# Katie Coleman, MSPH


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| Address | MacColl Center for Health Care Innovation<br>Group Health Research Institute<br>1730 Minor Avenue, Suite 1600<br>Seattle, WA 98101 |
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## EDUCATION AND TRAINING

2004-2006 M.S.P.H. University of North Carolina at Chapel Hill
Major: Health Policy and Administration, Concentration: Finance
Masters Thesis: *The Impact of Pay-for-Performance on Diabetes Process & Outcomes in a Large Network of Community Health Centers*, Chaired by Kristin Reiter, PhD

1997-2001 B.S. Northwestern University
Major: Social Policy, Concentration: Health Policy
Honors Thesis: *Health Care Coverage & the Unintended Consequences of Welfare Reform*, Faculty Advisor Jane Holl, MD, MPH

2009 Group Health Cooperative, Lean Daily Management Training
2008 Duke University Health System, TeamSTEPPS Master Trainer
2007 Dartmouth Clinical Microsystems, Coaching-the-Coaching Training
2004 Chicago Metropolitan Battered Women's Network, Domestic Violence 40-hour Training Certificate
2001 Grantsmanship Center, 40-Hour Grants Training Certificate

## EMPLOYMENT/EXPERIENCE

2008- Research Associate II, MacColl Center for Health Care Innovation, Group Health Research Institute
2006-2008 Research Associate I, MacColl Center for Health Care Innovation, Group Health Research Institute
2005-2006 Teaching Assistant, Financial Management, Executive Masters Program, University of North Carolina at Chapel Hill School of Public Health
2005-2006 President, UNC Student Chapter AcademyHealth
2005 Resident, Strategic Planning, Wake Forest University Baptist Medical Center
2003-2004 Manager Planning & Development, Access Community Health Network
2002-2003 Coordinator Planning & Development, Access Community Health Network
2001-2002 Development Associate, Access Community Health Network
2001 Health Policy Consultant, Illinois Representative Sandra Pihos Campaign
2001 Executive Assistant, CIO Tim Zoph, Northwestern Memorial Hospital
2000 Intern, Center for Health Improvement, Blue Shield of California

## HONORS/AWARDS

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| 2007 | Extraordinary Achievement Bonus, Group Health Cooperative |
| 2006 | Jean G. Yates Health Policy Award for Outstanding Second Year Policy Student |
| 2006 | Delta Omega Honorary Public Health Society Member |
| 2005 | Moulton Wong Scholarship Recipient for Excellent First Year Policy Student |
| 2004 | Miriam Cole Scholarship Recipient for Most Promising Master's Applicant |
| 2001 | Alpha Lambda Delta Honorary Society |
| 2000-2001 | National Society of Collegiate Scholars |
| 2000-2001 | Rho Lambda Honorary Society |
| 1999-2000 | Gamma Sigma Alpha Honorary Society (treasurer) |
| 1997-2001 | Northwestern University Dean's List |
| 1997 | Kansas Honor Scholar |

## CURRENT GRANTS AND CONTRACTS

1. Advanced Primary Care Practice Demonstration. (Ed Wagner, PI Group Health Research Institute). Center for Medicare and Medicaid Innovation, July 2012.

2. The Primary Care Team – Learning from Effective Ambulatory Practices. (Ed Wagner, PI Group Health Research Institute). Robert Wood Johnson Foundation, September 2011.

3. National Medical Home Curriculum. (Ed Wagner, PI Group Health Research Institute). The Commonwealth Fund, September 2011.

4. Aligning Forces for Quality. (Robert Graham, PI George Washington University). The Robert Wood Johnson Foundation, July 2009.

5. Transforming Safety Net Clinics into Patient Centered Medical Homes. (Jonathan Sugarman, PI Qualis Health). The Commonwealth Fund, May 2008.

## PAST GRANTS AND CONTRACTS

1. Transforming Primary Care: Evaluating the Spread of the Medical Home. (Robert Reid, PI Group Health Research Institute). Agency for Healthcare Research and Quality, 7/10-9/12.

2. Patient Centered Medical Home Demonstration Lab and Coordinating Center. (Stephan Fihn, PI VA Puget Sound Health Care System). Veterans Administration, 9/10-8/12.

3. Group Health Medical Home Evaluation. (Robert Reid, PI Group Health Research Institute). Group Health Research Institute Development Fund, 1/09 – 12/11.

4. Impact of Patient Decision Aids on Health Care Use and Costs of Care. (David Arterburn, PI & Katie Coleman, Co-Investigator Group Health Research Institute). The Commonwealth Fund, 4/09 – 3/11.

5. California Improvement Network. California Health Care Foundation, 7/1/08 – 6/30/10.

6. Research Support. (Katie Coleman, Group Health Research Institute). The Robert Wood Johnson Foundation, 8/1/06 – 3/31/10.

7. Technical Assistance for Prescription Pennsylvania. Commonwealth of Pennsylvania, 7/15/08 -3/31/09.

8. Content of Care. (Michael VonKorff, PI Group Health Research Institute). Group Health Research Institute Development Fund, 1/1/07- 12/31/08.

9. Washington State Collaborative to Improve Health – Coaches Training. (Katie Coleman, Group Health Research Institute). Washington State Department of Human Services, 12/1/07 – 3/31/08.

10. Use of Patient-Provider Agreements to Improve Quality. (Ed Wager, PI Group Health Research Institute). Commonwealth Fund, 3/1/08 – 9/30/08.

11. Integrating Chronic Care and Business Strategies in the Safety Net (Ed Wagner, PI Group Health Research Institute). Agency for Healthcare Research and Quality, 9/29/06 – 9/1/09.

## PEER REVIEWED PUBLICATIONS


1. Wagner EH, **Coleman K**, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation (2012). Primary Care: Clinics in Office Practice 39(2):241-59.

2. Nuño R, **Coleman K**, Bengoa R Sauto R (2012). Integrated Care for Chronic Conditions: the contribution of the ICCC Framework. Health Policy 105(1):55-64.

2. Hsu C, **Coleman K**, Ross TR, Johnson E, Fishman PA, Larson EB, Liss D, Trescott C, Reid RJ (2012). Spreading a Patient-Centered Medical Home Redesign: A case study. Journal of Ambulatory Care Management 35(2):99-108.

4. Fishman PA, Johnson EA, **Coleman K**, Larson EB, Hsu C, Ross TR, Liss D, Tufano J, Reid RJ (2012). Impact on Seniors of the Patient Centered Medical Home: Evidence from a Pilot Study. The Gerontologist Epub ahead of print.

5. Wagner EH, **Coleman K**, Reid RJ, Phillips K, Sugarman JR. Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. The Commonwealth Fund, February 2012.

6. **Coleman K**, Reid RJ, Johnson E, Hsu C, Ross TR, Fishman P, Larson E (2010). Implications for Reassigning Patients for the Medical Home: A Case Study. Annals of Family Medicine 8(6):493-498.

7. Reid RJ, **Coleman K,** Johnson E, Fishman P, Hsu C, Soman MP, Trescott CT, Erikson M, Larson EB (2010). The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. Health Affairs 29(5):835-843.

8. Ralston JD, **Coleman K,** Reid RJ, Handley MR, Larson EB (2010). Patient Experience Should Be Part of Meaningful Use Criteria. Health Affairs 29(4):614-621.

9. **Coleman K**, Phillips KE (2010). Providing Underserved Patients with Medical Homes: Assessing the Readiness of Safety-Net Health Centers. Issue Brief (Commonwealth Fund) 85;1-14.

10. **Coleman K**, Austin B, Brach C, Wagner EH (2009). Evidence on the Chronic Care Model in the New Millennium. Health Affairs 28(1):75-85.

11. **Coleman K**, Mattke S, Perrault P, Wagner EH (2009). Untangling practice redesign from disease management: How do we best care for the chronically ill? Annual Review of Public Health 30:385-408.

12. **Coleman K**, Reiter KL, Fulwiler D (2007). The Impact of Pay-for-Performance on Diabetes Care in a Large Network of Community Health Centers. Journal of Health Care for the Poor and Underserved 18(4):966-83.

13. **Coleman K,** Hamblin R (2007). Can Pay-for-Performance Improve Quality and Reduce Health Disparities? PLoS Med 4(6):e216.

## IN PRESS

1. Reid RJ, Johnson EA, Hsu C, Ehrlich K, **Coleman K**, Trescott C, Erikson M, Ross TR, Liss DT, Cromp D, Fishman PA. Spreading a PCMH Redesign: Effects on Emergency Room Use and Hospital Admissions. Annals of Family Medicine. Accepted 9/3/2012.

## BOOK CHAPTERS

1. Weppner W, **Coleman K**, Reid RJ, Larson EB (2012). Improving management of chronic disease. In Joint Commission Resources: From Front Office to Front Line: Essential Issues for Health Care Leaders, Second Edition. (pp. 127 – 158). Oakbrook IL, Joint Commission Resources.

2. **Coleman CF** and Wagner E (2008). Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model. In To Cure and To Care. Innovation in the Management of Chronic Illness: A practical Guide to Move Forward. (pp. 3-15). Barcelona, Spain: Elsevier Masson.

## OTHER PUBLICATIONS

1. **Coleman K** ( May 18, 2012). How does a facilitation program use local learning collaboratives to reinforce its work with practices? AHRQ's Primary Care Practice Facilitation Forum.

2. **Coleman K** (February 2012). Continuous and Team-Based Healing Relationships: Redefining Staff Roles: Where to Start. Safety Net Medical Home Initiative. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health.

3. **Coleman K** (November 22, 2011). Without Changes in Care, Should We Expect Changes in Outcomes? Invited Commentary. Annals of Family Medicine.

4. Van Borkulo N, **Coleman K** (August 2011). Quality Improvement Strategy Implementation Guide, Part 1: Choosing and Using a QI Framework. 1st ed. Phillips K and Burton T, eds. Safety Net Medical Home Initiative. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute.

5. Van Borkulo N, **Coleman K** (February 2011). A Practice Facilitator's Guide to Visiting Clinical Teams. 1st ed. Safety Net Medical Home Initiative. Seattle WA: Qualis Health and the MacColl Center for Health Care Innovation.

6. **Coleman K** (January 31, 2011). Pay for performance not sufficient to cure what ails us. Group Health Blog. http://ghcview.org.

7. **Coleman K**, Reid R (December 2010). Continuous and Team-based Healing Relationships Part 1: Improving Patient Care Through Teams. Safety Net Medical Home Initiative. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health.

8. MacColl Center for Health Care Innovation at Group Health Research Institute (August 2010). 10 State Scan of Ambulatory Quality Improvement Resources: A Brief Report. Washington D.C.: Aligning Forces for Quality, a program of The Robert Wood Johnson Foundation.

9. Schaefer J, **Coleman K**, Morales L, and Brownlee B (June 2010). Patient-Centered Interactions Implementation Guide, Part 1: Measuring Patient Experience. Safety Net Medical Home Initiative. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health.

10. **Coleman K**, Phillips KE, eds. (March 2010). Empanelment Implementation Guide: Establishing Patient-Provider Relationships. Safety Net Medical Home Initiative. Seattle, WA: The MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health.

11. **Coleman K** (May/June 2009). Real Redesign Required. Invited Commentary. Annals of Family Medicine.

12. **Coleman K**, Pearson M, and Wu S (April 2009). Integrating Chronic Care and Business Strategies in the Safety Net: A Practice Coaching Manual. AHRQ, under Contract No./Assignment No: HHSA2902006000171). Rockville, MD: Agency for Healthcare Research and Quality.

13. MacColl Center for Health Care Innovation at Group Health Research Institute, in partnership with RAND and the California Health Care Safety Net Institute (September 2008). Integrating Chronic Care and Business Strategies in the Safety Net: A Toolkit. AHRQ Publication No. 08-0104-EF. Rockville, MD: Agency for Healthcare Research and Quality.

14. Austin B, **Coleman K**, Wagner E (2007). Innovation for Better Health: Making the Promise a Reality. Seattle, WA: Group Health Cooperative.

15. Wagner E, Austin B, and **Coleman C** (2006). It Takes a Region: Creating a Framework to Improve Chronic Disease Care. Oakland, CA.: California Health Care Foundation.

## POSTER PRESENTATIONS

1. Reid RJ, Johnson E, Fishman P, Hsu C, Ross T, **Coleman K**, Ehrlich K, Liss D, Trescott C, Larson EB. Spread of the Patient-Centered Medical Home at Group Health: Preliminary Findings. Agency for Healthcare Research and Quality Annual Meeting. Rockville, MD, September 2011.

2. Hsu C, **Coleman K**, Ross T, Johnson E, Fishman P, Larson E, Liss D, Cheadle A, Trescott C, Reid RJ. Implementing a Patient-Centered Medical Home Redesign Using Lean: A Case Study. AcademyHealth Annual Research Meeting, Seattle WA, June 14, 2011.

3. **Coleman K**, Wu S, Pearson ML, Austin BT, Brach C, Jameson WJ, Wagner E. Improving Chronic Care and Business Strategies in the Safety Net. AcademyHealth Annual Research Meeting, Washington DC, June 10, 2008.

4. **Coleman K**. Screening and Treatment of Gestational Diabetes and its Impact on Offspring's Quality of Life: An Economic Evaluation. Center for Women's Health Research, University of North Carolina at Chapel Hill: 7th Annual Women's Health Research Day, Chapel Hill, NC April 5, 2006.

5. **Coleman K**. The Impact of Pay-for-Performance on Diabetes Care in a Large Network of Community Health Centers. University of North Carolina at Chapel Hill, Chapel Hill, NC, April 27, 2006.

## ORAL PRESENTATIONS

1. "Transformation Lessons and Issues: Medical Homes in Safety Net Practices." California Health Care Safety Net Institute. Learning from the Leaders: The Next Frontier in Medical Homes." Oakland, CA. November 15, 2012.

2. "Primary Care & Health Care Reform: Where we are, Where we're going." Oregon Primary Care Association Quadruple Aim Learning Session. Bend, OR. October 1, 2012.

3. “Care Coordination.” Maine Quality Counts Provider Lunch and Learn Session. Webinar. November 8, 2011.

4. “A National Patient Centered Medical Home Curriculum.” National Association of Community Health Centers Patient Centered Medical Home Learning Institute. New Orleans, LA. November 2, 2011.

5. “Care Coordination in the Medical Home.” Montana Primary Care Association Patient Centered Medical Home Learning Session #2. Helena, MT. September 21, 2011.

6. “Delivering Organized, Evidence-Based Care: The Heart of the Medical Home.” Montana Primary Care Association Patient Centered Medical Home Learning Session #2. Helena, MT. September 21, 2011.

7. “Keeping Focused on What Matters in the Medical Home.” [Panel Moderator]. Montana Primary Care Association Patient Centered Medical Home Learning Session #2. Helena, MT. September 21, 2011.

8. “PCMH-Assessment Results: Using Quality Data for Improvement.” Pittsburg Regional Coordinating Center Learning Session. Pittsburg, PA. May 19, 2011.

9. “Continuous & Team-based Healing Relationships.” Montana Primary Care Association Patient Centered Medical Home Learning Session #1. Helena, MT. May 4, 2011.

10. “National Perspectives on the Patient Centered Medical Home.” [Panel Moderator]. Montana Primary Care Association Patient Centered Medical Home Learning Session #1. Helena, MT. May 4, 2011.

11. “The Patient Centered Medical Home: Care Coordination.” Colorado Regional Learning Session. Denver, CO. April 15, 2011.

12. “Patient Centered Interactions in the Medical Home.” Group Health Patient Centered Care Interest Group Meeting. Seattle, WA. March 17, 2011.

13. “Getting off the hamster wheel: operational efficiency as a means to improving patient care.” Safety Net Medical Home Initiative National Meeting. Boston, MA. March 7, 2011.

14. “Coaching Practices to Become Medical Homes.” North American Primary Care Research Group Annual Meeting. Seattle, WA. November 16, 2010.

15. “Transforming Safety Net Practices into Patient-Centered Medical Homes.” Montana Primary Care Association. Helena, MT. November 4, 2010.

16. “Transforming Chronic Care: What Works and What’s Next.” O+Berri, Instituto Vasco de Innovacion Sanitaria Transforming Care for Chronic Patients: The Challenge of Implementation. Bilbao, Spain. June 2, 2010.

17. “Patient Centered Medical Homes: Redesigning Care & Integrating with the Community.” Washington State Department of Aging Healthier Aging Conference. Seattle, WA. October 15, 2009.

18. “Patient Centered Medical Home and the Chronic Care Model.” Care Oregon & Oregon Primary Care Association. Portland, OR. July 31, 2009.

19. “Improving Chronic Care in the Safety Net: Helping Practices Improve Quality.” National Association of Public Hospitals. WebEx. July 23, 2009.

20. “Change Concepts and the Chronic Care Model.” Colorado Community Health Network. Denver, CO. July 8, 2009.

21. Technical Advisory Group. USAID Health Care Improvement Project. Washington DC. May 18, 2009.

22. “Transforming Safety Net Practices into Medical Homes.” Institute for Healthcare Improvement International Summit on Clinical Office Practice Redesign. Vancouver, B.C. March 23, 2009.

23. “Finding Breathing Room: operational efficiency as a means to improving patient care.” Humboldt Del-Norte Independent Practice Association Learning Session. Arcata, CA. March 19, 2009.

24. “Sifting Through the Noise: Getting Real About Quality Improvement.” Moderator. Washington Association of Community and Migrant Health Centers Annual Quality Conference. Tacoma, WA. March 17, 2009.

25. “Patient Centered Medical Home: Reinventing Primary Care.” Washington State House Appropriations Committee on Health and Human Services. Olympia, WA. February 17, 2009.

26. “Identifying and Addressing Unwarranted Variation in Specialty Care at Group Health.” Members of the Dartmouth Atlas and Washington’s Shared Decision Making Collaborative. Seattle, WA. January 6, 2009.

27. “The Dartmouth Atlas: What is it? How is Group Health using it?” Washington Office of Financial Management, Strategic Health Planning Technical Advisory Committee. Seattle, WA. November 13, 2008.

28. “Patient-Centered Care - From Buzz Word to Meaningful Reality.” Employees Benefits Planning Association. Bellevue, WA. September 18, 2008.

29. “Integrating Chronic Care and Business Strategies in the Safety Net.” Agency for Healthcare Research and Quality Annual Conference. Washington DC. September 9, 2008.

30. “Helping Practices Help Themselves Improve Quality.” California Improvement Network. WebEx. August 6, 2008.

31. “Improving Chronic Illness Care: A Quick Look at the Chronic Care Model.” Washington State Collaborative to Improve Health. Seattle, WA. April 23, 2008.

32. “Improving Chronic Illness Care: A Quick Look at the Chronic Care Model.” Washington State Collaborative to Improve Health. WebEx. April 17, 2008.

33. “New Methods for Improving Chronic Illness Care in Practice.” Center for Health Studies Seminar Series. Seattle, WA. March 25, 2008.

34. “Coaching the Coaches.” Washington State Department of Public Health Collaborative Coaches Training. Seattle, WA. January 24, 2008.

35. “New Methods for Teaching the Chronic Care Model.” Institute for Healthcare Improvement National Forum Minicourse. Orlando, Florida. December 10, 2007.

36. “What Can States Do to Improve Chronic Illness Care?” National Council of State Legislatures. Saint Louis, Missouri. October 5, 2007.

37. “Women’s Cardiology Service Line: the Business Case.” Strategic Planning Meeting, Wake Forest University Baptist Medical Center. Wake Forest, NC. July 2005.

## PROFESSIONAL SERVICE AND MEMBERSHIP

| | |
|---|---|
| 2011 | National Association of Community Health Centers – Patient Centered Medical Home Learning Institution Blue Print participant |
| 2010-2011 | Montana Primary Care Association – Patient Centered Medical Home Consultant |
| 2010-2011 | MacColl Center Director/Senior Investigator Search Committee |
| 2009-2011 | Dartmouth Clinical Microsystems Coaching Collaborative |
| 2009-2011 | Agency for Healthcare Research and Quality Consensus Panel on Practice Coaching in the Safety Net |
| 2009-2011 | Group Health Research Institute Scientific Policy Committee (Co-Chair 2009 – 2010) |
| 2009-2011 | The Commonwealth Fund’s National Patient Centered Medical Home Evaluator’s Collaborative |
| 2010 | Improving Performance in Practice Coaching Manual Editor |
| 2010 | The Robert Wood Johnson Foundation Online Expert Panel Defining Continuous Quality Improvement in Health Care |
| 2008-2010 | Institute for Translational Health Sciences, Scholar |
| 2007-2010 | Birnbaum Innovation Forum Planning Committee |
| 2009 | Group Health Research Institute Name Change Committee |
| 2008-2009 | Washington Association of Community and Migrant Health Centers, National Quality Conference Planning Committee |
| 2004-2009 | AcademyHealth Member |
| 2008 | Center for Health Studies, Strategic Planning Focus Areas Workgroup |
| 2008 | Center for Health Studies, Lean A3 Strategic Planning Committee – People Strategy |
| 2007-2008 | Center for Health Studies, Faculty Retreat Planning Committee |
| 2003 | Health Resources & Services Administration, 330 Objective Review Committee |

## EDITORIAL REVIEW

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|---|---|
| 2012 | *Perspectives in Public Health, Royal Society for Public Health* |
| 2011 - 2012 | *Health Affairs* |
| 2009-2011 | *Annals of Family Medicine* |
| 2007- 2011 | *American Journal of Managed Care* |
| 2010 | *BMJ Quality & Safety* |
| 2009 | *Health Research Board Ireland* |
| 2008 | *Quality in Primary Care* |
| 2008 | *Medical Care* |
| 2008 | *Milbank Quarterly* |
| 2008 | Robina Foundation |
| 2006 | *Public Library of Science* |