M12: Why QI Often Doesn't Work – The Value of Rigour

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Session M12

Disclosures

The faculty have no conflicts of interest to declare

Faculty Introductions

Workshop Agenda

Welcome

Storytelling

Grounding: What does the evidence tell us about why QI often doesn't work?

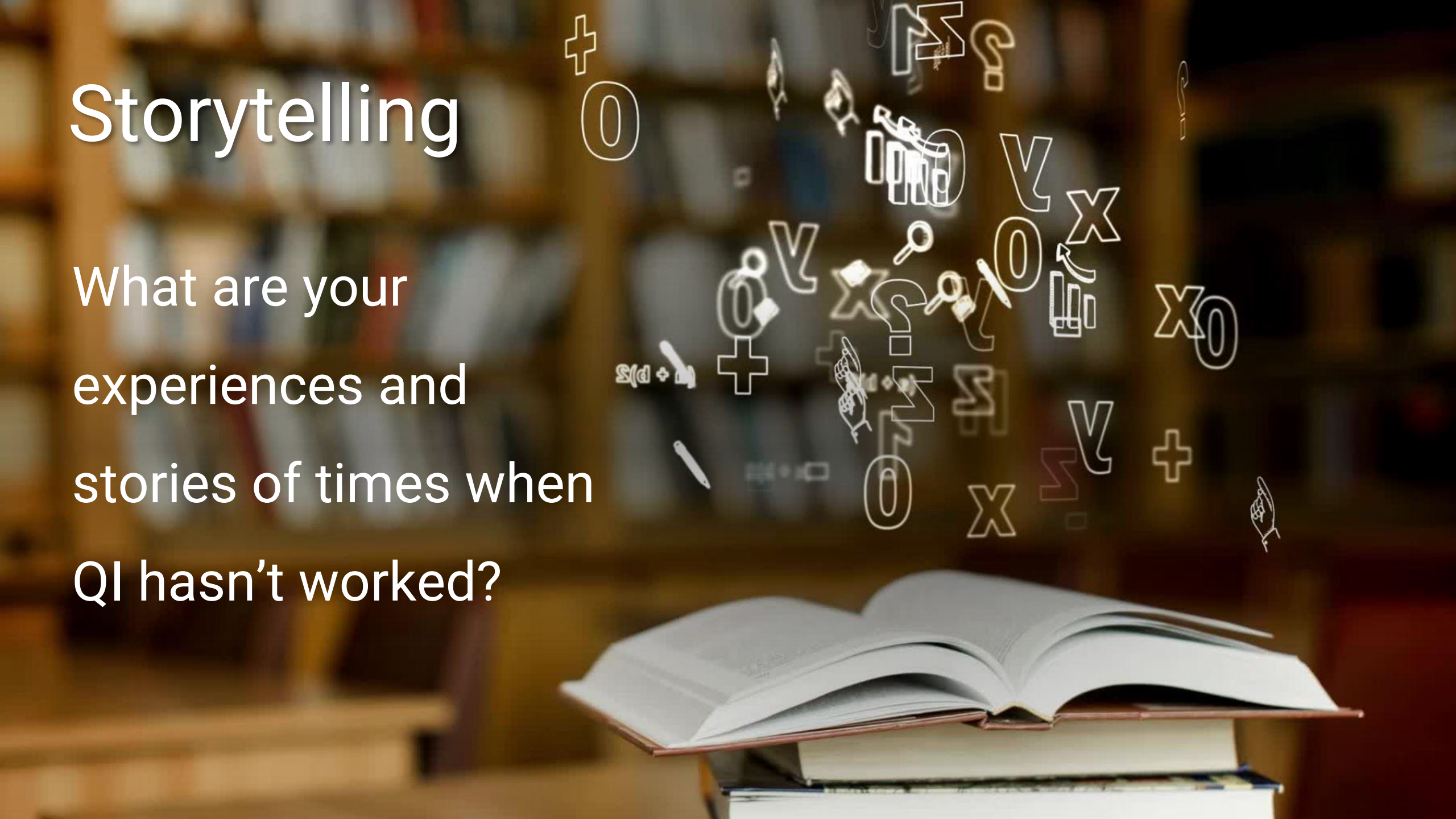
What Can we Do About It? Four tools to help us reduce the risk of failure

Closing

Storytelling

Storytelling

What are your experiences and stories of times when QI hasn’t worked?



Grounding:

Why does QI often not work?

- what does the evidence tell us?

Does QI Work? (vs other Implementation Methods)
Experience from Low and Middle Income Countries

Effectiveness estimates of implementation strategies to improve practices of healthcare providers (Rowe, A. et al, Lancet 2018. Garcia-Elorrio et al, PLoS 2019)

Interventions	Median effect size (%)
Printed information or job aids for HWs	1
Incentives	1
Training	10
Improving infrastructure	13
Supervision	15
Training + supervision	18
QI teams	28
QI teams + training	56
Strengthened infrastructure + supervision + QI teams + training + financing/other incentives	58
Collaborative improvement + training	63

The less effective approaches are commonly used

The more effective approaches are less commonly used

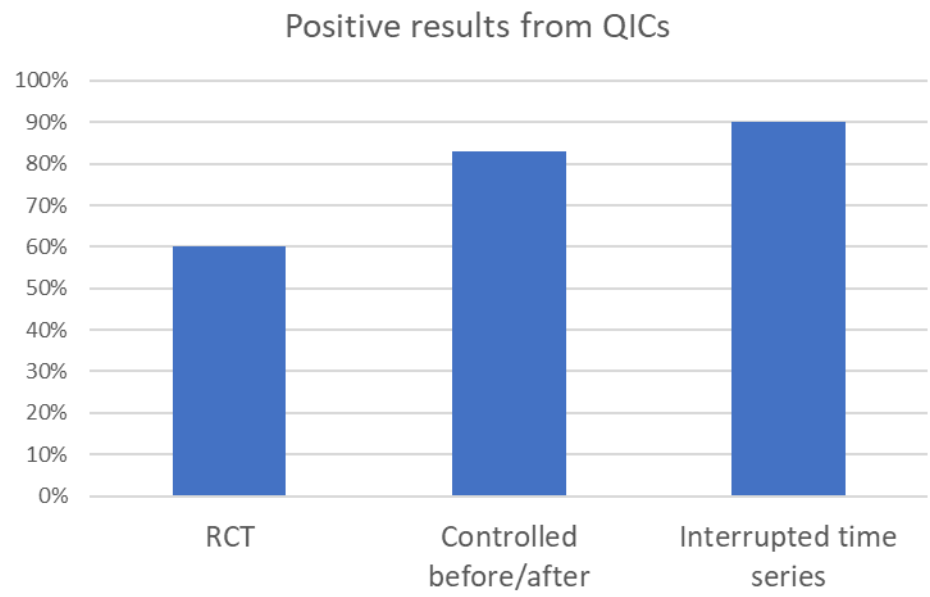
Do QI Collaboratives Work?

Improvement collaboratives in health care. Health Foundation 2014
7 RCTs and Reviews
167 uncontrolled studies

Evidence about collaborative effectiveness

Impact	% of trials or reviews that found benefit	% of other studies that found benefit
Processes	33% of 3 studies	72% of 136 studies
Patient outcomes	20% of 5 studies	77% of 43 studies
Service use or costs	100% of 1 study	89% of 9 studies

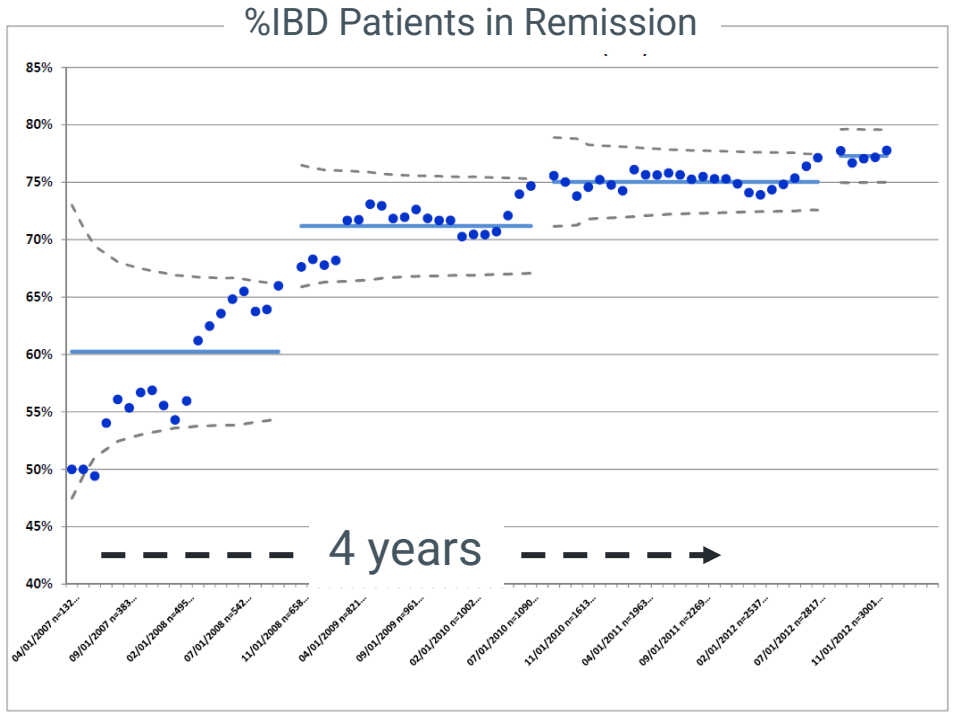
Wells et al. Are quality improvement collaboratives effective? A systematic review. BMJ Qual Saf. 2018.
64 studies met EPOC study design standards for inclusion.
Positive results in 73% of the studies



Can Improvement Science speed up Scale and Spread?

Average 17 years, in the time between high quality trial results and widespread adoption of an intervention

(Balas and Boren, 2000)

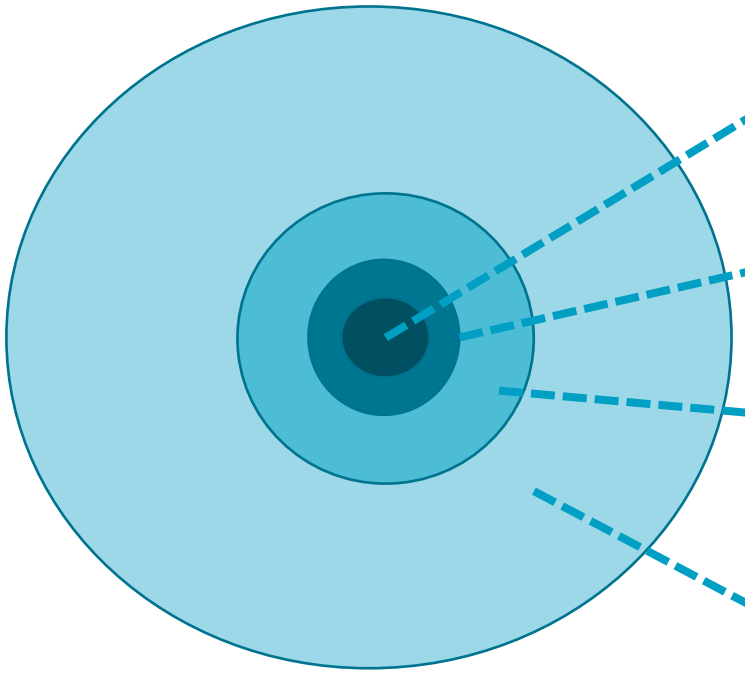


https://www.improvecarenow.org

- >35k children with IBD
- 100+ care centers in 30 states

Where could QI go wrong?

4 places where improvement or implementation can fail



1. Innovation – bad idea to start with
2. Demonstration – bad design or theory
3. Adaptation – model does not work in different contexts
4. Spread – model loses impact at scale

C-Section in Brazil:

Brazil CS Rates:

Private Sector – 85%

Public Sector 50%

Global Benchmark:

Finland, Sweden, Denmark, France CS rates 15-20%

WHO Statement:

No benefit to mother or newborn if population CS rates >15%

Step1 - Build the Demonstration Model

1. Build Broad Coalition of Stakeholders within 2 Hospitals
2. New Care Model
3. Empowerment of Women
4. Quality Management System (frontline to leadership)

% Vaginal births

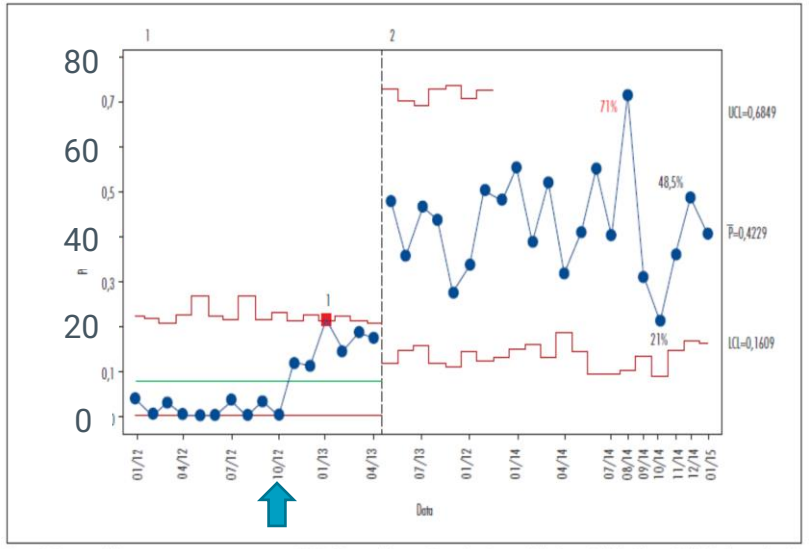
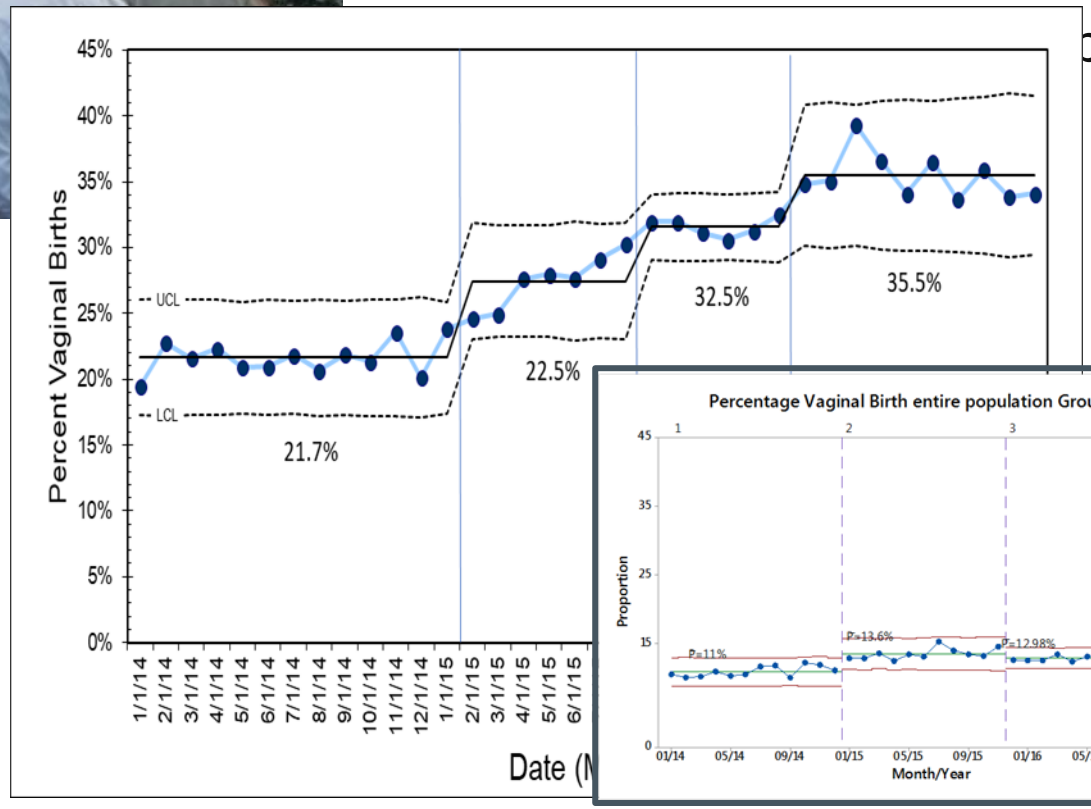


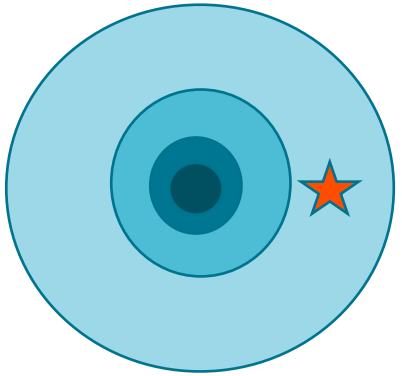
Figure 3. Percentual de partos vaginais entre gestantes UNIMED atendidas no Hospital e Maternidade Santa Isabel, Jaboticabal (SP), de outubro de 2012 a agosto de 2014

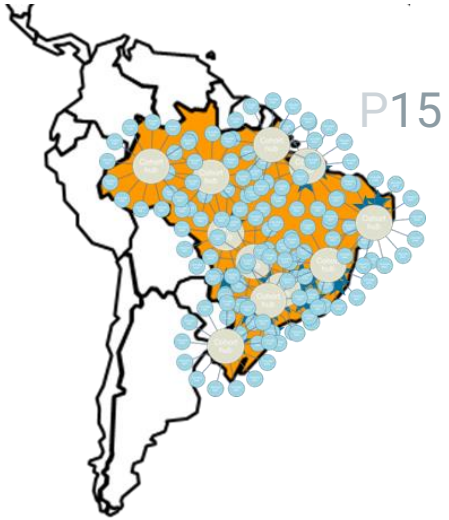
Step 2 – Test the Demonstration Model in Broader Contexts

1. Broaden the Coalition of Stakeholders
2. Test and Refine New Care Model in 26 hospitals
3. Group Learning (BTS)
4. Quality Management System (frontline to leadership)



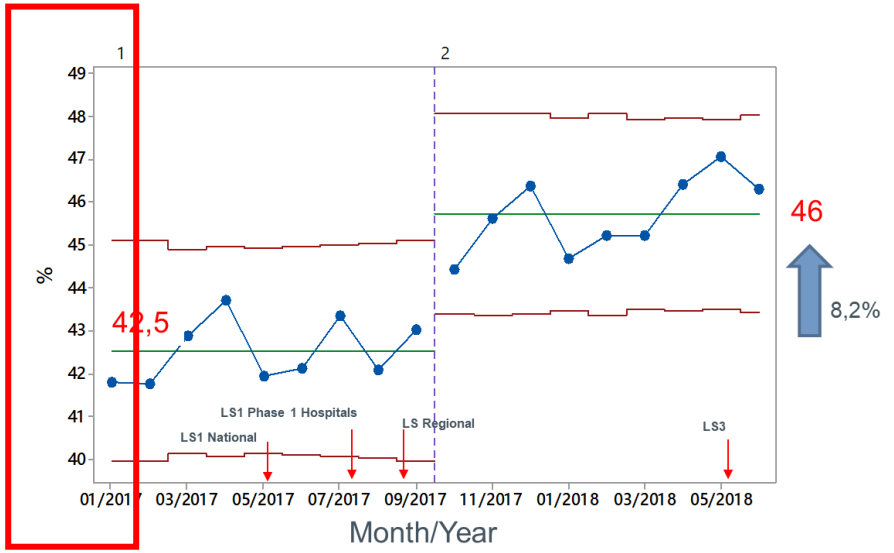
Step 3 – Spread the Model in Much Broader Contexts



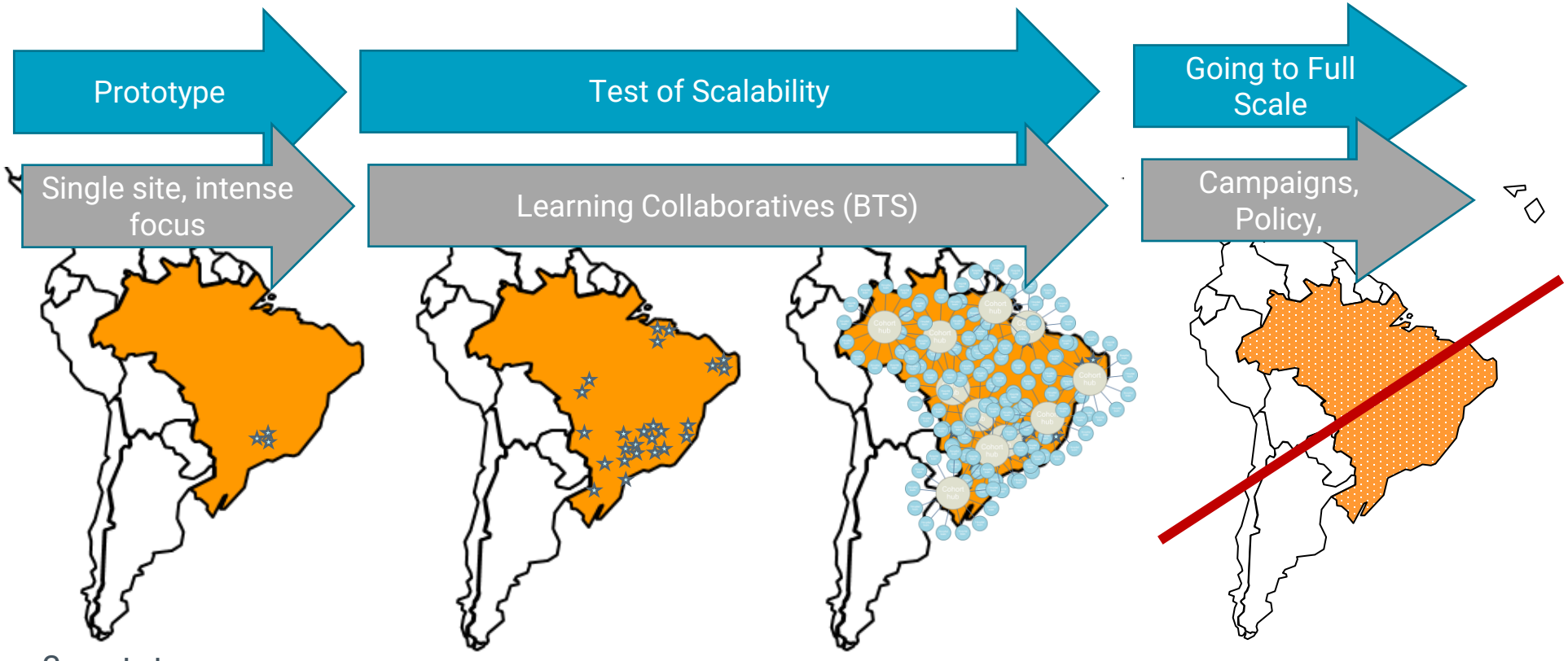


150 Hospitals

1. Broaden the Coalition of Stakeholders
2. Implement/Adapt the New Care Model in 150 hospitals
3. Hub and Spoke learning Network



Reaching National Scale up using QI methods



3 prototype hospitals

Phase 1

26 active hospital participants

Phase 2:

150 hospitals - hub and spoke model

Institute for Healthcare Improvement

ALBERT EINSTEIN HOSPITAL ISRAELITA

ANS Agência Nacional de Saúde Suplementar

Ministério da Saúde BRASIL UM PAÍS DE TODOS GOVERNO FEDERAL

What does the literature tell us?

Future Healthcare Journal 2022 Vol 9, No 3: 333–4 OPINION

QUALITY IMPROVEMENT

Challenges in conducting quality improvement projects: reflections of a junior doctor

Author: Alpha Madu[A]

KEYWORDS: healthcare quality improvement, quality improvement projects, quality improvement, patient safety

DOI: 10.7861/fhj.2022-0076

Introduction

Quality improvement (QI) in healthcare dates back to the mid-19th century.[1–3] It has now evolved into a very systematic and structured approach for improving the safety and effectiveness of patients' care and has become a mandatory requirement for many healthcare professions.[4]

While the importance and relevance of QI are well established, not much experience has been shared about real-life challenges

structure was not as hierarchically linear as we expected (ie 'orders from above' did not necessarily translate to 'actions below') and, second, ownership of change mechanisms should be clearly defined early in a project. We were unable to secure the cooperation of the stakeholders because they did not 'own' the project from the start. A final lesson was that implementation of change is difficult if change implementation structures are lacking.

In a similar project to introduce weighing all patients attending the emergency department (ED), we encountered similar challenges as critical stakeholders refused to buy into the project.

Interprofessional frictions

I noticed a subtle friction between different professional groups in the health sector and found that people were less likely to be

Organisational rigidity

Interprofessional frictions

Inadequate support

Poor resources

Lack of teamwork

Knowledge gap

Poor motivation

Am J Med Qual. 2000 Mar-Apr;15(2):49-53. doi: 10.1177/106286060001500202.

Commentary: why quality improvement efforts in health care fail and what can be done about it

D J Shulkin [1]

Affiliations + expand

PMID: 10763217 DOI: 10.1177/106286060001500202

Abstract

When you scratch below the surface, there is a palpable frustration in the field of quality improvement. More often than not, these disappointments are rooted in the slow pace of progress seen with improvement initiatives. Little is written about the shortcomings of quality improvement in health care. Medicine, in general, shuns from publicly discussing its failures. This article will focus on 10 features of failing quality improvement efforts.

Ten challenges in impro healthcare: lessons from Foundation's programm and relevant literature

Mary Dixon-Woods, Sarah McNicol, Graham Martin

► An additional appendix is published online only. To view this file please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2011-000760).

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ABSTRACT

Background: Formal evaluations of programmes are an important source of learning about the challenges faced in improving quality in healthcare and how they can be addressed. The authors aimed to integrate lessons from evaluations of the Health Foundation's improvement programmes with relevant literature.

Methods: The authors analysed evaluation reports relating to five Health Foundation improvement programmes using a form of 'best fit' synthesis, where a pre-existing framework was used for initial coding and then updated in response to the emerging analysis. A rapid narrative review of relevant literature was also undertaken.

Results: The authors identified ten key challenges: convincing people that there is a problem that is relevant to them; convincing them that the solution chosen is the right one; getting data collection and monitoring systems right; excess ambitions and 'projectness'; organisational cultures, capacities and contexts; tribalism and lack of staff engagement; leadership; incentivising participation and 'hard edges'; securing sustainability; and risk of unintended consequences. The authors identified a range of tactics that may be used to respond to these challenges.

Discussion: Securing improvement may be hard and slow and faces many challenges. Formal evaluations

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Box 1 How to address ten challenges in improvement

DESIGN AND PLANNING OF IMPROVEMENT INTERVENTIONS

Challenge 1: Convince people that there's a problem
Use hard data and to secure emotional engagement by using patient stories and voices.

Challenge 2: If you do it, will it work? Convince people of the solution.
Come prepared with clear facts and figures, have convincing measures of impact and be able to demonstrate the advantages of your solution.

Challenge 3: Data collection and monitoring systems
This always takes much more time and energy than anyone anticipates. It's worth investing heavily in data from the outset. Assess local systems, train people and have quality assurance.

Challenge 4: 'Projectness' and ambitions
Over-ambitious goals and too much talk of 'transformation' can alienate staff if they feel the change is impossible. Instead match goals and ambitions to what is realistically achievable and focus on bringing everyone along with you. Avoid giving the impression that the improvement activity is unlikely to survive the time-span of the project.

ORGANISATIONAL AND INSTITUTIONAL CONTEXTS, PROFESSIONS AND LEADERSHIP

Challenge 5: Organisational context, culture and capacities
Staff may not understand the full demands of improvement when they sign up, and team instability can be very disruptive. Explain requirements to people and then provide ongoing support. Make sure improvement goals are aligned with the wider goals of the organisation, so people don't feel pulled in too many directions.

Challenge 6: Tribalism and lack of staff engagement
Overcoming a perceived lack of ownership and professional or disciplinary boundaries can be very difficult. Clarify who owns the problem and solution, agree roles and responsibilities at the outset, work to common goals and use shared language.

Challenge 7: Leadership
Getting leadership for quality improvement right requires a delicate combination of setting out a vision and sensitivity to the views of others. 'Quieter' leadership, oriented towards inclusion, explanation and gentle persuasion, may be more effective.

Challenge 8: Incentivising participation and 'hard edges'
Relying on the intrinsic motivations of staff for quality improvement can take you a long way, especially if 'carrots' in the form of incentives are provided—but they may not always be enough. It is important to have 'harder edges'—sticks— to encourage change but these must be used judiciously.

BEYOND THE INTERVENTION: SUSTAINABILITY, SPREAD AND UNINTENDED CONSEQUENCES

Challenge 9: Securing sustainability
Sustainability can be vulnerable when efforts are seen as 'projects' or when they rely on particular individuals.

Challenge 10: Side effects of change
It's not uncommon to successfully target one issue while also causing new problems elsewhere. This can cause people to lose faith in the project. Be vigilant about detecting unwanted consequences and be willing to learn and adapt.

Quality in Primary Care 2009;17:303–5

Editorial

Engaging clinicia initiatives: art or

A Niroshan Siriwardena MMedSc
Foundation Professor of Primary Care, S

Engaging clinicians, from whichever heal discipline, whether they are doctors, nur health professionals, is increasingly ackn be an essential precondition for the succe improvement initiatives. This is because cli increasingly clinician assistants such as support workers) are at the front line of where service users' health needs are ad healthcare is delivered.[1] Clinical engage might range from passive support to ac pation to effective leadership, is often quality improvement initiatives to work. Al ity improvement is viewed as self-eviden

Quality in Primary Care 2012;20:1–3

Editorial

Why quality improvement initiat succeed or fail: the MUSIQ of q improvement

A Niroshan Siriwardena MMedSci PhD FRCGP
Professor of Primary and Prehospital Health Care, University of Lincoln, UK

A fundamental question in quality improvement (QI) is why do QI initiatives succeed or fail? Even when using apparently similar methods, there are marked variations in outcomes from QI interventions and the effects of widely used methods, such as Quality Improvement Collaboratives (QICs) are often unpredictable.[1] This has even led to scepticism about whether these methods could work.[2] Three main elements determine whether and to what extent QI initiatives succeed: first, the topic and evidence for the change;[3] second, the interventions or activities used;[4] and last, but by no means least, the context in which they are applied. The first two elements are often the focus of greatest

and payment mecha organisation. Finally, strategic imperatives enced by internal cor the organisation (Fig

Kaplan and collea their model needs to be and different QI initiatives elements may be absent or subsumed into other health system components. The model focuses on what and how: which contextual elements might be present and how they might affect each other and the outcomes of the QI initiative. This is a problem inherent in the model.

Three main factors:

1 – the topic & evidence for change

2 – the interventions or activities used

3 – the context in which they are applied

3-2014

Why Hospital Improvement Line.

Paul D. Longenecker
Otterbein University

Clinton O. Longenecker
University of Toledo

Top 10 Barriers to Successful Hospital Change as Identified by Frontline Hospital Leaders*

1.	Poor implementation planning and overly aggressive timelines	73%
2.	Failing to create buy-in/ownership of the initiative	67%
3.	Ineffective leadership and lack of trust in upper management	62%
4.	Failing to create a realistic plan or improvement process	55%
5.	Ineffective and one-way communications	52%
6.	A weak case for change, unclear focus, and unclear desired outcomes	50%
7.	Little or no teamwork or cooperation	43%
8.	Failing to provide ongoing measurement, feedback, and accountability	38%
9.	Unclear roles, goals, and performance expectations	36%
10.	Lack of time, resources, and upper-management support	33%

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DOI: 10.1111/jep.13154

EDITORIAL ARTICLE

WILEY Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

The "problem(s)" with quality improvement in health care

Health care has always had a quality issue. For much of our history, health care was provided by practitioners whose basis for their craft was spiritual (or quasi-spiritual) or unsubstantiated theory, or by charlatans peddling cure-all concoctions.* As such care often had little or no effect on the patient's disease or ailment, one would be justified in considering that care to be of low quality. Some would argue that little has changed. Variations in the care patients received, first observed by Glover[2,3] in the early part of the last century and notably by Wennberg and colleagues 40 years later (eg, Wennberg and Gittelsohn[4]), raised concern amongst health-care stakeholders that resources were being used inefficiently and/or some patients were not receiving the best care available†—both of which are considered by many as issues of quality in health care. Variations in care can still be seen today despite increasing knowledge of which therapies are effective for which health conditions and considerable attention to the organization and distribution of health care resources. It is difficult to see how quality care would result in patients with similar needs receiving different care (especially where effective therapies are known and available and the resources exist to provide those therapies)

six domains: quality health care is care that is safe, effective, patient-centred, timely, efficient, and equitable.[8] The National Health Service defines quality along similar terms as the IoM.[9] Formal definitions of health care quality have also been proposed in the literature. For example, the IoM defines quality as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" [[10]; p.4]. Campbell et al[11] suggest quality of care for individuals is "whether individuals can access the health structures and processes of care which they need and whether the care received is effective" (p.1614). Batalden and Davidoff[12] provide perhaps the most ambitious definition: quality is "the combined and unceasing efforts of everyone—health-care professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)" (p.2). These definitions share much in common. However, they also all struggle in that it is not clear exactly how to operationalize them such that quality can be measured, which limits our ability to identify when quality is poor or has

Future Hospital Journal 2016 Vol 3, No 3: 191–4

COMMENT

Does quality improvement improve quality?

Authors: Mary Dixon-Woods[A] and Graham P Martin[B]

ABSTRACT

Although quality improvement (QI) is frequently advocated as a way of addressing the problems with healthcare, evidence of its effectiveness has remained very mixed. The reasons for this are varied but the growing literature highlights particular challenges. Fidelity in the application of QI methods is often variable. QI work is often pursued through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required. There is insufficient attention to rigorous evaluation of improvement and to sharing the lessons of successes and failures. Too many QI interventions are seen as 'magic bullets' that will produce improvement in any situation, regardless of context. Too much improvement work is undertaken in isolation at a local level, failing to pool resources and develop collective solutions, and introducing new hazards in the process. This article considers these challenges and proposes four key ways in which QI might itself be improved.

KEYWORDS: evaluation, healthcare organisation, hospitals, patient safety, quality improvement, research design/methods

Introduction

The quality and safety of healthcare worldwide remain

US studies suggest that nurses deal with an average of 8.4 work system failures per 8-hour shift, and they are continually interrupted.[5,6] The need for staff to learn and re-learn, associated with the variability in fundamental processes, is significant. Much professional time is consumed unproductively in learning anew how to undertake tasks as basic as ordering tests, knowing whether equipment has been cleaned, or how things are arranged in the resuscitation trolley in each setting. Personnel may also make errors as they move from place to place, either because they have not yet learned the new procedures or they apply previous learning to new but different contexts, sometimes with tragic outcomes.[7]

The problems with quality improvement

Healthcare has increasingly been encouraged to use quality improvement (QI) techniques to tackle these operational defects (clearly, healthcare faces many other challenges but they may require different approaches). Capacity to improve quality is clearly critical to healthcare organisations; every organisation needs to be able to detect its operational (and other) problems and solve them using structured methods. For many problems (although far from all), that may mean using methods adapted

Variable fidelity in application of QI methods

Lack of expertise, power, resources by those undertaking the work

Insufficient attention to rigorous evaluation and sharing learning

Learning from the lived experience of improvers in the US & UK

Our research question

QI success depends on many factors

Which are crucial?

According to those who are actively engaged in practicing and leading QI efforts

Learning from the lived experience of improvers in the US & UK

A survey!

- Invitees: US & UK Improvement practitioners and leaders
- 36 US invitees, 49 UK
- Asked to rate the criticality of 15 aspects of a quality improvement initiative
  - “Of no importance”
  - “Of little importance”
  - “Very important”
  - “Absolutely necessary”

Learning from the lived experience of improvers in the US & UK

What aspects of QI are most critical for success?

- **A culture of improvement**
- **Alignment of improvement work to institutional priorities**
- **All relevant stakeholder group's perspectives represented**
- **Appropriate data analysis and interpretation**
- **Data accessibility**
- **Design and execution of a plan to sustain project successes long-term**
- **Improvement expert or consultant support for improvement teams**
- **Improvement science knowledge, skills, and experience**
- **Involvement of patients and/or caregivers**
- **PDSA cycles used and clearly documented**
- **Project design aligned with improvement science best practices**
- **Project teams having adequate time for improvement efforts**
- **Senior leadership support**
- **Sufficient data collection**
- **Theory of change that incorporates evidence base**

Mean of all 15 = 3.4/4.0

Between “very important” and “absolutely necessary”

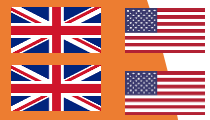
Response rate

US response rate 33%, UK 43%, Total response rate = 39%

Learning from the lived experience of improvers in the US & UK

Differences “across the pond”


- **A culture of improvement**
- **Alignment of improvement work to institutional priorities**
- **All relevant stakeholder group's perspectives represented**


- **Appropriate data analysis and interpretation**
- **Data accessibility**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- **Project design aligned with improvement science best practices**


- **Project teams having adequate time for improvement efforts**


- **Senior leadership support**
- **Sufficient data collection**
- **Theory of change that incorporates evidence base**

4 Categories / Failure Modes

1. Context: Culture, environment, leadership engagement
2. Design & execution
3. Sustainability and scale (taking it past innovation)
4. Data & learning Systems

What Can We Do About it? Ways to Mitigate Against Risks

1. Context

A tool for understanding context for QI

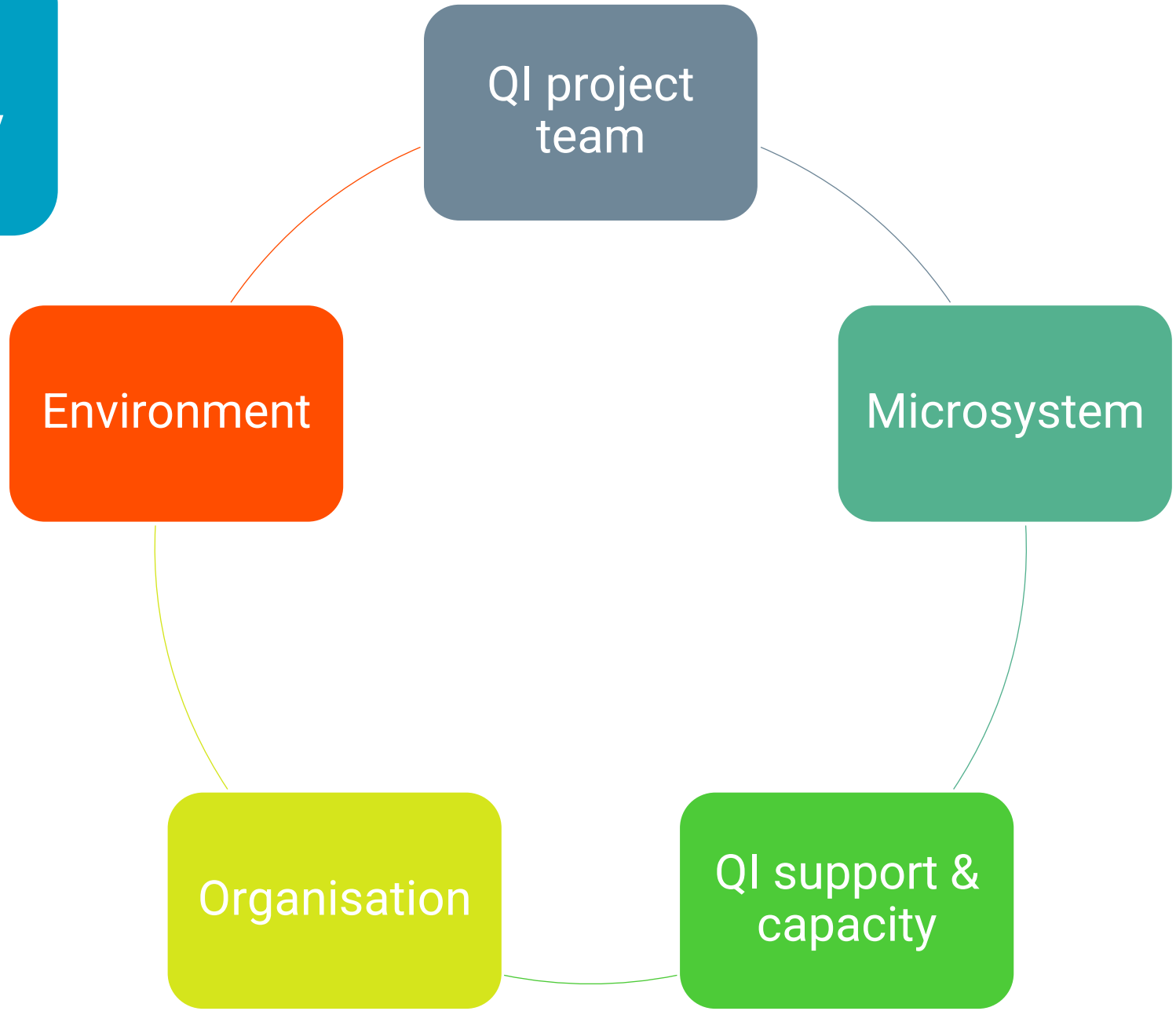
MUSIQ
(The Model for Understanding Success in Quality)

Heather Kaplan, Lloyd Provost, Craig Froehle, Peter Margolis
BMJ Qual Saf 2012; 21:13-20

MUSIQ v2.0
A new typology for understanding context: qualitative exploration of the model for understanding success in quality (MUSIQ)

Julie Reed, Heather Kaplan, Sharif Ismail
BMC Health Services Research 2018; 18:584

Model for Understanding Success in Quality (MUSIQ)



Model for Understanding Success in Quality (MUSIQ)

- Excel calculator
- Sit down with the project lead to fill out at the start of your project
- Score each element of context, and it will calculate your total score

168	Highest Possible MUSIQ Score
120-168	Project has a reasonable chance of success
80-119	Project could be successful, but possible contextual barriers
50-79	Project has serious contextual issues and is not set up for success
25-49	Project should not continue as is; consider deploying resources to other improvement activities
24	Lowest Possible MUSIQ Score

- Look at areas of weakness with project team and QI sponsor, and see if you can address at the start of the project

For table discussion

At the start of your next quality improvement initiative…

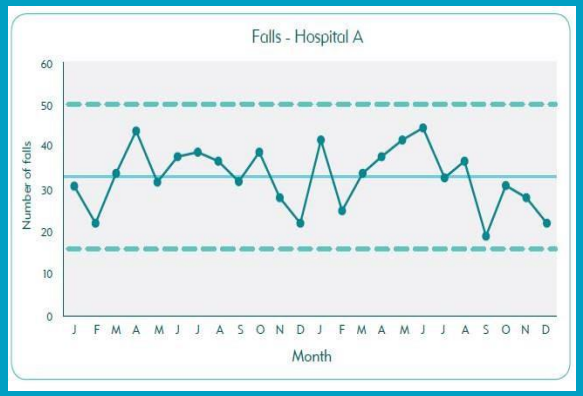
Which aspects of the MUSIQ framework would you feel confident to intentionally address?

Which aspects would you feel less confident with, and why?

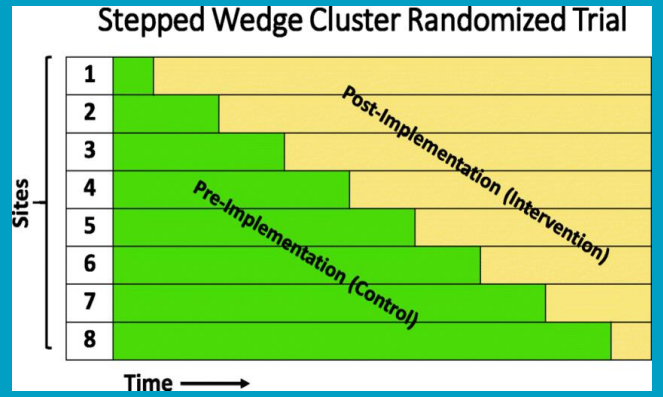
Design and Execution

A brief overview of methodology and rigor

Before and after/cross-sectional



Interrupted time series and mixed-methods



Experimental design

Increases in complexity and ability to detect causation (generally)

Some dialogue among experts

Editorial

February 2018

Quality Improvement for Quality Improvement Studies

Deborah Grady, MD, MPH[1]; Rita F. Redberg, MD, MSc[1,2]; Patrick G. O'Malley, MD, MPH[3]

Author Affiliations | Article Information

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[2]Editor, *JAMA Internal Medicine*

[3]Department of Medicine, Uniformed Services University, Bethesda, Maryland

Key points

- QI should generalize, "actually" result in outcome improvement, examine adverse outcomes, and costs
- QI should have concurrent control groups, randomization, blinding
- QI should have IRB review
- Please use clustered randomization and stepped wedge designs

May 2018

Rigor in Quality Improvement Studies and the Role of Time-Series Methodologies

Brian M. Wong, MD, FRCPC[1]; Kaveh G. Shojania, MD[1,2]

Author Affiliations | Article Information

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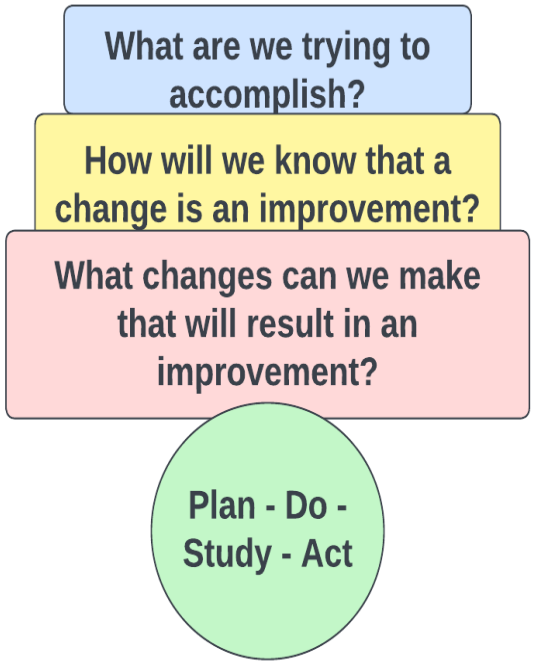
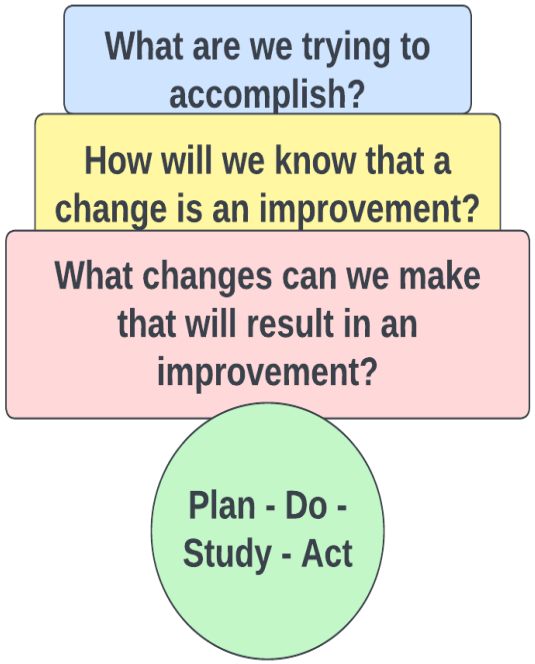
Key points

- Disagree that rigor requires concurrent controls and randomization
- Time series methods offer comparable rigor
- SQUIRE 2.0 guidelines set an expectation
- We don't support uncontrolled before-after studies

A clear “roadmap” for consistent execution



One “roadmap”



Initiation

- Problem statement
- Scope
- Team formation
- Service agreement
- Communication plan
- Executive sponsor interview
- Project charter
- IRB submission
- SQUIRE 2.0
- Develop Evaluation strategy

Discovery of current state

- Fishbone diagram
- Process map
- Pareto chart

Goal setting and measurement

- Global & SMART Aim
- Outcome, Process, Balancing measures
- Operational definitions
- Run chart
- Control charts

Develop theory of change

- Key Driver Diagram

Design, test, & adopt changes

- PDSA preparation and execution
- Spread and scale

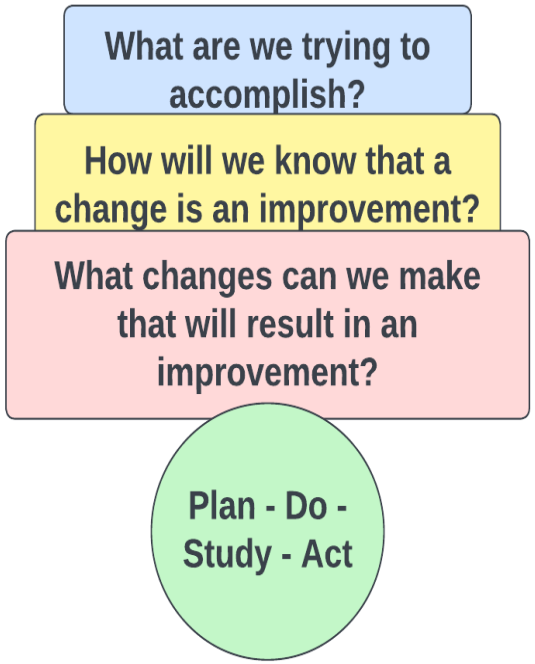
Transition to Control

- Closeout/handoff plan
- Inact Evaluation strategy

Disseminate

- Internal awareness
- Conferences
- Publication
- SQUIRE 2.0

With expectations



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To ensure best outcomes, we strongly suggest that each project contains the following elements:

- Project charter
- Evidence of the discovery of root causes and contributing factors input provided by all partners (completed fishbone, process map, etc.)
- Data over time, preferably at least 1 outcome, 1 process, and 1 balancing measure
- Key Driver Diagram
- PDSAs prepared in advance and results documented
- Project handoff/closeout document completed

At your tables

Part One:

- By yourself, review the roadmap for 1-2 minutes
- Then with your table mates, discuss:
  - Does your organization have a similar roadmap to help ensure consistent rigorous execution of improvement work?
  - What aspects of it do you like, not like?

Part two:

- With your table mates, discuss:
  - Do you agree with the elements of the "minimal viable product?"
  - What would you add or remove?

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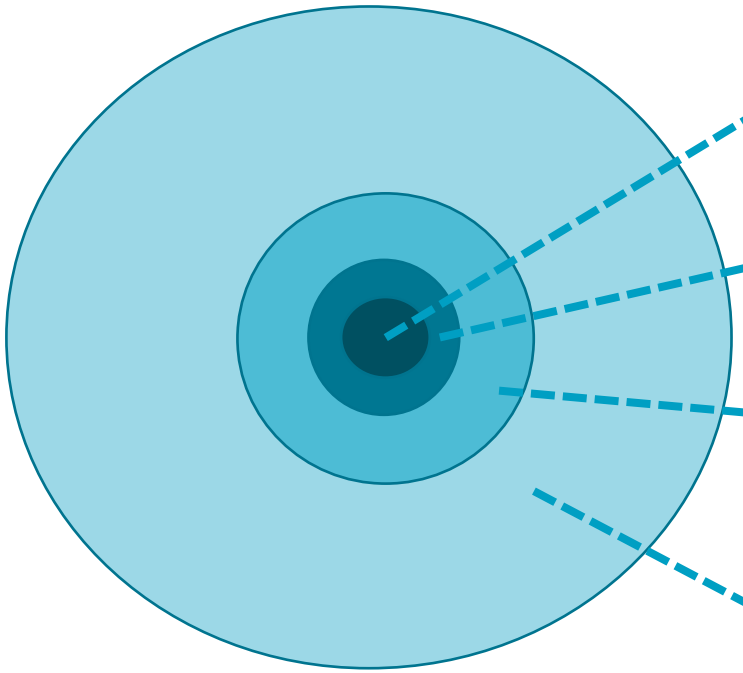
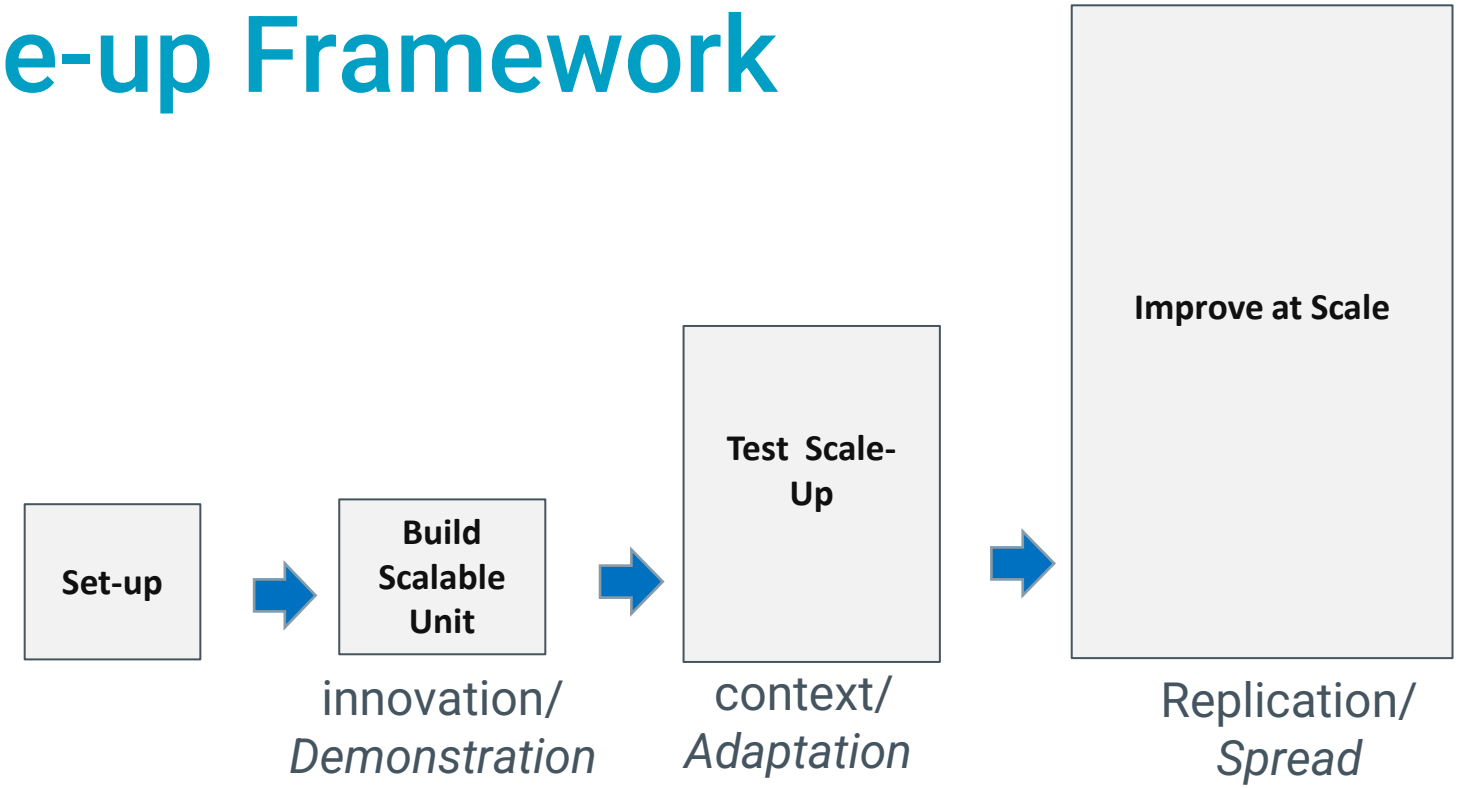
3. Are you ready for Scale-up?

Lets get this Right

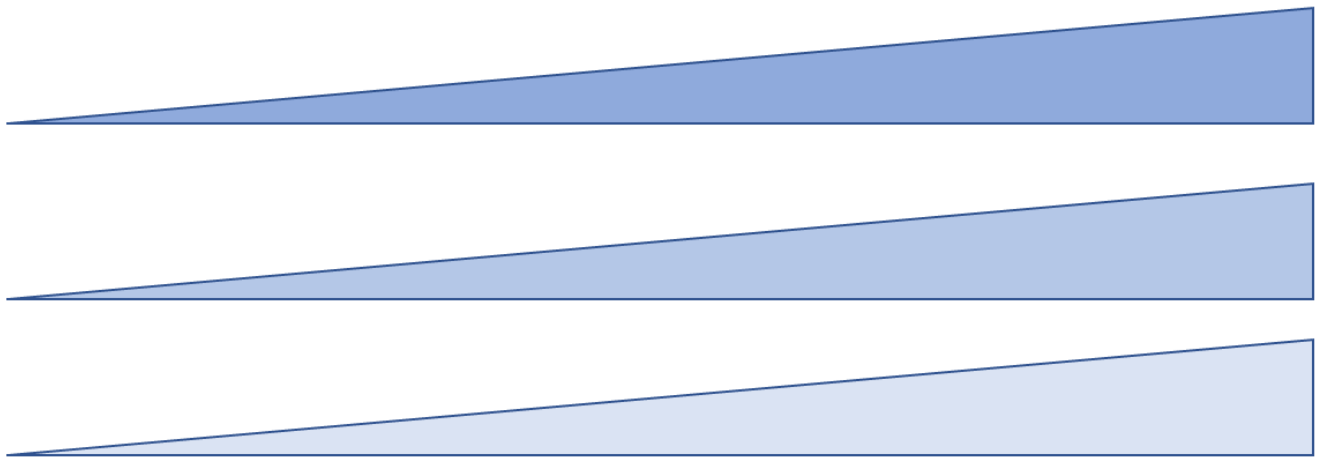


1. Innovation – prototyping
2. Demonstration – showing effectiveness
3. Adaptation – showing effectiveness in different contexts
4. Spread – showing wide-scale spread and sustainability

IHI Scale-up Framework



1. **Phased approach** to scale-up improvement



2. Build **will** for change and spread

3. Develop credible implementation **ideas**

4. Build **QI capability, infrastructure and tools**

METHODOLOGY Open Access

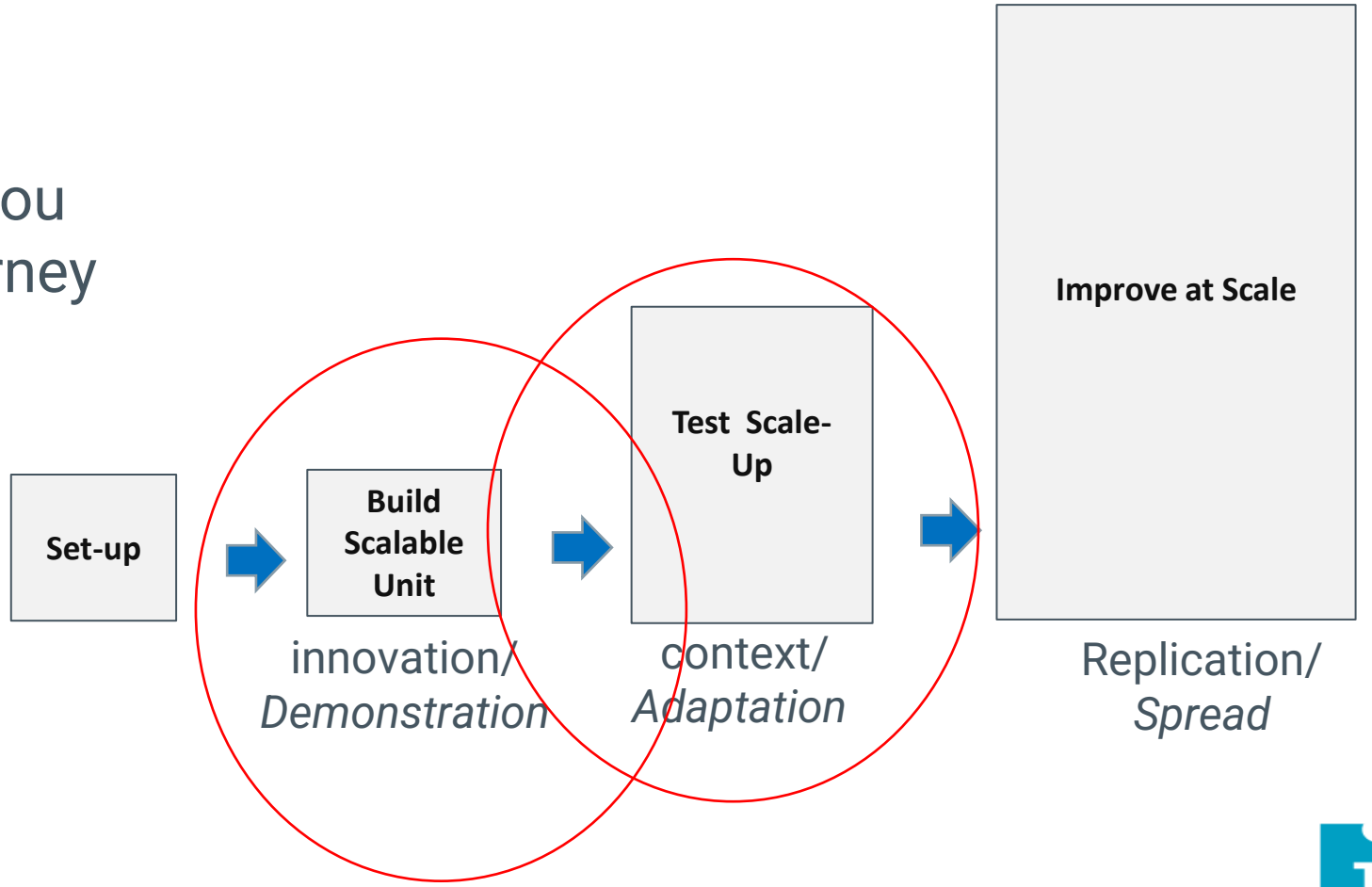
A framework for scaling up health interventions: lessons from large-scale improvement initiatives in Africa

Pierre M. Barker[1,2*], Amy Reid[1] and Marie W. Schall[1]

IHI Scale-up Framework

At your tables….

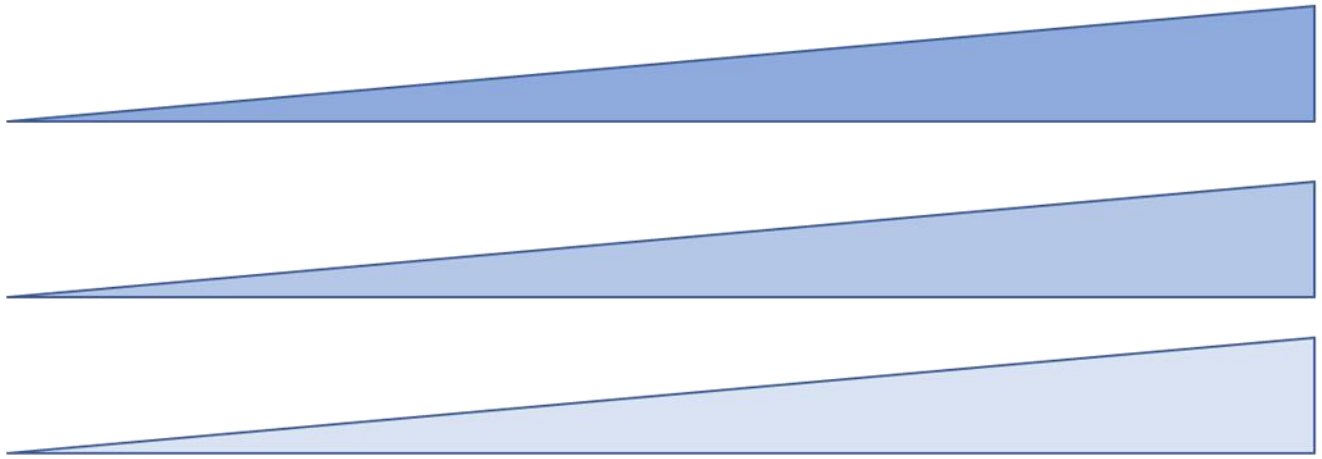
Circle where you think you are in your scale up journey



IHI Scale-up Framework

At your tables fill out your “Readiness for Scale” survey…..

Do you have the will, ideas, infrastructure to take the next step of scaling up?



2. Build **will** for change and spread

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Do you have the Will and Engagement needed to Scale?

Alignment with Scale-Up Model	Question/Prompt	Strongly Disagree to Strongly Agree (1-5)	Alignment with Will, Ideas, Execution Model
Adoption Mechanism	Compared to other programs and initiatives, the community that we are planning to scale-up into (adopter community) regards the improvement initiative as a top priority.		Will
	The adopter community shares a sense of urgency in closing the gap in performance or outcomes around our main aim.		
	The adopter community/organization recognizes the benefits of participating in this improvement initiative.		
	The adopter community believes the approach we are advocating will reach our goals faster relative to other initatives.		
	The adopter community understands that the approach we are advocating is simple to understand, easy to try out and easy to measure.		
	The improvement approach we are advocating aligns with the culture and values of our community/organization.		
	Leaders and champions of the adopter community have been identified and have shown a willingness to advocate for the improvement intiative in their community.		
	TOTAL Adoption Mechanism Score		

Are your Ideas ready for Scale or Spread?

Question/Prompt	Strongly Disagree to Strongly Agree (1-5)	Alignment with Will, Ideas, Execution Model
We have a set of best practices or tested change ideas that are ready test or spread to the sites of the next phase of work.		Ideas
We have a compelling theory of change.		
We can show the evidence base for our theory from previous studies and/or we have results that show how the theory has been applied to our own improvement work.		
If we are testing scale or going to full scale, improvement has been sustained in the sites where we are currently testing or implementing changes.		
We have identified test/implementation sites most likely to adopt a new approach for the next phase of the work.		
TOTAL Next Phase of Scale-up Score		

Do you have the infrastructure ready for the next step of Scale or Spread?

Question/Prompt	Strongly Disagree to Strongly Agree (1-5)	Alignment with Will, Ideas, Execution Model
Adequate human capacity (resources, dedicated time, seniority) is available to support the scale-up of improvements across the community/organization.		Execution
Adequate improvement capability exists to support the planned work of the next phase.		
Capability exists in managers and leaders to facilitate the changes required for improvement.		
Staff and leadership across our community/organization see improvement and scale-up work as an integral part of their daily work.		
Data collection and reporting tools are available for scale up.		
Other anticipated resources are/will be available to undertake this work.		
A learning system exists to spread knowledge from improvement initiatives systematically across the organization; i.e. learning loops back into quality planning.		
TOTAL Support Systems Score		

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4. Do you have the Data and Learning Systems to Demonstrate the Rigor of your Work?

IHI's Framework for Improvement Research and Evaluation

1 Progress

What results are you seeing in the project so far?
How do the results you're seeing compare to your predictions?

2 Activity, Theories & Context Affecting Results

Activity

To what extent is the project being delivered and received as planned?

Theory

What aspects of the project's content and execution theory are influencing the results?

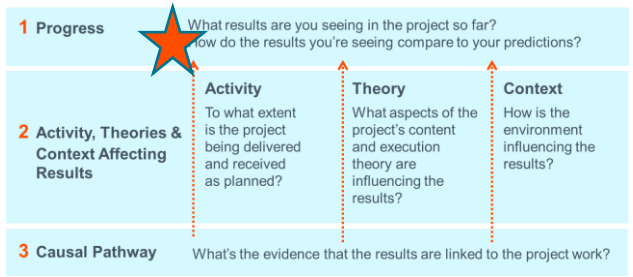
Context

How is the environment influencing the results?

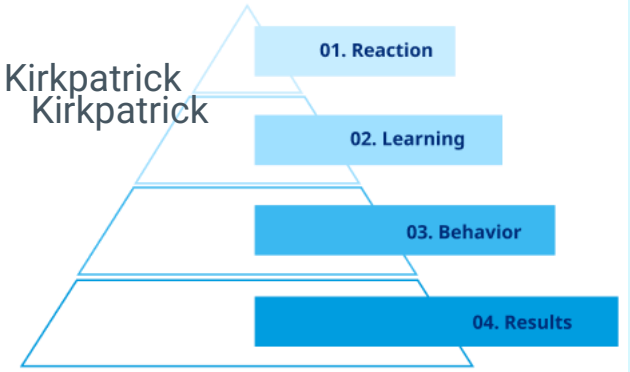
3 Causal Pathway

What's the evidence that the results are linked to the project work?

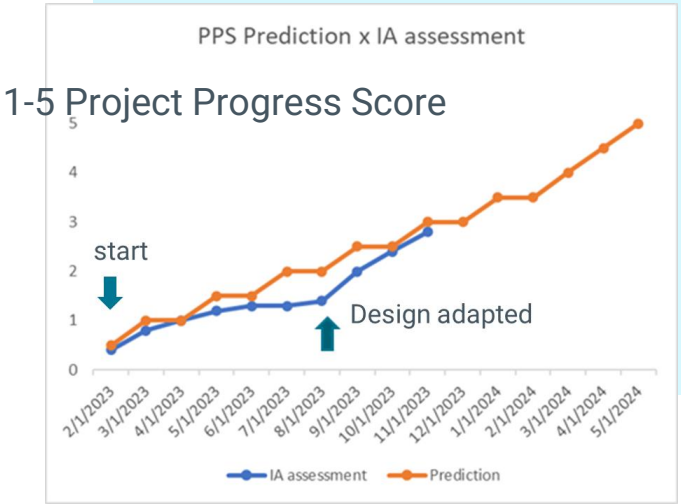
At your Tables…..
1. Understanding Progress



1 Progress

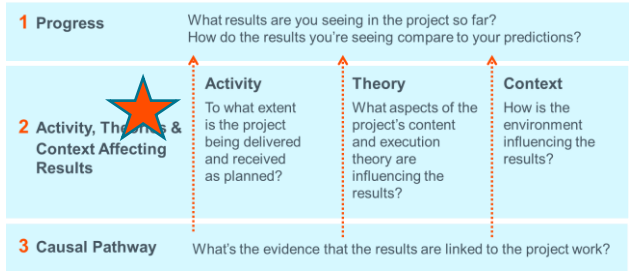


1. What results are you seeing in the project so far in service of your Project Aim?
    - Qualitative: Surveys
    - Quantitative: Process and Outcomes (Run Charts, SPC Charts)



2. How do the results you're seeing compare to your predictions?
    - Are you "on track" to achieve you Project Aim (how much, by when)

At your Tables…..2. Activities, Theories, Context: choose ONE of 3 to discuss



2 Activity, Theories & Context Affecting Results

1. Activity

To what extent is the project being delivered and received as planned?

2. Theory

What aspects of the project's content and execution theory are influencing the results?

3. Context

How is the environment influencing the results?

1. Are you able to show that you are delivering the implementation intervention according to the design?
Are you providing the QI dose you designed?

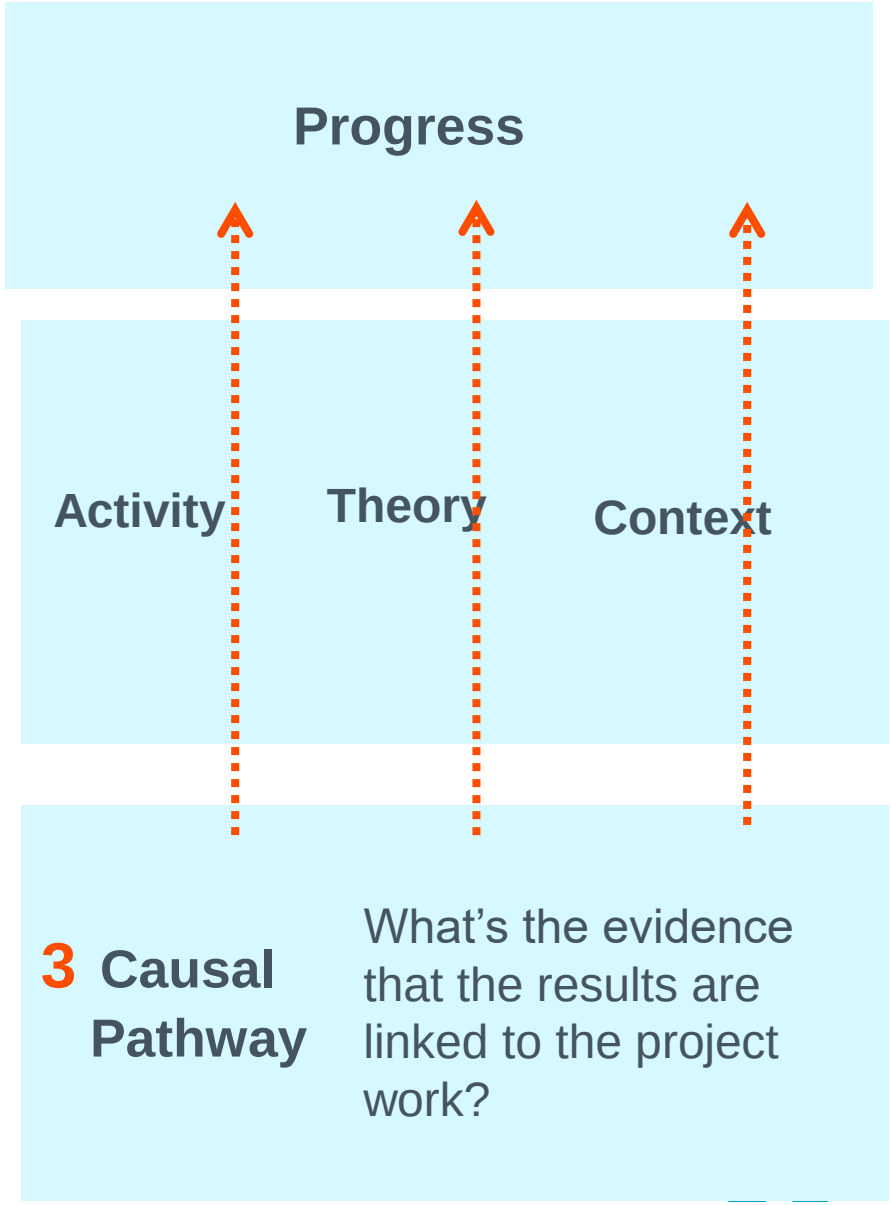
2. Are you able to track the impact of the different primary and secondary drivers?
What assessment can you make about the effectiveness of your implementation design?

3. What is the impact of external events and conditions on the results you are seeing – macro (e.g. politics/policy/social) –meso (organization wide influences) – micro (e.g. participant responses)

At your Tables…….
3. The Causal Pathway

Assumes Quasi-experimental design (no counterfactual/comparator) –

- Are you using qualitative and quantitative data?
- Do your stories illustrate how and why your project is working/not working
- Do your run charts to show timing and dose of implementation changes?
- Are you assessing the strengths of your content theory (driver diagram)
- Are you assessing the impact of your execution theory (implementation design)
- Are you able to understand the impact of the environment on your results?



Shared Reflections & Closing