Commentary

Translating ECHO findings into practice: lessons from local dissemination groups

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Introduction

The perennial challenge for research projects is getting the results taken up. For the European Collaboration for Healthcare Optimization (ECHO) project, with its large administrative data set on patient outcomes at hospital level and by patient postcode across six countries, there were three related challenges: would countries and institutions validate the data, would they be interested in instituting further in-country data collection using the ECHO model and could such data be used effectively to improve healthcare performance? In addition, to add another layer of complexity, the ECHO data does not speak for itself but requires further interrogation—it is not a diagnostic but a screening tool to highlight potential problems.

Dissemination of ECHO’s findings required a non-standard approach, and it was clear that the project findings were going to be of great interest to policymakers, clinicians and managers as well as other researchers in the field. The direct practical applicability of the ECHO analyses lent themselves to an interactive structured engagement within the ECHO countries. Within the project the dissemination methodology was designed to test the interest in uptake and use of the data by target groups. This article presents the outcome of the dissemination, and our methodology notes the differing abilities and willingness to use the ECHO research output for decision-making in addressing causes of variations and presents possible barriers and opportunities for the process of addressing variations.

The dissemination took place in the five countries where data were collected, with a total of 160 participants over nine meetings. The meetings, in two rounds, were organized in Portugal, Slovenia, England and Denmark. The same countries were involved in the second round, joined by Spain.

Methodology

European Union (EU) funded projects often meet their core aims of delivering high-quality research and bringing excellent researchers together. However, the latest review of the EU’s Seventh Framework Programme, the Union’s key research funding programme, highlighted the need to improve commercial exploitation, and urged the further development of methodologies that facilitate the feeding of research results into wider societal goals. A narrow understanding of disseminating results—organizing a conference, publishing books and scientific articles—often falls short in connecting scientific research with practice. Instead of a ‘didactic model’, transmitting information based on researchers’ beliefs and interests, a ‘dialogue model’ should increase the involvement of target groups in the knowledge transfer process, contributing to better informed and presented research results and better use of results in practice.

One methodological approach to making the dialogue model a reality is focus groups, as it allows parties to “…identify a range of different views around the research topic and to gain an understanding of the issues from the perspective of the participants themselves.” Focus groups are a method of indirect interviewing in which the researcher plays a less dominant role in favour of group discussions. This provides insights into the social interaction between actors and arguably results in greater spontaneity of discussion. The aim of focus groups is not to find consensus, but to learn about the attitudes and views of actors on a certain issue.

In the ECHO project we used the focus group model as our methodological base to build our dissemination strategy. We created local dissemination groups (LDGs), strategy groups of key decision makers, influencers, users and implementers. The meetings, structured in similar ways across the different countries, gave insight into how the methodology worked in different cultural contexts and allowed for some comparison of the meeting outputs. The same team presented at and facilitated in each meeting. Chatham House Rules were used in the meetings, meaning that participants are free to use the information received but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed. This was in recognition of the fact that the ECHO data covers sensitive and complex topics and frank discussion and reactions were important to the research team.

The LDG methodology was designed in order, as far as possible, to place the research findings in a context that related to the countries’ health systems. The intention of this was to create excitement and an appetite for using the data as well as helping the research team to understand better the context in which the data might be used.

The main aims of the first round of LDG’s were 2-fold: to validate the data and initial findings of the ECHO project, and to gain first impressions as to whether the format of the data presentation was easily usable and helpful. Validation was required, as the administrative data used in the project was affected sometimes by changes in the system or in local coding practices. Validation and target groups’ opinions on the presentation of output were gathered through questionnaires.

The second round of meetings discussed the potential uptake and use of project output by different stakeholders, as well as barriers, opportunities and stakeholders’ willingness to use the output of the ECHO project. In the second round a wider audience, including more senior decision makers, was invited. For the first round, project partners were asked to invite mid-level stakeholders only, to limit the influence of senior stakeholders’ presence (hierarchy effects) in the group dynamics as much as possible.

In both rounds, close involvement of the local project partners was vital. They were asked to invite providers (e.g. health care professionals), local opinion leaders, local authorities, hospital managers, patient advocates, and others as members of their focus groups.
managers), purchasers (e.g. regions and national health funds), policy makers and researchers. These groups were not further specified—it was left to the judgement of project partners and colleagues who best to invite. The project partners supported by the dissemination partner identified the right participants for their respective system and they used their networks and influence to get those stakeholders to the meeting.

Outputs

All data provided surprises both in country and across countries. Participants from all countries found some of their assumptions about individual hospital performance challenged, some had better outcomes and some worse. The international data also showed clear variations across countries. Hospitals that had good comparative outcomes at a national level did not necessarily perform well in international comparison. In general the high performers were interested to find out how they might get to the top of the international tables.

In all the countries few hospitals were good at providing high-quality services across the board. This finding highlights the importance of looking beyond the overall score to understand the performance of individual clinical teams. It reinforces the need for a sensitive and moderated approach to the use of outcome data and for continuous work on quality improvement at team as well as at hospital level.

All the countries saw value in the data and ways it could be directly applicable to their health systems. Whilst there was an acceptance that the analysis could not be used to make direct judgements on hospital performance, it was clear that the analysis did raise legitimate questions that required answers. Participants were positive that the data allowed them to begin a conversation with clinicians and managers. However, there were different views across the countries about how easy it would be to engage physicians and the level of political will at national level to tackle variations.

The added value of the cross-country comparisons was found to be particularly powerful, especially in countries that had access to in-country outcome data analysis. The cross-country analysis highlights countries that are consistently outperforming others. However, further detailed contextual work is needed to understand the reasons for better country outcomes. Discussions in the LDGs and project team highlighted the impact of the full chain of care: improvements in primary care and in emergency and pre-hospital care, both being cited as reasons for better hospital outcomes.

Discussion

We found that using this methodology with a mix of participants, those that will use the data, legislate for its use and those whose performance is the topic of the data’s findings, inevitably placed the research findings in the complex context of the system and exposed some inbuilt tensions and resistance to change. This manifested itself in different ways from country to country. In some there was reticence in expressing true opinions and, on occasion, the tendency to revert to familiar and well-rehearsed arguments, thus diverting attention from some uncomfortable questions raised by the data.

What the LDG approach made clear was the critical role of politics not only in the role of elected politicians but also in relation to the political power of professional groups, particularly doctors. In some countries, the poor outcomes of particular providers were well known, but managers and policy makers felt powerless to act in the face of opposition and denial from powerful well-connected clinicians. Whilst this might seem to call for greater transparency, in other contexts the close attention of national politicians to outcome data raised concerns that this data would cause inappropriate reactions and potentially hostile interventions at the hospital level. The experience of presenting the data across the countries highlighted that systems that were committed to quality, to approaching poor results with interest and determination to improve as opposed to punish, appeared to be more open, able and willing to use the data.

There were limitations to the approach we took to dissemination. First, the large number of participants, which might have inhibited the responses a different approach might be to present the data to different professional groups separately in the first round, bringing them together for a structured interactive session in the second round. However, there is rarely time or budget for work as detailed as this and the groups aimed to draw out possible tensions between the views of different stakeholders that could affect later take-up of the data. This could be best done with the various stakeholders in the same room.

More seriously, and unfortunately more commonly with multi-million euro projects, delays earlier in the project meant the full range of project outputs was not available, leaving only a limited analysis available and resulting in a shorter timeframe to prepare and hold the meetings. Finally, the highly interesting but complex discussions were summarized in brief reports, which captured the essence of the discussions but might not always have conveyed the depth and details of discussions.

Conclusions and next steps

The ECHO analysis raises challenging questions for the EU, the research team and for countries receiving the data. For countries, particularly those with clear outliers, it raises the challenge of how to address these complex issues. It was clear from the discussions that in a number of countries managers and policy makers felt unable to tackle clinical issues.

There is a clear challenge for the EU to broker cross-country peer review mechanisms to support clinicians in understanding the variance in their outcome measures and, if necessary, to support change in practice to improve outcomes. The analysis also shows that some countries are performing better across the board. Again, for the EU it raises the challenge of supporting further research to understand why some countries are doing better to support sustainable health systems.

With the current EU rhetoric about rapid translation of research from bench to bedside how does research of this nature fit into that model? It is valued in countries and across countries, it has important implications for health systems and the citizens using them, but as yet there is no process for support or implementation. This research could save thousands of lives, but who is going to make that happen?

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References

