Katie Coleman, MSPH

MacColl Center for Health Care Innovation ● Kaiser Permanente Washington Health Research Institute
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EDUCATION AND TRAINING

2006 Master of Science in Public Health (MSPH) 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

2001 Bachelor of Science (BS) 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

2020 Strategic Leadership Program, Kaiser Permanente Washington
2009 Lean Daily Management Training, Group Health Cooperative
2008 TeamSTEPPS Master Trainer, Duke University Health System
2007 Coaching-the-Coaching Training, Dartmouth Clinical Microsystems
2004 Domestic Violence 40-hour Training Certificate, Chicago Metropolitan Battered Women's Network
2001 40-Hour Grants Training Certificate, Grantsmanship Center

PROFESSIONAL POSITIONS

2019-present Director, MacColl Center for Health Care Innovation, Kaiser Permanente Washington Health Research Institute
2018-present Director, Learning Health System Program, Kaiser Permanente Washington
2014-present Research Associate, Kaiser Permanente Washington Health Research Institute
2012-present Katie Coleman, Independent Consultant
2014-2016 Founder & Board Member, Woodland Park Cooperative Kindergarten
2008-2014 Research Associate II, MacColl Center for Health Care Innovation, GHRI
2006-2008 Research Associate I, MacColl Center for Health Care Innovation, GHRI
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

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

PROFESSIONAL SERVICE AND MEMBERSHIP

2004-present	AcademyHealth Member
2019	Global to Local Expert Panel
2019	Agency for Healthcare Research and Quality Roundtable on the Future of Health Services Research
2018	K12 Learning Health System Scholar Applicant Review
2018	Northwest Regional Primary Care Association in-kind consultant on strategy
2018	VA State of the Art Care Coordination convening (invited)
2018	KPWA Research and Evidence-Based Nursing Practice Committee
2017	The Commonwealth Fund Annual FQHC Survey Review
2016	MacColl Strategic Planning Workgroup; Dissemination & Implementation Workgroup
2016	North Cascade Accountable Communities of Health in-kind consultant on strategy
2015	17th Annual Birnbaum Endowed Lecture Planning Committee
2015	Group Health Research Institute Leadership Structure Envisioning
2015 -2017	KPWHRI Scientific Advisory Committee member
2014	University of Toronto Teaming Project – A commitment to patient-centered care
2014	Wagner Symposium Developing & Sustaining a State-Wide Primary Care Extension Program
2013	Washington State Innovation Plan Consultant Team
2013	Canadian Institutes of Health Research & Canadian Foundation for Innovation - Organizational Readiness for Knowledge Translation in Chronic Care: A Delphi Study
2012-2013	MacColl Center for Health Care Innovation Strategic Planning Committee, work stream lead
2009-2014	The Commonwealth Fund's National Patient Centered Medical Home Evaluator's Collaborative
2009-2014	Dartmouth Clinical Microsystems Coaching Collaborative
2011	National Association of Community Health Centers – Patient Centered Medical Home Learning Institution Blue Print Committee
2010-2011	Montana Primary Care Association – Patient Centered Medical Home Consultant
2010-2011	MacColl Center Director/Senior Investigator Search Committee

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)
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
2008-2009	Washington Association of Community and Migrant Health Centers, National Quality Conference Planning Committee
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 RESPONSIBILITIES

2017	Annals of Family Medicine
2016	Journal of Health Care for the Poor & Underserved, Journal for General Internal Medicine
2015	Journal of General Internal Medicine
2014	Medical Care, American Journal of Managed Care
2013	Journal of Health Care for the Poor and Underserved, Social Science and Medicine
2012	Perspectives in Public Health, Royal Society for Public Health, Health Affairs
2011	Annals of Family Medicine, Health Affairs, Annals of Family Medicine
2010	BMJ Quality & Safety, Annals of Family Medicine
2009	Health Research Board Ireland, Annals of Family Medicine, American Journal of Managed Care
2008	Quality in Primary Care, Medical Care, Milbank Quarterly, Robina Foundation
2007	American Journal of Managed Care
2006	Public Library of Science

RESEARCH FUNDING

Current projects:

No Grant # (Coleman/Lozano) $6,404,202 (direct) 6/1/2017-12/31/2021
Kaiser Permanente Washington
Learning Health System Program: to connect with our partners at Kaiser Permanente Washington and develop alignment across existing Learning Health System (LHS) work; design a LHS program for 2018 and beyond; evaluate three high value initiatives to support care delivery decision making; and provide support and consultation in selected areas of strategic importance.
Role: Co-PI, 50% FTE

74899 (Tobey) $341,940 (direct) 10/1/2017-9/30/2020
Robert Wood Johnson Foundation
Safety-Net Learning and Action Hub for Value-Based Payment and Care: to build capacity among primary

care associations and other state-wide agencies to prepare practices for value-based care and payment. This initiative will leverage quality improvement, primary care, and payment expertise in service of community health centers and community mental health agencies and their patients.
Role: Site PI, 25% FTE

No Grant # (Coleman) $40,300 (direct) 4/1/2019-2/29/2020
Kaiser Permanente Washington Health Research Institute Development Fund
MacColl Capacity Building for Implementation Science and Practice: to generate a model, infrastructure, data structures, products, and funding streams for advancing an integrated implementation science and practice model for MacColl.
Role: PI, 10% FTE

No Grant # (Coleman) $134,763 (direct) 8/1/2019-3/31/2021
Kaiser Permanente Washington Community Benefit
Building the Capacity to Address Social Needs in Washington: to support the Washington Association of Community Health to design, implement, and evaluate a social needs screening collaborative for federally qualified health centers in Washington.
Role: PI, 8% FTE

Completed Projects:

No Grant # (Olesen) $219,571 (direct) 4/1/2015-4/30/2019
Colorado Health Foundation
The Colorado Health Foundation Technical Assistance Partner (TAP)
Role: Site PI, 15% FTE

Grant #R18 HS023908 (Parchman) $11,262,282 (direct) 5/1/2015-4/30/2019
Agency for Healthcare Research and Quality
The Northwest Coalition for Primary Care Practice Support
Role: Key Personnel, 18% FTE

Grant #Y605996 (Coleman) $32,704 (direct) 7/1/2017-10/31/2018
Kaiser Permanente Community Benefit
Partnering with OPCA
Role: PI, 10% FTE

Grant #19815 (Coleman) $207,653 (direct) 10/1/2016-4/30/2018
California Health Care Foundation
Essential Capabilities and Emerging Models for Advancing High-Performance Primary Care in the Safety Net
Role: Site PI, 20% FTE

Grant #157 (Coleman) $54,121 (direct) 9/1/2016-11/30/2017
Group Health Foundation
Expanding the Medical Assistant Role in Advancing Primary Care
Role: PI, 7% FTE

Grant #71986 (Wagner) $2,101,747 (direct) 9/1/2014-7/31/2017
Robert Wood Johnson Foundation
Primary Care Teams: Learning from Effective Ambulatory Practices Phase 2
Role: Key Personnel, 20% FTE

Grant #1011 (Hsu) $1,112,785 (direct) 3/1/2013-8/31/2016
Patient-Centered Outcomes Research Institute
Creating a Clinic-Community Liaison Role in Primary Care: Engaging Patients and Community in Health Care Innovation
Role: Key Personnel, 5% FTE

Grant #HHSA2901000004i (LeRoy) $219,809 (direct) 8/18/2014-7/17/2016
Agency for Healthcare Research and Quality
New Models of Primary Care Workforce and Financing
Role: Key Personnel, 13% FTE

No Grant # (Coleman) $61,967 (direct) 10/1/2013-10/31/2015
Oregon Primary Care Association
Alternative Payment Model (APM) Initiative
Role: PI, 20% FTE

Grant #65529/72042 (Siegel) $1,248,588 (direct) 9/1/2009-5/31/2015
Robert Wood Johnson Foundation
Technical Assistance and Direction for RWJ's Regional Quality Strategy Program (Aligning Forces for Quality Initiative)
Role: Key Personnel, 25% FTE

Grant #71178 (Wagner) $291,720 (direct) 9/1/2013-4/30/2015
Robert Wood Johnson Foundation
Primary Care Emerging Leaders
Role: Key Personnel, 20% FTE

Grant #20130308 (Sugarman) $89,589 (direct) 6/1/2013-11/30/2014
The Commonwealth Fund
Safety Net Medical Home Initiative Dissemination Grant
Role: Key Personnel, 15% FTE

Grant #69788 (Wagner) $3,088,897 (direct) 2/1/2012-11/30/2014
Robert Wood Johnson Foundation
The Primary Care Team: Learning from Effective Ambulatory Practices
Role: Key Personnel, 23% FTE

Grant #20110467 (Wagner) $212,163 (direct) 8/1/2011-9/30/2013
The Commonwealth Fund
Creating a National PCMH Curriculum: Diffusion of the Safety Net Medical Home Initiative

Role: Key Personnel, 15% FTE

No Grant # (Fihn) $134,169 (direct) 9/10/2010-8/31/2013
Veterans Administration
Patient Centered Medical Home (PCMH) Demonstration Laboratories: VA Coordinating Center
Role: Key Personnel, 10% FTE

Grant #20090344 (Sugarman) $748,772 (direct) 5/1/2008-7/31/2013
The Commonwealth Fund
Transforming Safety Net Clinics into Patient-Centered Medical Homes
Role: Key Personnel, 33% FTE

Grant #HHSM-500-2011-00147 (Wagner) $235,196 (direct) 3/1/2012-4/30/2013
Center for Medicare and Medicaid Innovation
Technical Assistance to Support the Learning and Diffusions Activities at Center for Medicare & Medicaid Innovation (CMMI)
Role: Key Personnel, 35% FTE

No Grant # (Reid) $429,318 (direct) 7/1/2010-6/30/2013
Agency for Healthcare Research and Quality
Transforming Primary Care: Evaluating the Spread of the Medical Home
Role: Key Personnel, 10% FTE

Grant # R18 HS019129 (Reid) $803, 877 (direct) 8/1/2006-12/31/2011
Group Health Research Institute Development Fund
Group Health Medical Home Evaluation
Role: Key Personnel, 20% FTE

Grant #20080479 (Arterburn) $367,208 (direct) 4/1/2009-3/31/2011
The Commonwealth Fund
Assessing the Impact of Patient Decision Aids on Health Care Utilization and the Costs of Care
Role: Key Personnel, 20% FTE

Grant #07-1136/08-1262 (Wagner) $142,397 (direct) 6/11/2007-12/31/2010
California Health Care Foundation
California Improvement Network
Role: Key Personnel, 5% FTE

Grant #HHSA2902006000171 (Wagner) $202,467 (direct) 9/29/2006-7/31/2009
Agency for Healthcare Research and Quality
Integrating Chronic Care and Business Strategies in the Safety Net
Role: Key Personnel,

Grant #058194 (Wagner) $170,390 (direct) 8/1/2006-6/30/2009
Robert Wood Johnson Foundation

Scientific Support for Field Building and ICIC Transition
Role: Key Personnel, 75% FTE

Grant #PO4300094533 (Bailit) $106,476 (direct) 7/15/2008-3/31/2009
Commonwealth of Pennsylvania
Technical Assistance (TA) for Prescription for Pennsylvania
Role: Key Personnel, 5% FTE

No Grant # (Von Korff) $142,909 (direct) 4/1/2007-12/31/2008
Group Health Research Institute Development Fund
Content and Costs of Care
Role: Key Personnel: 20%

No Grant # (Wagner) $17,273 (direct) 3/1/2008-9/30/2008
The Commonwealth Fund
The Use of Patient-Provider Agreements to Improve Quality
Role: Key Personnel, 50%

No Grant # (Wagner) $2,581 (direct) 12/1/2007-3/31/2008
Washington State Department of Health
Washington State Collaborative to Improve Health – Coaches Training
Role: Key Personnel, 90% FTE

PUBLICATIONS

Peer-reviewed publications

1. Parchman ML, Anderson ML, **Coleman K**, Michaels LA, Schuttner L, Conway C, Hsu C, Fagnan LJ. Assessing quality improvement capacity in primary care practices. BMC Fam Pract. 2019;20(1):103.
2. Hertel E, Cheadle A, Matthys J, **Coleman K**, Gray M, Robbins M, Tufte J, Hsu C. Engaging patients in primary care design: An evaluation of a novel approach to codesigning care. Health Expect. 2019;22(4):609-16.
3. Gray MF, Sweeney J, Nickel W, Minniti M, **Coleman K**, Johnson K, Mroz T, Forss B, Reid R, Frosch D, Hsu C. Function of the medical team quarterback: Patient, family, and physician perspectives on team care coordination in patient- and family-centered primary care. Perm J. 2019;23.
4. **Coleman K**, Wagner EH, Ladden MD, Flinter M, Cromp D, Hsu C, Crabtree BF, McDonald S. Developing emerging leaders to support team-based primary care. J Ambul Care Manage. 2019;42(4):270-83.
5. Wagner EH, LeRoy L, Schaefer J, Bailit M, **Coleman K**, Zhan C, Meyers D. How do innovative primary care practices achieve the quadruple aim? J Ambul Care Manage. 2018;41(4):288-97.
6. Parchman ML, Hsu C, **Coleman K**. Why is external facilitation effective as an implementation strategy? Evidence for tailoring to the learning capacity of primary care practices in conference proceedings for the society for implementation research collaboration (SIRC) 2017: Implementation mechanisms: What makes implementation work and why? Part 2. Implementation Science. 2018;13(Suppl 3):B13.

7. Hsu C, Hertel E, Johnson E, Cahill C, Lozano P, Ross TR, Ehrlich K, **Coleman K**, BlueSpruce J, Cheadle A. Evaluation of the learning to integrate neighborhoods and clinical care project: Findings from implementing a new lay role into primary care teams to address social determinants of health. Perm J. 2018;22.

8. Blasi PR, Cromp D, McDonald S, Hsu C, **Coleman K**, Flinter M, Wagner EH. Approaches to behavioral health integration at high performing primary care practices. J Am Board Fam Med. 2018;31(5):691-701.

9. Hsu CW, Hertel E, BlueSpruce J, Ross TR, Cheadle A, Johnson E, Matthys J, Ehrlich K, **Coleman K**, Tufte J. Connecting primary care patients to community resources: Lessons learned from the development of a new lay primary care team role. Journal of Patient-Centered Research and Reviews. 2016;3(3):218.

10. Cromp D, Hsu C, **Coleman K**, Fishman PA, Liss DT, Ehrlich K, Johnson E, Ross TR, Trescott C, Trehearne B, Reid RJ. Barriers and facilitators to team-based care in the context of primary care transformation. J Ambul Care Manage. 2015;38(2):125-33.

11. Wagner EH, Sandhu N, **Coleman K**, Phillips KE, Sugarman JR. Improving care coordination in primary care. Med Care. 2014;52(11 Suppl 4):S33-8.

12. Wagner EH, Gupta R, **Coleman K**. Practice transformation in the Safety Net Medical Home Initiative: A qualitative look. Med Care. 2014;52(11 Suppl 4):S18-22.

13. Sugarman JR, Phillips KE, Wagner EH, **Coleman K**, Abrams MK. The Safety Net Medical Home Initiative: Transforming care for vulnerable populations. Med Care. 2014;52(11 Suppl 4):S1-10.

14. Johnson KE, **Coleman K**, Phillips KE, Austin BT, Daniel DM, Ridpath J, Schaefer J, Wagner EH. Development of a facilitation curriculum to support primary care transformation: The "coach medical home" curriculum. Med Care. 2014;52(11 Suppl 4):S26-32.

15. Derrett S, Gunter KE, Nocon RS, Quinn MT, **Coleman K**, Daniel DM, Wagner EH, Chin MH. How 3 rural safety net clinics integrate care for patients: A qualitative case study. Med Care. 2014;52(11 Suppl 4):S39-47.

16. **Coleman K**, Phillips KE, Van Borkulo N, Daniel DM, Johnson KE, Wagner EH, Sugarman JR. Unlocking the black box: Supporting practices to become patient-centered medical homes. Med Care. 2014;52(11 Suppl 4):S11-7.

17. Reid RJ, Johnson EA, Hsu C, Ehrlich K, **Coleman K**, Trescott C, Erikson M, Ross TR, Liss DT, Cromp D, Fishman PA. Spreading a medical home redesign: Effects on emergency department use and hospital admissions. Ann Fam Med. 2013;11 Suppl 1:S19-26.

18. Daniel DM, Wagner EH, **Coleman K**, Schaefer JK, Austin BT, Abrams MK, Phillips KE, Sugarman JR. Assessing progress toward becoming a Patient-Centered Medical Home: An assessment tool for practice transformation. Health Serv Res. 2013;48(6 Pt 1):1879-97.
    **Best of the 2013 AcademyHealth Annual Research Meeting

19. Wagner EH, **Coleman K**, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The changes involved in patient-centered medical home transformation. Prim Care. 2012;39(2):241-59.

20. Nuno R, **Coleman K**, Bengoa R, Sauto R. Integrated care for chronic conditions: The contribution of the ICCC framework. Health Policy. 2012;105(1):55-64.

21. Hsu C, **Coleman K**, Ross TR, Johnson E, Fishman PA, Larson EB, Liss D, Trescott C, Reid RJ. Spreading a Patient-Centered Medical Home redesign: A case study. J Ambul Care Manage. 2012;35(2):99-108.
22. Fishman PA, Johnson EA, **Coleman K**, Larson EB, Hsu C, Ross TR, Liss D, Tufano J, Reid RJ. Impact on seniors of the Patient-Centered Medical Home: Evidence from a pilot study. Gerontologist. 2012;52(5):703-11.
23. **Coleman K**, Pearson M, Wu S. Integrating chronic care and business strategies in the safety net: A practice coaching manual. Operations Management: A Modern Approach. 2011:267.
24. **Coleman K**. Invited commentary: Without changes in care, should we expect changes in outcomes? Ann Fam Med. 2011.
25. Reid RJ, **Coleman K**, Johnson EA, Fishman PA, Hsu C, Soman MP, Trescott CE, Erikson M, Larson EB. The group health medical home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. Health Aff (Millwood). 2010;29(5):835-43.
    ** Cited by Dr. David Blumenthal during his 2/27/13 testimony to the Senate Special Committee on Aging "Strengthening Medicare for Today and the Future" hearing.
26. Ralston JD, **Coleman K**, Reid RJ, Handley MR, Larson EB. Patient experience should be part of meaningful-use criteria. Health Aff (Millwood). 2010;29(4):607-13.
27. **Coleman K**, Reid RJ, Johnson E, Hsu C, Ross TR, Fishman P, Larson E. Implications of reassigning patients for the medical home: A case study. Ann Fam Med. 2010;8(6):493-8.
28. **Coleman K**, Phillips K. Providing underserved patients with medical homes: Assessing the readiness of safety-net health centers. Issue Brief (Commonw Fund). 2010;85:1-14.
29. **Coleman K**, Mattke S, Perrault PJ, Wagner EH. Untangling practice redesign from disease management: How do we best care for the chronically ill? Annu Rev Public Health. 2009;30:385-408.
30. **Coleman K**, Austin BT, Brach C, Wagner EH. Evidence on the chronic care model in the new millennium. Health Aff (Millwood). 2009;28(1):75-85.
    ** Thirteenth most read Health Affairs publication in 2009.
31. **Coleman K**. Invited commentary: Real redesign required. Ann Fam Med. 2009.
32. **Coleman K**, Reiter KL, Fulwiler D. The impact of pay-for-performance on diabetes care in a large network of community health centers. J Health Care Poor Underserved. 2007;18(4):966-83.
33. **Coleman K**, Hamblin R. Can pay-for-performance improve quality and reduce health disparities? PLoS Med. 2007;4(6):e216.

In Press

34. Crabtree BF, Howard J, Miller W, Cromp D, Hsu C, **Coleman K**, Austin BT, Flinter M, Wagner EH. Leading innovative practice: Leadership attributes in LEAP practices. Milbank Quarterly In Press.
35. Shuttner L, **Coleman K**, Ralston JD, Parchman ML. The association of practice adaptive reserve and development of quality improvement capacity in primary care. Ann Fam Med. In Press.

In Review

36. **Coleman K**, Allen C, Shepherd C, Eslan A, Sanchez J, Leibig P. Supporting team development based on lessons learned from high performers. J Health Care Poor Underserved. In Review.

37. **Coleman K**, Kraakauer C, Anderson ML, Michaels LA, Dickinson C, Brantley S, Conway C, Dorr D, Fagnan LJ, Hsu C, Balderson B, Parchman ML. Smaller, faster better: Assessing small practices' progress toward improving heart health. Health Serv Res. In Review.

38. Singer A, **Coleman K**, Hsu C. Empathic inquiry: Developing and piloting a patient-centered approach to social needs screening. J Health Care Poor Underserved. In Review.

In process

39. Gray M, Walsh-Bailey C, Girard S, Lozano P, **Coleman K**. Expanded medical assistant roles and training. Perm J. In Process.

40. Hsu C, **Coleman K**, Fagnan LJ, Baldwin LM. Making changes in small practices to improve heart health: Understanding pdsa cycles. BMJ Qual Saf. In Process.

41. Allen C, **Coleman K**, Mettert K, Lewis C, Westbrook E, Lozano P. How do we know learning health systems work? A measurement approach. Health Aff (Millwood). In Process.

42. Higgins T, **Coleman K**, Crosson J, Eslan A. A team-based care implementation in 19 diverse colorado primary care practices: How practices transformed; factors influencing success; and effects on patient, clinician and staff satisfaction. Health Aff (Millwood). In Process.

Book chapters

1. Weppner W, **Coleman K**, Reid R, Larson E. Improving management of chronic disease. From front office to front line: Essential issues for health care leaders 2nd edition. Oak Brook, IL: Joint Commission Resources; 2011. p. 127-58.

2. **Coleman CF**, Wagner EH. The chronic care model. To cure and to care innovation in the management of chronic illness: A practical guide to move forward. Barcelona, Spain: Elsevier Masson; 2008. p. 3-15.

Other publications

1. **Coleman K**, Tobey R, Shepherd C, Phillips K, Houston K, Hsu C, Maxwell J, Berthoud H, Rojasova S, Hummel J, Austin BT, Wagner EH. Partnering to succeed: How small health centers can improve care and thrive under value-based payment. Oakland: CHCF; 2018 March 2018.

2. **Coleman K**, Wagner EH, Schaefer J, Reid R. Redefining primary care for the 21st century. Rockville; 2016. Contract No.: 16(17)-0022-EF.

3. **Coleman K**. Implementing team-based care: Small changes for big payoffs. In: Quarterly P, editor. Medical Home Best Practices from NCQA. Washington, DC: National Committee for Quality Assurance 2016. p. 7.

4. **Coleman K**. Paying for team-based care. Princeton: Robert Wood Johnson Foundation; 2016 [Available from: http://www.improvingprimarycare.org/.]

5. **Coleman K**. Using teams to improve access to primary care. Princeton: Robert Wood Johnson Foundation; 2014 [Available from: http://www.improvingprimarycare.org/.]

6. **Coleman K**. Evidence that the medical home works. New York: The Commonwealth Fund; 2013 [Available from: http://www.safetynetmedicalhome.org/.]
7. **Coleman K**, Reid R, Initiative SNMH. Continuous and team-based healing relationships: Improving patient care through teams. In: Phillips KE, Weir V, editors. Safety Net Medical Home Initiative implementation guide series. 2nd ed. Seattle: Qualis Health and the MacColl Center for Health Care Innovation at Group Heatlh Research Institute; 2013.
8. **Coleman K**. Module 3: Fundamentals first - sequencing changes. New York: The Commonwealth Fund; 2013 [Available from: http://www.coachmedicalhome.org/.
9. Fox E. Interview with director of lean improvement and promotion, group health cooperative. In: Coleman K, Daniel DM, editors. Medical Home Digest. Seattle: The Commonwealth Fund; 2012.
10. **Coleman K**. How does a facilitation program use local learning collaboratives to reinforce its work with practices? Rockville; 2012 May 18.
11. **Coleman K**. Invited commentary: Without changes in care, should we expect changes in outcomes? Ann Fam Med. 2011.
12. Van Borkulo N, **Coleman K**. A practice facilitator's guide to visiting clinical teams. Safety Net Medical Home 1st ed. Seattle: Qualis Health and the MacColl Center for Health Care Innovation at Group Health Research Institute; 2011.
13. **Coleman K**. Pay for performance not sufficient to cure what ails us. Group Health Blog [Internet]. Seattle: Group Health Cooperative; 2011.
14. **Coleman K**, Pearson M, Wu S. Integrating chronic care and business strategies in the safety net: A practice coaching manual. Operations Management: A Modern Approach; 2011. p267.
15. **Coleman K**. Patient centered interactions in the medical home. Group Health Cooperative Patient Centered Care Interest Group Meeting; March 17, 2011; Seattle.
16. Austin BT, **Coleman K**. Ask the expert: Registries New York: The Commonwealth Fund; 2009
17. **Coleman K**. Invited commentary: Real redesign required. Ann Fam Med. 2009.
18. MacColl Center for Health Care Innovation at Group Health Research Institute, RAND Corporation, California Health Care Safety Net Institute. Integrating chronic care and business strategies in the safety net: A toolkit. Rockville; 2008 September. Report No.: 08-0104-EF.
19. Austin BT, **Coleman K**, Wagner EH. Innovation for better health: Making the promise a reality. Seattle: 2007.
20. Wagner EH, Austin BT, **Coleman K.** It takes a region: Creating a framework to improve chronic disease care. Oakland: 2006.

Poster presentations and abstracts

1. Allen C, Mettert K, **Coleman K**, Lozano P, Westbrook E, Lewis C. Constructs to evaluate a learning health system. AcademyHealth Annual Research Meeting; June 13, 2019; Chicago.
2. Parchman ML, Hsu C, **Coleman K**. Why is external facilitation effective as an implementation strategy? Evidence for tailoring to the learning capacity of primary care practices in conference proceedings for

the society for implementation research collaboration (sirc) 2017: Implementation mechanisms: What makes implementation work and why? Part 2. Implementation Science. 2018;13(Suppl 3):B13.

3. Berthoud H, **Coleman K**, Tobey R, Phillips K, Austin BT, Houston K, Hsu C, Hummel J, Rajasova S, Shepherd C, Wagner EH. Advancing high performance in the safety net: Partnerships as key facilitator for success under value-based payment. AcademyHealth Annual Research Meeting; June 24, 2018; Seattle.
4. Lozano P, **Coleman K**. KPWA providers, staff and patients partner with the learning health system program to achieve the quadruple aim. Washington Permanente Medical Group; September 22, 2017; Seattle
5. Parchman ML, Fagnan LJ, **Coleman K**, Michaels LA, Van Borkulo N, Tuzzio L, Dorr D, Hummel J, Baldwin LM. Quality improvement learning capacity in primary care predicts clinical quality measures AcademyHealth Annual Research Meeting; June 25, 2017; New Orleans.
6. Michaels LA, Van Borkulo N, Sommers B, Dickinson C, Brill C, Tuzzio L, Parchman ML, **Coleman K**. Creation of a high-leverage change package to achieve EvidenceNow quality improvement goals. North American Primary Care Research Group; November 16, 2016; Colorado Springs.
7. Johnson K, **Coleman K**, Wagner EH, Phillips K, Daniel DM, Sugarman JR, Schaefer J. Coach medical home: A curriculum to facilitate patient-centered medical home transformation American Public Health Association; November 2, 2013; Boston.
8. Derrett S, Gunter KE, Nocon RS, Quinn MT, **Coleman K**, Daniel DM, Chin MH. We're isolated in a way that most people don't understand - care coordination among rural safety net clinics. AcademyHealth Annual Research Meeting June 23, 2013; Baltimore.
9. Reid RJ, Johnson E, Fishman P, Hsu C, Ross TR, **Coleman K**, Ehrlich K, Liss D, Trescott C, Larson E. Spread of the patient-centered medical home at group health: Preliminary findings. Agency for Healthcare Research and Quality Annual Meeting; September 18, 2011; Rockville.
10. Hsu C, **Coleman K**, Ross TR, 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; June 14, 2011; Seattle.
11. **Coleman K**, Wu S, Pearson ML, Austin BT, Brach C, Jameson WJ, Wagner EH. Improving chronic care and business strategies in the safety net. AcademyHealth Annual Research Meeting; June 10, 2008; Washington, DC.
12. **Coleman K**. Screening and treatment of gestational diabetes and its impact on offspring's quality of life: An economic evaluation. Annual Women's Health Research Day; April 5, 2006; Chapel Hill.
13. **Coleman K**. The impact of pay-for-performance on diabetes care in a large network of community health centers. University of North Carolina; April 27, 2006; Chapel Hill.

Oral presentations

1. Advancing the conversation on implementation science and quality improvement: Leaders working at the nexus with Lewis C, Check D, Mittman B, Sales A, Goldman D. AcademyHealth D&I Conference; December 5, 2019; Arlington, VA.

2. The future of high-performing primary care. Northwest Regional Primary Care Association Strategic Planning Meeting; November 14, 2019; Seattle, WA.
3. Exploring how care team members can contribute to quality KPWA Clinical Quality Champions Fall Forum October 15, 2019; Renton, WA.
4. Learning to change practice & inform health: Stories from group health's medical home. K12 Scholars CATALyST Forum: The Learning Health System in Washington State; May 20, 2019; Seattle, WA.
5. The learning health system: Where are we now? KPWA Learning Health System All Hands Meeting; July 30, 2019; Seattle, WA.
6. Quality improvement as a management approach. University of Washington; April 23, 2019; Seattle, WA.
7. New partnerships for a new era. Delta Center for a Thriving Safety Net Learning Session 3; February 11, 2019 Oakland, CA.
8. Burien data and insights. KPWA Patient Experience Team; December 13, 2018 Seattle, WA.
9. How learning health systems can make real the promise of embedded pragmatic research. AcademyHealth D&I Conference; December 5, 2018 Washington, DC.
10. Connecting care delivery changes to the main models of value-based pay. California Health Care Foundation Insight Forum; November 6, 2018 Oakland, CA.
11. Understanding your members' needs. Delta Center for a Thriving Safety Net Learning Session 2; October 16, 2018 Seattle, WA.
12. Improving care in a value based environment. National Association of Community Health Centers Payment and Delivery Reform Summit; August 7, 2018 Webinar.
13. Celebrating and sustaining empathic inquiry Oregon Primary Care Association and Kaiser Permanente Northwest Empathic Inquiry Closing Training; July 30, 2018 Portland, OR.
14. Sustaining team-based care in a value-based environment: What capabilities do we have? A conversation. . Colorado Health Foundation Team Based Care Initiative; July 10, 2018; Webinar.
15. Quality improvement as a management tool. University of Washington; April 24, 2018 Seattle, WA.
16. Fostering clinic-community connections. Colorado Health Foundation Team Based Care Initiative; April 12, 2018 Denver, CO.
17. Empathic inquiry: An evaluation approach. Oregon Primary Care Association and Kaiser Permanente Northwest Empathic Inquiry Training; February 15, 2018 Portland, OR.
18. Empathic inquiry: How will we know if we're making a difference for our patients? Oregon Primary Care Association and Kaiser Permanente Northwest Empathic Inquiry Training; February 6, 2018 Portland, OR.
19. Expanded ma role training program: Evaluation findings. KPWA Partnership for Innovation; October 16, 2017 Seattle, WA.
20. Achieving high performing primary care in the safety net: Successful models for small to medium-sized community clinics and health centers. California Primary Care Association Annual Conference; October 12, 2017; Anaheim, CA.

21. Team-based care collaborative: A roadmap. Colorado Health Foundation Team-Based Care Learning Session; October 4, 2017; Denver, CO.
22. Using quality improvement strategies to create improvements in team-based care. Colorado Health Foundation Team-Based Care Learning Session; October 4, 2017; Denver, CO.
23. Essential capabilities and emerging models for advancing high-performance primary care in the safety net. California Health Care Foundation Expert Advisory Board Meeting; August 23, 2017 Oakland, CA.
24. Population segmentation: Examples from the field. Oregon Primary Care Association Alternative Payment and Care Model; August 17, 2017 Bend, OR.
25. Primary care and the patient with complex needs. Wagner Symposium; June 29, 2017 Seattle, WA.
26. Celebrating LEAP and sustaining team-based care. Robert Wood Johnson Foundation; May 23, 2017 Webinar.
27. Using quality improvement to create sustainable improvements in health. University of Washington Fundamentals of Implementation Science in Global Health; April 25, 2017; Seattle, WA.
28. Open space: Team-based care. Colorado Health Foundation Team-Based Care LEarning Session; April 6, 2017; Denver, CO.
29. Care management. Colorado Health Foundation Team-Based Care Learning Session; April 6, 2017 Denver, CO.
30. Primary care fundamentals: A panel. Colorado Health Foundation Team-Based Care Initiative; November 24, 2016 Denver, CO.
31. Social care and the role of primary care in understanding and addressing the social determinants of health. Oregon Primary Care Association Alternative Payment and Care Model November 3, 2016; Portland, OR.
32. Reimagining the medical assistant role: Lessons learned from LEAP. Partnership for Innovation Advisory Group for the Expanding Medical Assistants Role Project; October 13, 2016; Tukwila, WA.
33. Transformational leadership: Linking good health outcomes and financial sustainability Oregon Primary Care Association Strategic Planning Retreat; September 19, 2016; Eugene, OR.
34. Quality improvement as a management tool. University of Washington Fundamentals of Implementation Science in Global Health; September 16, 2016; Seattle, WA.
35. Clinic community partnership. Oregon Primary Care Association Alternative Payment and Care Model; July 22, 2016 Newport, OR.
36. Dissolving the walls: Clinic community connections. Health Resources and Services Administration Clinical Workforce Development; June 2, 2016 Webinar.
37. Achieving full integration of behavioral health and primary care. Health Resources and Services Administration Clinical Workforce Development; May 18, 2016; Webinar.
38. Chronic disease prevention & management inside the health care system. University of Washington HSMGMT503: Population Health Management Strategy; October 27, 2015 Seattle, WA.
39. Complex care management in primary care. Health Resources and Services Administration Clinical Workforce Development; May 5, 2016; Webinar.

40. A team approach to prevention of chronic illness management. Health Resources and Services Administration Clinical Workforce Development; April 21, 2016; Webinar.
41. Plan-do-study-act. Group Health Research Institute Healthy Hearts Northwest Coach Booster Training; April 25, 2016 Seattle, WA.
42. Data driven dashboards to support team-based care. Health Resources and Services Administration Clinical Workforce Development; April 7, 2016 Webinar.
43. Nursing best practices. Colorado Health Foundation Team-Based Care Initiative April 6, 2016; Denver, CO.
44. Team roles world cafe. Colorado Health Foundation Team-Based Care Initiative; April 5, 2016; Denver, CO.
45. SMILES dental project: Team-based care. Colorado Health Foundation March 17, 2016; Webinar.
46. Community health workers & new care team roles: What are innovations in team-care?` . Oregon Primary Care Association Alternative Payment and Care Model; March 7, 2016; Portland, OR.
47. Building your primary care team to transform your practice. Health Resources and Services Administratiojn Clinical Workforce Development; February 18, 2016 Webinar.
48. Well-organized primary care teams. Oregon Primary Care Association Alternative Payment and Care Model; February 10, 2016; Webinar.
49. Chronic Disease Prevention & Management Inside the Health Care System. University of Washington. HSMGMT 503: Population Health Management Strategy. October 27, 2015; Seattle, WA.
50. Unlocking the black box: Supporting practices to transform. Group Health Research Institute Healthy Hearts Northwest Practice Coach Training; September 30, 2015; Seattle, WA.
51. The role of the medical assistant Colorado Health Foundation Team-Based Care Learning Session 1; September 11, 2015; Denver, CO.
52. Using quality improvement to create sustainable improvements in health. University of Washington Intensive Course on Implementation Science for Family Planning and Reproductive Health; August 7, 2015; Seattle, WA.
53. Getting started with team-based care. Colorado Health Foundation; August 3, 2015; Webinar.
54. Care teams and alternative visit types. Oregon Primary Care Association; July 30, 2015; Webinar.
55. Prapare as a tool for patient engagement. Oregan Primary Care Association Alternative Payment and Care Model Learning Session; April 22, 2015; Portland, OR.
56. Using social data and segmentation to improve primary care services for your customer. Oregon Primary Care Association Alternative Payment and Care Model Learning Session; April 22, 2015; Portland, OR.
57. Practice coaching. Colorado Health Foundation; April 16, 2015; Denver, CO.
58. Team-based primary care: Effective practices from high-performing organizations. Institute for Healthcare Improvement 16th Annual International Summit on Improving Patient Care in the Office Practice and the Community; March 15, 2015; Dallas, TX.

59. Rapid fire session: Patient engagement. Oregon Primary Care Association Alternative Payment and Care Model Learning Session; January 23, 2015; Portland, OR.
60. So you want to create primary care teams - now what? Oregon Primary Care Association; December 11, 2014; Webinar.
61. Perspectives on population management. Oregon Primary Care Association; October 27, 2014; Bend, OR.
62. How will we get to transformed care? Oregon Primary Care Association; October 27, 2019; Bend, OR.
63. The primary care team - celebrating emerging leaders. Robert Wood Johnson Foundation; October 22, 2014; Webinar.
64. Access to care in an advanced care model (invited keynote). Oregon Primary Care Association; July 21, 2014; Portland, OR.
65. How do we meaningfully solicit patient needs and then act on them? Oregon Primary Care Association; April 25, 2014; Portland, OR.
66. Team-based care: Effective innovations in practice (moderator). Institute for Healthcare Improvement; March 10, 2014; Washington, DC.
67. Developing a team-based change package (moderator). Oregon Primary Care Association; January 16, 2014; Portland, OR.
68. PCMH-A: A tool to evaluate transformation in patient centered medical homes. Briefing with Margaret O'Kane, President, National Committee for Quality Assurance; December 16, 2013; Seattle, WA.
69. Patient centered medical home - beyond group health. Group Health Cooperative Primary Care Forum; October 1. 2013; Seattle, WA.
70. Primary care transformation: Lessons from the Safety Net Medical Home Initiative Group Health Research Institute Scientific Seminar; July 9, 2013; Seattle, WA.
71. Unlocking the black box: Supporting practices to transform (invited keynote). Patient Centered Primary Care Institute; July 16, 2013; Portland, OR.
72. Learning from the Safety Net Medical Home Initiative (invited keynote). San Francisco Department of Health Primary Care Quality Improvement Retreat; May 17, 2013; Oakland, CA.
73. Transforming care: Implications for patient health outcomes (invited keynote). Oregon Primary Care Association Quadruple Aim Spring Symposium April 25, 2013; Portland, OR.
74. Do improvements in health care quality reduce costs? Group Health Research Institute Faculty Meeting; March 5, 2013; Seattle, WA.
75. Transformation lessons and issues: Medical homes in safety net practices (invited keynote). California Health Care Safety Net Initiative Learning from the Leaders: The Next Frontier in Medical Homes; November 25, 2012; Oakland, CA.
76. Primary care and health care reform: Where we're going (invited keynote). Oregon Primary Care Association Quadruple Aim Learning Session; October 1, 2012; Bend, OR.
77. Care coordination. Maine Quality Counts Provider Lunch and Learning Session; November 8, 2011; Webinar.

78. A national patient centered medical home curriculum. National Association of Community Health Centers Patient Centered Medical Home Learning Institute; November 2, 2011; New Orleans, LA.
79. Care coordination in the medical home. Montana Primary Care Association Patient Centered Medical Home Learning Session 2; September 21, 2011; Helena, MT.
80. Delivering organized, evidence-based care: The heart of the medical home. Montana Primary Care Association Patient Centered Medical Home Learning Session 2; September 21, 2011; Helena, MT.
81. Keeping focused on what matters in the medical home (moderator). Montana Primary Care Association Patient Centered Medical Home Learning Session 2; September 21, 2011; Helena, MT.
82. PCMH-assessment results: Using quality data for improvement. Pittsburgh Regional Coordinating Center Learning Session May 19, 2011; Pittsburgh, PA.
83. Continuous and team-based healing relationships. Montana Primary Care Association Patient Centered Medical Home Learning Session 1; May 4, 2011; Helena, MT.
84. National perspectives on the patient centered medical home (moderator). Montana Primary Care Association Patient Centered Medical Home Learning Session 1; May 4, 2011; Helena, MT.
85. The patient centered medical home: Care coordination. Colorado Regional Learning Session; April 15, 2011 Denver, CO.
86. Patient centered interactions in the medical home. Group Health Cooperative Patient Centered Care Interest Group Meeting; March 17, 2011; Seattle, WA.
87. Getting off the hamster wheel: Operational efficiency as a means to improving care. Safety Net Medical Home Initiative National Meeting; March 7, 2011 Boston, MA.
88. Coaching practices to become medical homes. North American Primary Care Research Group Annual Meeting; November 16, 2010 Seattle, WA.
89. Transforming safety net practices into patient-centered medical homes (invited keynote). Montana Primary Care Association November 4, 2010; Helena, MT.
90. Transforming chronic care: What works and what's next (invited keynote). O+Berri, Instituto Vasco de Innovacion Sanitaria Transforming Care for Chronic Patients: The Challenge of Implementation; June 2, 2010; Bilbao (Spain).
91. Patient centered medical homes: Redesigning care and integrating with the community Washington State Department of Aging Healthier Aging Conference October 15, 2009; Seattle, WA.
92. Patient centered medical home and the chronic care model. Care Oregon and Oregon Primary Care Association; July 31, 2009 Portland, OR.
93. Improving chronic care in the safety net: Helping practices improve quality. National Association of Public Hospitals; July 23, 2009; Webinar.
94. Change concepts and the chronic care model. Colorado Community Health Network; July 8, 2009; Denver, CO.
95. Technical advisory grouip (invited keynote panelist). USAID Health Care Improvement Project; May 18, 2009; Washington, DC.

96. Transforming safety net practices into medical homes. Institute for Healthcare Improvement International Summit on Clinical Office Practice Redesign; March 23, 2009; Vancouver, BC (Canada).
97. Finding breathing room: Operational efficiency as a means to improving patient care (invited keynote). Humboldt Del-Norte Independent Practice Association Learning Session; March 19, 2009; Arcata, CA.
98. Sifting through the noise: Getting real about quality improvement (panel moderator). Washington Association of Community and Migrant Health Centers Annual Quality Conference March 17, 2009 Tacoma, WA.
99. Patient centered medial home: Reinventing primary care. Washington State House Appropriations Committee on Health and Human Services; February 17, 2009; Olympia, WA.
100. Identifying and addressing unwarranted variation in specialty care at group health. Members of the Dartmouth Atlas and Washington's Shared Decision Making Collaborative; January 6, 2009; Seattle, WA.
101. The dartmouth atlas: What is it? How is group health using it? Washington Office of Financial Management Strategic Health Planning Technical Advisory Committee; November 13, 2008; Seattle, WA.
102. Patient-centered care - from buzz word to meaningful reality. Employees Benefits Planning Association September 18, 2008; Bellevue, WA.
103. Integrating chronic care and business strategies in the safety net. Agency for Healthcare Research and Quality Annual Conference September 9, 2008; Washington, DC.
104. Helping practices help themselves improve quality. California Improvement Network; August 6, 2008; Webinar.
105. Improving chronic illness care: A quick look at the chronic care model. Washington State Collaborative to Improve Health April 23, 2008; Seattle, WA.
106. Improving chronic illness care: A quick look at the chronic care model. Washington State Collaborative to Improve Health; April 17, 2008; Webinar.
107. New methods for improving chronic illness care in practice Center for Health Studies Seminar Series; March 25, 2008; Seattle, WA.
108. Coaching the coaches. Washington State Department of Public Health Collaborative Coaches Training; January 24, 2008; Seattle, WA.
109. New methods for teaching the chronic care model. Institute for Healthcare Improvement National Forum Minicourse; December 10, 2007; Orlando, FL.
110. What can states do to improve chronic illness care? National Council of State Legislatures; October 5, 2007; St. Louis, MO.