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Using Learning Communities to Support Adoption of Health Care Innovations

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Background: Diffusion of innovations can be a slow process, posing a major challenge to quality improvement in health care. Learning communities can provide a rich, collaborative environment that supports the adoption of health care innovations and motivates organizational change. From 2014-2016, the Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange established and supported three learning communities focused on adopting innovations in three high-priority areas: (1) advancing the practice of patient- and family-centered care in hospitals, (2) promoting medication therapy management for at-risk populations, and (3) reducing non-urgent emergency services.

Methods: Members of each learning community worked collaboratively in facilitated settings to adapt and implement strategies featured in the Health Care Innovations Exchange, receiving technical assistance from content experts. Project staff conducted a mixed methods evaluation of the initiative, both formative and summative.

Results: The activities and outcomes of the three learning communities provided insights about how this approach can support local implementation efforts, and about factors influencing innovation adoption. Using a qualitative synthesis method, lessons were identified related to learning community startup (recruitment and goal setting), learning community operations (engagement, collaborative decision-making, and sustainability), and innovation implementation (changing care delivery processes and/or policies).

Conclusions: Findings from this work indicate that the learning community model of group learning can serve as an effective method to support dissemination and implementation of innovations, and to achieve desired outcomes in local settings.

INTRODUCTION

Health care organizations seek to identify and implement service delivery innovations designed to improve quality and performance. Adopting innovative strategies with the promise to improve care delivery offers patients, providers, and payers many potential benefits, including improvements in the quality of care and patient experience, reduced costs, and better health outcomes. While factors influencing the uptake of evidence-based innovations in health care delivery systems are complex, it is generally recognized that the diffusion of innovations can be a slow process, posing a major challenge to quality improvement in health care.[1,2]

The U.S. Agency for Healthcare Research and Quality (AHRQ) created the Health Care Innovations Exchange[3] in 2006 to speed the adoption of new and better ways of delivering health care. The Innovations Exchange offered a robust, Web-based repository of more than 900 evidence-based service delivery and policy innovations, as well as over 1,500 tools for improving quality and reducing disparities, suitable for a range of health care settings, patient populations, and care processes. This resource supported AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with partners to ensure that the evidence is understood and used.[4] The Innovations Exchange has also offered potential innovation adopters a variety of learning and networking opportunities to support this mission, including Web events, online discussions, and in-person meetings. Midway through the last 5-year contract that supported the Innovations Exchange work, AHRQ leadership expressed interest in shifting away from its focus on dissemination to concentrate on more robust learning and networking activities. Driving factors were the desire to have direct positive impact on patient care services (offering a web-based repository of innovations was seen as an indirect mechanism) and to learn how facilitated learning communities could influence adoption of service delivery innovations within a 2-year time frame (there were no plans to extend the contract). In 2014, the program refocused its efforts and resources to concentrate on proactively catalyzing change in health care practice through active dissemination and shared learning. To help meet that goal, the Innovations Exchange established three learning communities focused on addressing common challenges through the adoption of several specific innovations (i.e., "innovation clusters") to improve health care delivery. The cluster concept was designed to provide an array of strategies and solutions so that

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participants could adapt and tailor innovations to their organizations' unique context.

In recent years, organizations have recognized the value of systematically promoting group learning as a way for people and organizations to efficiently share knowledge and resources, solve problems, improve professional practices, and achieve goals. A 2017 systematic review noted that quality improvement collaboratives have been widely adopted in health care and those included in the review reported significant improvements in both clinical processes and patient outcomes, though the authors express caution about the reported results because of inconsistent study quality and possible publication bias.[5] Commonly used terms for group learning models in health care include "learning collaboratives," "learning networks," "learning communities," and "communities of practice." Despite variations in terminology, all these models emphasize key elements, including support for interpersonal interactions, implementation of appropriate structures and functions, and promotion of shared learning aimed at achieving participants' common goals. At the outset of its Innovations Exchange Learning Communities initiative, AHRQ defined a learning community as "a select group of potential adopters and stakeholders who engage in a shared learning process to facilitate adaptation and implementation of innovations featured in the Innovations Exchange." A main objective of the learning community model was to provide participants with opportunities to learn from each other, share resources, and receive expert coaching and implementation support, thereby reducing the time required to move innovations into practice.

The learning communities were characterized as problem-based in nature; they convened participants around a common problem and offered potential solutions, encouraging the adoption of a range of strategies highlighted in several innovation profiles selected from the Innovations Exchange. By selecting multiple profiles and encouraging tailored implementation, participants could adapt innovations specific to their needs without forcing a prescribed set of steps that all participants must follow. In this way, the learning community methodology recognized that not all sites would encounter the same challenges, and allowed participants to adjust strategies to fit their unique organizational contexts. Through the learning communities, participants worked together with "champions"—content experts who guided the implementation process—to identify challenges and strategies that could help overcome local, contextual barriers to innovation adoption. Although the learning communities were closed networks, their goal was to share learnings, findings, and processes to enhance dissemination of improvements with broader audiences.

In addition to achieving meaningful change in care delivery, this project offered an opportunity to study the use of a learning community model to foster adoption of health care innovations. The activities and outcomes of the three learning communities provided insights about how this approach can support local implementation efforts, and about factors influencing innovation adoption. The purpose of this article is to share these insights to help inform and guide future work of this type.

METHODS

Logic Model

The work of the three learning communities was guided by an underlying logic model shown in Figure 1. The "5S Model" focuses on key elements of operating and maintaining a learning community, including Supporting, Sharing, Strengthening, Sustaining, and Scaling up the group learning process. This model guided the design of all processes that undergirded the learning communities—i.e., expert consultancy, strong facilitation and project management, and innovative collaboration technologies—and informed the implementation plan. Notably, the graphic shows a key feedback loop supporting the need for operational flexibility, adaptation, and continuous improvement to ensure that the learning community activities could accomplish the aims.

Implementation

From September 2014 through September 2016, the AHRQ Health Care Innovations Exchange established and supported three learning communities focused on adopting innovations in three high-priority areas: (1) advancing the practice of patient- and family-centered care in hospitals (PFCC Learning Community), (2) promoting medication therapy management for at-risk populations (MTM Learning Community), and (3) reducing non-urgent emergency services (ES Learning Community).[6] Each learning community topic area was chosen a priori based on the following criteria: aligns with AHRQ priorities; focuses on a common clinical challenge; can be addressed by readily available "clusters" of innovations (solutions) from the Innovations Exchange with evidence of success; is amenable to improvement through group collaboration; and has a strong, inspirational "champion" to lead the initiative.

After applying these criteria, project staff conducted strategic planning for each learning community and consulted with a core group of stakeholders to refine and implement learning community formation and recruitment approaches. Targeted organizations were formally invited and provided letters of commitment indicating their willingness to actively participate as members. The size of the learning communities ranged from 9 to 14 member organizations, represented by approximately 30 individual members in each learning community. Types of participants ranged across the learning communities and included clinical staff, health care administrators, and representatives of commu-