National Demonstration Project (NDP) provides a rich resource with which to understand the facilitation process. Practices were asked to adopt approximately 50 different components involving access to care and information, practice services, care management, continuity of care services, practice-based care teams, quality and safety, health information technology and practice management (9). Findings from the project indicate that the transformation from conventional practice to PCMH is difficult, even for highly motivated, resource-rich primary care practices with easy access to external facilitation (10). An in-depth analysis from the NDP revealed that the most far-reaching examples of practices that made substantial change involved role and identity shifts among practice members, especially physicians (11). This is a shift away from earlier conceptions of PCMH implementation, which often focused on the incorporation of technological components. While technological innovations are certainly necessary (10,12,13), creating a PCMH also requires a series of deep organizational and mental model shifts (14). The use of practice facilitators represents one strategy for guiding practices through these shifts over time.

This manuscript communicates the results of a secondary analysis of qualitative data collected during the 2006–08 NDP. It operates in the tradition of implementation science studies seeking to open the black box of improvement interventions (15,16) in order to find out exactly what works and why. Here, we report on a specific sequence of coaching strategies used by a highly effective facilitator.

Methods

Intervention

In 2006, the American Academy of Family Physicians (AAFP) created a new division called TransforMED to support family medicine practices in their efforts to adopt a new, advanced PCMH model of care (17–19). A group randomized controlled trial called the National Demonstration Project, or NDP, selected 36 family practices from a pool of 337 that completed the online application (9,19). An independent advisory committee chose practices maximizing diversity of geography (~30% rural and ~15% urban, from 25 different states), size (~60% 3 physicians or less), age of practice (~35% < 5 year old and ~35% > 20 years old) and ownership arrangements (60% physician owned). Practices were randomized into either ‘facilitated’ (n = 18) or ‘self-directed’ (n = 18) groups, and three facilitators from diverse, non-clinical backgrounds (finance, health care administration, practice management, social science and organizational change) were hired to help facilitated practices implement the TransforMED model of care (20), based on the 2004 New Model of Family Medicine (17). This model asked practices to adopt a checklist of technological, management and care delivery components (11). For 3 months, facilitators were trained to help practices adopt as many components as possible, and during the intervention itself, facilitators undertook biweekly check-ins with members of the evaluation team (9). However, coaching strategies were not included or taught in the TransforMED model.

Over the course of 2 years, facilitators worked with their practices during four learning sessions, a series of monthly conference calls, and 3–6 site visits of 2–4 days each. Facilitators interviewed practice members, observed work flow and modelled new meeting styles. They also engaged in daily or weekly email and telephone contact with practice leaders and members. Depth and breadth of contact varied by facilitator.

The AAFP also funded an independent study evaluation team that included investigators with expertise in primary care, ethnography, epidemiology, biostatistics, mixed-methods research and organizational change. The team selected measures of patient and practice experience, and designed strategies for collecting ongoing descriptive data to describe the process of practice transformation. Its findings are published elsewhere (9,11,19,21–23). The AAFP Institutional Review Board reviewed and approved the evaluation team’s protocols and the Institutional Review Boards from each evaluation team member’s institution also approved secondary data analyses.

Data collection

Many qualitative data elements were generated throughout the intervention. Facilitators made multiple site visits, as did a member of the evaluation team (EES). Data include facilitator field notes, post-site visit reports, conference call minutes, learning collaborative notes and depth interviews with practice members. Email strings documenting all correspondence among practices and facilitators preserved a large body of chronological qualitative data (9). Finally, data include qualitative analyst debriefing notes and summaries of informal interviews with the facilitators. A complete description of qualitative data collection has been provided elsewhere (24).

Data analysis

Data analysis utilized the qualitative data described above. Initially, two of the authors (BFC and SMC) read one practice file for each of the three TransforMED facilitators to determine the types of facilitation strategies used. In choosing
these three, evaluators first eliminated those practices that had experienced extraordinary events (deaths, catastrophes), practices that entered at very high or very low levels of functioning, and practices with unusual organizational features. The final three were selected from the remaining group of practices because they offered well-rounded portraits of each facilitator’s work style. All qualitative data for these practices were reviewed and detailed case descriptions were constructed for each, revealing that each facilitator utilized consulting, negotiating, connecting and sometimes coaching strategies. They all answered questions, guided practices in implementing targeted PCMH components and connected practice leaders with resources and experts who could provide technical assistance.

The analysis also showed variation among facilitators. One utilized her background in social science and organizational change to coach practice members in overcoming obstacles. Her practices reported shifts beyond the incorporation of PCMH components. This paralleled previous evaluation team findings noting that her coaching style departed from the TransforMED norm: while other facilitators had also supported the incorporation of PCMH components, they had not been as able to help practices overcome setbacks. Both the evaluation team analysis and the three case studies showed that this social science-trained facilitator had emphasized coaching over consulting, negotiation and connecting, while the other two facilitators had done the opposite.

As SMC and BFC reviewed this data, two research questions emerged: how did this facilitator’s coaching strategies help her practices adapt to change in addition to helping them achieve benchmarks? Which strategies did she utilize and in what order? To answer these questions, SMC coded qualitative data from this facilitator’s remaining five practices. Codes identified facilitation strategies, practice member responses, and long-term changes identified by practice members themselves. In order to complete this analysis, SMC, BFC and PAN met periodically to read the data and review codes. Results were distributed to the entire NDP evaluation team and compared with that group’s written interim and final analyses. Each author submitted their own revisions to the analysis, and disagreements were debated until agreement was reached.

**Results**

All six practices included in this analysis utilized the same facilitator. One practice was a year old, four were 5–6 years old, and one was 25 years old. Four were suburban practices, one was urban and another, rural. All employed five or fewer physicians; two also included mid-level clinicians. Four were physician-owned; two were hospital-system-owned. Practices advanced at differing paces. Those with a starting advantage (target components in place; long-term stability) often progressed faster. Several practices experienced significant challenges that interfered with their momentum.

Our analysis found that a coaching style of facilitation proved useful in helping practices adapt to change and recover from setbacks. Here, coaching refers to the ongoing process of building rapport and encouraging practice members’ self-belief in their own ability to manage challenges through brainstorming, teamwork and resourcefulness (25) (see Fig. 1). Further, while consulting is directed at the practice as a whole, coaching is directed at individuals or groups of individuals within it; coaching is personal skill development. Examples include changing or enhancing behaviours or leadership. However, consultation is the passing on of specific information such as assisting in the incorporation of target components and providing resources or data. Consultation is directed towards an issue or a thing, not a person.

Practice leaders who received continuous coaching from this facilitator eventually began articulating their visions of a collaborative and transformed family practice. And though coaching was not part of TransforMED’s original approach, practices whose members received coaching appeared to

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**Excerpt from an interview with a practice member at Practice 2:** “Don’t get me wrong, [the other facilitators] seem nice and I’m sure they do a great job. But [our facilitator] became one of us. Everything we did, she did it, too. She was part of our team, part of our family. She talked to each one of us. If we didn’t want to talk here, we went out for a coffee and talked. It really made a difference. We just knew she was there for us. If someone came in here and just started telling us what to do without getting to know us... that just wouldn’t work.”

**Excerpt from an interview with the lead physician at Practice 2:** “[The facilitator] was the best part, her as a person. Her personality, values, calmness, expertise...she came in, stayed for days, helped convince people that this is important, she became a friend, a confidante... She got people excited...She got to know everyone. She made everyone care...[she] was unrelenting in the beginning – always there, always pushing us. Then it just became part of what we did. It took awhile—-it was a good strategy. We needed the push. I like to think all good practices need the push.”
exhibit far-reaching changes. While the intensity of the facilitator’s approach varied by practice, she used the same basic strategies with all of them. In practices with a high capacity to function smoothly under stress and adapt to change, she acted as a supportive presence, ready and able to respond to signs of emerging challenges. Where capacity was moderate, she engaged more intensely, spending more time with practice members. Where capacity to change was low and practices struggled with many obstacles, she intensified her efforts further and coached members as needed throughout the organization as they worked on their problems and their relationships with each other. In one case, she organized an emergency all-practice retreat. In every case, the facilitator consciously ‘joined the practice,’ but she did so variably, after assessing what each practice actually needed. Coaching strategies fell into four categories that were emphasized in a specific order, each building upon the strategies that came before it: (i) encouraging practices to develop new styles of communication, (ii) emboldening practices to collaborate and work as a team, (iii) modelling and reinforcing a facilitative leadership style and (iv) prodding practice leaders to articulate a greater vision.

Encouraging an expansive, multi-directional, attentive style of communication

Very early in the facilitation process (even before the first site visit), the facilitator began to emphasize the need for everyone in her assigned practices to adopt new styles of communication. Via email, she encouraged physician leaders to switch from a hierarchical, top-down, need-to-know communication style to a more expansive, multi-directional, attentive style. As a result of continually modelling and encouraging this change, one of the earliest shifts occurred in practice-wide communication styles (see Fig. 2 examples), which in turn enabled new meeting and work styles.

Encouraging practice members to solve practical problems together

As practice members adopted new styles of communication, the data indicate that on-the-ground collaboration improved. The facilitator supported this development through the creation of ongoing, project-oriented teams in which practice members designed and implemented new ideas using team problem-solving and the introduction of daily morning huddles that encouraged teams to make practical plans for smoothing out the day’s schedule. Both strategies appeared critical for teaching practice members to collaborate in new ways (see Fig. 2 examples). Project teams were formed to explore new strategies for leadership improvement, EHR integration and other goal-specific projects; most included a combination of administrators, physicians and staff. The facilitator invested considerable time and energy in assisting practices to develop their teams and start collaborative work, often attending many rounds of meetings by phone or in person.

Daily huddles (26) were introduced as a quick way to enable physicians and support staff to review the day’s schedule together and plan for each patient in advance. Morning huddles typically took less than 10 minutes, yet were frequently mentioned as the single most crucial strategy for improving practice teamwork. The success of teams and daily huddles appeared to hinge on the adoption of more expansive communication styles that had been introduced earlier.

Modeling facilitative leadership

As practice members began to adopt different styles of communication and then collaboration, the same kinds of leadership challenges began to emerge across practices. These included dealing with leaders’ internal conflicts, managing interpersonal conflicts, reconfiguring the hiring and firing process and encouraging hesitant practice members to take ownership of new initiatives. The facilitator coached physician leaders into addressing these tasks directly, often for the first time, instead of passing them off to practice managers or ignoring them entirely. She modelled and encouraged physicians to adopt the tenets of facilitative leadership: leading with a clear purpose, empowering others to participate, aiming for consensus and directing the process (27) (see Fig. 2 examples). The facilitator also coached office managers and fledgling leaders in how to address these problems, responding quickly to requests for help. Guiding practice members through these roadblocks appeared to be a crucial part of her coaching style.

Encouraging the development of a greater vision

As coached practices changed their communication styles and redefined practice member responsibilities, some physicians began to explore a greater vision for their work. It was at this point that they spoke about the unexpected role and identity shifts practice members had experienced as they began to communicate, collaborate and interact differently. Physicians articulated this in a variety of forms: website pages, articles, learning session presentations or simple musings offered during email exchanges and interviews. The facilitator encouraged each physician to describe these experiences and share them with the rest of the practice (see Fig. 2 examples).

Discussion

Even accounting for the expected confounders in a complex primary care practice, our data suggest that practice member coaching can be an important strategy for achieving transformative change at both individual (physician) and group (practice) levels.
Practice Facilitation Strategy 1: Encouraging Expansive, Multi-directional, Attentive Styles of Communication

Excerpt from Practice 1 coordinator email to facilitator: “Do you think it would be advantageous for me to be “in person”…with [the office manager and lead physician], or is by phone okay?

Excerpt from the facilitator’s response: “Yes, in general it is better to go in person whenever possible when there is a lot of communication and change going on. How about if you go the first couple of weeks and then see what you think? The bonus of being on-site is that you get a chance to see all the body language—this is a rich source of information.”

Practice Facilitation Strategy 2: Encouraging Practice Members to Solve Problems Together

Excerpt from facilitator email to a Practice 1 administrator: “We will have our…leadership meetings every Tuesday from 12:30 to 1:00. The leadership team will be [the office manager], [a physician], [an administrator] and [the facilitator]. I will talk with [the office manager] about a good time to have weekly staff meetings…We can see as we get going with these meetings and teams whether you and I will still need our weekly meeting. I want to be sure you don’t feel overwhelmed – we can either cut them down to ½ hour or not do them and talk as needed. After the first couple of weeks, let’s reassess.”

Excerpt from a document written by a lead physician at Practice 3 about collaboration across both halves of its conjoined practice: “We made teams on leadership, billing, finances, practice integration, and huddles. These team meetings introduced the concept of teamwork by presenting actual problems in need of solutions. Through mutual problem solving, members rose to a different level of participation than previously had been expected of them. Fresh ideas for improved access and efficiency began to be implemented as a result of their work…Over time this approach meant that each [of the two sides of the] practice developed its own culture of collaboration…”

Facilitation Strategy 3: Modeling Facilitative Leadership

Excerpt from a Practice 2 post-site visit report: “[The facilitator] took Dr. X out to dinner Tues night and talked to him about work/life balance… he agreed that he needed one. She talked to him about the importance of not spending so much time with patients that he gets home at midnight every night. They developed an agreement together – if he’s in room more than 20 min. [The MA] will knock on door to signal him. [The MA] and [the office manager] will put together a sensible off-site schedule to maximize nursing home visits.”

Facilitator response to a request for advice from the office manager at Practice 3: “Hi A, Sounds like some hurdles to overcome. What do you think can change this and make it smoother? You have a good sense of things. What would help them become less defensive and feel less burdened? How about if you just take a billing meeting to address the issue and say- ‘I feel that something is not working here and I want to be sure it works for you and us - what is not working for you and what can we do to change it where we can all get what need to done?’ If the issue is not resolved, when I come out I will meet with you with you all and facilitate a discussion of the issues. Can the docs be helpful in any way? Regards, [Facilitator]”

Practice Facilitation Strategy 4: Encouraging an Expanded Vision

Excerpt from a document written by a lead physician at Practice 3: “To lead a group to this better place, the vision must first be clear. Our…facilitator had the vision for us, and now we can see what she had envisioned. We had natural motivation and commitment to adhere to changes which helped when new ideas seemed foreign to us initially. The improved communication let this spread to the team members and accelerate our change by showing positive benefits more rapidly. It has taken courage to deal with the resistance we have faced, but adhering to the goals has helped truly transform our functioning. I am excited to think what this new team can accomplish as it addresses the needs of the practice in time to come.”

Figure 2. Coaching strategies.
Although TransforMED’s facilitation approach emphasized consulting, connecting and negotiating, practices whose members also received coaching reported an extremely positive change experience. Practice members who had been coached reported internal shifts and new ways of conceptualizing their work, not just success at implementing PCMH components. They indicated that their facilitator had helped them think and behave in new ways in addition to helping them achieve benchmarks.

There are a number of limitations to this study, including its focus on one PCMH pilot and the strategies of a single facilitator. Additionally, practices that did not receive facilitation were not part of this analysis. Multiple facilitation strategies can yield practice benefits, and although this analysis allows us to demonstrate the efficacy of one specific approach, it does not demonstrate that these are the most effective facilitation strategies available. However, it does provide concrete examples of specific coaching strategies that have been shown to be highly effective in helping family medicine practices adapt to change. Finally, it is important to acknowledge the authors’ own biases: they believe that there is a difference between change and transformation, and that the simple addition of PCMH components will not fundamentally transform a practice. Thus, they favour strategies that enhance each practice’s capacity to adapt to change. The primary author has also has facilitated practice change initiatives utilizing coaching strategies herself.

It was once believed that the transition from traditional family medicine to a PCMH meant focusing on the implementation of new technological components, suggesting that facilitators needed consultant-level expertise in technology and/or family medicine. However, this analysis suggests that successful practice facilitation involves much more than technological and health services delivery consulting. Coaching appears crucial because it goes beyond connecting practices to resources and implementing new technological components. This finding is also consistent with recently published work focusing on the importance of facilitation in overcoming PCMH implementation barriers (4).

Because the goal of primary care practice transformation is broad—providing better care for families and communities at lower costs—the changes required to achieve such transformation encompass much more than plugging in missing components. There has been a tendency to underestimate the level of transformation required to make and sustain changes of this magnitude (22). Practice facilitators who coach have a very different skill set than many practice consultants, yet they may help to guide, model and sustain these changes. Coaching can encourage practice members to strengthen their communication and facilitation skills (28,29), hold frequent practice wide, team-based meetings (30) and develop alternate styles of leadership (31) because its intensive, hands-on style encourages practice members’ self-belief in their own ability to manage challenges through brainstorming, teamwork and resourcefulness (25,32).

Coaching proved crucial to kick-starting and sustaining changes in communication and physician leadership styles, eventually resulting in both a shift in roles (i.e. changes in what practice members actually did (10)), and even a shift in their internal mental models. By staying in close email, telephone and in-person contact with multiple practice members, especially leaders and emerging leaders, the facilitator encouraged reflection, broad communication and innovative decision-making that diffused throughout the entire practice.

Such dissemination bolstered the self-belief of physicians and practice members over time as they attempted to adopt new strategies and behaviours. Throughout this process, the facilitator integrated herself into many parts of the practice, interacting with office managers, clinical staff and administrative/front desk workers and assisting the practice to build a strong adaptive reserve as a whole (33). Previous analysis shows that the adaptive reserve exists alongside the day-to-day activities of a practice’s organizational core, but consists of those features that enhance resilience and allow a practice to thrive in the midst of change (21,33). By the end of the project, many of the coached physicians identified their facilitator as the key figure who helped them and their practices make the transition to a new style of care while overcoming the inevitable roadblocks that emerged. This suggests that an outside facilitator utilizing a coaching approach can prove crucial in helping primary care teams adapt to change.

Given that external practice coaches appear to offer such substantial benefits, how might family medicine clinicians fund them? Historically, most practice facilitators have been recruited through externally funded academic research projects (34), but change looms on the horizon. As Phillips et al. observe, in USA, The Affordable Care Act of 2010 has created the potential for new practice coaching funding mechanisms, including the Primary Care Extension Program (PCEP (35,36)), while the Agency for Healthcare Research and Quality has funded multiple states to work on this model. Phillips et al. point out that it is the mission of the PCEP to assist primary care providers to implement the PCMH through the deployment of practice facilitators known as Health Extension Agents. This may signal the beginning of new opportunities for practice coaching innovations across a wider range of primary care practice environments internationally.

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