Recommendations for Organizations Interested in Running Learning Collaboratives

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform. As part of this commitment, the AF4Q National Program Office (NPO) has conducted a number of hospital quality improvement (QI) learning collaboratives focused on improving the quality of care provided to patients and reducing disparities. Each offering has focused around three content areas: improving language services delivery, reducing hospital readmissions, and reducing emergency department crowding. The intention of the learning collaboratives was to help hospitals build the capacity to achieve their QI goals by applying what they learn about effective practices and assessing the impact of those practices on patient care.

Between 2006 and 2009, learning collaboratives were conducted as more traditional collaboratives with face-to-face meetings and site visits conducted between participating hospitals and the NPO. In 2009, RWJF recommended that the NPO pursue a virtual approach as the economic downturn was impacting participation in in-person collaboratives, especially related to expenses associated with travel. For this reason, a completely virtual learning collaborative was offered in each content area from 2010-2012.

By sharing what they have learned with others, the Aligning Forces for Quality National Program Office hopes to support and encourage other organizations interested in implementing successful quality improvement collaboratives. The lessons are organized into two sections:

- Planning a learning collaborative
- Implementing a learning collaborative

Planning a learning collaborative

1. Choose a topic that potential participants are eager to address.
2. Define the geographical scope of the collaborative.
3. Determine role of financial incentives to motivate participation.
4. Design a mutually beneficial application process.
5. Establish ambitious but feasible goals.
6. Anticipate the trade-offs associated with a virtual collaborative.
7. Think through your staffing model.
8. Think through the collaborative size.
9. Give participants enough time to see the impact of their work.

Implementing a learning collaborative

1. Assign "prework" before the official collaborative begins.
2. Compensate when the collaborative is too big to function effectively.
3. Incorporate some kind of face-to-face time.
4. Offer access to credible faculty, ideally with real-world experience.
5. Request data in order to create accountability and urgency.
6. Offer ongoing encouragement and positive feedback to participants.
7. Support the participants' efforts to effect change.

Planning a Learning Collaborative

The first set of nine recommendations focuses on decisions that organizations have to make before the collaborative begins.

1. Choose a topic that potential participants are eager to address.

For the NPO collaboratives, RWJF selected the focus areas based on its sense of national priorities; the NPO then refined those topics for the purposes of the collaboratives. (See table below.) All of the focus areas addressed issues that many hospitals were already working on. Additionally, RWJF and the NPO strove to select topics that had a known "solution," (i.e., a set of changes that have been proven to be effective), because a collaborative is most effective when everyone involved has a high degree of belief that they know what will get a result.

Timing was also a consideration for the NPO when selecting potential focus areas. For example, public reporting of hospital quality measures was a big concern when Expecting Success was introduced, and so the collaborative focused on improving the core measures of care for patients who had a heart attack or heart failure that were being reported by CMS. When a topic is not "hot," it's may be harder to find hospitals willing to go through the process of participating in a collaborative.

Table 1. Collaboratives Sponsored by the National Program Office of Aligning Forces for Quality

Name	Topic	Length of Collaborative	Number of Participants
First Generation (Prior to AF4Q)			
Urgent Matters	Patient flow in emergency departments	18 months	10 hospitals*
Expecting Success	Hospital readmissions	3 years	10 hospitals*
Speaking Together	Language services delivery	18 months	10 hospitals*
Second Generation			
Language Quality Improvement Collaborative	Language services delivery	18 months	9 hospitals
Equity Quality Improvement Collaborative	Hospital readmissions	18 months	8 hospitals
Urgent Matters	Patient flow in emergency departments	18 months	6 hospitals*
Transforming Care at the Bedside (TCAB)	Nursing care	3 years	17 hospital units
Third Generation: Hospital Quality Network			
Increasing Throughput	Patient flow in emergency departments	18 months	40 hospitals
Reducing Readmissions	Hospital readmissions	18 months	77 hospitals
Improving Language Services	Language services delivery	18 months	32 hospitals
Transforming Care at the Bedside (TCAB)	Nursing care	18 months	135 hospital units in 6 AF4Q communities

*Hospitals participating in these collaboratives did not need to be located in one of the 16 AF4Q communities.

2. Define the geographical scope of the collaborative.

There are tradeoffs between offering national and regional collaboratives. In their national collaboratives, the NPO had more control over the information being conveyed and the activities that were supported. The regional offering, like Regional TCAB, control shifted away from the NPO. Once the NPO kicked off a Regional TCAB collaborative with an in-person meeting, a regional clinical leader (RCL) hired by the local sponsor within the AF4Q Alliance handled all contact with the hospitals. Although these leaders received training from the NPO to prepare them to coach and lead the nursing units participating in the collaborative, the RCL was largely on their own to work with the hospitals.

That being said, regional implementation offered several benefits. First, this approach made it possible to inundate a geographic area with the goal of transforming culture and making a greater collective impact on quality. Second, this approach encouraged collaborative rather than competition. For example, regional TCAB hospital staffs were more likely to transfer ideas and practices from one institution to another due to the close proximity of other hospitals participating in the collaborative. A third benefit, which may be unique to the NPO, is that this approach fit with the goals of AF4Q, which aims to improve health and health care in specific communities by building local capacity to create and sustain change.

3. Determine role of financial incentives to motivate participation.

The role of financial incentives to motivate and support collaborative work remains unclear. Until the virtual HQN collaboratives, the NPO provided some level of financial support to participating hospitals as funding was thought to create a sense of obligation that would keep the hospitals engaged; it may have also enabled participants in the traditional collaboratives to devote more resources to a given issue than they would have otherwise. However, the overwhelming interest in the HQN contradicts that earlier evidence that the money mattered.

On the other end of the funding scale, charging hospitals a fee for participation can be regarded as a way for the hospitals to demonstrate their commitment to the program and to using the information. A couple of the AF4Q Alliances who participated in Regional TCAB charged hospitals a modest fee to cover the time of the RCL in addition to some of the meeting expenses. Although the regions that charged a fee had significant participation numbers, the RCLs still struggled with motivating hospital to invest the time and energy needed to get results.

4. Design a mutually beneficial application process.

The application process should communicate multiple messages, including the goals of the collaborative, criteria and expectations for participants, the case for why the effort should be undertaken, and a timeline for the program. (Social and Scientific Systems, Inc., April 2009) (Robert Wood Johnson Foundation, November 2008)

This process should also attempt to capture what hospitals are interested in, what is motivating them to improve in the given area, and how sophisticated they may already be. In the HQN and TCAB, the NPO used a self-assessment tool to obtain more information about each applicant team to help staff prepare for the hospital and adjust the collaborative resources if needed.

Based on their experiences, the NPO would recommend that organizations define specific eligibility criteria for participation in the learning collaborative. In HQN, which did not use selection criteria, some hospitals did not actually need help within the focus area, while others were not truly committed to the collaborative goals. In addition, many hospitals had such small volumes of readmissions or emergency department patients that data were not meaningful, generalizable, or helpful in quality improvement efforts.

5. Establish ambitious but feasible goals.

The NPO set goals ambitiously to help participating hospitals focus and feel a sense of urgency while also striking a balance between being challenging and achievable. Setting ambitious goals was also a way to communicate the idea that the collaborative was just a first step; participants were expected to keep working towards their goals after the collaborative has ended. To help hospitals meet these goals, the NPO outlined aims, which served as the basis for hospitals setting their own measurable and time-specified targets, both for outcomes and for processes or care activities.

6. Anticipate the trade-offs associated with a virtual collaborative.

The transition to virtual collaboratives offered both benefits and disadvantages. The virtual collaboratives allowed for significant diffusion of quality improvement methods and evidence-based practices. They were also relatively low-cost for both the hospitals and the NPO. However, virtual collaboratives are not set up to achieve the same high level of engagement and improvement that is typical of the more traditional, hands-on approach. That diminished interaction with peers undermines one of the most important aspects of collaboratives. (Nembhard, 2009) It also means that the organizers may lose the capacity to support participants effectively in overcoming their challenges and identifying the drivers of improvement.

For collaborative organizers choosing between a virtual or traditional approach, it is important to recognize that each approach appeals to different organizations. Some organizations need handholding, while others already have training in improvement methods and just need some motivation and external accountability. Still others are already internally motivated and only need help identifying effective strategies. Another factor for hospitals is whether they have their own process improvement resources and staff; if so, they may have little use for the hands-on aspects of a collaborative. No matter what approach is selected by the organizer, the collaborative will appeal to some and not to others.

7. Think through your staffing model.

Running a collaborative is a demanding job that requires the time and the skills to plan the work, support the hospital, and maintain proactive contact with participants. (Ovretveit J, 2002) The NPO staffed each collaborative to include a quality improvement specialist, one or two full-time research associates, and a shared data analyst.

During HQN, the NPO realized that it should have better matched the capacity of the program office (i.e. staffing, technical expertise and technology) with the number of participants. Low uptake of earlier collaboratives led the NPO to believe that while learning from past experience would increase uptake, the nearly 6-8-fold enrollment compared to earlier collaboratives was unexpected and required significantly more resources even in a virtual environment.

8. Think through the collaborative size.

During the planning stages, it is important for organizations to consider how many hospital the collaborative will support.

The NPO found that the smaller collaboratives were effective in accelerating the improvement process in a narrow area (e.g., for one specific measure). They also found it useful for "prototyping," i.e., experimenting with solutions to problems when effective practices are unknown. But the risk with a small collaborative is that one or two unengaged or inactive participants can undermine the entire collaborative. Another issue is that there may be only one "early adopter," which makes it much harder for the hospital to see each other's progress.

Larger collaboratives have the benefit of being inclusive. However, unlike campaigns that aim to spread ideas across a large number of organizations, the collaborative strategy is designed to reach deeply into hospitals in order to effect change. Because this approach requires sufficient support from the collaborative sponsor, especially in the early stages, having a large number of collaborative participants poses multiple challenges. For example, during the HQN collaborative, the NPO found that:

- Staff did not have the time or the resources to deal as effectively with the data coming in from so many hospitals as with the smaller collaboratives.
- Staff did not have the time for sufficient contact with the participating hospital that they did with the smaller collaboratives. This did affect the engagement of some hospital, which in turn affected the quality of the reports they submitted.
- Staff encountered trouble engaging all hospital in discussion during the monthly education session. As a result, webinars become didactic rather than being an opportunity for participants to discuss how ideas and practices could be applied in different settings.
- Staff was unable interact and bond with a large number of hospital. When the relationship feels superficial, participants may not have been as comfortable with sharing what is really happening and asking for help.

Based on experience with the HQN, the NPO learned that high uptake is flattering but not necessarily a good thing. The NPO recommends being more upfront about expectations and constraints and, if possible, cap the number of hospital rather than allowing open enrollment.

9. Give participants enough time to see the impact of their work.

An important feature of collaboratives is that they are time-limited. The constraint on time helps to give the improvement work an intensity and urgency. The timeframe that is best will vary by topic, since some are more complex than others. Another consideration is how long it will take to gather enough data to assess the impact of changes. Over time, the NPO found that 18-months was the best minimum length given their data requirements. Twelve months would not have allowed enough time for the hospitals to form their teams, deal with the data issues, and apply and test changes to drive improvement—let alone change the culture of an organization.

Implementing a Learning Collaborative

The next seven recommendations address activities that occur during the collaborative.

1. Assign "prework" before the collaborative officially begins.

"Prework" refers to activities that the hospital can do before the collaborative begins so that they are clear on why they are involved in the collaborative and are ready to hit the ground running. By preparing teams the teams leading the effort in the hosptials for their work in the collaborative, this tactic helps to accelerate the progress they can make. It also gives the organizers an opportunity to communicate expectations and get to know the teams.

In the NPO collaboratives, prework included several components including forming teams, getting buy-in and support from senior leaders and their input on aims and team members, and gathering baseline data so that the hospital are clear on their starting point. The NPO encouraged hospital to use the prework period to assess the usability of available data and determine how they will collect, analyze, and report the data required for the collaborative. As data management was typically the most challenging issue faced by hospitals, working through these challenges during the pre-work allowed them to focus on using data for the improvement process once the collaborative began. When allowed a longer prework period, the NPO was able to educate hospitals about the process of planning for and collecting data and coach them as needed to develop their skills and capabilities.

2. Compensate when the collaborative is too big to function effectively.

As the NPO learned from its own experience, sometimes collaboratives exceed the size that was deemed optimal for the organizer. When this happens, there are ways to compensate for having more hospitals than anticipated. To help establish relationships and promote interaction, the NPO:

- Scheduled check-in calls with small groups or individual hospitals. Using a rotating schedule, the NPO was able to interact with every hospital over the course of a few months and facilitate interaction among those participants.
- Used available technology (e.g., video-conferencing, webcams, and photos) to help people identify each other and form personal connections.
- Encouraged opportunities for people to interact in smaller settings, such as site visits among regional peers. Especially in the Regional TCAB offerings, these visits let the hospitals see how others operationalize the improvement practices, share ideas, and discuss challenges.
- Assigned specific staff to support each team so that they can establish relationships.

3. Incorporate some kind of face-to-face time.

Based on the NPO's experience with the HQN collaboratives, staff feel strongly about incorporating face-to-face meetings, preferably at the regional or local to help keep costs down and to build regional and local capacity for change.While any meeting adds to the cost of the collaborative, the relationships that form when hospitals can spend time with the organizers, faculty, and colleagues from other institutions are uniformly regarded as worth the effort. Participants can still share information without that face-to-face time, but that sharing of activities and problems is limited in the absence of the trust that forms when people know whom they are talking to in collaborative activities.

4. Offer access to credible faculty, ideally with real-world experience.

In both the traditional and virtual collaboratives, the NPO offered access to expert faculty, past collaborative participants, and QI specialists during in-person visits and meetings, virtual meetings

(including webinars and conference calls), web site resources, listservs, and written feedback or updates. This access legitimized the collaborative and motivated participants by explaining best practices and practical changes that participants could test and provide information on "real-world" applications of recommended practices.

The NPO's QI Specialists assigned to each collaborative were invaluable for hospitals that were tackling a topic where the answer was unclear. These specialists were able to work directly with participants and offer more intensive technical assistance. In the traditional collaboratives, the QI specialists were able to see first-hand during site visits the issues hospitals were encountering. In the virtual collaboratives, this type of technical assistance was harder to deploy and hospitals had to be more pro-active about seeking and utilizing more one-on-one assistance.

5. Request data in order to create accountability and urgency.

The requirement to collect and report data was a major factor in the success of the NPO learning collaboratives. For the NPO, having this data enabled them to monitor the hospitals and identify any participants who may need additional coaching. The NPO believes that providing benchmarking data engages participants, drives them to focus on outcomes, and helps them see the impact of their actions. In the absence of the NPO's reports, the hospitals would have no way of getting this larger perspective.

Regular progress reports were also a common component of the NPO learning collaboratives. They were widely perceived as useful but burdensome. The progress reports used by the NPO prompted hospitals to provide information about the changes they implemented, the issues or challenges they encountered, the results they got, and any lessons learned.

Based on their collaborative experience, the NPO recommends the following to collaborative organizers regarding the collection and submission of data:

- In the planning stages of a collaborative, carefully evaluate what will be required of the participants and the organizer.
- Be prepared to accept and handle all of the data the hospitals are being asked to submit. This will require having staff qualified to analyze the data, a system that enables participants to upload the data themselves, and access to a statistician who can help resolve issues related to interpreting data, presenting data, dealing with incomplete data, and running statistical packages.
- Require everyone use the same measures so that the data can be aggregated and compared among and within participating hospitals.
- Recommended that hospitals involve a team member with a data background who could facilitate the process of gathering data and reporting it in the required format.
- Set an expectation for the hospitals to connect the data to their activities so that their progress reports are explicit about the changes they made and what impact those changes had.

6. Offer ongoing encouragement and positive feedback to participants.

Collaborative teams leading the effort within hospitals often lack confidence in their ability to make improvements and the motivation to overcome their doubts. In the early stages and throughout the process, the NPO worked to motivate the teams and build their confidence that they can succeed. The "learning sessions" planned by the NPO did more than teach skills; they also conveyed a sense

of urgency, purpose, and mission. The NPO reiewed accomplishments with the teams, discussed individual hospital work in the context of the entire collaborative, and reminded hospital teams that the goals were meant to be ambitious. This qualitative feedback to hospitals were supported by quantitative feedback to hospitals via data analysis, trends and benchmarking reports, which were distributed to each hospital on a quarterly basis. The NPO felt that open sharing of results helped to encourage the hospitals to maintain a focus on their goals during the collaborative and after it ends.

6. Support the participants' efforts to effect change.

The value of developing and making available various resources to support the improvement work of collaborative participants is well established. In its collaboratives, the NPO learned:

- Resources need to be easily found and accessed on the collaborative website. The usability of the site can undermine the usability of even the best resources.
- Resources should be "real" tools that hospitals can adapt to their own needs, not just information about strategies and stories about what others have done.
- Organizers must send regular reminders that drive participants to the resources – including web-based tools and e-mail lists. Organizers cannot expect the hospitals to keep the collaborative's resources "top of mind." It may not be enough to just include website links in written feedback, organizers may have to attach relevant tools to written feedback.