Nearly a million Americans will die as a result of vascular diseases this year. In fact, heart attack, stroke, and heart failure kill more Americans than any other disease, causing nearly twice the number of deaths as all cancers combined. But this is not a new problem—vascular diseases were the number one killer of Americans in every year of the 20th century except 1918, when a massive flu epidemic swept the world.

In the United States as in other developed nations, vascular diseases are predominantly lifestyle diseases. Although genetics plays a role, they arise primarily as a result of how people eat, drink, smoke, exercise, and handle stress. Today, there are 22 million Americans who have already been diagnosed with vascular diseases, and another 80 million who are highly susceptible. The direct cost of their treatment and the economic side effects of their hospitalizations run into the hundreds of billions of dollars each year. As the baby-boomer generation approaches their years of prime susceptibility, the costs
will only increase, unless, that is, American society finds a way to help millions of people change their behaviors and avoid vascular diseases altogether.

Enter the American Heart Association. Established in 1924 to help Americans fight vascular diseases, the American Heart Association is one of the leading sources for scientific information about vascular diseases for the medical profession. The association has invested millions of dollars in research and outreach, but while you've probably donated money to the American Heart Association at some point, and you may have grabbed a brochure in your doctor's office somewhere along the way, it's clear that there's a need for a much more comprehensive health education program.

Not long ago the association approached a team from Stanford University School of Medicine with the intention of changing that. The Stanford Cardiac Rehabilitation Program team has been conducting research and developing advanced programs in Cardiac Rehabilitation for nearly two decades. With its extensive expertise in helping people manage chronic cardiovascular disease, the team also had the expertise to begin developing a national education program.

Dennis Milne, vice president of patient education for the American Heart Association, worked with the Stanford team to explore the feasibility of designing and implementing a national program. As Milne says, "It was time for the American Heart Association to address the problem in a new way. We already have a lot of the scientific knowledge we need, and by working with the Stanford team we gained the expertise in behavior change and the patient experience. We felt we could do something significant, and we were enthusiastic to get started."

To fund the initial design phase, they enlisted the support of Guidant Foundation, the charitable arm of a leading manufacturer of cardiac health devices, in a project to develop a new education system to help the 22 million diagnosed-and eventually the other 80 million undiagnosed as well-to actually change their behaviors and improve their chances of avoiding vascular disease.

The team realized that in the context of American culture this was a daring goal and not at all a simple task. To succeed, the team would have to understand numerous interlinked and underlying factors related to vascular disease, American culture, the medical profession, and not least, human behavior. They recognized that to design the system using a traditional project team or committee approach probably wouldn't work because the underlying problems are so complex, and so deeply embedded in American culture. They also knew they would have to get a very large number of people to work together to share their collective experiences and devise an innovative, cohesive, and effective education system. They needed, in other words, to get a large number of people
to collaborate with an incredibly high level of effectiveness. And, they had a tight budget and time constraints, too.

Nancy Houston Miller, associate director of the Stanford Cardiac Rehabilitation Project, was a driving force from the very beginning. "Defining the right vision for a huge project like this requires the expertise and buy-in of many individuals who have many different points of view," she says. "Being able to come together in a positive collaborative environment was essential to getting the vision right, figuring out what the content needed to be, and getting people excited about what we could do."

**Prescribing just the right medicine**

To accomplish its goal, the team turned to a unique collaborative process designed for the project by InnovationLabs, a consulting firm that specializes in facilitating collaborative workshops to accelerate the innovation process. Using a combination of face-to-face collaboration, online collaboration, and ethnographic research conducted by Point Forward, Inc., the InnovationLabs process enabled the project to engage more than 200 people from around the country in a concentrated effort of research, conceptualizing, and design that went from start to finish in six months.

Participants, who were primarily volunteering their time, included: doctors, nurses, patients, family members, public health officials, pharmaceutical representatives, media, public relations experts, health educators, technology experts, government, foundations, and experts from other non-profits.

**Face-to-face collaboration**

Four face-to-face collaborative workshops were held throughout the six-month period. The first was a one-day Visioning session for the 25 members of the project steering committee. Cap Gemini Ernst & Young donated use of its Accelerated Solution Environment in Chicago, where the group defined the scope of project and produced a document that laid out the project's broad ambitions and laid out the project's educational and coaching methodology.
Two months later, a three-day brainstorming session was held in Dallas involving a very diverse group of more than 100 participants. About 125 ideas emerged from this session covering a huge range of topics. Examples included education programs for heart-healthy kids, tips on healthy grocery shopping, workplace fitness and coaching programs, national media and education campaigns, outreach to underserved populations, use of the Internet, and methods of working with existing community groups.

Following the brainstorming session, the project team consolidated the ideas into eight major themes. The next session was then held in Palo Alto, Calif., during which a team of 35 people refined the theme areas and designed specific conceptual prototypes for each one. Participants included technology experts well versed in various Web and graphic arts applications, who built sample programs and images in the midst of the session to show how the system could work and what it could consist of.

These rough concepts were then refined a month later in a second development session involving a group of about 20 people.

"We were really happy with how fast it went," comments Houston Miller. "We started with a vision of a smaller project, but very quickly we discovered that we could be successful in dealing with a much larger scope. We saw the necessity of addressing the broader vision, so the collaborative approaches enabled us to go from defining the vision to final critical concepts for the overall system and the proposed component parts in just six months."

**Online coordination and participation**

Since the team running the project and all of the participants were widely distributed throughout the United States, an online collaboration tool from CoVision, the WebCouncil system, was used to support and complement the face-to-face collaborative sessions.
Using WebCouncil as a turnkey, hosted service meant that the project didn't have to provide any infrastructure, and the look and feel of the project site was fully customized, designed, and up and running in a couple of days.

WebCouncil was used for the following:

**Centralized logistics information.** Everyone was able to access a single source for logistics information and reimbursement instructions, which eliminated a lot of hassles and made it easy for everyone to be at the right place at the right time.

**Project planning.** The overall project description and plan was posted and accessible to all. Everyone who joined the project in any capacity was invited to the Web site to review the entire project archive. This enabled Innovation-Labs to bring people up to speed very quickly.

**Preparatory materials.** In advance of each face-to-face session, preparatory materials were uploaded onto the Web site so that all participants could access them prior to getting together. This helped everyone to have the right expectations coming into each session, to prepare appropriately, and to ensure a shared understanding of the purpose of each session and its intended outcomes.

**Document repository.** Each face-to-face session was documented in detail so that all project participants would have full access following the session.

**Reference materials.** Reference documents and links to other Web sites were posted to WebCouncil for participants who wanted to explore various issues and topics.

**Surveys.** Detailed surveys were prepared using WebCouncil's built-in tools and accessed by participants throughout the project. This survey information proved critical to the design process, helping with the development of ideas in advance of each session, and in the evaluation of prototypes following the two prototyping sessions.

**Project directory.** WebCouncil also hosted a project directory, including a digital photo of each project team member, helping participants to get in touch with each other whenever they needed to.

**Ethnographic research**
In addition to the face-to-face and online collaborative efforts, a team of ethnographers from Point Forward, Inc., a Silicon Valley, Calif., research and design firm, interviewed dozens of patients, family members, doctors, and nurses in clinics and hospitals in five communities across the United States to help the
team understand the day-to-day life of patients and their caregivers in hospitals and clinics.

The purpose of this research was to expose the hidden factors affecting care and treatment of vascular disease patients, and many important insights emerged. For example, an early assumption of the project team was that patient education would largely be delivered in hospitals, but the research made it clear that it would not because there was neither the time nor the money in the hospital setting. Another discovery was that many healthcare providers are not equipped to provide the type of education and encouragement needed to help their patients actually change their behaviors, exposing the need to equip the providers as well as the patients.

**The result**

When the project began, it was assumed that focus would be on patient education, but the final conceptual design is based instead on a model that emphasizes coaching in addition to education. This shift reflects the awareness that it’s much easier for people to make lifestyle and behavior changes when they are supported by a good coaching relationship. Hence, the working name for the system emphasizes coaching, as do its three proposed major elements:

First is a comprehensive, multimedia, multilingual information system that will enable everyone involved in vascular disease to access the information they need in a format that is appropriate for them. Proposed for inclusion in the information system is information fully customized for each individual patient, educational content delivered potentially via video, DVD, and CD materials, and coaching materials to help people understand the choices that they have, and to help them make good ones.

Second is a training program for medical professionals to help them to become effective coaches for their patients, and strong advocates for the system.

The third element is involvement in the community. There are numerous organizations and institutions in the local community that can also coach and
educate, including health clubs, churches, senior centers, and many different kinds of community groups that simply need to be mobilized and given the methods and materials to help them reach and support their own members.

**Key lessons**

Here are some of the key lessons that were learned from this project.

1. **Dealing with a complex problem.** The development of the "Health Coach System" is essentially a large-scale research and development (R&D) project on a very complex topic. The same types of underlying issues and problems associated with any kind of R&D project came into play here. Vascular disease is certainly complex, and developing a meaningful solution required the collaboration of people from many different walks of life. The methods applied here are generally applicable to many other kinds of problems that typically occur in organizations.

![Collaboration Continuum](image)

2. **The Collaboration Continuum.** In the course of the project, the Stanford team and Innovation-Labs learned that there was some confusion in the current lexicon about collaboration. When you examine the issue closely, you find that people use the term "collaboration" to mean a very wide variety of activities. To avoid confusion, it may be important to define terms precisely. Thus, we make the distinction between coordination and collaboration, which helps us to see that while a Web-based tool such as WebCouncil is very helpful in coordinating the activities of a large group, meeting face-to-face is probably necessary for some kinds of sharing, learning, and problem-solving. We call this the Collaboration Continuum (see Figure).

3. **Complementary modes of working.** Face-to-face and online collaboration are complementary modes of working. While face-to-face collaboration is probably necessary when a group has to deeply explore the scope of a complex issue, online approaches to collaboration can be very efficient for follow-up work.
Online tools are also great for gathering data from a large number of people through surveys, which enable us to efficiently get feedback from hundreds of people in a way that we could not do face to face.

**What’s next?**
The Health Coach System is Phase 1 of a three-phase project. Phase 2 is currently under way, and focuses on prototype development and testing of the multimedia materials pertaining to coronary artery disease. Pilot testing will be done in major markets. Phase 3 will address all other types of vascular disease, including stroke, heart failure, and those at high risk.

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**About the Author**
Langdon Morris is a partner of InnovationLabs (www.innovationlabs.com), and was co-facilitator of the Health Coach System Project. He is the author or co-author of three books and numerous white papers. He is also Senior Practice Scholar of the Ackoff Center of the University of Pennsylvania, where he is researching the dynamics of accelerating change in markets under the title of “Business Model Warfare”. You can reach him at LMorris@innovationlabs.com.