Foundations of Equity Learning Collaborative – Evaluation Report

August 2023

Introduction

The Learning Collaborative (LC) is a short-term learning system that brings together peers from multiple organizations to seek improvement in a focused topic area, with guidance from a coach or practice facilitator. This approach is based on the Institute for Healthcare Improvement (IHI)'s Collaborative Model for Achieving Breakthrough Improvement.

At the 2020 Alliance for Healthier Communities' (Alliance) annual general meeting, Alliance member organizations made a commitment to achieving a 75% completion rate for sociodemographic (SD) data by 2024. To support this commitment to equity, the Alliance planned and implemented its second learning collaborative (LC). The purpose of this collaborative was to:

- Increase organizations' ability to pursue equity by increasing the completeness and usefulness of SD data.
- Increase knowledge of quality improvement (QI) methods and tools and increase the capability to do QI.
- Support the development of and transition of the community health sector to a learning health system.

This learning collaborative ran from May 2022 to April 2023 with 27 teams participating and included three learning sessions, two sharing sessions, a capstone event, and a lot of work in between (see Figure 1).

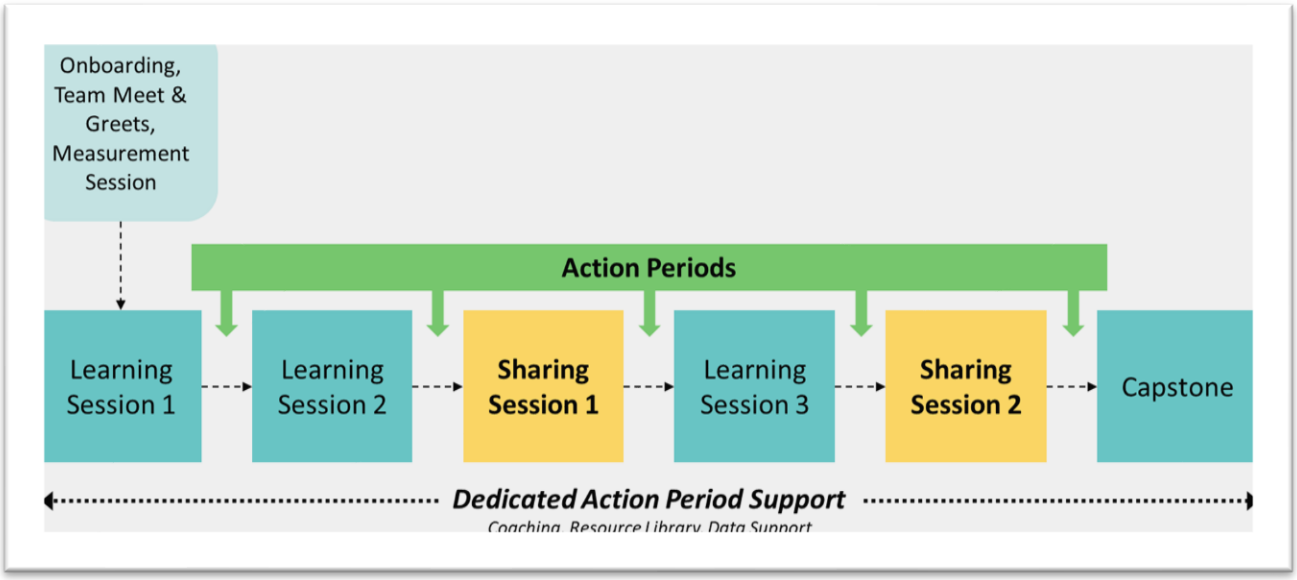


Figure 1: Learning Collaborative Framework

Evaluation was embedded throughout the collaborative to answer two overarching questions:

1) Did participating organizations see an improvement in their SD data?
2) Did the LC increase knowledge of QI methods and tools and increase the capability to do QI?

This report relays a summary of key evaluation findings, key strategies teams implemented to improve data collection rates, as well as recommendations shared by participating teams in order to improve ongoing and future LCs.

Summary of key findings

- ✓ **Key finding #1 –** Establishing a common approach or process for sociodemographic data collection is key to supporting improvements in SD collection completion rates.

- ✓ **Key finding #2 –** Building capacity and collaboration for quality improvement across the sector allowed teams to learn new skills, build on existing skills and use these skills collaboratively within their respective teams.

- ✓ **Key finding #3** – Engagement with the QI coach varied by team, however, those who did fully engage, highlighted coaching as one of the main advantages of the LC. Many teams highlighted the value of having this external expertise as they moved through the various stages of the model for improvement.

> "Having a coach was key to our success…"
>
> – LC participant

Evaluation Methods

In order to continue to improve what and how we are supporting the sector throughout the learning collaboratives, we used the following evaluation methods:

Surveys to assess experience and satisfaction were disseminated to LC members after each learning session and a final survey was shared after the capstone event. Only survey results from the final survey are presented in this report.

Interviews were conducted with 7 of the 27 teams at the end of the collaborative to gauge if the learning collaborative met its objectives, to understand what worked well, and identify areas for improvement. Both new teams and repeat teams (i.e., those who participated in the first LC) were interviewed.

Team-based run charts (outcome measure): Throughout the LC, teams used run charts to monitor changes to their selected outcome measures over time. The run charts often included annotations of tested and implemented change ideas.

Results

Did participating organizations see an improvement in their sociodemographic data?

A total of 27 teams participated in the learning collaborative, including 20 Community Health Centres (CHCs), 2 nurse practitioner-led clinics (NPLC), and 5 Aboriginal Health Access Centres (AHACs). Of the 20 CHCs that participated in the LC, nearly all saw improvement in their SD data collection. The average percentage of complete SD data[1] prior to the start of the LC (2021/22) was 43.5%. This increased to 51.1% in 2023/24 (a percent change of 17.5%).

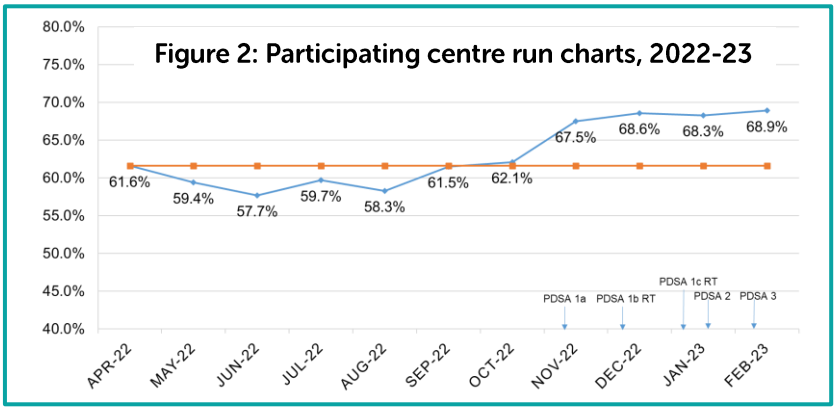
The average completion rate for each individual indicator[2] can be found below:

Table 1: Participating CHCs percentage completion by indicator, 2022-23

Indicator	2021/22 average completion rate	2023/24 average completion rate
Gender identity	39.9%	46.9%
Sexual orientation	34.7%	39.3%
Racial/ethnic group	34.0%	40.6%
Disability	34.1%	48.4%

*Percentage completion includes all response options including "prefer not to answer" and "don't know/unsure"

Figure 2 is an annotated run chart shared by a participating centre. The run chart displays the improvements over time and is annotated to highlight each Plan Do Study Act (PDSA) cycle the centre tested prior to implementation.



[1] Common QIP indicator: percentage of clients aged 13+ with at least 1 encounter in the past year who have completed at least 1 of 4 sociodemographic indicators (racial/ethnic group, sexual orientation, gender identity and disability)

[2] In 2020, at the Alliance's Annual General Meeting (AGM), members were informed that only 20% of race, gender, and sexual orientation demographic data were being captured – therefore a resolution was supported to collect and monitor demographic data indicators, including race, gender and sexual orientation.

Did the LC increase knowledge of QI methods and tools and increase the capability to do QI?

Overall, our survey and interview results indicate that teams' knowledge and capability of using and applying QI methodology and tools did increase as a result of participating in the LC. The three key components that contributed to this increase was the content covered in learning sessions, the opportunities to share and collaborate with other teams, and the tailored support offered by QI coaches.

Learning Sessions helped build quality improvement capacity

The three learning sessions, focused on building QI knowledge and skills and providing opportunities to apply this knowledge in a group setting and in between each session.

94% Of survey respondents (n=32) agreed that the learning sessions had improved their knowledge of quality improvement. All interview participants (n=7) were also in agreement.

100% Of survey respondents (n=32) agreed the learning sessions supported the application of the QI tools and knowledge. Interview participants commented on learning and applying a variety of QI tools (e.g., fishbone) to "facilitate knowledge to practice" - LC participant

94% Of survey participants (n=32) agreed the key learning and application of QI tools supported their journey to improve sociodemographic data collection.

Collaborative learning and sharing across the sector

An important aspect of these learning collaboratives is the opportunities for teams from different organizations to come together and learn with and from one another during sharing sessions.

88% Of survey respondents (n=32) agreed the capstone was an important part of the learning collaborative and that attending the capstone contributed to their learning.

"It is refreshing to hear people talk about some of the same challenges and then getting ideas from them" - LC participant

"These sessions provide learning and validation moments for our team" - LC participant

"The validation and positivity from both the coaches and the other teams was very beneficial and encouraging" - LC participant

Coaching support

Throughout the LC, engagement with the QI coach varied by team, however those who did fully engage, highlighted coaching as one of the main benefits of the LC.

94% Of survey respondents (n=32) agreed that their quality improvement coach supported their understanding of QI. All interview participants (n=7) were also in agreement.

94% Of survey respondents (n=32) reported access to the coach positively supported their work and helped them work through challenges.

94% Of survey participants (n=32) agreed having access to a QI coach supported working through challenges.

Interview participants described the coaches as having a level of expertise they brought to team meetings and found it helpful when coaches would share lessons learned from other teams. Coaches also helped to keep work on track and guide conversations by asking:

"What are the factors that are actually applicable here and what are maybe the things that are kind of just noise around what we're doing?" – LC participant

In addition, they acted as an objective person that facilitated consensus building and encouraged them to slow down and take small steps by breaking down larger ideas and suggestions. One team noted that often staff will be very guarded when "adding new work" but having an outside person such as a coach helped mitigate that.

Overall, interview participants who had participated in previous learning collaboratives, as well as new participants, shared that attending the learning sessions as well as engaging with the QI coach saw the most progress and improvement. This reflection was validated by the QI coaches.

> *"Even for a team who talked about us having some quality improvement, knowledge and background, it was still... You still need someone, especially when you're not seeing much changed to either help encourage you or help guide you." – LC participant*

Key Learnings and Strategies

Below we have highlighted the key learnings and challenges experienced by participating teams through their participation in the LC, and the experience of the quality improvement coaches leading the learning collaborative work.

Key Strategies

- Teams that focused on building a reliable process were able to increase their SD data collection rates, which was achieved by:
  - ✓ Implementing, reviewing, updating, and refining process maps by monitoring data regularly while also conducting PDSA cycles on their change ideas
  - ✓ Committing to a series of weekly or bi-weekly meetings to test, adapt and implement new SD data collection processes
  - ✓ Working within an integrated team of nurses, health promotors, medical office assistants, reception and front desk staff, data support, and administrators
  - ✓ Using OCEAN, proved to be an efficient, secure, and convenient tool as part of the process for collecting and completing SD data for clients with active email addresses

- Training staff on the "why" of the SD data is important and may be necessary under specific circumstances but may not be sufficient on its own to bring about improvement. This was achieved by:
  - ✓ Offering tailored training opportunities for staff to increase their comfort and ability to answer client questions related to SD collection indicators. For example, one team supported providing training to staff on "gender identity and sexual orientation", and they found the training increased staff comfort as well as client comfort in sharing this information.

- Educating clients on what SD data is and why it is important is part of the data collection process. This was achieved by:
  - ✓ Having a script to facilitate conversations around gender identity and sexual orientation, led to improved comfort in sharing SD data.
  - ✓ Involving clients in drafting language for why such data were being collected in the intake form helped to improve communication on the importance of collecting this data.

- Bringing teams together to learn, share and collaborate on a mutual goal motivated and built relationships to better support the overall goal for SD data collection. This was achieved by:
  - ✓ Learning and collaborating as a group, including meeting consistently, dedicating time, and monitoring data
  - ✓ Building staff capacity to use and apply QI methodology
  - ✓ Sharing experience with different QI tools and resources
  - ✓ Using and adapting the SD toolkit and resources to meet the needs of each centre's unique population
  - ✓ Connecting SD data collection back to program development
  - ✓ Scheduling and meeting regularly created consistency and built a culture of celebrating small and big gains

Challenges

Common challenges experienced by surveyed and interviewed members of QI teams included:

- Time commitment and dedication in addressing complex challenges
- Keeping all members engaged in the process especially when not all team members could attend sessions (i.e., providers)
- A slow pace was challenging for some teams, as they were eager to jump ahead or jump to solutions.
- New leadership/lack of leadership support in supporting SD data collection
- Sustaining the momentum once the LC ended
- Significant staff shortages due to illness, holidays, retirements and other competing priorities
- Understanding limitations of data (i.e., useable vs unusable data; completion rates-prefer to not answer or unsure)
- For some teams, OCEAN proved to be difficult as a result of client comfort with completing e-forms (e.g., believing the email was spam).

Recommendations to Improve LCs

Using the findings from our evaluation, we have incorporated our plan to incorporate the following recommendations to improve our LCs:

	Recommendation	Action
Process improvements	*Consider improvements to the delivery, format, and materials of the learning sessions to support participant engagement, understanding, and implementation of QI skills and knowledge.*	➔ Continue to use the evaluation and other feedback to improve the content, delivery, and format of learning collaborative learning sessions.
	Create space for LC teams to work at their own pace.	➔ Continue to engage with and support teams where they are in their learning journey.
	Spread and scale the learnings the collaborative to the rest of the sector.	➔ A Rapid Action Learning Intensive (RALI) was initiated to spread and scale the learnings from this LC. This is a short-term initiative focused on improving the process of SD data collection.
Communication and knowledge exchange opportunities	*Consider opportunities to communicate and emphasize the benefits of regular data collection to build accountability and highlight the impact of the work.*	➔ Continue to explore opportunities (conferences, webinars, etc.) for knowledge exchange with the sector post-collaborative to highlight the results of teams who participated in the learning collaborative.
	Consider opportunities to sustain the momentum generated and confidence in teams to continue to test and ultimately implement their change ideas.	➔ Explore opportunities to host webinars and have organizations share their experiences and success stories to encourage further engagement from organizations across the sector.
		➔ Explore the opportunity for additional sharing sessions to allow teams to continue to collaborate and share their progress and lessons learned.

Next Steps

Evaluation has been embedded throughout both learning collaboratives and we continue to engage with former and current learning collaborative participants to learn and improve. One key area of learning for us is how to improve engagement with all teams, especially in regards to coaching given the benefits highlighted by surveyed and interviewed participants. Future learning collaborative topics (e.g., access to care) are currently being explored through a review of sector-wise strategic priorities, data and evidence reviews, and collaboration with sector members.

If you have any questions or comments regarding this report, please do not hesitate to contact either Sara.bhatti@allianceon.org or Stephanie.bale@univi.ca

Alliance for Healthier Communities

500-970 Lawrence Ave. W.

Toronto, Ontario M6A 3B6

Canada

416-236-2539

www.AllianceON.org

Alliance for Healthier Communities

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