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What Is Best for Esther? Building Improvement Coaching Capacity With and for Users in Health and Social Care—A Case Study

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While coaching and customer involvement can enhance the improvement of health and social care, many organizations struggle to develop their improvement capability; it is unclear how best to accomplish this. We examined one attempt at training improvement coaches. The program, set in the Esther Network for integrated care in rural Jönköping County, Sweden, included eight 1-day sessions spanning 7 months in 2011. A senior citizen joined the faculty in all training sessions. Aiming to discern which elements in the program were essential for assuming the role of improvement coach, we used a case-study design with a qualitative approach. Our focus group interviews included 17 informants: 11 coaches, 3 faculty members, and 3 senior citizens. We performed manifest content analysis of the interview data. Creating *will*, *ideas*, *execution*, and *sustainability* emerged as crucial elements. These elements were promoted by *customer focus*—embodied by the senior citizen trainer—*shared values* and *a solution-focused approach*, by the supportive coach *network* and by participants' expanded *systems understanding*. These elements emerged as more important than specific improvement tools and are worth considering also elsewhere when seeking to develop improvement capability in health and social care organizations.

Key words: coaching, community health services, community participation, health services for the aged, quality improvement

In health care, it can be argued, everyone has 2 parts to their job: to perform the job and to improve it.[1] While knowledge about how to accomplish improvement is growing, many organizations struggle to apply new knowledge and adopt new ways of working in practice.[2] Consequently, many improvement efforts do not yield the intended results and patients and families do not get the best care possible.[3-5] Developing consistently high-performing health systems remains a significant challenge.[6] A growing body of literature shows that coaching can facilitate the improvement of care.[7-12] Spear[9] argues that high-performing health care organizations need coaches at all levels so that everyone can accomplish systematic, continuous improvement through repeated, rapid experiments. In addition, client involvement in improvement efforts is emerging as a key ingredient to secure that improvement efforts are informed by clients' experience and perspectives to achieve better care.[13]

BACKGROUND

The term "coach" became popular in the world of sport, but has its origins in the Hungarian word *kocsi* after the town where vehicles—coaches—were made. The "coach" helped people get from where they were to where they wanted to go.[14] Today, the word "coach" is used in many ways. As a metaphor, the "coach" (a person) supports and encourages people "being coached" ("coachees"), thereby freeing their potential to go to where they want to be.[14,15] The coach uses various techniques such as active listening, identifying development issues that enriches the person being coached, illustrating alternative actions, and reinforcing successful aspects of the coachee's work.[14]

When an organization uses coaching as a means of human and organizational development, it is important that the coaching be aligned with the organization's vision and goals.[16] Organizations find coaches either by hiring *external* consultants or by training their own, *internal* coaches. Advantages of internal coaches include their preexisting familiarity with the context, employees, and culture[17-19] and relative cost-effectiveness, as competency and learning remain in the organization longer than with temporary consultants. In addition,

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whether organizations use external or internal coaches, one choice coaches need to make concerns their approach to coaching: a *problem-based* or a *solution-focused* coaching approach.[20] The former starts with a problem and seeks to identify and deal with underlying causes. The latter places more emphasis on opportunities for improvement and strengthening what is already working well. The focus is forward, on what the organization wants to achieve and not on the analysis of the problem.[21] While both methods can be effective, coaches who worked with solution-focused questions achieved results significantly faster than those who focused on identifying problems.[20]

While there thus is growing support for the potential benefits of coaching for improvement, it remains unclear how to develop coaching improvement capability in health and social care organizations. We therefore examined one attempt at training improvement coaches within health and social care to discern which training program elements were essential for assuming the role of internal improvement coach.

STUDY SETTING, DESIGN, AND METHODS

Study setting

Health and social care—public responsibilities governed by law in Sweden—are complex systems run by 20 county councils and regions and 290 municipalities. They are democratically governed organizations with their own autonomy and taxation power. In recent years, health and social care have been opened up to a plurality of provider organizations that can compete for public financing alongside publicly run services.[22]

The Highland health care district, which includes the Highland Hospital ("Höglandssjukhuset" in Swedish) in Eksjö, is 1 of 3 health care areas in the region of Jönköping County. This mostly rural area harbors 107 000 inhabitants in 6 municipalities. With tax-based public funding, the area has both public and private health care providers. In 2009, approximately 8600 people were working in the area's health and social care sector.[23]

The Esther Network and Esther coaches

In the Highland area, the so-called Esther Network[24] involves the municipalities, the Highland Hospital, primary care providers, and local private providers of health or social care that provide publicly funded services. To clarify the need for care coordination and good service, the founders of this network invented a figurative person, "Esther" (initially thought of as an elderly lady but subsequently made representative for anyone in the target group), who is in need of services from multiple health and social care providers. What matters for Esther is the output of the entire system, not merely that of the individual parts. The network's vision is that "Esther will feel safe and independent with the support of an energetic network."[24]

The network is based on voluntary commitment of the different care providers and becomes tangible through their mutually agreed action plans. To manage improvement opportunities, there is a coordinator (the first author, N.V.) and a steering committee of representatives from the hospital, primary care (both publicly and privately organized), and municipal social care (public and private). The Esther Network idea has spread, and there are similar projects, both elsewhere in Sweden and around the world.[25-27] There is widespread curiosity about the Esther Network and its coaching program.[28]

The hallmark of an Esther coach is to always ask "What is best for Esther?" and let the answer (rather than narrow organizational self-interest) guide subsequent action. One senior citizen in the area described an Esther coach as a person with a genuine interest in helping fellow humans who are affected by the gaps in the health system (Web interview, December 6, 2011, available at: http://plus.rjl.se/esther; accessed June 18, 2015). When facing difficult choices in service improvement, considering "What is best for Esther?" serves as a guidepost.

Esther coaches are "system coaches" in that they promote the development of the whole system—across organizational boundaries—around Esther's needs toward the vision of the network.[29,30] Coaching can include time-limited projects, but it mainly consists of continuous coaching of ongoing, everyday improvement.

Esther coaches are recruited among the staff who work closest to Esther because network leaders assumed that they would remain in the organization, thus developing the human capital throughout the network. In addition, these "local eyes and ears" provide close-to-the-patient ways to identify improvement opportunities.[25,31] An external evaluation found that Esther coaches enhance facilitation of improvement in everyday life by leading projects to their goal.[32]

With the ambition to foster even greater focus on Esther, the coach training program in 2011 included a local senior citizen in the faculty who volunteered to participate every day in the program. This senior citizen contributed actively by interacting with the trainees and providing frequent reflective moments and questions during the whole program.

Study design

To capture essential elements of the program and discern what appeared to be crucial when assuming the role of improvement coach, we used a case-study design since it allows the research to examine a real-world situation in a holistic manner as it unfolds over time in its particular context.[33,34] We conducted focus group (FG) interviews since it is helpful for gaining insight into individual's perceptions and experiences and can benefit from interaction among group members.[35] The research also drew on Esther Network documents and on participant observation of the training program by one of the authors (N.V.).

Study participants

The FG interviews included 17 informants, recruited at coach training courses and workplace visits or via

e-mail. Of the informants, 11 were Esther coaches, 3 were faculty members, and 3 were senior citizens. The participating Esther coaches had 2 to 27 years of professional experience and represented nursing assistants, registered nurses, occupational therapists, and chief and social workers within health and social care. Seven of them were enrolled in the basic education coaching program that started in 2011. Four senior coaches had completed the basic program in 2006 and subsequently taken a second-level training program. The faculty FG participants were 3 of the 7 managers in the Esther Network responsible for the content of the 2011 Esther coaching program. The senior citizens, who already were familiar with the Esther Network, were invited by e-mail to participate in a separate FG at a neutral venue.

Data collection

We conducted 6 FG *interviews* with 2 to 5 participants between September and December 2011. Our plan was to have 2 FG interviews with Esther coaches in the basic training. Because of dropouts we decided to perform a third FG to secure multiprofessionalism and participants from different organizations. The fourth FG consisted of Esther coaches at the advanced level. The fifth group included senior citizens, who had been involved as guests and teachers in the coaching programs, and the sixth included program faculty. This grouping approach aimed at promoting a sense of safety—from being with others in a similar role—during the FG interviews to make participants comfortable to express themselves and share experiences[35,36] and help us obtain a wealth of information.[37,38] The interviews took place at neutral venues close to the respondents' workplace or home (senior citizens) and lasted approximately 1 hour. All interviews were conducted by an experienced independent moderator and 1 researcher (N.V.) as an observer.[39] The moderator used an interview guide with semistructured, open-ended questions.[35,36]

The faculty and the first author (N.V.) developed an interview guide, based on a study of coaching at the Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire,[40] which they adapted to a Swedish context. The guide was pilot-tested with a small group of coaches and then adjusted to the final version by keeping and editing what was most important and removing less central questions. The interviews focused on the respondents' experiences of going through the training to become, and then of being, an Esther coach, that is, thoughts about the content of the program, about having a senior citizen join the faculty, and about what they benefited from the training program. Faculty respondents and senior citizens were asked to share their thoughts about patient involvement in this program and what they identified to be crucial elements for moving into the coach role. During the interview, the moderator used probes such as "How do you mean?" and "Can you explain more?" to add more depth to the answers.

Analysis of data

We studied relevant documents and documented observations to characterize the training program—its content and conduct—as a frame for the case study. Within the case-study frame, we analyzed the experiences of different participants, as expressed in FG interviews, as follows (Table): The recorded interviews were transcribed verbatim. We performed a conventional, inductive content analysis,[41] with each interview regarded as 1 unit of analysis. The analytic process focused on the manifest content, that is, the visible and obvious meaning of the text, without preconceived codes. In the first step, the first author (N.V.) read the transcripts several times to become familiar with the text. Next, she identified meaning units, such as sentences or paragraphs related to the topic.[42] Meaning units include not only a single participant's opinion but also opinions held within the group during the discussion.[37] Second, the meaning units were condensed and then coded with labels emerging directly from the context. The third step was the abstraction of codes, corresponding to the meaning of the quotes. Then the codes were sorted into subcategories, which, in the final step, were gathered to exclusive categories.[42] For validation of the coding and the labels, a second researcher (M.S.L.) took part in that step of the analysis.[43] To further strengthen the validity of the results, a summary of the findings was sent to each of the FG participants. In the final step, the researcher (N.V.) discussed the coding and category system with an experienced Esther coach to reach consensus.[43] Finally, the analyses were integrated into the case-study report.

Ethical considerations

Information about the study was given both orally and in an information letter, at meetings, to the health and social care organizations' managers, the local managers, and the study participants. The study was approved by the Ethics Committee at the School of Health Sciences at Jönköping University. Participation in the interviews was voluntary. All participants gave oral and written consent to participating after considering information about the study. To minimize potential threats to participants' personal integrity, in addition to requesting their

Table. Examples of Meaning Units, Condensed Meaning Units, Codes, Subcategories, and Categories

Meaning Units	Condensation	Codes	Subcategory	Category
In the improvement program there should be space for your own creativity	Creativity			
The mission should not come from the top		Creativity	Challenges in daily work	Ideas
The program should be open-minded so people dare to think and do freely	Open minded			

informed consent, we treated individuals confidentially when reporting the study findings. Quotes that can be linked to particular individuals are included only after each person's approval.

FINDINGS

In 2006, the County Council Development unit, Qulturum,[44] launched a multidisciplinary Esther coaching program both to promote the Esther Network vision and values and to support ongoing improvement in daily work. The aim was to develop internal coaches to facilitate improvement across organizational boundaries. The Esther coach development program offers 2 levels of training. The first level consists of 8 daylong training sessions over 6 months (Figure 1). It covers basic improvement knowledge and coaching techniques for the coaches to use in their organization. As part of the training, participants identify an improvement opportunity and undertake an improvement project. The second level offers Esther coaches another 8 days of training to develop their skill in supporting improvement projects across organizational boundaries. Between 2006 and early 2013, approximately 130 coaches had completed these programs.

In general, study participants pointed out the following elements as fundamental to preparing for the coaching role: (i) customer focus, modeled by involvement of senior citizens in the training program; (ii) a shared set of values; (iii) networking skills with a solution-focused approach; and (iv) systems thinking. They considered these program elements to be more important than learning about particular improvement tools. Improvement tools were described as "rigid," although they were good to know, but when the participants were asked what was most helpful in the program, they emphasized the foundational values—as exemplified by the question "What is best for Esther?"—and the solution-focused approach as crucial elements for becoming able to coach in their context. The Esther coaches found improvement tools to belong more to specific projects than to coaching in everyday work.

The coaching program respondents emphasized that involvement of a senior citizen, who participated in every training session, gave them completely new perspectives, for example, from a different generation and from an entirely different kind of activity, in this case a business context. Another benefit they highlighted was the "real-life" modeling of customer focus created by having an "Esther" representative in the room. Respondents described the contribution of the volunteer senior citizen as an inspiration and a source of motivation for moving from words to action. He actively helped make the improvement work more concrete and outcome-oriented. He promoted a sense of security in the group through his supportive behavior. Many participants appreciated his observations and reflections at each session, and several of them noted that he actually was acting as a coach, by listening, encouraging, and giving inspiration. One participant said that the senior citizen had "adopted" the group almost as his own family. A faculty member argued that the program's credibility regarding client focus increased through the involvement of a senior citizen.

The senior citizen repeatedly made the participants aware of their "professional" language and how it was not well suited to the "customers." He offered to hold a workshop on customer focus and involvement, which, he did to great effect. For future programs, participants suggested further involvement of senior citizens to

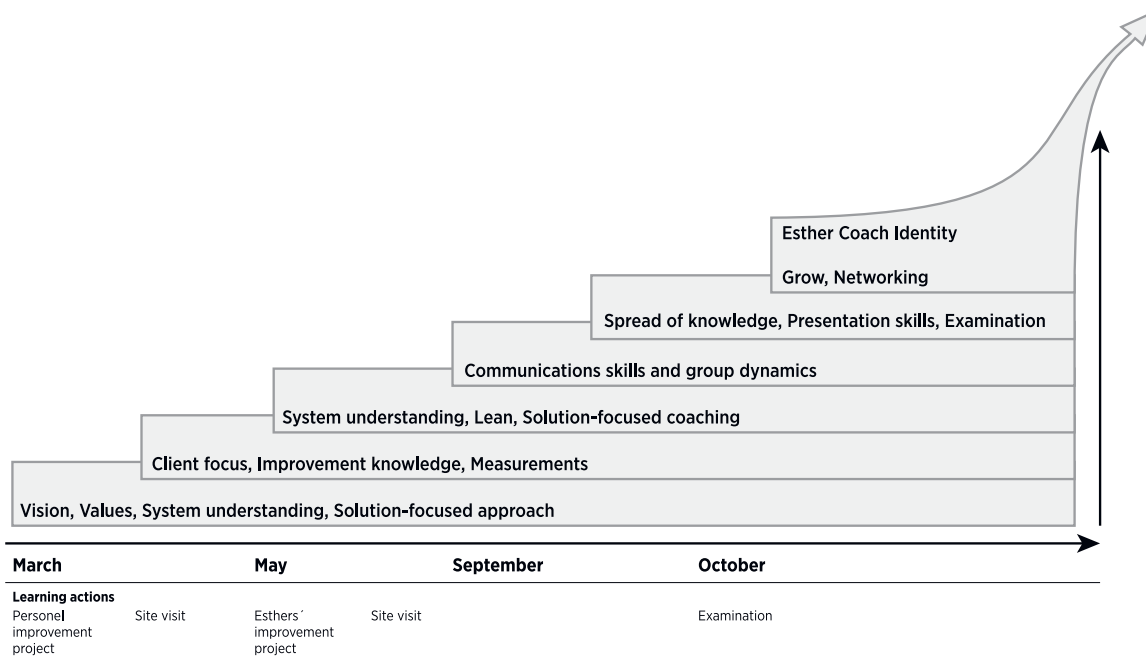


Figure 1. Overview of the level 1 Esther coach training program.

increase the possibility of more time and personal interaction.

The coaches valued in particular that the senior citizen participated every time and not just as an occasional guest. Asked about their view on his participation in the training program, several respondents signaled its value: "It has been extremely positive."

In our interpretation of the case-study data, 4 aspects emerged as essential for preparing to become an Esther coach: *will*, *ideas*, *execution*, and *sustainability*. The importance of senior citizen involvement was apparent in all 4 elements, starting with the *will* to improve.

How did the coaches develop *will* to improve?

The *will* to improve grew among the coach trainees on the basis of their expanded understanding and the increased energy that came from seeing peers do things together along the whole care chain and from seeing a meaning in it all.

> To find out that there is a world outside my workplace that also has great significance for Esther and to lift it.

> You get a lot of strength of these meetings. All are passionate about the same thing and that is Esther.

Many participants indicated that they had gained more insight into systems thinking, recognizing that they were part of a system of interdependent actors. They appreciated the freedom to choose their improvement project, which reinforced their motivation for it. Respondents appreciated the diversity of coaches and improvement projects as a source of expanded understanding. More than the level 1 trainees, the experienced coaches emphasized the uniqueness of each coach as a driver of the will to improve.

> All need not be like me.

> We have different coaches for different contexts.

How did the coaches identify *ideas* for improvement?

All the coaches identified their *ideas* for improvement, recognizing challenges and opportunities together with peers, based on their daily work in health or social care. This generated strong motivation and highlighted the value of a bottom-up approach. Customer focus seemed to be essential, and many stated that it was important to constantly ask: Will it be better for Esther?

> We always put Esther herself in the first place.

> Get Esther[s] to prioritize and rank their most important areas.

> Every day when you go to your work place, you have yourself as an improvement tool.

What helped coaches to *execute* the improvement idea?

Reflecting the element of *execution*, participants mentioned skills in using tools such as the PDSA (Plan-Do-Study-Act) cycle, the fishbone diagram, and flowcharts. Although described as "rigid," they were considered good to know of, even if belonging more to specific projects than to coaching in everyday life. Some respondents, however, stated that these tools were important because they gave them a good structure for their coaching, whereas other respondents argued that building good relationships with staff and Esther was more important than using particular tools for the execution. Furthermore, the solution-focused approach in the program helped coaches engage in constructive and energizing conversations.

> You can coach in other ways than by a template.

> You get a lot of power and energy from this.

What helped the coaches to *sustain* momentum in their coaching?

The experienced coaches argued that sustainability requires coaching endurance skills, which they developed in the program. They identified the solution-focused approach as a positive force in creating endurance, as it generates power and energy. They highlighted the relation between the solution-focused approach and job satisfaction.

> The way to work is imbued with positive thinking and solution-oriented focus. This gives me increased job satisfaction even in times of high workload. At the same time, I have the opportunity to spread this particular approach to others in similar situations, so that we put energy on what we can improve.

Furthermore, respondents identified a supportive context as central to sustainability, including leaders who allocate time to coaching and developing coach competence, and having a coach network where you feel safe and can find support.

> Together [in the network] we are at our best. Together we are strong.

> I feel very safe and get very much energy from these network meetings.

DISCUSSION

In this study of a community improvement coach training program, *ideas*, *will*, *execution*, and *sustainability* emerged as crucial elements. These elements were promoted by the program's tangible *customer focus*—embodied by a senior citizen who served as a continuously present trainer—by *a solution-focused approach*, by the supportive coach *network*, and by participants' expanded *systems understanding*. In this case, a regional network of health and social care organizations

jointly developed their capability for continuous improvement by training internal improvement coaches based there before, during, and after their training. The way that the training gave participants both skills—in solution-focused coaching—and a set of shared values and relationships, with customer focus, helped them assume their new coaching role.

Crucial elements in the coach training program

Involvement of a senior citizen was appreciated by all participants who subsequently recommended that it ought to be a core part in all future coach training programs. It may not be enough to invite a senior citizen occasionally. What was helpful here was the active participation and involvement throughout the program, echoing previous research about user involvement.[13]

Participants in the study indicated that knowledge and skills, which strengthen *will*, *ideas*, *execution*, and *sustainability*, were essential to the program. The Institute for Healthcare Improvement has proposed a similar framework for strategic improvement initiatives where success depends on *will*, *ideas*, and *execution*.[45] This study identified an additional area—*sustainability*—as important to building long-term endurance (Figure 2). To be able to enter the role as a coach, the trainees need knowledge and skills in each area.

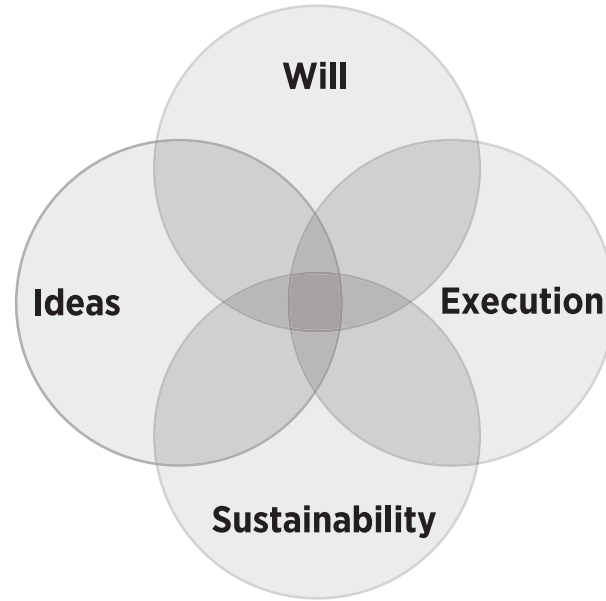
How the coaches identified *will* and *ideas*

Study participants appreciated the bottom-up, transparent, and flexible approach to their training, as it promoted their motivation to support improvement efforts for Esther, a form of intrinsic motivation.[47,48] Today, there are several forms of coaching in Swedish health care, for example, the so-called Senior Alert coaches, focused on "care prevention" among the frail elderly through use of a national quality register (Senior Alert),[49] health coaches, and fall prevention coaches. Participants in this study preferred a wider scope of work than that work. They appreciated space for their own ideas, which can be limited if coaching is restricted to specific actions.

Differing views on how to *execute* an improvement initiative

The coaches had different views on the importance of improvement tools in the execution phase. Some stated that tools were helpful to get a structure in their coaching, whereas others highlighted the building of good relationships with staff and Esther as more important than using particular tools. A study of 9 successful health care organizations[50] concluded that improvement is a dynamic process that requires a more flexible approach than the extensive analysis and planning found in much of the change and improvement literature. This resonates with views of health and social care organizations as complex, adaptive systems.[51] In such systems, change is not limited to linear relationships. Improvement approaches that seek to disentangle problem causation mechanisms in complex situations could prove difficult and a waste of time and energy.[52] Furthermore, identifying causes does not automatically lead to solutions.[53] As an alternative, a solution-focused approach for improvement of complex systems identifies, and builds on, what works well.

In this training program, coaching concerns more than time-limited improvement projects. For Esther coaches, it is equally important to address everyday attitudes and collaboration opportunities. What may be more important for coaching in everyday working life than technical improvement tools are other tools such



Ideas
Patient involvement
Client focus
Multiprofessionell groups
Challenges in daily work (frontline)

Will
Patient involvement
Sense of coherence
Own drive
Open minded
Good group climate
Management support
Group tolerans to do tests

Execution
Patient involvement
Communications skills
Solution-focused approach
Group dynamics
Improvement tools
Scheduled time for improvement

Sustainability
Patient involvement
Sense of coherence
Networking
System understanding
Solution-focused approach
Anchored in the organization
Leadership
Communication canals

Model: Nolan (2007), modified by Vackerberg 2012

Figure 2. Crucial elements that emerged in the Esther coach training program that helped the coaches prepare for their role. Adapted from Nolan's[45] model for strategic change, modified by Vackerberg.[46]

as communicative skills and ways to understand and work with different personalities.[52]

What helped the coaches to *sustain* their coaching?

It is often hard to sustain improvement—it rarely happens automatically but requires continuous efforts.[54,55] Internal coaches are more likely to remain in the organization over the long haul. It is important, therefore, to have a strategy in a program in order to nurture and maintain their long-term commitment. The experienced coaches argued that the solution-focused approach had a positive effect on their endurance, energy, and joy in the improvement process. The solution-focused approach promotes such energy and joy as—instead of focusing on, and analyzing, problems—it involves envisioning the desired future state, identifying positive interactions, what works, when, and what has moved a situation small steps forward.[53]

The interviews signaled the importance of the coaching network to support and spread improvement and new knowledge. Similarly, team members in Norwegian Breakthrough Collaboratives identified support as an important prerequisite for continuous improvement.[10]

Methodological considerations

This is a study of a pioneering initiative set in one particular context. To become more widely applicable, the model it has yielded should be further tested and refined in different settings. The format and content of the training, and the involvement of a senior citizen, are features that may well need to be adapted to work elsewhere. Given the long-lasting existence of the Esther Network with its improvement coaches, we surmise, however, that the insights revealed through this study could be helpful in the important quest to build sustainable improvement capability in health and social care systems everywhere.

FG interviews are helpful when the purpose is to gather a range of accounts, as the participants encourage and stimulate one another to remember and share memories.[37,38] It is important to choose meaning units illustrating individual's opinions as well as group consensus to verify labels, subcategories, and categories found in the analysis.[37] Hence, in this analysis, both types of data were selected, which serve to strengthen the credibility and transferability of the results.[56,57] Reviewing the summary, the FG participants validated the findings and found no misunderstandings.[43,56,57] Further credibility, transferability, and dependability could have been achieved if additional researchers had participated in the analysis process.[43]

CONCLUSION

Improvement coach training in health and social care involving multiple stakeholders in a community can benefit from modeling *customer focus* by including a "customer" representative and by adopting *a solution-focused approach*, by providing a supportive coach *network*, and by promoting *systems understanding*.

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