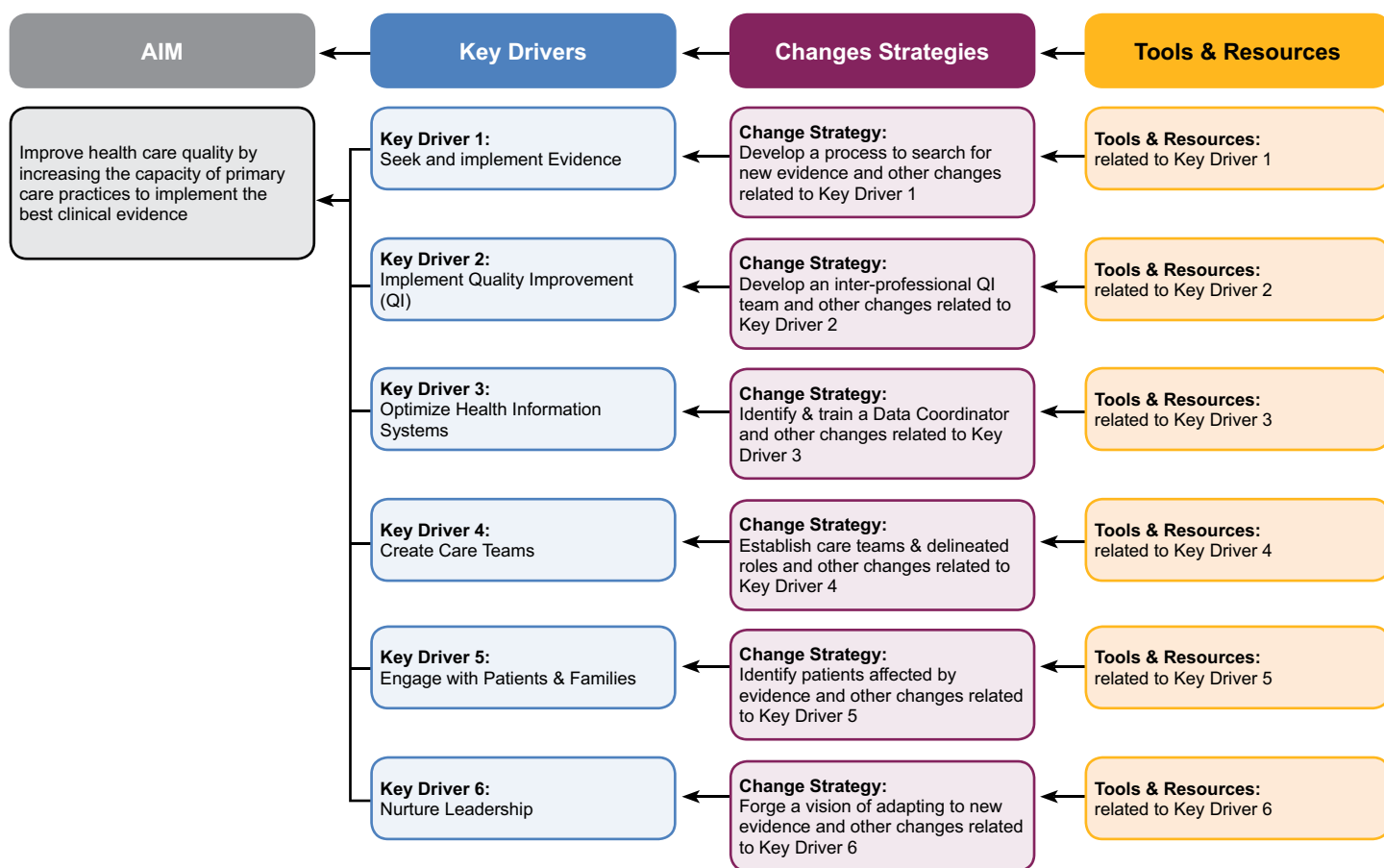


EvidenceNow Key Drivers and Change Strategies



Key Driver 1: Seek, select, and customize the best evidence for use by the practice

The practice of medicine evolves in response to new knowledge about what care produces the best outcomes for patients and how best to deliver that care. Because of their commitment to delivering the best possible care, both solo practices and large groups will want to have a plan for identifying and selecting evidence, recommendations, and guidelines that are important enough to merit practice-wide adoption. Once the practice agrees to implement new evidence, it often must customize it to the practice environment. This does not mean that evidence-based care is a cookbook to be followed unwaveringly. Care must be tailored to meet the needs, circumstances, and preferences of individual patients, and practice teams may find different ways to approach the delivery of evidence-based care. Translation of evidence into practice-wide protocols, however, allows care team members to create expectations of each other and use clinical information systems to ensure the right care is provided to the right patient at the right time. Practices should proudly inform their patients that the care they provide is evidence-based.

Change Strategies

Develop a process to search regularly for new evidence

The medical literature is large and new research findings are published continually. Primary care clinicians usually have their own individual processes for staying up-to-date. Nonetheless, the practice should have a process in place to ensure that the practice as a whole is aware of important new syntheses of evidence and high-quality evidence-based guidelines. Not all recommendations and guidelines are equally useful. Some rely less on evidence and more on expert opinion and others are biased by the perspective of the organization creating them. In addition to being aware of new robust clinical evidence, practices should also be on the lookout for evidence on how to organize and deliver care. As well as encouraging all clinicians to share evidence updates with the practice, practices should designate one or more team members to be responsible for consulting trusted sources of evidence on a regular basis, such as monthly or quarterly.

Select and customize evidence for practice-wide implementation

Practices will need to prioritize which types of evidence they will implement practice-wide. It is critical that clinicians discuss and agree on the value of a body of clinical evidence before they attempt to implement it. Clinical evidence may be chosen based on what: is important to and has the greatest impact on their patients, is not already the standard of care for the practice, and is aligned with other practice goals and initiatives. In addition, practices may select organizational evidence (e.g., use of standing orders, expanded role for medical assistants) based on its ability to affect efficiency, job satisfaction, and external requirements. All team members should participate in the customization of evidence to the practice, such as deciding how to incorporate recommendations into practice workflow, developing educational materials, and selecting appropriate quality improvement measures. Agreeing on an approach to implementation paves the way for shared expectations of how different members of the practice support various steps in the implementation process. This does not mean that everyone in the practice has to execute protocols in exactly the same way. The evidence may support multiple pathways. But a degree of consistency across the practice is desirable, for example, so that clinical information systems can support newly established processes.

Embed selected evidence and guidelines into clinical information systems

Research shows that relying on individual clinicians to recognize all of a patient's needs and remember all recommendations leads to gaps in care. Functional clinical information systems can make it easier for teams to adhere to agreed-upon actions to implement evidence. For example, electronic information systems (e.g., electronic health records, registries) can identify which evidence-based recommendations apply to a given patient and provide teams with standing orders that allow each team member to complete their designated tasks. Non-electronic information systems, including paper templates, checklists, and written scripts for front office staff and medical assistants, can also keep the integration of evidence into usual care on track. Embedding processes into information systems decreases the chance that any steps will be skipped, has the potential to reduce the tracking burden on the care team, and can make the computation of quality measures easier. (See Key Driver 3: Optimize health information systems to extract data and support use of evidence in practice.)

Inform patients and families about the evidence the practice uses and its implications

Practices should communicate to their patients that the practice pays attention to evidence, and why this matters. This general message, which can be communicated via the practice's website, bulletin boards, patient portals, and brochures, lays the groundwork for explaining specific evidence-based recommendations, such as why to get a flu shot or to stop smoking. Practices benefit when patients and families know that when clinicians make recommendations for care, they are based on research findings showing that patients who follow the recommendations usually have better health outcomes. (See Key Driver 5: Engage patients and families in evidence-based care and quality improvement for more on clinician-provider conversations and shared decision-making.)

Key Driver 2: Implement a data-driven quality improvement process to integrate evidence into practice procedures

Evidence is always evolving, so practices have to change if they are to stay current. Quality improvement (QI) is a systematic, data-driven process for managing that change. QI starts with the assumptions that opportunities to improve are abundant, that quality problems and solutions rest with the system as a whole, and that change is possible. Practices serious about incorporating new evidence will dedicate resources to a QI Team that can drive the changes required to respond to new evidence. Once a practice chooses a QI approach and tools and sets improvement goals, it can identify and test specific changes to care delivery processes and workflows. A key step is to choose QI measures that provide information to guide implementation, and to collect and review data regularly. Small practices can start simply, using common sense and a can-do attitude to get the process going. Practices that are part of larger systems may have more QI resources to draw on and likely will need to align themselves with interests of the larger system while working to keep QI priorities and activities practice-driven. Regardless of a practice's size, the important point to remember is that QI is a continuous activity, not a one-time effort. With QI teams that consist of care team members and other staff, practices can systematically apply evidence, improve patient care and outcomes, and make incremental progress towards their goals.

Change Strategies

Develop an inter-professional quality improvement team that meets regularly

Quality improvement is a team sport – improving quality is everyone’s job. However, practices should recruit team members to lead QI work and carve out time to plan and execute QI activities. To be successful, the QI team should include enthusiastic clinical and non-clinical staff who occupy diverse roles at all levels of the practice. In some practices, patients and patients’ family members have been productive members of the QI Team. It is helpful to have a core group that understands QI processes, but the QI team will need to be dynamic, drawing in different people who will be affected by the changes being considered, including front office and data management staff. When involving new staff on the QI team, it is important to be clear about the expectations of what they will contribute and because of organizational hierarchies, to empower non-physicians and non-clinicians on the QI Team. In very small practices, the QI Team may encompass the entire staff. Even so, dedicated time to do QI work is important. Holding regular meetings, with planned agendas to ensure productive sessions, signals that QI is a practice priority and can help prevent the press of clinical or administrative workloads from crowding out QI work.

Adopt a consistent QI approach and use QI tools to make changes

Attempts to implement new evidence can be inefficient and ineffective unless practices use a systematic approach to achieve identified goals. Several QI approaches have become popular in health care. These include the Model for Improvement (focused on continuous change made by rapid cycle testing), Lean (focused on efficiency), Six Sigma (focused on standardization), and several patient safety approaches (e.g., root cause analysis, failure mode and effects analysis). Each of these QI approaches employs a set of QI tools, such as run charts, process and workflow maps, cause and effect diagrams, patient shadowing protocols, patient and family feedback forms, and Plan-Do-Study-Act (PDSA) or A3 worksheets. Regardless of which QI approach a practice chooses, the QI team can use it to set goals and develop and implement a QI plan. A QI plan can specify what changes will be made, when they will be made, for how long they will be tested, and how the success of the changes will be assessed. Which QI approach is selected is not critical, and ambitious practices may choose to use more than one. What matters is that practices choose at least one, learn how to use it, set goals, and start making changes.

Select internal QI measures, collect data, compare with goals and benchmarks, and act on data regularly

QI measurement answers the question, “Did we do what we set out to do?” Change is difficult. There is a tendency to revert to familiar ways of doing things. Practices will want to collect data to see if the changes that have been agreed upon have in fact been made and that they have achieved the desired results. When selecting quality improvement measures, practices will want to remember that, unlike accountability measures, they are for internal purposes and only need to be accurate and quick enough to guide improvement activities. Comparing results – including team-specific results – with practice goals will confirm if planned changes have occurred. Experienced practice facilitators report that using QI measures help practices make decisions on more than anecdotes. Practices should also regularly compare quality measures to practice-level goals and external benchmarks to ensure that quality improvement activities are helping them meet and exceed their expectations for patient care.

Engage care teams and other staff to support implementation of new evidence

Although the QI Team shoulders the load in terms of QI planning and data collection, most of the practice workforce is likely to be involved in making changes. Engaging those not serving on the QI team – both clinical staff and others involved in implementing new evidence (e.g., practice managers) – at the outset of the improvement process increases the likelihood of success. Practice staff are the experts in what is feasible and can prioritize which changes to make first, suggest new changes to try, assess ideas on changing workflows or roles, and identify consequences of changes that members of the QI Team did not anticipate. Transparency is critical to the effectiveness of the QI enterprise. If all members of the practice do not serve on the QI Team, the QI Team should regularly report to the rest of the practice on what progress is being made and also solicit their input regarding QI processes and goals.

Key Driver 3: Optimize health information systems to extract data and support use of evidence in practice

Accurate and actionable data are needed to put evidence into practice, and clinical information systems can facilitate or hamper a practice’s ability to generate and use data. Practices may have focused their data efforts on producing information related to payment incentives and not yet harnessed their data for quality improvement (QI). Effective use of clinical information systems requires purposeful planning, effort, and allocation of resources. To produce and report on data efficiently, practices will want to master more advanced functions in electronic health records (EHR) and use other information systems, such as registries and laboratory systems, to fill the gaps. Involving care teams in the process can help practices increase the reliability of their data and generate meaningful reports.

Change Strategies

Identify and train a Data Coordinator

The demands on primary care practices mean that sometimes non-urgent, non-clinical activities can fall by the wayside. Practices gain efficiency by having a point person for data, a Data Coordinator, who has learned the ins and outs of the practice’s information systems and ensures data tasks are completed. Having a Data Coordinator doesn’t mean that one person has to collect all of the data and generate all of the reports. As the name implies, the Data Coordinator manages data operations and trouble shoots problems as they arise. Small practices may have one person doing the Data Coordinator job on a very part time basis. Larger practices may have more than one person serve as Data Coordinators. Responsibilities can include making changes to documentation in EHRs, developing auditing tools, designing and programming reports, using registries, and being a key member of the practice QI Team. In addition, Data Coordinators can be cheerleaders, motivating and engaging staff in using data to drive the QI process. Staff throughout the practice, even data novices, may be tapped to take on data coordination duties. It is therefore critical that practices give Data Coordinators training and, for part-time Data Coordinators, protected time from their other responsibilities to devote to data management tasks.

Use electronic health records to improve data collection

For most practices, data collection for QI will be done using the electronic health record. Although it is possible, and sometimes preferred, to gather data for QI using paper-based records,

paper-based methods result in collecting less data on fewer measures, which can limit QI progress. EHRs are nearly universal in primary care practices, yet their potential to be catalysts for the use of evidence and for quality improvement has not been realized for many. QI teams can coax actionable data out of their systems by learning to use existing untapped EHR functionality, standardizing documentation, and adopting innovations that other practices have developed. Implementing new clinical evidence, such as screening recommendations or treatment guidelines, usually entails implementing new data collection processes. However, some EHRs are better at supporting QI and QI measurement than others. Maximizing the use of EHRs to attain actionable data may require working closely with the EHR vendor. While data are key to improving quality, it is critical that practices not give up on meaningful QI work simply because they cannot get the data they want out of their EHR.

Use registries and other data sources creatively to track the provision of evidence-based care

Using registries to track the care provided to patients with particular diseases, provide care management services, or contribute to national surveillance efforts can be an alternative to wrangling data out of an uncooperative EHR. Creative use of other data sources such as a patient web portal, a laboratory system, a billing system, or a practice's paper-based system, may provide the best solution. Using data that are already available in another system is often more efficient than investing time in revising an EHR to collect the same data. The goal, however, remains the same: making it simple for the practice and teams to be able to track their progress in delivering evidence-based care.

Involve care teams in refining documentation workflows to minimize burden

Clinicians and other team members often report that they are overwhelmed by documenting the care they provide. Involvement of care teams is key to balancing the need to document and track the delivery of evidence-based care and the need to keep documentation requirements manageable. Care teams provide vital information about how they currently record data as well as ideas and suggestions about what a better process might look like. Furthermore, documentation procedures developed by partnering with care teams are more likely to be followed.

Improve data accuracy and transparency and secure staff trust

When QI teams first produce performance and QI data, they frequently encounter problems such as large amounts of missing data, documentation errors, or mistakes in data extraction algorithms. Collaborating with care team members on data documentation not only improves the accuracy of data, it also increases staff's confidence in the data. Since data are only as good as the documentation in the information systems, QI teams can address some data errors by working with staff on the best ways to capture data and what needs to be documented. After these initial checks, QI teams can use additional validation strategies, such as sample chart audits to test data extraction processes, before sharing results with the entire practice. Even with this preparation, practice members may question the data. QI teams can review results with clinicians and teams privately to ascertain their comfort with the data. QI teams should try not to be defensive when data accuracy is challenged, and remain open to potential improvements and acknowledge that it may not be possible to get 100 percent accuracy. Time spent building confidence in the data early on usually pays off in trust and action down the road.

Link patients to their clinicians and teams within information systems to improve usefulness of performance reports

Once care teams have taken responsibility for a panel of patients (see Key Driver 4: Create and support high functioning teams to deliver high-quality evidence-based care), it is important to assign those patients to their teams in electronic or other information systems. Although practice-level data are useful, practices that link patients with individual clinicians and teams allow QI teams to identify high-performers from whom others can learn, and target places where performance is lagging for additional attention and support. Electronic systems may require the addition of new fields and paper-based systems will need a coherent coding system. Linking patients with care teams in the EHR has the added benefit of supporting population health efforts of the team.

Create dashboard reports for selected measures

Dashboards – ongoing targeted reports on selected processes and outcomes related to the integration of new evidence, preferably graphical and in real time – allow practices to easily see their progress, let them make adjustments, and keep them engaged. Analyzing data and creating reports takes specialized skill and can be a labor-intensive process. When building dashboards, designers should think about how to present the data visually to make them easy to understand. Once developed, production of dashboard reports should be automated to the extent possible.

Key Driver 4: Create and support high functioning care teams to deliver high-quality evidence-based care

Given the demands of primary care practice, no clinician can single-handedly incorporate new evidence into all aspects of practice. Care teams blend a complementary set of skills and expertise and take joint responsibility to give patients the highest quality care possible. Each team member knows his or her job and is empowered to get it done. All the moving parts come together because the team communicates well. Creating an environment in which teams can succeed in keeping up with the ever-changing evidence base involves developing a culture of cooperation and shared accountability for outcomes, embracing learning about new ways of doing things, and engaging teams in the quality improvement endeavor.

Change Strategies

Establish care teams and delineate team roles for clinical and non-clinical staff

There are two aspects to establishing high functioning teams: deciding who is on each team and agreeing on what each team member does. No one team size or structure will work for all practices. Consistency of team composition and roles throughout a practice, however, can make it easier to function when there are staff absences or departures. Team members need to understand not only their own responsibilities, but also those of others on the team. Written job descriptions can document these responsibilities, and training can help bring clarity to each team member's understanding of how the team gets its work done. New evidence can mean that both clinical and non-clinical team members have to take on new tasks. If someone changes positions or shifts roles, it is important that everyone in the practice be notified and adjust their expectations accordingly.

Assign patients to clinicians and teams to create accountability and a sense of shared responsibility among the team for their patient panel

Assigning patients to clinicians and teams, a process known as empanelment, is the basis for population health management. Team members share responsibility to make sure that all patients in their panel receive care that is consistent with current evidence, whether or not those patients regularly come in for visits. Empanelment also helps create stable patient-care team relationships, which build trust and make it more likely that patients will follow recommendations for evidence-based care. The process of empanelment, however, can be complex. Even in solo practices it is important to identify who are the practice's active patients. In larger practices, empanelment also includes determining the size of each team's panel, which may involve projecting the intensity and type of services each patient requires and soliciting and respecting patient preferences. (See Key Driver 3: Optimize health information systems to extract data and support use of evidence in practice for information about linking patients with care teams in clinical information systems.)

Empower team members

In order to apply new evidence effectively and efficiently, all members of the team need to have the authority and skill to accomplish their responsibilities. Practices can explore delegating to other team members some tasks that the primary care clinician has traditionally performed. Practices may find that team members are capable of taking on more complex tasks because they have skills that the practice is not aware of. In other cases, practices will need to provide additional training. Everyone will need to have confidence in each team member's competence and respect their ability to execute their duties autonomously. At the same time, team leaders cultivate an environment where everyone takes on shared responsibility for delivering high quality care. Practices empower team members by creating a culture that emphasizes collaboration, celebrates each team member's unique contribution, and makes it easy for anyone to identify obstacles, offer improvement ideas, or speak out if there is a safety issue or other concern.

Optimize care team communication

Working well as a team requires good communication, which can take many different forms. One way is holding regularly scheduled team meetings to address team and practice functioning and opportunities, challenges, and priorities related to implementing evidence. Another form of team communication is the team huddle during which the team addresses daily opportunities and challenges, sets priorities, and prepares to meet the needs of scheduled patients. A shared expectation that each team member will keep their colleagues informed and involved in changes to their workflow or responsibilities is fundamental to good communication. Practices can enhance team communication by providing training in communication techniques and co-locating team members in the same physical space.

Support care team learning about new evidence

Practices may have to augment in-service training to address the constantly evolving nature of evidence. Ongoing education informs care team members about new evidence as it emerges, and training can help team members incorporate new processes involved in implementing the new evidence. Approaches to team learning include lunch and learn sessions, shadowing, mentoring, consultation with experts, in-service training and online learning modules, among others.

Make reviewing their performance and participating in quality improvement (QI) activities part of everyone's roles and responsibilities

Quality improvement is part of each team member's job and each care team is collectively accountable for its performance. While the QI team may pull the data and produce the reports, practices will want each care team to review its own data and compare its performance with that of others in the practice, and other benchmarks. When a team realizes there are opportunities for improvement, it can learn from higher performers and test possible solutions to improve results. Sharing performance data with care teams also creates opportunities for practices to celebrate improvement together.

Key Driver 5: Engage with patients and families in evidence-based care and quality improvement

The best evidence will not result in improved clinical outcomes unless it is put into practice. One often overlooked aspect of making care evidence-based is engaging patients and their families in considering the evidence and how it applies to them and their care. Practices need to know how to identify patients who are affected by new evidence, communicate clearly about the evidence and its implications, and use shared decision-making techniques to arrive at an evidence-informed care plan. Some patients will need support in the community to help them follow through on their plans. Practices can assess patients' need for community resources and direct them to organizations with which the practice has established referral agreements. Finally, practices can recognize that patients and families have a unique perspective to lend to quality improvement efforts and involve them in them in process of moving evidence into practice.

Change Strategies

Establish workflows that identify and engage patients affected by changing evidence

When evidence changes, practices need to determine which of their patients are affected by the new recommendations or guidelines. This function could be handled centrally by the practice, or each clinical team could take responsibility for identifying and reaching out to patients in its panel to reassess care plans in light of the new evidence. Practices that have electronic health records and registries will find them useful to identify affected patients. Practices can establish protocols to identify affected patients as they come for appointments. Clinicians can engage patients at that visit, or make an appointment to discuss the implications of the new evidence at a future visit. When affected patients are not scheduled for a visit and the evidence is significant enough to require urgent action, practices experienced in population health care should assign a team member to use phone calls, patient portals, postcards, and secure emails to contact patients.

Support patient and family engagement in their own evidence-based care

Clinicians and other team members can successfully engage patients and families by listening and being respectful, tailoring presentations of the evidence to patients' specific conditions and concerns, and explaining risks and benefits clearly. Patient education materials have to be easy-to-understand, bearing in mind that a third of adults have limited health literacy and even more face significant challenges in understanding numbers and estimations of risk. Successful patient and family engagement also involves checking understanding, eliciting values and preferences, encouraging questions, using other shared decision-making techniques such as high quality

decision aids, co-developing patient-centered care plans, and providing self-management support. Practices should train staff in these skills and consider periodic refreshers. This does not mean that clinicians cannot use more traditional methods of engaging patients and families, such as motivational interviewing or the 5 A's. The essential thing is keeping the focus on creating partnerships and trusting relationships. Recognizing that support at home is often critical to following through on care plans, practices can invite patients to bring family members or friends with them. Clinicians may also need to help patients who come to the office with "evidence" printed from the Internet or torn out of a magazine understand that good evidence comes from more than one study, and that not all sources of information are trustworthy.

Link patients and families with community resources to assist them in implementing evidence-based care plans and meeting their health goals

Patients may need help in following evidence-based care plans, such as an exercise class or a nutritional assistance program to make healthy eating affordable. Care teams should determine which community resources patients need in order to be able to focus on evidence-based recommendations for improving their health. To successfully link patients and families with community resources, practices should assign responsibility for keeping information about resources current.

Involve patients and families in moving evidence into practice

Practices can benefit from enlisting the help of patients and families in moving evidence into practice. A frequent first step is for practices to ask patients and families for feedback on materials to educate their peers on new evidence. Practices can also convene groups of patients and families, as well as other members of the community, to tell the practice what about this new evidence is important to them and what messages are likely to be effective. Some practices obtain feedback by administering brief surveys. More advanced practices can integrate patients and family members into their quality improvement teams, in general or for a specific topic. Practices need to have clearly defined roles for patients on QI teams and should show them how their feedback is used. Another advanced strategy for partnering with patients and families is forming a Patient and Family Advisory Committee (PFAC) to ensure that improvements for delivering evidence-based care also meet patients' and families' needs.

Key Driver 6: Nurture leadership and create a culture of continuous learning and evidence-based practice

A maxim of organizational change theory is that leaders' support for change is crucial. When it comes to making fundamental changes in a practice, however, more than support alone is necessary for success. Leaders need to convey a vision and manage the process of change actively through deliberate and consistent communication, role modeling, education, review of implementation and outcome measures, and use of resources to reinforce their message. Part of that continual effort is enlisting others in the practice to be champions for seeking and implementing new evidence. Another important role for leaders is empowering everyone, especially those who do not traditionally exert influence, to speak freely about opportunities for improvement. While leadership looks different in small practices, even solo practitioners need to nurture themselves and their employees to create a culture of flexibility in which new evidence is eagerly and routinely integrated into practice.

Change Strategies

Forge a vision of a practice that adapts to a changing evidence environment

Leaders must first develop, and then communicate, a vision of the practice as one that responds flexibly to changes in evidence. This vision provides a foundation for customizing and implementing new evidence. Making changes in a practice is always difficult. Without a consistent and sustained message from practice leaders, staff tend to stay entrenched in their customary routines, and believe them to be the best way of delivering care. Communicating the vision can begin with the practice mission statement or charter, but it can't end there. Leaders should develop their own style for re-enforcing the vision, such as sharing their excitement about new evidence as it emerges, modeling how they use it with their own patients, nominating new evidence for quality improvement projects, and publicly praising those who identify and use new evidence.

Provide organizational and leadership support for evidence-based practice and quality improvement

Like any quality improvement effort, the drive to be responsive to new evidence will require staff time and other practice resources. Everyone in the practice, not just clinicians, may need time to create and adjust to shifts in what and how they deliver care. Leaders can provide support by acknowledging those activities in job descriptions and releasing staff from other duties to participate in quality improvement and team meetings. Leaders also should ensure that adequate resources are available to implement new evidence, for example by revising information systems to monitor the delivery of evidence-based care, re-structuring the built environment, or purchasing new supplies. Leaders will also need to stand at the ready to defend staff for following the evidence. For example, if new evidence dictates de-prescribing a certain medicine, leaders should support staff in the face of patient complaints. Leaders should champion the adoption of evidence that improves health outcomes, while also working to align the practice's business model with what is best for patients (e.g., through value-based payments). (See Key Driver 2: Implement a data-driven quality improvement process to integrate evidence into practice procedures.)

Encourage learning about new evidence and best practices

Leaders who are committed to ensuring that people receive the most up-to-date care embrace learning as an organizational value. Leaders create a learning atmosphere by freeing up bandwidth for staff to take advantage of learning opportunities in the daily flow of work as well as the occasional out-of-the-office experience. This means more than just paying for conference registrations. Leaders steer practice members toward opportunities that provide either a deep dive into new evidence on specific topics, or more general skill building, such as teaching practice members to be savvy consumers of clinical and organizational evidence or learning about the quality improvement process. In this way, practice members join practice leaders in becoming locators and customizers of new evidence. (See Key Driver 1: Seek, select, and customize the best evidence for use by the practice.)

Review measures of implementation and impact of evidence-based practices regularly

To create a culture of evidence-based care, it is essential that leaders review measures of whether the practice has in fact made the changes needed to align care with new evidence and whether those changes are having the expected effects on patient outcomes. This is in addition to the reviews done by the practice's quality improvement and clinical teams. (See Key Driver 2: Implement a data-driven quality improvement process to integrate evidence into practice procedures.) Leaders should visibly use those measures to signal the importance of adapting to new evidence. When results are disappointing, leaders should collaborate with practice members to figure out what the barriers are and how the practice can adjust resources and supports to spur improvement. Similarly, when results are good, leaders should commend practice members and celebrate.

Identify and support champions for learning, evidence-based practice, and quality improvement within the practice

Successful organizational change efforts require both strong senior leadership and collective and distributed leadership throughout the practice. Leaders should identify individuals, such as clinicians, practice managers, nurse leads, and others who are passionate about evidence-based practice and quality improvement and are able to motivate others. If natural champions are scarce, leaders can cultivate champions through training, mentoring, appropriate rewards for improvement, and helping practice staff engage in self-reflection about the unique contributions they can make and leadership skills they would like to develop. Recruiting opinion leaders from every corner of the practice increases the likelihood of getting the entire practice on board and sustaining changes over time.

Create a culture in which all practice members feel comfortable identifying opportunities for quality improvement

The pursuit of evidence-based practice will inevitably engender some missteps. Leaders should find ways to overcome the reluctance of practice members to admit mistakes, doubts, or ignorance or to voice potentially controversial ideas. As with patient safety, leaders want to establish a blame-free atmosphere where mistakes are considered learning opportunities. To create a cohesive culture, leaders will need to engage in active listening and gain an understanding of the perspectives and motivations of practice members. Leaders can model the behavior they want to see by publicly expressing appreciation when their views are challenged. It is important to recognize that not everyone in the practice has the same amount of power, and to make a point of seeking out and respecting the voices of people who have less power or are otherwise cautious. By creating an ethos that everyone is equally responsible for making sure the practice lives up to high, jointly held expectations, leaders free people to go into problem-solving mode rather than being on the defensive.

<https://www.ahrq.gov/evidencenow/tools/keydrivers/index.html>



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