

**BRIEF REPORT**

# Peer-Coaching for Family Physicians to Close the Intention-to-Action Gap

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**Introduction:** Peer coaching has the potential to enhance the effectiveness of clinical performance feedback reports to family physicians, but few peer-coaching quality improvement programs have been implemented and evaluated in primary care. Authors designed, implemented and evaluated a peer-coaching program for family physicians in a large, academic primary-care organization to explore its potential to enhance family physicians' use of clinical performance data for quality improvement.

**Methods:** Coaches were nominated by their peers and were trained to follow an evidence-informed facilitated feedback model for coaching. Data were collected through surveys, a focus-group with coaches, and individual interviews with coached family physicians ("coachees"). Data were analyzed inductively using reflexive thematic analysis.

**Results:** Authors trained 10 coaches who coached 25 family physicians over 3 months. Coachees who completed the survey (21/25) indicated a desire for additional coaching sessions in future; most (19/21) reported confidence in making practice change. Interview (n = 11) and focus-group participants (n = 8) findings validated acceptability of the coaching approach that emphasized empathy ahead of change-talk. Coaches helped coachees interpret care-quality measures, deal with negative emotional responses evoked, encouraged a sense of accountability for improvement, and sometimes offered new ways to manage common challenges. Coaching sessions led to a wide range of practice-improvement goals. However, effects on practice change were felt to be limited by the data available and the focus on individual physician factors when broader clinic issues acted as important barriers to improvement.

**Conclusions:** Peer coaching is a feasible approach to supporting family physicians' use of data for learning and practice improvement. More research is needed to understand the impact on practice outcomes and physician wellness. (J Am Board Fam Med 2024;37:996–1008.)

**Keywords:** Coaching, Family Medicine, Family Physicians, Feedback, Primary Health Care, Qualitative Research, Quality Improvement

## Background

There are persistent gaps in the quality of primary care, from long wait times to suboptimal chronic

disease management.<sup>1–6</sup> Feedback of clinical performance data to family physicians has been identified as a valuable strategy<sup>7</sup> to improve quality of

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care, but its effectiveness depends on various factors, including the nature of the data, how it is presented, and who presents it.<sup>8</sup> Our previous research noted a gap between physicians' intention to use clinical performance data for practice improvement and their actions.<sup>9</sup> Discussions with colleagues are one recognized way to improve the effectiveness of clinical performance feedback<sup>8</sup> but more research is needed on how structured discussions can potentially close this intention to action gap in the context of family medicine.

Specifically, targeted peer-coaching interventions piloted in specific contexts and settings have shown promise for improving performance of physician trainees,<sup>10</sup> improving patient experience scores in outpatient settings,<sup>11</sup> and improving physician readiness for self-directed learning.<sup>12</sup> Yet, there is limited evidence guiding integration of peer-coaching for fully-licensed family physicians. In 2018 to 2019, we launched 3 cointerventions sequentially to accompany physician-level audit and feedback reports at a large academic practice. The cointerventions included structured self-reflection, peer-coaching, and facilitated group discussions. This article describes the implementation and process evaluation of the peer-coaching program and explores its potential to support family physicians to use clinical performance data to improve practice. We hypothesized that our program would be feasible to implement, acceptable to physicians and have the potential to shift family physicians along the behavior change spectrum, from reviewing data to making changes in clinical practice.

## Methods

### Context

The peer-coaching program was implemented at St. Michael's Hospital Academic Family Health Team (SMHAFHT) in Toronto, Canada. The team consisted of approximately 75 staff physicians,

40 resident physicians, and 60 other health professionals, serving around 45,000 patients across 6 downtown clinics. The team received performance reports on quality measures, covering patient experience, continuity, diabetes, cancer screening, and high-risk prescribing (Appendix 1), collected from electronic medical records, administrative data, patient experience surveys, and manual collection.<sup>13</sup>

### Intervention

The coaching program was based on Sargeant's R2C2 facilitated feedback model<sup>14</sup> and informed by the Institute for Health care Improvement's (IHI) Model for Improvement<sup>15</sup> and the Clinical Performance Feedback Intervention Theory (CPFIT).<sup>16</sup> Peer-coaches were physicians nominated by peers who participated in structured self-reflection.<sup>9</sup> Coaches attended a 2-hour training session covering the theory of clinical performance feedback, quality measures, and common physician concerns.<sup>14</sup> The R2C2 approach consists of 4 phases: build Relationship, explore Reactions, explore Content, and Coach for performance change.

In their one-time coaching interaction, coaches and coached physicians ("coachees") collaborated on a 'commitment to change' form, identifying areas for improvement, setting SMART goals following IHI's Model for Improvement, and sharing practical change ideas (Appendix 2). Coached physicians and coaches submitted this form to the coordinator, and 3 months postcoaching, coachees received their forms reflecting on goal progress. Coaches were compensated at \$135 per coaching hour.

### Recruitment

In January 2019, staff physicians received personalized e-mails with instructions on accessing feedback reports. The e-mail included an invitation to sign up for a one-on-one session with a peer-coach.

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*Conflict of interest:* Drs. Kiran, Ramji, and Weyman were all in physician leadership roles with the St. Michael's Hospital Academic Family Health Team during the study period. Dr. Ramji has been a Quality Improvement Coach with the College of Physicians and Surgeons of Ontario since December 2021. The authors declare no other conflicts of interest.

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*Authors' contributions:* TK, KD, LD, KW and NI conceived of and designed the study together. KD collected the data and TK, KD, LD and NI conducted the analysis. All authors helped interpret the data. TK and NI drafted the manuscript and all authors critically reviewed it. All authors read and approved the final manuscript.

*Ethics approval:* Ethics approval was obtained from the Research Ethics Board at Unity Health Toronto, Toronto, Canada (Approval 18-105, 30.05.2018).

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Specifically, they were invited to indicate their top 3 coaches, and then matches were assigned based on preferences, coach workload, and availability. Three reminders were sent over a 4-month period, to encourage physicians to sign up for a session. Coachees could claim 4 professional development credits on submitting a commitment to change form. Coachees had the option of sharing practice data with their coach.

### Data Collection

Coachees had the option to complete an evaluation form and a subset of coachees participated in semi-structured interviews, guided by Normalization Process Theory (NPT),<sup>17</sup> between March and July 2019. Coaches completed a self-assessment survey, and a subsequent focus group with 10 coaches explored their perceptions of data for physicians, the impact of the coaching session, and reflections on supporting physicians in using data.

### Data Analysis

Data analysis utilized codebook thematic analysis and NPT's 4 components as the coding frame.<sup>18,19</sup> Two coders independently coded a subset of 3 transcripts, creating an initial codebook. Early codes and potential themes were shared with the research team to establish clarity on objectives of the coding and share initial interpretation. One team member coded the remaining transcripts, regularly meeting with the research team to discuss findings. The coaching experience and reactions of both coaches and coachees were explored using the R2C2

framework. We used NVivo 12 to organize our analysis. Themes were shared with SMHAFHT physicians at staff meetings as a form of member checking.

### Results

Out of 75 eligible physicians, 70 were nominated to become a peer-coach. We selected and trained 10 physician peer-coaches who had multiple nominations to cover a range of seniority, expertise, practice sizes, and location, with at least 1 representative from each of the 6 clinical sites. Of these peer-coaches, 60% were women, the number of clinical half-days ranged from 4 to 10, and medical school graduation year ranged from 1977 to 2010, with 60% graduating between 1997 to 2005.

In the first 3 months 33% of physicians completed a coaching session (Table 1). More than half of coachees chose a colleague from a different clinic site as their coach, and most were comfortable sharing their data with their coach. All completed a commitment to change form, with SMART goals covering various topics, leaving participants motivated and confident to make practice changes (Appendix 3).

### Peer-Coach Self-Assessment Survey

The average reported duration of a coaching session was 37 minutes. Coaches reported high levels of engagement from coachees and consistent application of the R2C2 model during the session (Table 2).

**Table 1. Characteristics of Coachees Who Participated in Peer-Coaching Sessions Compared to All Staff Physicians in the Primary Organization (2019)**

	Coachees (n = 25)		All Staff Physicians (n = 75)	
	n	%	n	%
Gender				
Women	15	60	51	68
Men	10	40	24	32
Graduation year range	1977 to 2015		1977 to 2015	
Graduation year				
1977 to 2001	7	28	25	33
2002 to 2007	9	36	17	23
2008 to 2015	9	36	33	44
FTE range	0.3 to 1.0		0.2 to 1.0	
FTE				
0.2 to 0.5	12	48	27	36
>0.5 to 1	13	52	48	64

Abbreviation: FTE, Full-time equivalent.

**Table 2. Results of the Self-Assessment Survey Completed by Coaches After Their Coaching Session to Assess Fidelity to the Planned R2C2-Informed Coaching Approach**

Question	n = 24
How long did the conversation last (approx.)? Mean (range)	37 minutes (20 to 60)
Was a follow-up call scheduled? Yes N (%)	5 (21%)
How much do you agree or disagree with each of the following statements. Strongly agree/agree N (%)	
The physician I coached thought the feedback was valuable.	22 (93%)
The physician demonstrated understanding and cooperativeness.	24 (100%)
The physician demonstrated self-reflection, self-awareness, and insight.	24 (100%)
The physician was able to develop a change plan.	24 (100%)
The physician demonstrates the commitment to making the change.	23 (96%)
Did you apply part or the entire R2C2 model over the course of your conversation? Yes N (%)	18 (75%)
Which of the following R2C2 stages did you use over the course of your conversation? N (%) of respondents	
Build rapport and relationship	20 (83%)
Explore reactions to and perceptions of the data/report	22 (92%)
Explore physician understanding of the content of the data/report	22 (92%)
Coach for performance change	22 (92%)
None	1 (4%)
Which of the following R2C2 stages would you like to improve on for your next conversation? N (%) of respondents	
Build rapport and relationship	4 (17%)
Explore reactions to and perceptions of the data/report	7 (29%)
Explore physician understanding of the content of the data/report	10 (42%)
Coach for performance change	20 (83%)
None	2 (8%)

*Abbreviation:* R2C2, Report, React, Recommend, and Commit.

### **Coachee Written Evaluation Survey**

Twenty-one of 25 coachees completed the optional written evaluation. Written feedback was generally positive (Appendix 3), with coachees expressing the desire to meet with a coach again (21/21), indicating learning from the session (20/21), and planning to make changes to their practice (19/21).

### **Qualitative Data**

Twenty physicians were invited for a qualitative interview; 11 agreed to participate, 2 declined, and 7 did not respond. Eight of the 10 coaches participated in a focus group.

### **Building Relationships**

Coachees highlighted the importance of qualities like humility, nonjudgment, curiosity, thoughtfulness, and support in a coach. Both coachees and coaches emphasized the development of a trusting, supportive relationship as foundational to coaching success. Coaches intentionally considered the broader context of a physician's life when discussing quality measures and described the importance of supporting physician wellness even though this was not a focus of the training. Many highlighted that the coaching session seemed to enhance collegiality (Table 3).

### **Exploring Reactions**

Coaches assisted coachees in dealing with negative emotions sparked by data, including feelings of inadequacy and hopelessness. The impracticality of improving care for each quality measure, potential time constraints, and concerns about unfair judgment led to a reluctance to engage fully with the data. Coaching sessions validated coachees' experiences of juggling numerous priorities and acknowledged emotional reactions to quality measures, providing reassurance and diminishing feelings of isolation and overwhelm (Table 3).

### **Exploring Content**

Coaches helped coachees interpret the data and supported them in gaining insights despite known data limitations. Coachees appreciated being able to set and lead the agenda of the conversation (Table 3).

### **Coaching for Performance Change**

Coachees described how the session led to a sense of feeling accountable for acting on the data. The dedicated time and coaching helped them focus on a practice area and set a goal. The sessions offered an opportunity to learn from colleagues and manage common challenges (Table 3).

### **Limitations and Dissent**

Participants highlighted that coaching could not compensate for incomplete or inaccurate data, or

**Table 3. Quotations from Coaches and Coachees Who Participated in the Focus Group and Interviews, Organized by the Sargeant's R2C2 Facilitated Feedback Framework**

<i>Building Relationships</i>	<p>“He’s senior but not too senior so he’s sort of, he is a peer and we have a good relationship going in so he’s collegial, he’s friendly, he’s open-minded, he’s non-judgemental which actually means a lot to me. . . we all want to be doing really well and we don’t want to be making mistakes so to share that you know there’s potentially gaps you want to be with somebody who you trust.” (Coachee 2302)</p> <p>“I found universally the conversation actually got back to individual providers’ balance and wellness too because it’s easy to say to fix this you just need to work harder or add more clinics but inevitably these one-on-one conversations got to like the root of who the person is and what their practice style is and trying to balance like what the outcome would be in terms of improving these numbers versus continuing to support their happiness and fulfillment as a doctor.” (Coach R8)</p> <p>“the first person that I was coaching is someone. . . who personality-wise I don’t necessarily align with all the time but, and so I was quite nervous going into it and did a lot of preparation looking at the data and just feeling, making sure I had some talking points and it was actually amazing. It went so well. This person was very open to exploring the data and learning and setting goals and I came away from it actually feeling a) very positive and b) also that I had a new appreciation for this person so that was really nice” (Coach R3)</p>
<i>Exploring Reactions</i>	<p>“I was overwhelmed by my practice and the data was just like another part of it that felt overwhelming and so their kind of validation of my perception of my patient population and then practical like problem-solving, yeah, it made me feel less overwhelmed.” (Coachee 2303)</p> <p>“you feel like you’re able to share your potential practice vulnerabilities without feeling as though you’re really a negative anomaly like you’re like oh, we’re, you know we have similar habits and so now maybe we can share ideas and not feel intimidated or as though there’s dissimilarity between the providers.” (Coachee 2302)</p> <p>“one of the challenges of course with the data is you feel a little bit hopeless about it like there are all these problems and what am I going to do about solving them and Lord knows I’m trying but. . .” (Coachee 1813)</p>
<i>Exploring Content</i>	<p>“It seems like a good idea. . . to better understand the data because as I said I did find it a bit overwhelming. . . I guess I was looking for someone to help me interpret it and kind of advise.” (Coachee 1813)</p> <p>“it was great cause she let me kind of drive what my priorities were but I also was able to ask her like was there anything else you noticed in my data as well.” (Coachee 2012)</p> <p>“the first one I think was more about we set priorities based on sort of that person’s kind of, their, what stuck out to them kind of thing and what was relevant to them. The second one. . . we worked together to actually see you know what stuck out for each of us. It just proceeded differently. I think that we ended up in the same place.” (Coach R5)</p>
<i>Coaching for Performance Change</i>	<p>“I just think like if you have an opportunity to look over data with someone else like why wouldn’t you take it because I think that when you look at the data on your own like I think it’s harder to pick out areas that you can work on and to kind of do this actively so I think having a peer-coach like forces you to look at it in more detail and then also to set some goals on what you want to try to improve.” (Coachee 2306)</p> <p>“it was kind of helpful that she wasn’t in my clinic because there were things that she was doing in her clinic or even their clinic as a whole that we do have little variations in that help improve some of the quality measures so I felt like maybe I had more to learn from her in some sense than the people I work right next to who we kind of do the same thing all the time as each other.” (Coachee 2012)</p>
<i>Limitations and Dissent</i>	<p>“The care is being delivered. It’s just not being documented in a way that it can be tracked and therefore you know the data tells a different picture.” (Coachee 2307)</p> <p>“It makes me feel inadequate as a clinician to be measured on things that are small snippets of care that don’t reflect a larger picture” (Coachee 2307)</p> <p>“I just don’t know, like other physicians are too busy and then anybody else I feel like you’re stepping on toes if you ask them to do more work like basically to improve your data requires more work which is fine but that’s, time is limited for all of us. Everybody feels a bit overstretched so I’m hesitant to ask anybody to do anything to help.” (Coachee 2302)</p> <p>“[T]he critical or negative things are the hardest things to kind of take; however, they’re often the most [Pause] useful because they do call us to action. They’re the things that people remember the most, I think are the critical or negative things.” (Coachee 1805)</p>

Abbreviation: R2C2, Report, React, Recommend, and Commit.

aspects of care not captured by the feedback report. In addition, peer-coaching focused primarily on physician-level actions rather than clinic-level actions, although both were often necessary for systemic change (Table 3).

## Discussion

The study demonstrates the implementation success and acceptability of a pilot peer-to-peer coaching program among family physicians. Coaching enabled physicians to develop specific quality

improvement goals in an area relevant to them. Evaluations found that physicians valued the time spent with the coach and left the session feeling highly motivated and confident that they would make practice change. Qualitative interviews suggested that the coaching supported physicians to move from intention to action. It helped them interpret the data and deal with negative emotional responses to the data, it helped keep them accountable to act, and it provided them with practical change ideas used by colleagues that they could enact in their own practice.

The findings align with existing literature on peer-coaching as an innovative model of continuing professional development, enhancing physician readiness for self-directed learning and improvement.<sup>12,20,21</sup> Our results are also consistent with research demonstrating relationship-centered coaching's positive impact on physician-assessor interactions during regulatory authority visits.<sup>22</sup> Sargeant's R2C2 facilitated feedback model to train and guide peer-coaches<sup>14</sup> provided a helpful framework for this program, emphasizing the importance of building relationships, exploring reactions and content, and coaching for performance change.

The study describes a pilot of a theory-informed peer-coaching program for family physicians that was well-received in a large, urban, academic primary care setting. However, data on potential impact is limited by biases inherent in self-reporting and self-selection of physicians into the program. Comments from both coaches and coachees suggested that coaching may have impacted family physician wellness and enhanced collegiality, however, these impacts were not formally measured in our study. We also did not collect data on clinical outcomes or patient. We report on early uptake, but further research is needed to understand the potential for spread, sustainability and medium to long-term impact with ongoing coaching sessions.

## Conclusion

Peer-to-peer coaching is a promising approach to supporting family physicians in using data for learning and practice improvement. Specifically, it has the potential to close the gap between improvement intention and action. Future research is needed to understand whether peer-to-peer coaching can improve practice outcomes and physician wellness.

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To see this article online, please go to: <http://jabfm.org/content/37/6/996.full>.

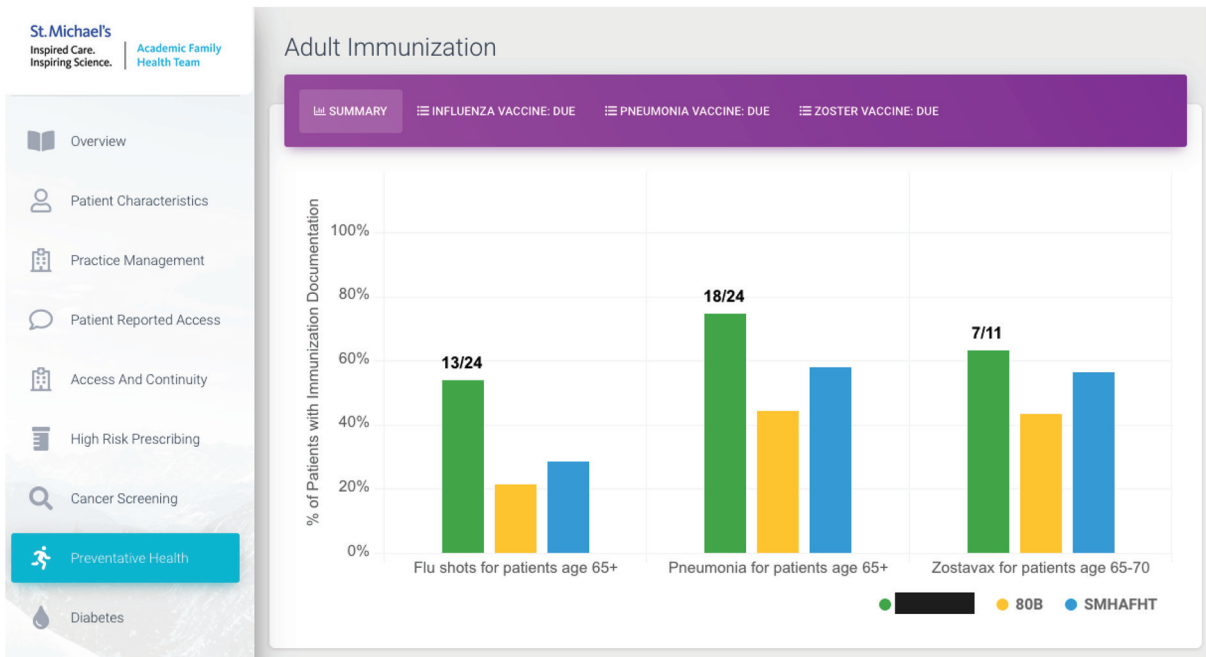
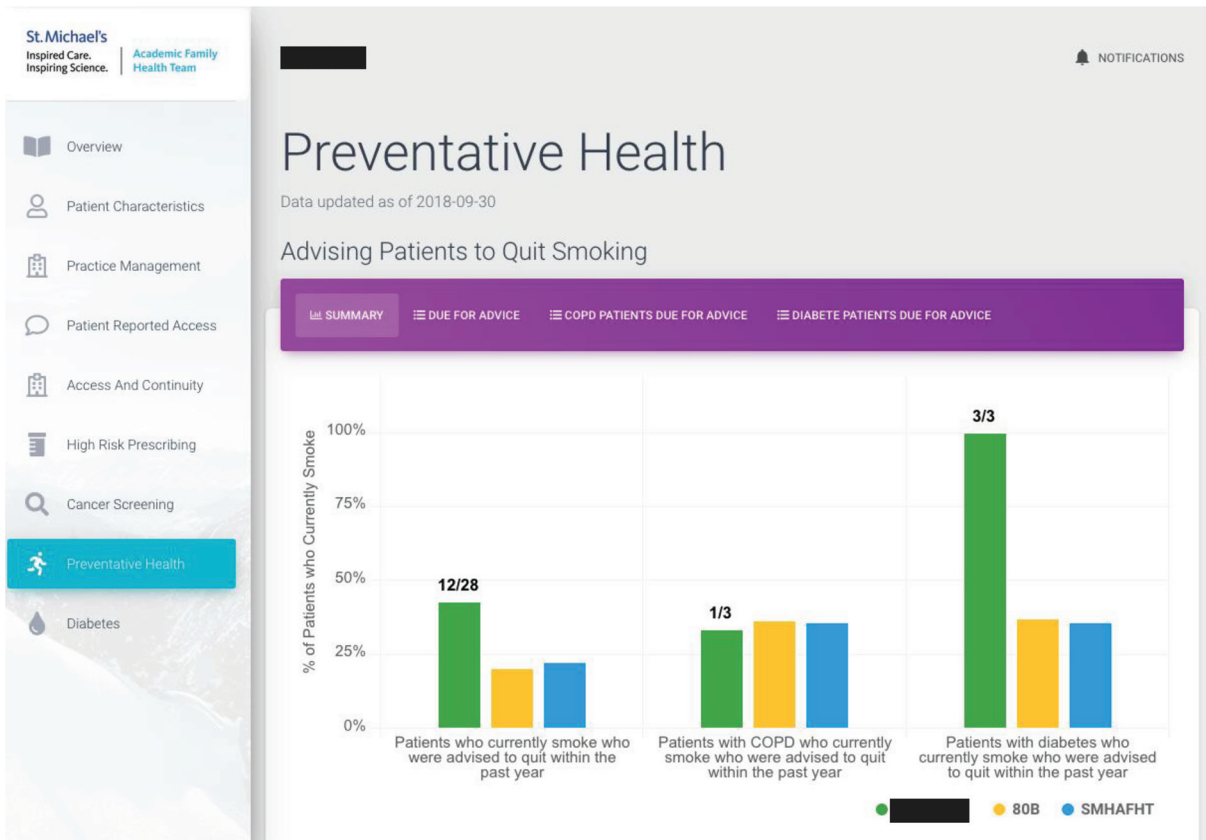
## References

1. Able to get same-day or next-day appointment when sick, selected health & system statistics. The Commonwealth Fund. Available at: <https://www.commonwealthfund.org/international-health-policy-center/system-stats/same-day-or-next-day-appointment>. Published 2020. Accessed May 10, 2023.
2. How Canada Compares: Results from the Commonwealth Fund's 2020 International Health Policy Survey of the General Population in 11 Countries. Ottawa, ON. Canadian Institute for Health Information. Available at: [https://secure.cihi.ca/free\\_products/how-canada-compares-cmwf-survey-2020-chartbook-en.pdf](https://secure.cihi.ca/free_products/how-canada-compares-cmwf-survey-2020-chartbook-en.pdf). Published 2021. Accessed May 10, 2023.
3. Lofters AK, Mark A, Taljaard M, Green ME, Glazier RH, Dahrouge S. Cancer screening inequities in a time of primary care reform: a population-based longitudinal study in Ontario, Canada. *BMC Fam Pract* 2018;19:147.
4. Morley CP, Schad LA, Tumiel-Berhalter LM, et al. Improving cancer screening rates in primary care via practice facilitation and academic detailing: a multi-PBRN quality improvement project. *J Patient Cent Res Rev* 2021;8:315–22.
5. Setting the Target for Improving Heart Health in America. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <https://www.ahrq.gov/evidencenow/research-results/results/infographics/baseline.html>. Published last reviewed August 2018. Accessed May 10, 2023.
6. Tu JV, Chu A, MacLagan L, Cardiovascular Health in Ambulatory Care Research Team (CANHEART), et al. Regional variations in ambulatory care and incidence of cardiovascular events. *CMAJ*. 2017;189:E494–E501.
7. Ivers N, Jamtvedt G, Flottorp S, et al. Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane Database Syst Rev* 2012; Cd000259.
8. Brehaut JC, Colquhoun HL, Eva KW, et al. Practice feedback interventions: 15 suggestions for optimizing effectiveness. *Ann Intern Med* 2016; 164:435–41.
9. Desveaux L, Ivers NM, Devotta K, Ramji N, Weyman K, Kiran T. Unpacking the intention to action gap: a qualitative study understanding how

- physicians engage with audit and feedback. *Implement Sci* 2021;16:19.
10. MacKenzie C, Chan TM, Mondoux S. Clinical improvement interventions for residents and practicing physicians: a scoping review of coaching and mentoring for practice improvement. *AEM Educ Train* 2019;3:353–64.
  11. Sharieff GQ. MD to MD coaching: improving physician-patient experience scores: what works, what doesn't. *J Patient Exp* 2017;4:210–2.
  12. Curran V, Fleet L, Whitton C. Fostering “reflection-on-practice” through a multisource feedback and peer coaching pilot program. *J Contin Educ Health Prof* 2022.
  13. Kiran T, Ramji N, Derocher MB, Girdhari R, Davie S, Lam-Antoniades M. Ten tips for advancing a culture of improvement in primary care. *BMJ Qual Saf* 2019;28:582–7.
  14. Sargeant J, Lockyer J, Mann K, et al. Facilitated reflective performance feedback: developing an evidence- and theory-based model that builds relationship, explores reactions and content, and coaches for performance change (R2C2). *Acad Med* 2015;90:1698–706.
  15. How to Improve. Institute for Healthcare Improvement. Available at: <https://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>. Accessed September 27, 2023.
  16. Brown B, Gude WT, Blakeman T, et al. Clinical performance feedback intervention theory (CP-FIT): a new theory for designing, implementing, and evaluating feedback in health care based on a systematic review and meta-synthesis of qualitative research. *Implement Sci* 2019;14:40.
  17. May C, Finch T. Implementing, embedding, and integrating practices: an outline of Normalization Process Theory. *Sociology* 2009;43:535–54.
  18. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health* 2019;11:589–97.
  19. Byrne D. A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Qual Quant* 2022;56:1391–412.
  20. Kahlke R, Pratt DD, Bluman B, Overhill K, Eva KW. Complexities of continuing professional development in context: physician engagement in clinical coaching. *J Contin Educ Health Prof* 2022;42:5–13.
  21. Roy M, Lockyer J, Touchie C. Family physician quality improvement plans: a realist inquiry into what works, for whom, under what circumstances. *J Contin Educ Health Prof* 2023;43:155–63.
  22. Arabsky S, Castro N, Murray M, Bisca I, Eva KW. The influence of relationship-centered coaching on physician perceptions of peer review in the context of mandated regulatory practices. *Acad Med* 2020;95:S14–s19. (11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 59th Annual Research in Medical Education Presentations).

# Appendices

## Appendix 1. Sample Screen Shots from the Physician Dashboard



St. Michael's  
Inspired Care. Inspiring Science. | Academic Family Health Team

- Overview
- Patient Characteristics
- Practice Management
- Patient Reported Access
- Access And Continuity
- High Risk Prescribing
- Cancer Screening**
- Preventative Health
- Diabetes

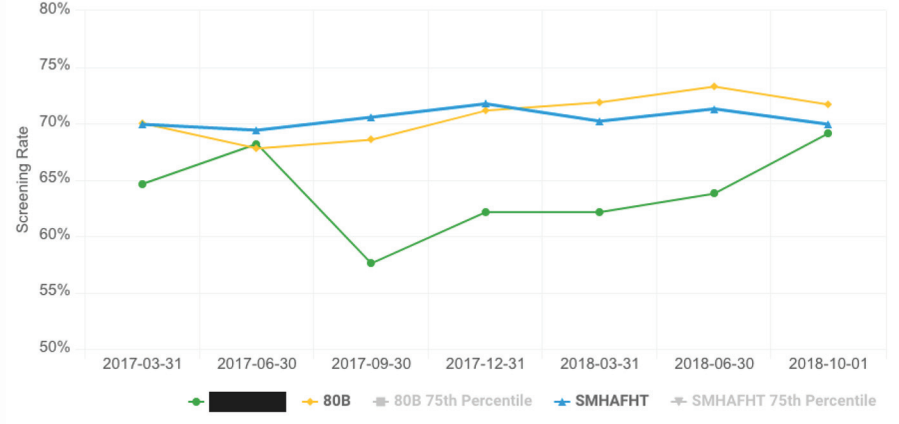
# Cancer Screening

Data updated as of 2018-09-30

## Rate Over Time

COLORECTAL | CERVICAL | BREAST

### Colorectal Cancer Screening Rates



You can click the legend items above to display or hide trend lines

Last DF < 149/93 (11=22) | Last A1C < 6.5% (11=21) | SMHAFHT DF 75th PERCENTILE | SMHAFHT A1C 75th PERCENTILE

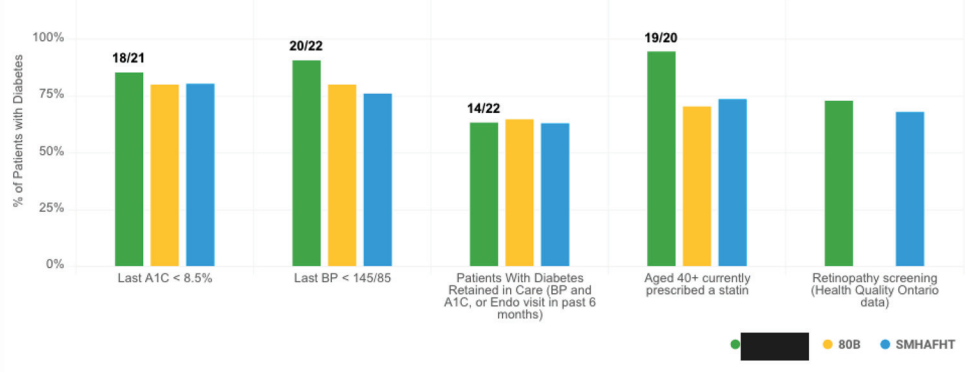
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St. Michael's  
Inspired Care. Inspiring Science. | Academic Family Health Team

- Overview
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## Risk Factor Management

SUMMARY | A1C < 8.5% | BP < 145/85 | LOST TO FOLLOW-UP | NO STATIN



- Overview
- Patient Characteristics
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- Cancer Screening
- Preventative Health
- Diabetes

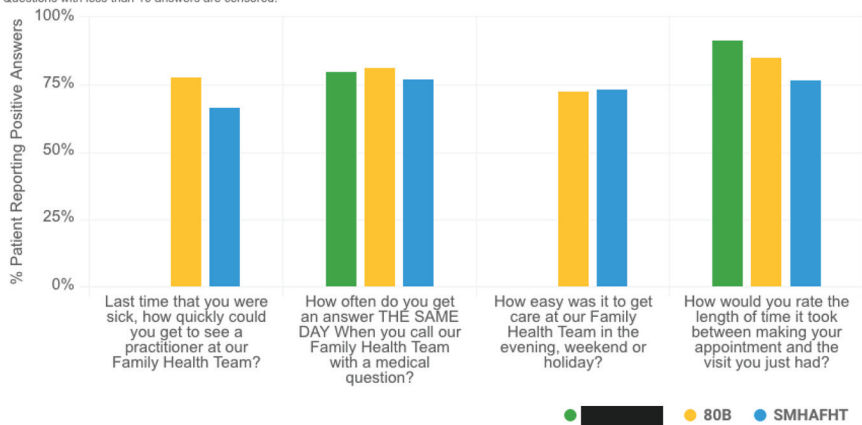
# Patient Reported Access

Data updated as of 2018-09-30

Your Patient Experience Survey Results (2017-01-01 to 2018-09-30)

- ACCESS TO CARE
- ACCESS TO CARE PART 2
- PATIENT CENTEREDNESS

Site and SMHAFHT are the latest results (2018-09-30).  
Questions with less than 10 answers are censored.



## Appendix 2. Commitment to Change Plan

Name:  Date:  Coach:

Identify one area of your practice that you want to improve and set a SMART\* goal (\*Specific Measurable Achievable Relevant Time bound)  
*(e.g. increase the proportion of people with diabetes who I have counseled to quit smoking from 50% to 75%)*

- a) List one learning opportunity that could help you achieve your goal?  
*(e.g. read a review article about the pharmacological options for smoking cessation in people with co-morbidities)*

- b) List 1-2 **practice changes that you can make** to help you achieve this goal  
*(e.g. use a diabetes flow sheet that includes a reminder to counsel on smoking cessation and a link to the OMSC form; ask the team nurse to assess and counsel for smoking during the diabetes pre-visit)*

- i) What factors may enable you to make the practice change(s)? What supports or resources might you need?  
*(e.g. having a flow sheet that links to the OMSC form that is easy to use during a visit)*

- ii) What factors might get in the way of making the practice change(s)?  
*(e.g. competing priorities during a visit. Needing to open multiple forms to document)*

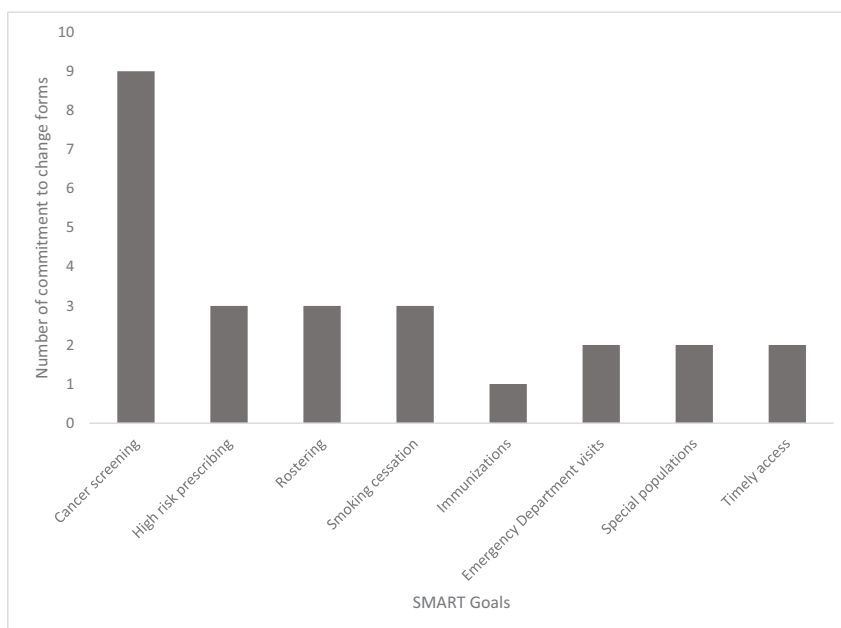
iii) How *motivated* are you that you can make the practice change(s)?  
1 2 3 4 5 6 7 8 9 10  
(not motivated) (highly motivated)

iv) How *confident* are you that you can make the practice change(s)?  
1 2 3 4 5 6 7 8 9 10  
(no confidence) (total confidence)

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### Appendix 3. Topic Foci for SMART Goals for Practice Improvement, Sample SMART Goals from the Commitment to Change Form and Feedback from Coachees

#### A) Topic foci for SMART goals for practice improvement that physicians and their coaches indicated on the commitment to change form following the initial peer-coaching session



#### B) Sample SMART goals from the commitment to change form and feedback from coachees

##### Sample SMART goals

**Cancer screening** Improve colorectal cancer screening rate from 59 % to 70 % by next year

**Access** Improve access through reduced TNA to consistently <10 days. Book f/u visits (routine) with interdisciplinary team members

**High-risk prescribing** Start using opioid maintenance tool with patients on opioids to improve care of pts on opioids and work toward deprescribing or reducing the dose

##### Motivation and Confidence to achieve practice change

**How motivated are you that you can make the practice change(s)?** mean 8.2/10 (range 7-10)

**How confident are you that you can make the practice change(s)?** mean 7.5 (range 5-10)

### **Sample Comments from post-session written evaluation**

- *“We don’t often get the luxury of looking at our practice at a whole and thinking about why we approach our every-day in the way that we do. I found this exercise extremely helpful for my future practice management and functioning, but also therapeutic as it was nice to find common challenges and frustrations.”*
- *“[coach] has tremendous practice experience and knowledge of CPSO policies to contribute. Pushed me to carefully review and reflect on the data. Contributed to sense of physician wellness – support of colleagues.”*
- *“It was informal and enjoyable (the product of getting to “choose” one’s coaching match). It was fascinating to learn how others run their practice and pick up new ideas and tricks.”*
- *“Informed. Frank and open discussion, non-judgmental. I learned a lot about my practice.”*
- *“A chance to have a different point of view discussed with my peer-coach. I value my peer-coach’s different point of view.”*