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| **KP Readiness-for-Spread Assessment****About This Tool**The purpose of this tool is to help KP succeed in spreading successful practices widely. One key factor is picking the ripest opportunities – some practices aren’t really ready to be spread widely. This tool can help program champions and KP leadership understand whether a promising practice is ripe for successful spread across KP. Using it can prevent wasting energy from trying to spread a practice that has not yet been developed sufficiently. The tool can highlight the aspects of a practice or its documentation that might need to be strengthened to support wide scale spread. It is meant as a discussion tool to support informed decision making and to help set realistic expectations. It is not intended to create “hoops to jump through,” or to interfere with spread efforts that enjoy strong support. **Who To Involve in the Assessment Process**The assessment can be used in two distinct settings, described below along with ideal participants1. Push – Program champions can use the tool to address the question: “Could my program or practice be spread widely from its current demonstration site(s)? Facilitator: A KP Improvement Advisor or other person, not directly responsible for the program, who is knowledgeable about practice transfer. Participants: Program champion, implementation lead, front-line staff.
2. Pull – Senior leaders can use the tool to address the question: “Is this program or practice ripe for transfer into my area or Programwide?” Facilitator: Leader or staff of a Program Office or Regional unit responsible for supporting spread of successful practices. Participants: Program champion, implementation lead, Improvement Advisor, and two or more “peer reviewers” who can provide an independent perspective.

**Instructions**1. Scan through the four main sections to get an overview of main areas for assessment.
2. The rows within each section present key elements of readiness for successful spread. For each element, simple statements illustrate different levels of readiness, from Start-Up to Well Established.
3. For each row:
* **First each participant rates the practice** on their own. **Circle all the statements** that describe the practice. **Be realistic** – assess the practice as it is, not how you hope it will be. **Use judgment** in deciding which statements to circle – do your best to capture the spirit of the assessment, not details of the wording.
* **Then the facilitator leads a brief discussion** to produce a “sense of the group.” Record the consensus on a master copy of the assessment tool. Don’t get hung up on unanimity. It’s OK to record a range of responses.
1. For each section:
* **First each participant assigns an Overall score** on their own, using the 1-10 scale. **Circle** the score. **Use judgment**, considering all the elements in the section. The **Overall score needn’t be an average** of scores representing each element. In some cases it might make sense for the Overall score to be based on the lowest score for any element.
* **Then the facilitator leads a brief discussion** to produce a “sense of the group.” **Circle the consensus** score on a master copy of the assessment tool. If some participants dissent from the consensus, note the range of outliers.
1. When scores are completed for all four sections, **go to the Scoring and Summary** page and follow the instructions. The Scoring and Summary also includes simple recommendations about where to focus energy in strengthening readiness for spread.
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| **Facilitator** – Please complete the following information on the master copy. |
| Facilitator (name, position) | Date\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Practice Assessed (title or description) | Participants(name, position) |
| 1. |
| 2. |
| 3. |
| Regional/Medical Center affiliations | 4. |
| 5.  |
| 6. |
| For more information about this tool or to provide feedback on the tool, please contact either:  Jim. Bellows@kp.org – Senior Director, Center for Evaluation and Innovation, Care Management Institute Lisa.Schilling@kp.org – VP for Health Care Performance Improvement and Execution Strategy We welcome feedback and suggestions! |

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| **1. Impact on Primary Objective**The first criteria for a promising practice relate to impact on the primary objective addressed. What is the one primary objective of the practice or intervention assessed? □ Patient Safety □ Physician/Staff Work Experience □ Effectiveness of Care □ Equity □ Patient Experience □ EfficiencyWhat is the primary measure of impact? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Element** | **Start-Up**  **Well-Established** |
| **Magnitude** | Number of potentially affected members is unknown or is less than 0.1% of total membershipNo impact has yet been observed, or relative impact is less than 5% | Potentially affects 0.1%-1% of membersRelative impact on primary performance measure(s) is 5-10%(e.g. improvement rom 40% to 43%) | Potentially affects 1-10% of membersRelative impact on primary performance measure(s) is 11-20% (e.g. improvement from 40% to 46%) | Potentially affects all members, or a subpopulation of 10% or more (i.e. all older adults, all members with cardiovascular disease, all members with an inpatient stay or surgical procedure, etc.)Relative impact on primary performance measure(s) is more than 20% (e.g. improvement from 40% to 50%) |
| **Confidence** | Impact has not been assessed | Compelling anecdotal informationOR…Measured improvement in processes or factors of interest, but measurement is less than robust (e.g. possible confounding, no trending, no comparison group) | Robustly measured improvement in processes or factors that are plausibly related to downstream outcomes, but casual relationship has not been well established (e.g. process reliability, improved follow-up after discharge, increased use of KP.org)OR…Measured improvement in downstream outcomes or well-established risk factors, but measurement is less than robust (e.g. possible confounding, no trending, no comparison group) | Robustly measured improvement in real, “downstream” outcomes:Downstream outcomes: Fewer never events, reduced complications of chronic disease, improved satisfaction, etc.Robusttly measured: Trended annotated run charts show significant improvement OR pre/post analysis with comparison groupOR… Robustly measured improvement in risk factors that have a clear, strongly established, causal relationship to downstream outcomes (e.g. improved hand hygiene, greater use of medications that reduce heart attack risk, reduced waiting times)Improvement has been robustly measured in more than 1 site and has been sustained over time.  |
| **Overall**(use judgment, based on all above) |  1 |  2 3 4 |  5 6 7 |  8 9 10 |
| **Comments** | (Record here the biggest gaps to address and the greatest strengths to build on.) |

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| **2. Impact on Other Aspects of Care** Successful spread of promising practices is affected not only by their impact on the primary objective but also by intended or unintended impact on other aspects of care delivery. Do not rate here the impact on primary objective rated in Section 1.  |
| **Element** | **Start-Up**  **Well-Established** |
| **Patient Safety**(consider factors including process reliability and safety culture) | Potential for adverse impact has not been assessedOR… Potential issues have been identified but not addressed | Potential issues have been identified and mitigation measures have been implemented | Risks have been assessed by one or more subject matter experts (SMEs) and are believed to be absent or negligibleSME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Data demonstrate positive impact or no adverse impact |
| **Effectiveness of Care**(consider factors including delivery of evidence-based care and addressing patient needs) | Potential for adverse impact has not been assessedOR… Potential issues have been identified but not addressed | Potential issues have been identified and mitigation measures have been implemented | Risks have been assessed by one or more subject matter experts (SMEs) and are believed to be absent or negligible SME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Data demonstrate positive impact or no adverse impact |
| **Patient Experience**(consider factors including service, clinician-patient relationships, and personalization) | Potential for adverse impact has not been assessedOR… Potential issues have been identified but not addressed | Potential issues have been identified and mitigation measures have been implemented | Risks have been assessed by one or more subject matter experts (SMEs) and are believed to be absent or negligible SME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Data demonstrate positive impact or no adverse impact |
| **Physician/Staff Work Experience**(consider factors including simplicity and fit with existing processes) | Potential for adverse impact has not been assessedOR… Potential issues have been identified but not addressed | Potential issues have been identified and mitigation measures have been implemented | Risks have been assessed by one or more subject matter experts (SMEs) and are believed to be absent or negligible SME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Data demonstrate positive impact or no adverse impact |
| **Equity**(consider equity across groups defined by health literacy, gender, race/ethnicity, and/or sexual orientation) | Potential for adverse impact has not been assessedOR… Potential issues have been identified but not addressed | Potential issues have been identified and mitigation measures have been implemented | Risks have been assessed by one or more subject matter experts (SMEs) and are believed to be absent or negligible SME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Data demonstrate positive impact or no adverse impact |
| **Overall**(use judgment, based on all above) |  1 |  2 3 4 |  5 6 7 |  8 9 10 |
| **Comments** | (Record here the biggest gaps to address and the greatest strengths to build on.) |

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| **3. Business Case**Promising practices are unlikely to spread without a clear understanding of their business case. All other factors being equal, practices with positive business cases are more likely to spread successfully. A positive business case means a positive return on investment – not only that the financial benefits (cost savings, cost avoidance, or revenue enhancement) exceed the costs, but that the benefits accrue to entity that bears the costs, the benefits are as certain as the costs, the benefits develop in a reasonable time frame, and the potential benefits can be harvested into real “hard green” dollars (e.g. reduced admissions translated into decreased hospital costs per member).  |
| **Element** | **Start-Up**  **Well-Established** |
| **Costs**(operating costs and start-up costs) | Substantial operating cost would require significant reallocation of resources | Modest operating costs can be covered within existing operations budgets, but start-up would require investment from other sources | Modest operating and start-up costs can be covered within existing operations budgets | No costs for implementation – changes work of existing staff rather than adding staffNo startup investment |
| **Savings**(cost reduction or cost avoidance) | No savings anticipated | Modest savings are projected but has not been demonstrated | Substantial savings have been projected but not documentedMeasurement of savings is less than robust (e.g. possible confounding, no trending, no comparison group, etc.) | Substantial savings have been documentedRobust measurement of savings, e.g. trended annotated run charts show significant improvement OR pre/post analysis with comparison group |
| **Revenue** (increased total revenue or revenue per member) | No revenue enhancement anticipated | Modest revenue enhancement is projected but has not been demonstrated | Substantial revenue enhancement is projected but not yet documentedData on revenue enhancement is not robust (e.g. possible confounding, no trending, no comparison group, etc.) | Substantial revenue enhancement has been documentedRobust measurement of revenue enhancement, e.g. trended run charts OR pre/post analysis with comparison group |
| **Return on Investment** | Financial costs exceed financial benefits (the practice may still be justified on the basis of other benefits, e.g. compliance) | Financial costs are roughly equal to financial benefits | Financial benefits substantially exceed costs, but transfers would be needed to return the benefits to the entity that bore the costs | Financial benefits substantially exceed costs, and accrue to the entity that bears the costs |
| **Certainty and Timing** | Costs are certain but benefits are less certain | Benefits have been demonstrated as robustly as costs, but will accrue 3 or more years later | Benefits have been demonstrated as robustly as costs, but will accrue 1-2 years later | Benefits have been demonstrated as robustly as costs and will occur during the same budget year |
| **Harvestability** | Harvesting potential benefits could require painful measures, such as closing facilities or eliminating positions | Translating potential benefits into real dollars would require no more than routine management efficiencies | Benefits could translate directly into real dollars, but other actors could undermine (i.e. contract hospitals could raise prices if KP utilization decreases) | Benefits would translate directly into real dollars (e.g. reduced drug costs) |
| **Overall**(use judgment, based on all above) |  1 |  2 3 4 |  5 6 7 |  8 9 10 |
| **Comments** | (Record here the biggest gaps to address and the greatest strengths to build on.) |

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| **4. Transferability**Research in and beyond health care has shown that promising practices are most likely to spread if they can be readily observed in a demonstration site at then piloted locally, are simple, can be adapted to local needs, fit with existing work culture and norms, and align well with leadership goals and strategies. Practices are more likely to spread further as/if they mature – being adopted and sustained by multiple sites and attaining reliable implementation among earlier adopters. Support structures and tools help accelerate transfer from site to site. |
| **Element** | **Start-Up**  **Well-Established** |
| **Observability** | No pilot sites are available to observe OR benefits are not readily observable | Processes and benefits can be observed by potential adopters at 1 pilot site | Processes and benefits are readily observable at 2-4 pilot sites | Processes and benefits can be readily observed at scale in 2+ KP Regions  |
| **Simplicity** | Requires participation by 4+ units or functions (e.g. primary care, ER, and laboratory) | Requires participation by 2-3 units or functions; interactions must be negotiated and tested  | Requires participation by 2-3 units or functions, but handoffs and accountabilities are clear and simple | Can be implemented within a single organizational unit and without broader modification of current delivery system |
| **Adaptability** | Adaptations have resulted in failure to achieve results anticipated  | Adaptation has occurred over time at 1 pilot site without compromising results | Adaptation has occurred, without compromising results, at 2+ diverse sites that adopted the practice | Key components are known and simple; the range of acceptable variation has been identified and communicated |
| **Cultural Fit** | Implementation requires changing significant aspects of work culture and roles | Implementation requires some adjustment of work culture or roles, but no fundamental changes | Fits smoothly with existing work culture and norms | Fits smoothly with existing work cultures, and goes beyond to fit with staff hopes and desires |
| **Goal Alignment** | Not clearly aligned with KP goals/strategies at national or local level | Directly supportive of lower-tier but not top-tier KP goals/strategiesCascading Program/Regional/local alignment is missing or weak | Arguably aligned with top-tier KP goals/strategies, but impact is less than direct and substantial | Direct, measurable, substantial impact on one of KP’s top 10 goals/strategiesLeadership has provided an unambiguous message that the status quo is unacceptable, with clear Program/Regional/local alignment |
| **Sustainability** | Not yet sustained for 6+ months at any KP siteReliability and performance data are not available | Implementation sustained 6-12 months at 1+ KP sites Performance is measured, but no control charts show reliability | Performance has been sustained for 1+ year at one site80-90% reliability has been documented in control chart(s) | Data demonstrates sustained performance for 1+ year 95%+ reliability has been documented in control chart(s), with balancing measure(s) |
| **Implementation Support** | No change package is availablePilot site champions are not readily available for consultation | No comprehensive change package, but sample tools and resources are sharedPilot site champion(s) are available for consultation by phone | Change package is available, with tools, metrics, case studies, etc.Pilot site champion(s) are available for on-site troubleshootingIT tools are built but not transferable | Active knowledge management supports ongoing improvement; tacit knowledge transfer is underway among adoptersDecision support and work flow tools are available in KPHC or other systems |
| **Overall**(use judgment, based on all above) |  1 |  2 3 4 |  5 6 7 |  8 9 10 |
| **Comments** | (Record here the biggest gaps to address and the greatest strengths to build on.) |

**Scoring and Summary**



**Instructions**

1. Transfer the Overall score from the previous pages into the Summary table below.
2. Write in the element(s) from each section that had the lowest score.
3. Consider the Recommendations corresponding to the Overall score. The Recommendations are more or less in order – in most cases spread will be best supported by addressing the earliest recommendations first.
4. Complete the Learnings box by indicating the Strengths and Gaps surfaced in the Readiness to Spread assessment.

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| Section | Recommendations by Score |
| **1. Impact on Primary Objective** | □ 1-4 Focus on improving performance and measurement at pilot site |
| Overall score: \_\_\_\_\_ Weakest element(s): | □ 5-7 Begin assessing impact on other aspects of care delivery while continuing to improve performance and documentation |
|  | □ 8-10 Focus your energy elsewhere (but sustain the gains; don’t let performance slip) |
| **2. Impact on Other Aspects of Care** | □ 1-4 It’s time to look beyond your primary objective; bring in others with responsibilities for aspects of care that might be affected |
| Overall score: \_\_\_\_\_ Weakest element(s): | □ 5-7 Strengthen documentation and/or measurement of impacts on other aspects of care |
|  | □ 8-10 Focus your energy elsewhere (but keep looking for synergies that can help improve other aspects of care) |
| **3. Business Case** | □ 1-4 Start collecting the data and/or expertise needed to put together a solid business case |
| Overall score: \_\_\_\_\_ Weakest element(s): | □ 5-7 You’ve got a good start on the business case, but it needs to be further developed to be convincing to leadership |
|  | □ 8-10 Focus your energy elsewhere (but keep monitoring costs) |
| **4. Transferability** | □ 1-4 Assess the weak elements to determine which could be strengthened; tackle those first |
| Overall score: \_\_\_\_\_ Weakest element(s): | □ 5-7 Collaborate with people or units responsible for spreading successful practices – they can help strengthen transferability |
|  | □ 8-10 You are ready to go! Strategize about how best to get your practice to senior leaders for their consideration |

**Learnings** from the Readiness to Spread Assessment

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| **Strengths**What stands out as the greatest strengths to build on? | How can you use these Strengths to promote spread? |
| **Gaps**What stands out as the biggest gaps to address? | What can you do to address these gaps? |