

The Roles and Qualifications of a Clinical Coach

Once staff complete the two day training they generally need to learn the intervention through experience and further on the job “ coaching “ from someone well versed in the intervention skills and model components as well as someone with behavioral health expertise ideally with older adults. The coach needs to work closely with the program champion and agency supervisors.

Background and Qualifications

Potential coaches may come from different professional backgrounds such as clinical social work, psychology, psychiatric nursing or psychiatry. In many instances the coach may also be a designated Clinical Consultant: In some agencies, a formal relationship with a single consultant clinician (physician, psychiatrist) exists to address client specific issues with respect to clinical consultation; however, this position does not involve direct care of program clients. Agencies also need relationships with community medical and mental healthcare resources to do further assessment and treatment of persons with undiagnosed or inadequately treated depression or other mental health problems. The coach may be someone from one of these agencies or may be in a position to facilitate linkage to this clinical service. When appropriate after an initial period of implementation a coach may train clinically qualified agency supervisors or program directors to acquire these skills for a sustainable program.

Roles of the Coach

The activity of coaching has two major goals: (1) to support the staff in developing confidence and acquiring skills to deliver the intervention with older adults (2) to assure adherence and competence of individual care managers to conduct the intervention as outlined and proven. Coaches need to devote more time in the first 3-4 months of program implementation and then decreasing effort over time as case managers develop skills and confidence.

HOW: “Coaching” care managers can involve some combination of: direct observation of their interactions, reviewing records or discussion of their visits, or conferring with them individually or in groups. Also includes advising care managers about clients with complex needs and depressive symptoms that do not improve despite adherence to the model. For example, some clients may have other mental health/substance abuse issues that the coach can recognize and advise as far as further referrals. Face-to-face interaction seems important early on and then over time telephonic communication has been used effectively. It is best to schedule 2 “Booster” training sessions/meetings and then to use email or phone contact.

Examples of how coaching has been accomplished in other organizations doing Healthy IDEAS

1. Agencies arrange for set-aside time during regular staff meetings for case managers to discuss challenges or raise questions.
2. Individual case managers who encounter challenges or are trying to strengthen their confidence and skills meet in person or by phone with the coach to “practice” steps, seek advice etc. In some communities a coach has accompanied a case manager on a home visit

Preparation and Assistance with Training:

Before: Review manual; do a pre-training inservice on Depression in Older Adults,

During: Participate in agency training of staff

After: Lead a group “Booster Training” 4 weeks after staff start using the program with their clients and provide ongoing clinical support to staff delivering the Healthy IDEAS Intervention.