AHRQ Health Care Innovations Exchange

Developing and Implementing Learning Communities:
Findings and Lessons from the AHRQ Health Care Innovations Exchange
https://innovations.ahrq.gov

I. Background

In 2015, the AHRQ Health Care Innovations Exchange focused its efforts on disseminating and implementing innovations by sponsoring three Learning Communities (LCs) in the following high-priority areas:

- *Reducing Non-Urgent Emergency Services (ES)* (Detroit)
  https://innovations.ahrq.gov/learning-communities/reducing-non-urgent-emergency-services
- *Advancing the Practice of Patient- and Family-Centered Care (PFCC) in Hospitals* (Florida)
  https://innovations.ahrq.gov/learning-communities/patient-and-family-centered-care
- *Promoting Medication Therapy Management (MTM) for At-Risk Populations* (Houston)
  https://innovations.ahrq.gov/learning-communities/medication-therapy-management

Each LC is a select group of potential innovation adopters and stakeholders who interact and engage in a shared learning process to facilitate adaptation and implementation of innovations featured in the Innovations Exchange. In addition to leading to meaningful change in care delivery in these communities, AHRQ expects to learn from this work more about how to foster the adoption and implementation of health care innovations. During the first year of the 2-year initiative, Westat conducted both a formative evaluation (to monitor implementation and guide decisions about potential changes in strategy) and a summative evaluation (to assess success at realizing programmatic goals and document lessons learned).

II. Understanding Practice Improvement Methods

Through the Innovations Exchange, AHRQ has a unique opportunity to compare and contrast three concurrent LCs that have applied a common collaborative learning approach to different topic areas and innovation strategies across a range of care settings, patient populations, and care processes. The evaluation has elucidated findings about the science of practice improvement based on the range of participant experiences in the three communities; these may be applicable to learning networks and other similar efforts in the field. Using a qualitative synthesis method, Westat identified lessons related to **LC startup** – including recruitment and goal setting; **LC operations** – including engagement, collaborative decision making, and sustainability; and **innovation implementation** – the process of making changes to care delivery processes and/or policies. These findings can guide future work in this area.

III. LC Startup Findings and Lessons

The LC topic areas and prospective membership groups were chosen *a priori* by AHRQ and Westat based on the following criteria: Aligns with AHRQ priorities; Focuses on a common challenge confronted in clinical practice; Can be addressed by readily available "clusters" of innovations (solutions) in the Innovations Exchange with evidence of success; Is amenable to improvement through a collaborative group setting; Has a strong, inspirational champion who will lead the initiative; and Aligns with existing and/or emerging communities and networks to leverage working relationships and reduce start up time.

After using these criteria to narrow down and prioritize the options for forming the LCs, Westat and AHRQ began conversations with subject matter experts and local organizational leaders to refine and implement the LC formation and recruitment processes. This experience yielded the following lessons on the startup process:

1. *Participants are most likely to consider and respond to an LC invitation if they are invited by a "champion", someone known and trusted, or a recognized expert in the field. The invitation should be presented as an opportunity to address a particular quality problem.* This approach keeps the focus on local problem solving and empowers participants to develop local solutions based on reputable evidence.

2. *Invite organizations that are ready to consider adopting the target innovation(s) to address an identified problem, and be clear about the expectations for their active participation.* LC organizers must understand organizational needs, and how those needs may differ across roles and levels in the organization, in order to help them see if and how the LC may help them achieve their goals.

3. *The innovations/interventions which serve as the starting point for the LC work must directly address the identified needs of the participants.* The AHRQ Health Care Innovations Exchange is a rich source of innovations to offer as models for adoption.

IV. LC Operations Findings and Lessons

After startup, each LC moved into the operational phase of its lifecycle, characterized by regular meeting schedules and processes for member engagement and participation. This phase yielded the following insights into maintenance and sustainability of LCs:

1. *The recruitment process is the first step in engaging participants and building the ongoing, permanent relationships necessary to achieve a collective vision.* Developing a written charter that includes a statement of goals and sets the expectation for participation strengthens engagement and cements commitment. Other operational lessons include:

    - The champion role is key to LC cohesion, goal setting, and progress towards goals.
    - Prepare relevant materials and speakers to support the goals of each meeting and enable participants to work on their own between meetings.
    - Carefully consider meeting frequency, type, and scheduling.
    - Tailor communication modes and frequency to the needs and preferences of the group.

2. *Continually monitor LC progress and tailor activities, materials, and information to support the evolving needs of the group.* LC leaders must be flexible in identifying opportunities to build on successes and take advantage of strengths and resources in the group. Some innovations are more difficult to implement than others as they require larger organizational and inter-organizational changes that can take time to achieve. Results are not always certain or guaranteed, but it is important for LC members to make progress toward the aim of LC.

    - Holding at least one in-person meeting is crucial to group cohesion and progress. The meeting provides a level of intensive interpersonal interaction that is difficult to foster using virtual technologies alone. An in-person meeting speeds progress and sets the stage for more successful virtual meetings that follow. To get these benefits, it can often be useful to hold an in-person meeting early in the life of the project.
    - Structure the strategic decision making process and be flexible so that the group can make progress without getting bogged down.
    - Be aware that not all organizations will have the interest, level of commitment, or ability to follow through with the desired changes, or to fully engage in all LC activities.
    - Periodically reorient all LC members to the aim of the LC, and assess progress towards LC goals. Be open to evolution in thinking about LC progress.

3. *Develop and implement plans for sustaining the innovation well before the end of the LC period.* Even if the innovation has a positive financial return on investment due to savings in other areas, it may require the continued funding of new activities. One of the uses of an LC is to provide a framework for collaborative thinking and shared effort at securing such funding.

    - Help the group develop a systematic approach to securing ongoing funding for the innovation.
    - Sustainability is reinforced when the innovation becomes integrated into routine policies, information systems, and clinical workflows.

V. Innovation Implementation Findings and Lessons

Each LC experienced challenges, findings, and lessons related to implementation of the specific innovations that were their focus. These diverse experiences illustrate some common themes as well as differences and contrasts.

1. *Several factors relate to organizational "buy-in" and effective innovation implementation decision making.* After there is broad agreement on the strategic goals and priorities for the LC, the collaborative decision making process typically turns to more technical implementation decisions. However, when the process is structured well, the collaborative thinking and discussion that takes place within the LC can result in more creative and effective solutions. Lessons relating to engagement and implementation include:

    - It is crucial to have the right participants at the table at the right times, and the mix of participants may change over time.
    - There has to be a clear and documentable value proposition for the participating organizations to adopt the innovations.
    - Process changes must fit into local clinical workflows and information systems.

2. *LCs can provide a rich collaborative environment that motivates organizational changes in a number of ways.* A well-functioning LC offers peer support and mentoring, and the opportunity for collaborative brainstorming, creativity, and problem solving. It can also help newer or less experienced members avoid having to solve problems on their own or making mistakes that other group members have already addressed. The group also holds members accountable by setting expectations, deadlines, and milestones. Because of the interdependent relationships among members, there is a form of peer pressure to meet LC goals and expectations:

    - A key role of the LC is to collaborate and advise on the development of implementation protocols, policies, and tools.
    - It is essential to test the intervention on a small scale and refine it before rolling it out more widely; after testing it is possible to broaden implementation of the innovation over time.

3. *There is a tradeoff between the need for fidelity to the original innovation and the need for local adaptation.* Some LCs are formed specifically to implement a particular innovation (e.g., the MTM LC). Others are oriented towards solving a common problem and rely on the innovation(s) for inspiration and ideas, but may not necessarily implement specific innovations directly (e.g., the ES LC). Other LCs may fall in between (e.g., the PFCC LC members agreed to implement one common innovation across sites, but also selected from a short list of optional innovations to support the general goal of advancing patient- and family-centered care).

    - All of these models raise the issue of the need to maintain fidelity to the components of the source innovation(s), a topic which should be discussed explicitly by the LC members.
    - Too much emphasis on fidelity may make it difficult to implement the innovation when local circumstances don't exactly fit the original. Yet, too little emphasis on fidelity can weaken the rationale for collaborative implementation, and may lessen the chances of achieving the desired results.