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Appendix 1

This appendix was part of the submitted manuscript and has been peer reviewed. It is posted as supplied by the authors.

Appendix to: Ski CF, Vale MJ, Bennett GR, et al. Improving access and equity in reducing cardiovascular risk: the Queensland Health model. *Med J Aust* 2015; 202: 148-152. doi: 10.5694/mja14.00575.

Appendix 1. Description of The COACH Program

Core components and distinguishing features of The COACH Program include:

- Coaches always initiate contact with the patients for coaching sessions – the program does not depend on the patient contacting the coach;
- Coaches identify the 'treatment gaps' in each patient's management – the gaps between guideline-recommended care and the care patients actually receive;
- Coaches educate, advise and encourage patients to close the 'treatment gaps' and achieve guideline-recommended risk factor targets whilst working with their usual doctor(s); and
- Coaches encourage patients to work with their usual doctors to achieve the most practical medication regimens possible, in order to facilitate lifelong adherence to recommended medication.

The COACH Program is delivered entirely by telephone and mail outs. Patients receive an average of five coaching sessions over six months. The coach develops a plan of action with patients to reduce risk factors via goal/target setting, and guide patients using a step-by-step process to achieve the guideline-recommended risk factor targets (e.g. LDL-cholesterol, blood pressure). Patients are coached to take the initiative with their doctors and ask for measurement of risk factors, results of tests, prescription of guideline-recommended medication, and treatment intensification. In doing so, coaches encourage patients to seek more intensive care from their regular doctors in regard to their personal risk factors and medication.

Each verbal coaching session is followed by a structured written report that summarises the session. These written reports, which are generated by The COACH Program software application, provide reference and reinforcement for the patient of expected progress to be achieved by the next session. Each report is followed with a risk factor chart which allows patients to track their progress towards achieving their risk factor targets. The structured summary reports are also forwarded to the patients' general practitioners, specialists and other health professionals. Patients may contact their coach for advice and support between coaching sessions. The COACH Program guides patients step-by-step through the process of achieving their risk factor targets.

Centralised data collection to monitor quality and outcomes

Regular data collection is crucial to success in improving outcomes for patients with chronic diseases such as CVD and diabetes. The COACH Program is fully computerised via a web-based

software application, which is an integral part of the program delivery. It provides a centralised audit system which measures patient baseline characteristics, patient uptake, discontinuation rates, achievement of guideline-recommended biomedical and lifestyle risk factor targets, and adherence to guideline-recommended medications at entry to and exit from the program. All relevant medical guidelines are incorporated into the software application. The software application is continually updated as guidelines change, and dynamically adjusts risk factors and targets based upon all the relevant guidelines for different chronic conditions. This system is ideal for audit of individual coaches and organisations delivering the program. It also allows healthcare organisations and doctors to receive helpful feedback on the program outcomes of their patients.

Training of the coaches at the Health Contact Centre

Coaches are trained face-to-face for 2 weeks in the principles and practice of The COACH Program and then undergo a formal 12-week preceptorship program of intensive mentoring, by experienced coaches, where patient communication is checked against set criteria. Coaches perform a minimum of 60 coaching sessions per month to maintain competency.

Experienced coaches can undergo advanced training in the form of a Train-the-Trainer Coach Course where they become a trainer of novice coaches and conduct quality assurance (QA) activities. The Health Contact Centre conducts regular monthly QA of phone coach sessions and patient letters. All session letters are reviewed by a trainer to ensure that the documented advice follows guideline recommendations and that letter formatting, structure and messaging remain consistent between coaches. Additionally, a trainer reviews session call recordings with the coach during monthly quality review sessions and rates sessions against a best practice matrix. Training and delivery of the program is standardised and streamlined. For example, coaches use The COACH Program software application as a tool to structure the coaching sessions and standardise the information delivered. Software and training materials are updated whenever guidelines for CVD, diabetes, COPD and kidney disease are revised, and on a monthly basis for updates to the Pharmaceutical Benefits Scheme. Coaches are given continuing education whenever guideline changes occur and whenever areas for improvement are identified through QA and program evaluation.