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Partnerships for Health

A Chronic Disease Prevention and Management Initiative

Practice Coaching Makes Change Happen

When we hear the word "coach," a lot of us think of someone with a whistle and a clipboard, standing at the sidelines shouting directions and encouragement at the players.

But coaches can be much more. Recently three Practice Coaches joined the Partnerships for Health leadership team. Diane Koz, Linda Hebel and Sally Boyle work closely with primary care teams across the South West to support them in moving their quality improvement efforts forward. There are no clipboards but yes, encouragement is a big part of their role.

Practice coaches bring expertise and experience to primary practice teams, helping them plan, sequence and manage change, and providing structure and focus to quality improvement efforts. They are facilitators, conveners, task masters, skill builders, knowledge brokers, sounding boards, problem solvers and change agents. They advise on team building, encourage creative thinking, help improve communication, facilitate meetings and develop leadership skills. They provide motivation, education and consultation. "Change is hard," says PFH leader Marg McAlister. "Practice coaches can help teams step back and reflect on where they were, where they are now and where they want to go. In a flurry of learning and doing, a coach can be the calm voice of reason."

Sally, Diane and Linda bring an impressive array of experience and knowledge, and a strong personal commitment to the work. Diane is driven in part by the fact that her husband's diabetes is not yet well controlled. "I see the impact that diabetes has on a person and a family, physically, emotionally and psychologically. I'm looking at one person, yet there are thousands of people who suffer from this disease." She has extensive experience in team-building, most recently from her work with the Mississauga Halton Local Health Integration Network (LHIN). "I'm fascinated by teams, and love helping individuals and teams realize their full potential."

Sally has spent her nursing career in community care, most recently as a diabetes educator. "I wanted to see the other side," she says, "to understand the issues that family practices were encountering and see if there was anything I could do to work with them and help the patients."

Linda has extensive experience in strategic planning and change management, most recently with the Fraser Health Authority in B.C. and as program director of the Fetal Alert Network in Toronto. After doing some virtual coaching, she is excited to be coaching teams face to face.

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Coaching is a delicate balance between supporting and guiding teams. "We want to see the teams learn, develop, nurture themselves, and realize what they can do on their own," says

Diane. "Our goal is to give them the tools and resources to be able to do that, and to gently guide them." Linda adds that she and her colleagues are catalysts for change. "We're not telling teams how to do it – we're coaching them through it so that they can see their potential and move forward in a sustainable way."

Teams have their own personalities and ways of working, and coaches adapt, giving each team what it needs to succeed. Says Linda: "It's a matter of deciding when to intervene and when to stand back and let the conversation flow." Part of the job, adds Sally, is to help teams address barriers that stand in the way of improving diabetes care in their practices. Time constraints, communication issues, and uncertainty about roles are some of the most common barriers that coaches help teams overcome.

Linda notes that Wave I teams may feel that they have "stalled" after months of hard work. The coaches encourage them to celebrate their successes and move forward. "I don't think they realize how much they're doing that is great," she says. "We can help them see that they've made changes and improved clinical outcomes for their patients. We can also help them see that if a test doesn't work, they can learn from that, re-group, try something new, and get the results they're looking for."

The three coaches are poised for the next stage of Partnerships for Health, when up to 100 practices will join the project and benefit from the work done during Wave I and Wave II. "It's an opportunity for practices to learn from their peers who have gone before them," says Diane. "We will bring them success stories and ways of doing things differently that have worked for other teams."

Linda says Wave III teams will benefit from IT support and expertise in business process mapping, and will have the opportunity to see real and measurable change in their clinical outcomes. Adds Sally, "This is specifically about diabetes, but practices can adapt the framework to other chronic diseases. This project helps us all move beyond silos. More integrated care makes it easier for everyone to do their work, and better for the patient."

Tips for Making PFH Teams Work

- Remember that everyone has something to contribute to the team and be open to collaboration
- Work together to clarify roles
- Find the best ways for your team to communicate
- Celebrate your successes
- When you're feeling stuck, turn to a coach for support
- Don't be discouraged if something doesn't work — take time to learn from your failures
- Don't hesitate to ask questions and think outside the box
- Nurture your team and support one another
- Consider applying new tools such as PDSA to other issues in your practice
- Adopt an attitude of continuous quality improvement
- Keep the patient at the centre of the conversation
- Respect other team members opinions or points of view
- Reach out to your community partners and engage other professionals

To get involved, or to refer a primary care practice for wave 3 of this important initiative, please contact Heather Goddard at 519-640-2594 or info@partnershipsforhealth.ca.

Partnerships for Health is sponsored by the South West LHIN. The initiative provides a unique opportunity to apply the Ontario CDPM framework to practice. The initiative integrates the health system by sharing information across the continuum of care; advancing partnerships amongst primary care, CCAC, diabetes education programs, mental health and other community support services; strengthening linkages to tertiary care; engaging the patient in self-care; and enabling improved information management. Ultimately the goal is to improve care to individuals with diabetes.

For more information about Partnerships for Health:
519-640-2594 • 1-866-294-5446 • www.partnershipsforhealth.ca

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