CQIP Cohort 5 Final Evaluation

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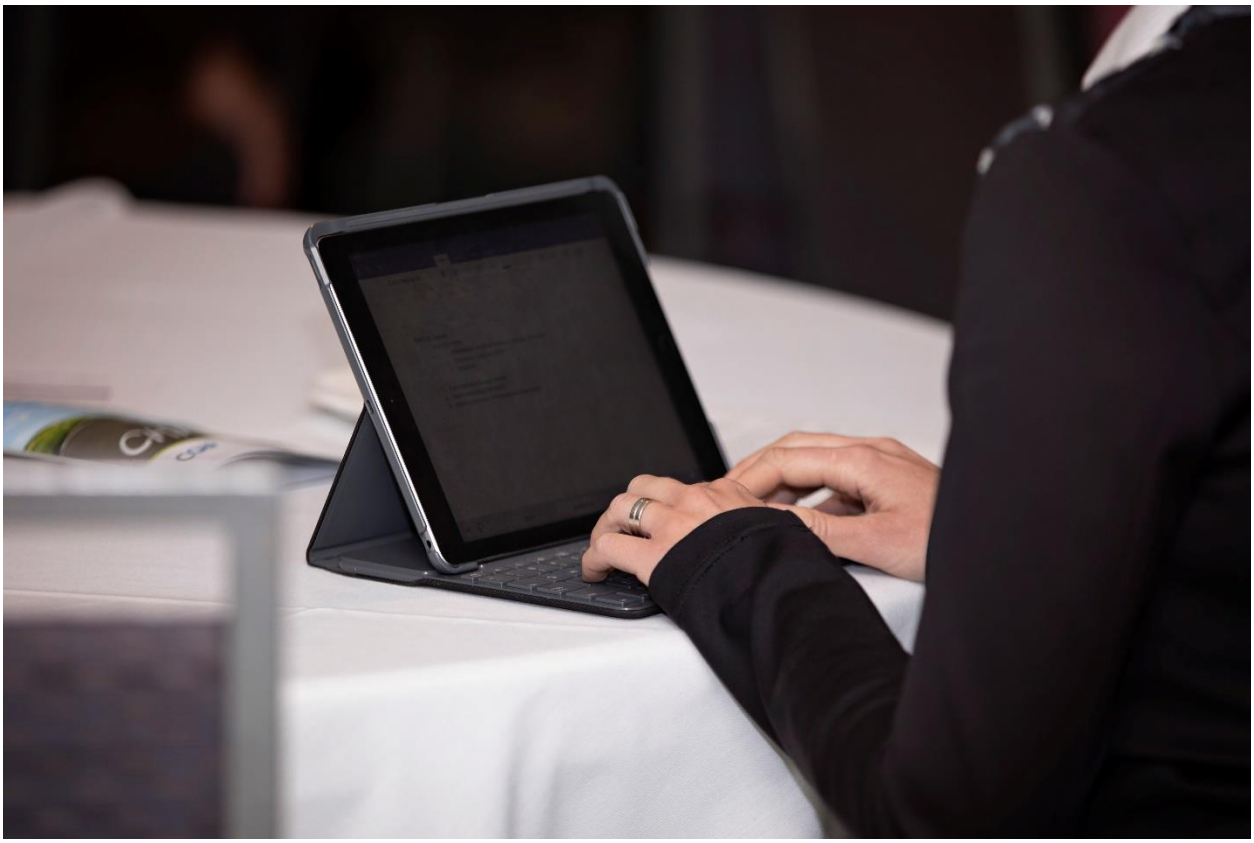

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Summary

Introduction

The fifth cohort for the Clinical Quality Improvement Program ran from August 2021 to May 2022. There was a 6 month postponement of the program, immediately following acceptance notification (i.e. before the first Learning Lab workshop) due to the COVID-19 Pandemic. The original dates of the program were December 2020 to September 2021. The onset of the pandemic resulted in a withdrawal of 9 of the 21 accepted participants in cohort 5, resulting in 12 participants successfully completing the cohort. As a result of ongoing restrictions and uncertainty accompanying the pandemic, cohort 5 was delivered virtually, marking a shift from the normal program delivery of the flipped classroom model (i.e. online self-guided theory modules, with in-person learning labs) of previous cohorts.

The program is designed to build capability for leading improvement work, with a particular focus on clinical quality improvement projects. The program includes a mix of theory and classroom instruction, along with experiential learning and individual coaching.

This is a sister program to the internationally recognized Advanced Training Program, developed by Intermountain Healthcare system. It has been adapted for the Saskatchewan health care system.

The program curriculum covers the following four core areas:

- Quality Improvement in the Saskatchewan Health Care System
- Quality Improvement Science and Methodology
- The Human Side of Change – Working with Teams in Complex Systems
- Deep Dive into Clinical Quality Improvement

Specifically, the program consisted of five online modules designed and developed by the Health Quality Council. The program used a flipped classroom approach whereby participants completed a module before coming together for a virtual workshop (a total of four virtual workshops, consisting of 2 half-day workshops each). In between workshops, participants were guided to advance their clinical quality improvement projects through individual coaching sessions with an assigned coach.

Twenty-one applicants were accepted into the program, and 12 participants completed the program in full. When surveyed in the summer of 2021 regarding revised dates, one participant indicated they were no longer available to participate, and three did not respond. Of those who were able to begin with the revised dates (August 2021 start), all completed the program.

The program participants were supported by 12 physician coaches who had training and experience in quality improvement, as well as physician faculty who helped design and facilitate the workshops with the support of HQC staff.

Methods

An evaluation framework using the Kirkpatrick model for evaluation was developed to understand how well the program achieved its aims.

Program Aims:

By the end of the program, participants will be able to:

A. Lead and facilitate clinical quality improvement projects.
B. Serve as internal consultants on clinical quality improvement work.
C. Teach clinical improvement tools and methods to others.

Overall, the framework focused on the following elements for evaluation:

- User experience of the program
- Program effectiveness
- Program engagement.

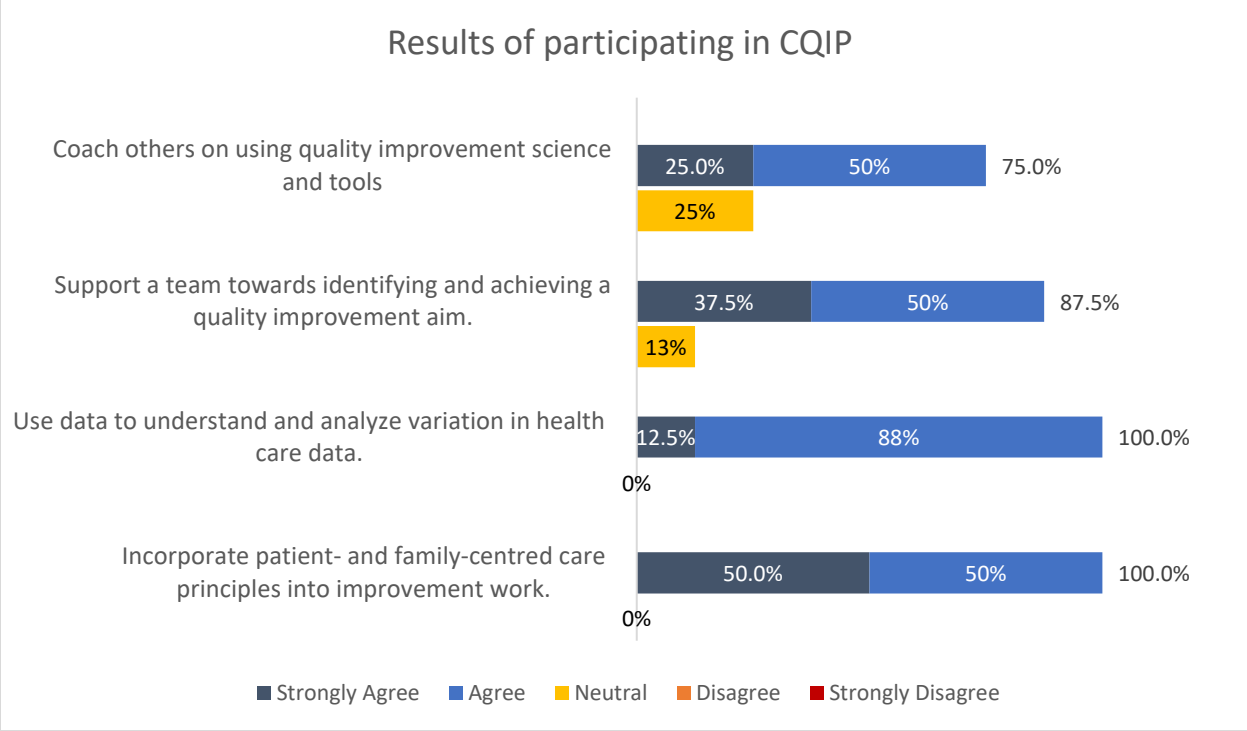
Cohort 5 participants provided their feedback through surveys.

Findings

Final feedback was received from the participants via 8 completed surveys. The response rate to the final survey was 67%. This represented 8 of 12 participants who completed the program.

Participants were asked to indicate their ability in leading clinical quality improvement (related to the program aims) on a 5-point Likert scale (1=strongly disagree to 5=strongly agree). The majority of ratings were on the positive end of the scale (either strongly agree or agree). Table 1 provides a summary of participants' responses.

Figure 1. Results of participating in CQIP



Note: Based on n=8 respondents out of 12 who completed the program

The evaluation explored overall program benefits to both the individual participant and their organization. This aims at uncovering the big picture impact of the program upon CQIP closure.

Benefit to individual

From those who responded, the most frequently cited personal benefit was gaining QI skills that they could implement into their practice. Specifically named skills included problem analysis, finding their "why", and QI leadership skills. Responding participants also indicated that they felt the ability to network with colleagues and experienced faculty, along with getting to know QI leaders, was a benefit to their experience.

Benefit to their organization

Responses to organizational impact varied amongst respondents. One theme that emerged was the ability to bring skills and specific tools back to the clinical setting. Furthering this, a couple participants indicated they are coaching others within their organization on how to utilize QI tools. Finally, a theme emerged indicating an overall shift in how participants approach problems and perceive situations both within their practice and outside their organization.

Word cloud based on responses from overall benefit questions

Active change to practice

Participants were asked one way their work has shifted as a result of completing CQIP. Two themes emerged: engagement and quality improvement thinking.

Engagement

Multiple respondents indicated that they have changed how they engage individuals both in their projects and within their practice. Recognition of the importance of engaging key stakeholders (including Patient and Family Partners) for implementation buy-in was noted. One individual noted that they now focus on Patient and Family-oriented care because of participating in CQIP.

Quality Improvement Thinking

The second theme that emerged from this was a change in thinking. Similar to what was noted in the overall benefit question, participants indicated that the way they approach their practice has shifted since completing this course. Ways that thinking shifted included problem analysis and ensuring that they understand the root causes of issues rather than the surface-level cause. A participant responded that they now see problems as areas for improvement. There was also an acknowledgment of thinking of different ways to collect data. A participant also listed monthly self-reflection and adapting their practice based on what is, and is not, working. Finally, one participant discussed now understanding the need to recognize balancing measures and potential impact on other unit areas.

Perception of value in CQIP project experience

Participants were asked if they viewed the project experience as valuable. Participants unanimously agreed that the project experience was valuable. 25% of respondents indicated that they experienced setbacks that impacted the total value, but still felt it was a useful experience. Overall, participants felt that this experience gave them the practical application skills to carry out a quality improvement project.

Barriers

Personal Barriers

Of those that responded, 62.5% (5 of 8) cited the COVID-19 Pandemic as a barrier to their project. The impact precipitated reduced team engagement from both Patient-Family Partners and other team members for at least three of these participants. Other participants mentioned that the pandemic created other priorities, reducing the buy-in for their project. One participant mentioned delays in ethics approval.

One participant found the infrastructure to engage Patient-Family Partners a barrier to their project's success. Namely, the difficulty to provide reimbursement to vulnerable populations. Canadian regulations require a significant amount of information to provide honoraria, which can be cumbersome for some individuals.

Program Addressable Barriers

Participants were also asked about barriers they felt could be addressed through program adjustments. 37.5% of participants did not list a barrier that they perceived could be addressed through program changes. Three participants (37.5%) indicated that they felt additional data support (either through programming or SHA resources) during and post-CQIP would be helpful. Two additional participants (25%) indicated that they had difficulties with the time required to complete, due to clinical responsibilities.

Project Progression

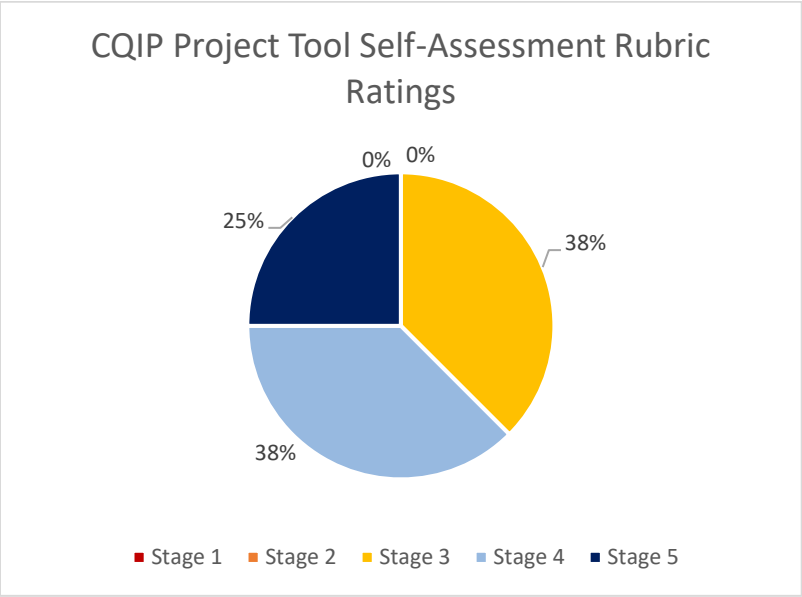
Participants were asked to self-assess their project progression based on the CQIP Project Tool Self-Assessment Rubric. This tool has participants assess their project to determine which stage their project is in, as follows:

1. Project established
2. Project planning
3. Changes tested, no improvement
4. Improvements achieved

5. Sustained improvements

Participants' rankings can be found in the figure below. Participant projects had all reached the changes tested phase (stage 3) or higher.

Figure 2. Results of participant project tool self-assessment



Project and Program Feedback

Participants were asked a few questions regarding project structure and program design for potential improvements.

Project structure

Participants listed a variety of factors that could improve the structure of projects. The most cited response was to return to in-person learning labs (37.5%) followed by support with quality improvement data support (25%). Other improvements suggested were more information on patient engagement and project scoping.

Program Feedback

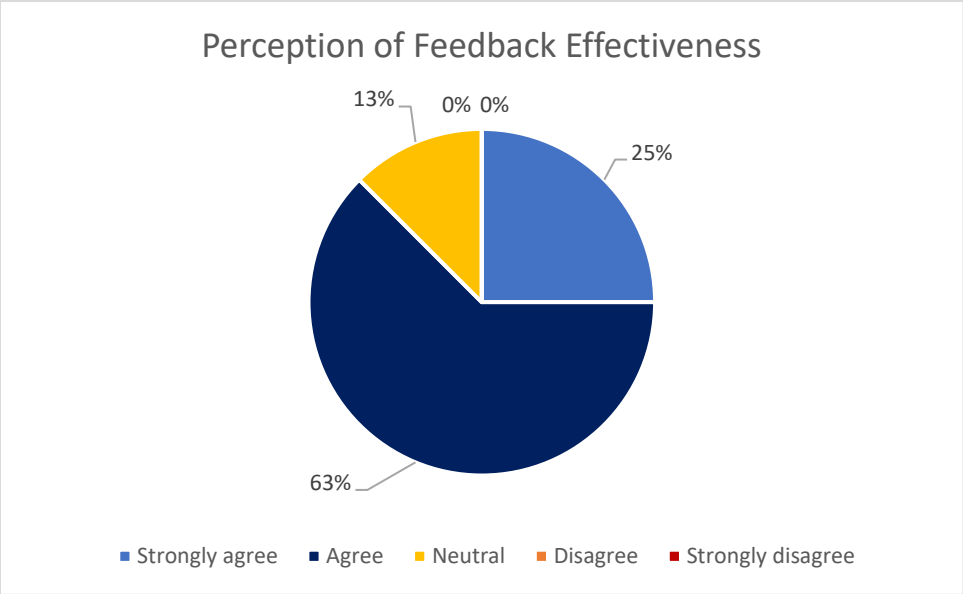
When asked about overall project enhancements, 50% (4/8) of participants indicated they had no suggested enhancements. Of those that had suggestions, two (25%) recommended more data support, one indicated they would benefit from more one-on-one coaching (12.5%), and one indicated they would be interested in seeing a longer course (12.5%).

Participants were also asked about a few course details regarding bias, time allotment, and CanMEDS competencies. There were unanimous responses that no bias was perceived in the course and that there was sufficient time to engage in the interactive learning components. Regarding CanMEDS competencies and roles, 62.5% of respondents agreed they were able to identify the relevant competencies and roles, with the remaining 37.5% strongly agreeing.

Provided Feedback to Participants

Participants were surveyed regarding whether they felt the amount of feedback provided to them was effective in assessing their knowledge and skills in quality improvement. Most participants agreed that the feedback was effective. The figure below demonstrates the responses.

Figure 3. Results of perception of feedback effectiveness



Net Promoter Score

Finally, participants were surveyed on the likelihood of recommending CQIP to colleagues. This received a Net Promoter Score of 88 (as shown in the figure below). This score was comprised of seven promoters (loyal and enthusiastic) and one passive (satisfied) participant. No detractors (unhappy) responses were measured.

Figure 4. Net Promoter Score

Discussion

Overall, participants responded positively about their experiences in the program. The following themes were noted throughout their responses:

Positive Program Experience

There were no overall negative associations with participating in the CQIP program. Like years past, participants continue to be pleased with the course curriculum and the support they receive during the process. A few participants have begun to coach others on QI, including team members and other clinicians. This is a great indicator of built QI leadership as a direct result of participating in CQIP.

Need for more Data Analysis Support

As cited in previous years, participants continue to have difficulties with data analysis. There is a desire to receive more information regarding data analysis supports earlier in the program, QI macros, linkage to the SHA data supports, and support beyond the end of the program. This is a continued theme from previous cohorts.

Continued impact of the COVID-19 Pandemic

Cohort four mentioned a slight impact on their CQIP experience due to the pandemic. Cohort 5 was impacted at several points along their program journey. They experienced two start delays and continued barriers during the program. One such barrier was the necessity to move to virtual learning labs at a half-day duration rather than a two-day experience. In addition to this, respondents noted barriers, especially regarding team engagement, due to COVID-19.

While the ethics delay did not explicitly state this was due to the pandemic, provincial ethics board did place holds on non-COVID-19-related project approvals at the start of the pandemic which caused a backlog. This may be a reflection of this delay.

Engagement Barriers

As indicated above, respondents indicated engagement barriers. This was most cited because of the COVID-19 Pandemic. Patient-Family Partner Engagement was difficult to maintain, and other team members had barriers due to competing priorities. As known in Quality Improvement theory, it is also difficult to engage in improvement testing in an unstable system, which may have created more difficulty in seeing successful changes (which 38% of participants experienced based on self-assessment project staging).

Conclusion and recommendations

In conclusion, the final evaluation feedback demonstrates that CQIP continues to meet the needs and objectives of responding participants. As a reflection of the feedback we heard, it is of value to consider the following:

- Ensure more supports for data are provided and communicated to participants, including connecting to SHA supports, providing QI macros support, and connecting with coaches for one-on-one support
- Return to in-person offerings for learning labs
- Investigate ways to assist with Patient-Family Partner engagement and ways to overcome engagement barriers.