Are Champions an Effective Strategy for Improving Knowledge Use and Outcomes in Healthcare Settings?

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Preface

Approvals to Conduct Thesis

Prior to conducting this thesis, I received approval for my thesis proposal from my thesis supervisor (Dr. Janet Elaine Squires), my thesis committee members (Dr. Ian D. Graham and Dr Michelle Lalonde), and the assistant director for graduate programs at the School of Nursing, Faculty of Health Sciences at the University of Ottawa. Ethics approval or other approvals was not required to conduct my thesis.

Author's Contribution to the Thesis

This thesis my original work as a Master student. I took the lead and was responsible for the conceptualization of the thesis, the conduct of the systematic review, analysis of results, presentation and discussion of results and in writing the chapters that makes up this thesis. Dr. Janet Elaine Squires (thesis supervisor), Dr. Ian D. Graham, and Dr. Michelle Lalonde (thesis committee members) provided conceptual (e.g., expert knowledge of implementation and systematic reviews) and instrumental (e.g., reading and suggesting revisions required for each chapter of the thesis) guidance throughout the whole thesis process, from initial planning to thesis completion.

The systematic review article found in Chapter 2 of this thesis represents my work as the primary author, and the contributions of all thesis committee members and Melissa Demery Varin (external to thesis committee). In Chapter two, I outlined the list of authors and provided a statement of each of the authors' contribution for the systematic review. Specifically, my contributions included: 1) conceptualizing the study (e.g., the rationale for conducting the review, and the research questions); 2) formulating and performing the search of the literature; 3)

selecting relevant studies according to the inclusion criteria; 4) creating a data extraction tailored for the systematic review; 5) performing data extraction; 6) analyzing results; 7) creating summary tables of findings and writing the manuscript. The thesis committee members provided input in conceptualizing the study, on the inclusion criteria for selecting studies, on the data extraction form, in the analysis and interpretation of results of. Melissa Demery Varin was my second independent reviewer for study selection, data extraction, and quality appraisal. Marie-Cécile Domecq (health science librarian at the University of Ottawa) provided advise and guidance on how to create a search strategy and Tamara Rader (health research librarian at Canadian Agency for Drugs and Technologies In Health) for peer reviewed the search strategy. I prepared the initial draft of the systematic review and circulated it to all committee members for comments and revisions. All the committee members read and approved the publication for publication in this thesis.

Abstract

The effectiveness of champions in increasing the use of innovations and improving outcomes across health care contexts is not well synthesized in the literature. A systematic review was conducted using the JBI systematic review method. A total of 35 studies (37 articles) were included in the review. The use of champions was related to improvements in system/facility use of innovations. However, the evidence pertaining to causal relationships between use of champions and use of innovations or outcomes is currently inconclusive according to the findings of systematic review. Key limitations of the included primary studies were the use of observational study designs (n = 28) and the lack of detailed description of the champion strategy (n = 26). Future studies that evaluate the effectiveness champions should:1) clearly describe the champion strategy in detail, 2) use experimental design in conjunction to process evaluation, 3) and evaluate the cost-effectiveness of deploying champions.

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First, I want to acknowledge my thesis committee who was with me throughout the whole process and has worked tirelessly in mentoring and guiding me. I am very grateful for all the work, support, and time that you have invested in my education and the thesis. Specifically, I would like to share my immense amount of gratitude for Dr. Janet Elaine Squires, who is my role model and mentor ever since the summer before my admission to the Master of Science in Nursing program at the University of Ottawa. Becoming a research assistant for Dr. Squires that summer began the cascade of experiences and learnings in systematic reviews, measurements, implementation science, health care research, and how to balance academic life with other aspects of my life. I would also like to acknowledge Dr. Ian D. Graham for his theoretical, conceptual, and pragmatic guidance throughout the thesis. Your immensely critical and detail-oriented mind and knowledge of implementation and facilitation has helped me further my critical thinking and communication skills. Last (but not the least!), I would like to acknowledge Dr. Michelle Lalonde for her immense knowledge of nursing and health care research, and on the importance of socialization and nursing environments. Thank you for your guidance and for always cheering me on; your positive comments helped me to keep on writing.

I would also like to thank the individuals outside of the thesis committee who helped me conduct my systematic review. Thank you Melissa Demery Varin for being my second reviewer, and Marie-Cécile Domecq and Tamara Rader for helping me develop the search strategy.

To my family (my parents, my sister and her husband, our family dog Tuffy, and extended family), I would not be where I am if it were not for your support and the cooked food during busy times. Thank you to all my friends who helped keep me company by working and studying with me daily (Alison Harper, Binita Thapa, Jamie Anne Bentz, Kathleen B. Whyte, Nikki Ho) and everyone else who helped me relax and take a break from studying and working. To my best friends Kim Thu Nguyen and Susan Nguyen, thank you for always being there. Thank you to all my colleagues, the educators, and management on 7East at the Ottawa Hospital for encouraging me to strive my best and for your understanding of my work availability.

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Recognition of Funding

My Master studies were supported by a financial Entrance Award from University of Ottawa.

List of Abbreviations

AMSTAR 2 = A MeaSurement Tool to Assess systematic Reviews

BPSO = Best Spotlight Organization

CI = confidence interval

CRCT = clustered randomized controlled trial

ED = emergency department

GRADE = Grading of Recommendations, Assessment, Development and Evaluations

iPARISH = the integrated Promoting Action on Research Implementation in Health Services

HIT = health information technology

JBI = Joanna Briggs Institute

MD = mean deviation

MESH = medical subject headings

PARISH = Promoting Action on Research Implementation in Health Services

PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PROSPERO = The International Prospective Register of Systematic Reviews

RNAO = Registered Nurses of Ontario

RCT = randomized controlled trials

RD = risk difference

SR = systematic review

Glossary of Terms

- **Champions**: Individuals belonging from a particular health care context who take personal ownership of implementing an innovation, they believe in (Cranley et al., 2017; Thompson et al., 2006).
- **Conceptual knowledge use**: Increase in knowledge pertaining to an innovation (i.e., awareness, enlightenment) or shift in attitude favouring the use of an innovation (Straus et al., 2013).
- **Evidence based practice**: A means of providing health care services that is concordant with the best (current and rigorous) research evidence and informed by health care providers expertise and patient's preferences (Melnyk & Fineout-Overholt, 2011).
- **Facilitation:** The process undertaken by certain individuals to make implementation of innovations easier (Harvey & Kitson, 2016).
- **Implementation:** An iterative process that includes the synthesis, dissemination, tailoring, and application of research evidence to a particular context, then the evaluation of the use and sustainability of an innovation (Graham et al., 2006).
- **Innovation:** New practices and technologies developed according to research evidence, providers' expertise, and patients' experiences that is tailored and adopted by local stakeholders to be usable within a particular context (Harvey & Kitson, 2016).
- **Instrumental knowledge use:** Change in behaviour or practice related to the innovation (i.e., actual use of the innovation) (Straus et al., 2013).
- **Knowledge users**: Individuals who are the intended users of the innovation (Harvey & Kitson, 2016)

- **Outcomes of knowledge use**: The resulting impact from using the innovation on patients, providers, and systems/facilities (Straus et al., 2013)

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Chapter 1

Introduction

According to a recent literature review, approximately 60% of health care practices and policies in the United States, Australia, and England are compliant with evidence- or consensus-based guidelines, while 30% is of low value, duplicated, or a waste of resources, and at least 10% is of iatrogenic harm (Braithwaite et al., 2020). Evidence-based practice emphasizes that health care practices and services should be based on research evidence and informed by health care providers' experience and knowledge and patients' needs and preferences (Melnyk & Fineout-Overholt, 2011). It is argued that by adopting evidence-based practices, patients will receive health services that are safe and effective, and health systems will be more efficient and cost effective (Powell et al., 2019; Varnell et al., 2008). Improving health services goes beyond the use of evidence-based practices. For instance, Campanella and colleagues (2016) conducted a systematic review and metanalysis of 47 articles and found that the use of electronic health records (a technology innovation) was associated with higher guideline adherence, reduced documentation time, lower number of medication errors and adverse drug effects. Greenhalgh and colleagues (2004) defined the term innovation as sets of behaviours, routines, and processes that are implemented to improve health outcomes and administrative efficiency and to decrease cost. This definition demonstrates that the purpose of implementing innovations is the same as that of implementing evidence-based practices -- to improve health outcomes and health care system efficiency. However, this definition of innovations does not incorporate the need for evidence-based practice to be based on research evidence, providers' expertise, and patients' experiences. Hence, in my thesis I will use the term innovation to describe both evidence-based practices and technologies developed according to research evidence, providers' expertise, and

patients' experiences that are tailored and adapted by local stakeholders to be usable within a particular context (Harvey & Kitson, 2016).

The implementation of innovations can be described as an iterative process that includes the synthesis, dissemination, tailoring, and application of research evidence to a particular context, then the evaluation of the use and sustainability of an innovation (Graham et al., 2006). Many authors believe that champions play an important role in facilitating the use of innovations in health care (Damschroder et al., 2009; Miech et al., 2018; Titler & Everett, 2001). Although Hall and colleagues (2021) contend that there is no standardized definition for the term "champion" in the healthcare literature, Cranley and colleagues (2017) and Thompson and colleauges (2006) have defined the concept as individuals belonging from a particular health care context who take personal ownership of implementing an innovation, they believe in. Ploeg and colleagues (2010) and Cullen and colleagues (2020) posit that champions leverage their enthusiasm and personal belief in the innovation, their charisma, and interpersonal relationships with their colleagues to overcome resistance to change. Cranley and colleagues (2017) stated that champions perform facilitation because their activities make implementation of innovations easier. Facilitation is defined as the process undertaken by certain individuals to make implementation of innovations easier and faster (Harvey & Kitson, 2016).

Background on the Use and Effectiveness of Champions in Health Care

The theoretical importance of champions in implementation has resulted in many groups and health care organizations investing in training, deploying, and studying champions' facilitation of implementation. Miech and colleagues (2018), in an integrative review, identified 199 published studies where champions were used as an implementation strategy in health care. They reported that the number of champion articles has nearly tripled between 2000 to 2004 and

2005 to 2009 and then tripled again in 2010 to 2014. Further, Miech and colleagues (2018) reported that 149 out of the 199 (74.9%) studies they included in their review were published after 2009. Hence, demonstrating that champions have been increasingly examined in implementation research during the last decade. In Ontario Canada, the Registered Nurses Association of Ontario (RNAO) encourages the use of champions in implementing their best practice guidelines. The RNAO hosts champion training monthly (Registered Nurses' Association of Ontario, 2020a). The champion training provided by the RNAO is designed to equip health care providers with the skills necessary to facilitate implementation (e.g., conducting a gap analysis, engaging stakeholders, develop tailored implementation strategies, and conducting evaluation of uptake and sustainability of use of evidence-based practice guidelines) (Registered Nurses' Association of Ontario, 2020b). Other examples of health care organizations that have promoted the use of champions includes the Northern Health and Social Care Trust (NHSCT) in Northern Ireland (Davidson et al., 2012), the National Health Services in the United Kingdom (Dunkley-Bent, 2018), the Veterans Health Administration (Hagedorn et al., 2016; Thomason et al., 2016), the Institute of Health Improvement in the United States of America (Agrell-Kann et al., 2015), and the Jhpiego which implements health initiatives in lower resourced countries but is based in the United States of America (Dao et al., 2015). Champions have also been deployed in individual health care settings (Jornsay & Garnett, 2014; Lewis & Edwards, 2008; Palmer et al., 2019) or networks of health care settings (Flanagan & Avalos, 2016; Hagedorn et al., 2016; Thomason et al., 2016).

Despite the growing popularity of champions in health care implementation, we do not know if, and to what extent, they are effective at increasing the use of innovations (evidence-based practice) and improving outcomes (e.g., the benefits of adopting an innovation, such as

improvements in patients' health status) (Hall et al., 2021; Miech et al., 2018). This gap is pertinent to decision makers who want to promote implementation of innovations using champions but have limited evidence to justify the use of champions to bring about the change. For instance, Colquhoun and colleagues (2017) reported based on their systematic review findings (N = 15 articles) that individuals should use implementation strategies that are proven to be effective at addressing a present barrier in their implementation initiative. Similarly, Powell and colleagues (2019) promoted the use of implementation strategies that are supported by evidence to be effective at improving an intended goal or outcome (e.g., patient's health status or satisfaction with care). Hoomans and colleagues (2007) and Powell and colleagues (2019) argued that the cost-effectiveness of implementation strategies should be known because decision makers often function on limited resources, which limits the number or the type of strategies that individuals or groups can use. Hence, it is important to understand the effectiveness and cost-effectiveness of champions, so that decision makers are equipped with the required knowledge to determine the appropriate circumstances in which to invest in champions.

Literature Review

I conducted a literature review on champions in health care implementation. An initial search of the grey literature and published articles conducted on Google and Google Scholar generated over 286 million hits. For my systematic review, I developed a search strategy in consultation with two health science librarians. The search strategy was composed of both Boolean phrases and medical subject headings (MESH) terms for the following three concepts and their related terms: champions, implementation, and healthcare/health care context. Eight electronic databases (Business Source Complete, CINAHL, EMBASE, Medline, Nursing and Allied Health, PsycINFO, ProQuest Thesis and Dissertations, and Scopus) were searched from

inception to October 26, 2020, using the search strategy. This search generated 93 citations from Business Source Complete, 851 citations from CINAHL, 1946 citations from EMBASE, 1498 citations from Medline, 653 citations from Nursing and Allied Health, 199 citations from PsycINFO, 104 citations from ProQuest Thesis and Dissertations and 1104 citations from Scopus (See **Additional File 2** on Chapter 2 for search strategy). Papers published beyond October 26, 2020, were found through colleagues' recommendations (thesis committee members or other graduate students) or through hand searching (e.g., in the journal *Implementation Science*). For this literature review, I included 35 articles. These materials provided greater understanding of the champions' role and their effectiveness in facilitating implementation in health care contexts. The following describes: 1) how champions are conceptualized in health care; 2) how champions are operationalized in health care; and 3) the literature describing the effectiveness of champions in facilitating implementation of innovations in health care.

Conceptualization of Champions

The champion role was initially used to promote the adoption of technological innovations in the management and business literature in the 1960s and 1970s (Chakrabarti, 1974; Locock et al., 2001; Rothwell et al., 1974; Schon, 1963). In one highly cited model of technological champions, developed by Howell and Higgins (1990), technological champions are conceptualized as individuals who originate from within an organization, who possess certain personal characteristics such as innovativeness and risk taking, conduct transformational leadership behaviours, and use a variety of influence tactics. Howell and Higgins (1990) stated that it is possible for individuals to be formally appointed by management and trained to become champions. However, they cautioned that the formality or structure prescribed by management

could result in champions who are less motivated, committed, and enthusiastic about an innovation than those who volunteer to be champions (Howell & Higgins, 1990).

In the health care literature, Cranley and colleagues (2017) and Thompson and colleagues (2006) reported that the concept of champions originates from the following theoretical works: 1) Rogers' (2003) Diffusion of Innovation Theory and 2) Zimbardo and Leippe (1991)'s Social Influence Theory. Rogers's (2003) Diffusion of Innovation Theory posits that an idea or use of an object (i.e., an innovation) spreads and is adopted by individuals within a context (i.e., a social system) because it is promoted by communication processes (e.g., promoted through media or by individuals through interpersonal relationships/networks). Zimbardo and Leippe (1991)'s Social Influence Theory posits that the behaviour of an individual or group is capable of changing others' attitudes, behaviours, or feelings to become more accepting of a particular belief or object that they are promoting.

There are some studies that highlight the attributes and activities performed by effective champions. Bonawitz and colleagues (2020) performed a comparative case study of implementation of inpatient postpartum contraceptive care in 11 United States maternity hospitals to identify main attributes of an effective champion. These authors reported that an effective champion should possess six main attributes: 1) influence (the ability to shape the behaviours and opinions of others) 2) personal ownership and belief in the innovation, 3) intimate knowledge of the local context (e.g., familiarity with staff and institutionalized workflows and policies), 4) grit (ability to persevere despite resistance to change), 5) persuasiveness (ability to present information in logical and compelling manner), and 6) empathetic leadership (ability to understand others perspectives) (Bonawitz et al., 2020). Similarly, Miech and colleagues (2018) conducted an integrative review (N = 199 articles) that

examined the use of champions in healthcare. This review outlined the activities performed by effective champions to include: 1) facilitate reflection of practice by clinical staff; 2) persuade both management and staff of the importance of the innovation; 3) create evidence-based resources (e.g., pamphlets); 4) provide in-services or act as role models to staff; 5) facilitate communication and collaboration between different specialties and authority level; and 6) collect, track progress, provide feedback, and troubleshoot any arising issues (Miech et al., 2018). Further, Thompson and colleagues (2006) and White (2011) stated that champions can be involved in all stages of implementation and often work above and beyond the requirements of their occupational role. They work in different levels in health care, from clinical staff to managers and administration, fulfill diverse roles (Thompson et al., 2006; Woo et al., 2017), and are believed to exert their influence in organization committees and interdisciplinary teams (Ploeg et al., 2010).

There are some studies that aimed to differentiate champions from other individuals that are also believed to facilitate implementation in health care. Cranley and colleagues (2017) performed a scoping review (N = 195 studies) and identified nine different facilitation roles, including champions. Based on their findings, champions come from the local context and use their expert knowledge and persuasiveness to convince others about the advantages of adopting an innovation and by mentoring others throughout the implementation process (Cranley et al., 2017). Miech and colleagues (2018) noted that there are inconsistences in the use of the term "champion", as well as in the use of other terms that refer to individuals that aid with implementation within the health care literature. They reported that certain studies fully substituted other terms (e.g., cheerleader) to describe individuals that fit their definition of a champion. They also found articles where individuals were both described as opinion leaders and

champions (Miech et al., 2018). Miech and colleagues (2018) and Thompson and colleagues (2006) argue that researchers' and knowledge users' (individuals who are the intended users of the innovation (Harvey & Kitson, 2016)) use of different terms to label champions creates confusion and makes it difficult to compare their effectiveness with other existing facilitation roles. Thompson and colleagues (2006) conducted a literature review of four databases to define and differentiate the concepts of opinion leaders, facilitators, champions, linking agents, and change agents in the health, education, and management literature. They concluded that these five roles are more similar than different from each other because they function as change agents and influence other's behaviour through providing information. However, Thompson and colleagues (2006) reported that each role has different theoretical foundations that guide how they function. Champions, according to Thompson and colleagues (2006), are based on the Social Influence Theory (Zimbardo & Leippe, 1991) and are believed to exert their influence in changing people's behaviour through enthusiasm.

The literature also identifies the existence of different kinds of champions. Miech and colleagues (2018) identified 37 types of champions and grouped them as either 1) topic related (e.g., hand washing champions and immunization champions), 2) related to a specific job position (e.g., nurse champion and physician champion), or 3) related to a broader organizational role (e.g., academic champion and facility champion). Similarly, others have emphasized the importance of having champions both at the provider level, who are tasked with performing the day-to-day tasks necessary for the uptake of innovations at the local level (e.g., units or facility), and champions at the managerial or executive level who are tasked with communicating a shared vision throughout the whole organization and with securing resources needed for implementation (Kuehl et al., 2013; Shaw et al., 2012; Soo et al., 2009).

Luz and colleagues (2019) differentiated between formally appointed and informally appointed champions. Champions who are formally appointed by management often have less work experience than champions who volunteer and are often tasked with promoting innovations that are related to the priorities set by management or the institutions (Luz et al., 2019). On the other hand, informally appointed champions have more work experience and promote more novel innovations that are based on the needs that they identify are important for their workplace (Luz et al., 2019). Lastly, although champions are often health care staff, there are some authors who included lay persons such as members of community organizations (Lee et al., 2017), or family members of patients as champions (Jennings, 2019).

Summary. Champions can be defined as individuals who utilize facilitation and enthusiasm to influence change in an individual or a group's attitudes, feelings, and behaviours towards an innovation (Cranley et al., 2017; Thompson et al., 2006). The concept of champions is based on Rogers (2003) Diffusion of Innovation Theory and Zimbardo and Leippe (1991)'s Social Influence Theory (Cranley et al., 2017; Thompson et al., 2006). Champions can differ in their occupational roles as they can be health care providers, administrators (Kuehl et al., 2013; Shaw et al., 2012; Soo et al., 2009) and lay persons (Jennings, 2019; Lee et al., 2017). There are different types of champions (e.g., formal vs. informal champions (Luz et al., 2019)), and champions can exert their influence in different levels of the organization (e.g., clinical areas or organizational committees) (Ploeg et al., 2010). Key attributes (Bonawitz et al., 2020) and activities (Miech et al., 2018) of effective champions are outlined in the literature. However, it is still difficult to differentiate the concept of champions from other individuals (e.g., opinion leaders, cheer leaders, change agents) who also facilitate implementation (Miech et al., 2018).

Operationalization of Champions

There is limited literature on the operationalization of champions. Most studies to date operationalize them as simply the presence or absence of a champion. For instance, Miech and colleagues (2018), reported that in over 90% of the 199 articles included in their review, champions were operationalized as a dichotomous variable (presence or absence of champions). In the same integrative review, the authors identified five articles that operationalized champions according to their skillset or effectiveness in influencing the implementation process (Aagaard et al., 2010; Damschroder & Lowery, 2013; Goodson et al., 2001; Hopkins et al., 2012; Valois & Hoyle, 2000). For example, in their qualitative study, Damschroder and Lowery (2013), rated the influence of champions on the implementation process from -2 (strong negative influence) to +2 (strong positive influence).

Miech and colleagues (2018) also identified three articles that used a scale to evaluate the presence of champions within a broader instrument measuring organizational readiness (Chang et al., 2013; Helfrich et al., 2009; Paré et al., 2011).

Chang and colleagues (2013) conducted a mixed method study (qualitative interviews and a cross-sectional survey) of leaders from 225 Veterans Affairs primary care clinics to evaluate the relationships between factors of organizational readiness and implementation of depression care models. They constructed 17 scales by performing an exploratory factor analysis with 58 items from the 2007 Veterans Affairs Clinical Practice Organization Survey (Yano et al., 2008). One of the scales was a single dichotomous item asking whether a clinical champion for depression treatment was present (Chang et al., 2013). Chang and colleagues (2013) did not report on the validity of this instrument, nor on the reliability of the champion item.

Helfrich and colleagues (2009) conducted a cross-sectional secondary analysis study of data (n = 80) from three quality improvement projects in Veterans Health Administration to test

the validity and the reliability of the Organizational Readiness to Change Assessment instrument (ORCA). The ORCA instrument measures organizational readiness by evaluating barriers and facilitators to implementing change according to the three core elements of the PARISH framework (Kitson et al., 1998): evidence, context, and facilitation (Helfrich et al., 2009). The ORCA has a total of 77 items and had three scales (evidence, context, and facilitation) that is further divided into 18 subscales. The ORCA instrument has a subscale that measures the characteristics of clinical champions according to four items. The clinical champion subscale is part of a larger facilitation scale. Based on the defined minimum threshold for an acceptable Cronbach alpha ($\alpha = 0.80$) (Bernard, 2000), the clinical champion subscale had acceptable internal consistency reliability ($\alpha = 0.94$) (Helfrich et al., 2009). However, Helfrich and colleagues (2009) reported that the champion subscale poorly reflected the facilitation construct because it had a factor loading of 0.49 which is lower than their defined threshold of 0.60 (Floyd & Widaman, 1995). They posited that this low factor loading is attributed to the fact that the items within the champions subscale may not adequately measure the champion construct. However, they reported that the low sample size may limit the accuracy of their findings (Helfrich et al., 2009).

Paré and colleagues (2011) conducted two cross-sectional survey studies to test their research model and questionnaire for organizational readiness in implementing clinical information systems at: 1) 11 home care organizations ($n = 134$ participants) and 2) one large teaching hospital ($n = 237$ participants). Their organizational readiness survey consists of 39 items divided into 10 subscales (Paré et al., 2011). The "presence of a project champion" subscale has three items that measures the existence of a champion who actively promotes the innovation, credible and trustworthy, and who overcomes barriers to implementation. The

"presence of a project champion" subscale is reported to have adequate internal consistency reliability (α = 0.87 (study one) and 0.84 (study two)) (Paré et al., 2011) and had evidence of convergent and divergent validity.

Convergent validity indicates that scales that are intended to measure similar constructs should have positive correlations with each other (De Vet et al., 2011b). Paré and colleagues (2011) hypothesized that the presence of a project champion should influence organizational readiness, and posit that champions are leaders that can communicate a shared vision with their colleagues. Paré and colleagues (2011) demonstrated that the "presence of a champion" subscale had positive significant correlations with organizational readiness (study one: r (132) = .45, p < .001); study two: r (235) = .73, p < .001) and top management support (study one: r (132) = .67, p < .001); study two: r (235) = .73, p < .001) in both study one and study two. Hence demonstrating convergent validity of the champion subscale.

Discriminant validity indicates that scales that are supposed to measure different constructs have no or little correlation with each other (De Vet et al., 2011b). Paré and colleagues (2011) demonstrated that the three items intended to measure the presence of champions had higher factor loadings for the "presence of a champion" subscale than any of the other subscales. Similarly, they reported that the average variance extracted (explained variance of a measure relative to amount of variance attributed to measurement error (De Vet et al., 2011a)) of the "presence of a champion" subscale (average variance extracted in study one= .89 and study two = .87) was higher than correlations coefficients (range of r (132) =.34 to .60 in study one and range of r (235) = -.30 to 0.73 in study two) with other subscales (Paré et al., 2011).

Summary. A recent integrative review on champions reported that champions are operationalized in most studies as single dichotomous items scales that measure either the presence or absence of a champion (Miech et al., 2018). The same synthesis study located two champions subscales that have adequate internal consistency reliability (Helfrich et al., 2009; Paré et al., 2011). However, Helfrich and colleagues (2009) raised concerns on whether the items of their champion subscale adequately capture the champion construct. Hence there is a need for more nuanced methods of operationalizing champions and for more valid, reliable, and pragmatic instruments that measures the champion construct.

Effectiveness of Champions in Implementing Innovations

There are at least four published review studies that summarized the literature on the effectiveness of champions (Hall et al., 2021; Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020). Shea and Belden (2016) performed a scoping review (N = 42 studies) to collate the characteristics, behaviours and impacts of health information technology (HIT) champions. They analyzed a subset of 28 studies (25 qualitative studies and three quantitative studies) regarding the impact (influence) of HIT champions in implementing HIT. Hall and colleagues (2021) performed a systematic review and metanalysis of 12 quantitative studies (one randomized controlled trial (RCT) and 11 cluster RCTs) that evaluated the effectiveness of champions, as a component of a multifaceted intervention, in improving adherence to guidelines in long-term care homes. They presented their findings with a level of certainty (high, moderate, low, and very low) that was determined independently by two reviewers according to five GRADE considerations (Guyatt et al., 2008). Wood and colleagues (2020) conducted a systematic review to summarize the role and efficacy of clinical champions in facilitating the implementation of evidence-based practices (e.g., screening tools and processes or pharmacological therapy) in

settings that provided drug and alcohol and mental disorder treatments such as inpatient mental health facilities or primary care practices (*N* = 13 studies). Ten of these studies was conducted using a qualitative study design, one was a mixed study and two were quantitative studies. Miech and colleagues (2018) analyzed a subset of 11 quantitative studies included in their integrative review (*N* = 199 included studies) which evaluated the effectiveness of champions in increasing the uptake of evidence-based practices and health care programs in different clinical specialties. Three of the studies included in their analysis were RCTs, one was a clustered controlled trial, one was a quasi-experimental study and six were observational studies (Miech et al., 2018). The findings of each of these review studies are summarized below as either champions' effectiveness in increasing innovation use or improving outcomes. A more detailed description of these four reviews (Hall et al., 2021; Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020) is outlined in **Table 1**.

Effectiveness of Champions in Improving the Use of Innovations

Shea and Belden (2016) reported that HIT champions impacted (influenced) the process of implementing HIT innovations, the use or successful implementation of HIT innovations, and organizational perceptions or readiness to implement HIT innovations. They reported that most of the studies demonstrated that champions had a positive influence on the uptake of the HIT innovation (*n* = 22 out of 28 studies). The remaining six studies demonstrated that the deployment of a HIT champion had variable results pertaining to champions relationship with uptake of HIT innovations (i.e., improved some, but not all study outcomes) (Shea & Belden, 2016).

Hall and colleagues (2021), based on three studies (two cluster randomized control trials, and one staff randomised randomized control trial), stated that there is low certainty evidence that

champions, as a part of multicomponent interventions, improves staff adherence to clinical and best-practice guidelines for pressure ulcer prevention, function-focused care (care focused on optimizing and maintain physical capabilities), and depression identification in long term care settings. They also reported that there it is currently uncertainty as to whether champions, as a part of multicomponent interventions, can improve the use of a depression screening tool because the evidence was from only one randomized control trial and was rated very low according to their GRADE assessment (Hall et al., 2021).

Wood and colleagues (2020) reported that four qualitative studies demonstrated that champions influenced health care providers to follow best practices or use evidence-based resources in health care settings that provided treatments for alcohol and drug use or mental health disorders. The remaining nine studies included in their review did not evaluate the effectiveness of champions (Wood et al., 2020).

Miech and colleagues summarized the effectiveness of champions in health care implementation in a subset (n = 11 studies) of the included in their integrative review (N = 199 studies). Miech and colleagues (2018) reported that in eight of the 11 studies (one RCT, one cluster randomized clinical trial, one quasi-experimental study, and five observational studies) champions influenced the increase in uptake of evidence-based practice or program. Miech and colleagues (2018) reported that the remaining three studies (two RCTs and an observational study) had mixed results pertaining to the relationship between exposure to champions and the uptake of evidence-based practices.

Summary. The findings from the four review studies outlined above demonstrate champions have an influence on the uptake of innovations. However, two of the review studies did not delineate whether champions influence innovation uptake by patients, providers, or

systems/facilities (Miech et al., 2018; Shea & Belden, 2016). Wood and colleagues (2020) and Hall and colleagues (2021) synthesized that the deployment of champions can influence the uptake of best practices by health care providers, but this conclusion is limited to drug and mental health and long-term care settings respectively. Furthermore, Shea and Belden's (2016) and Wood and colleagues' (2020) findings were based primarily on qualitative studies, which could indicate connections between champions and innovation use but not effectiveness. Hence, a synthesis of champions 'effectiveness in increasing innovation uses by patients, providers, and systems/facilities across different health care settings is currently warranted.

Effectiveness of Champions in Improving Outcomes

Out of the four reviews discussed above, only Hall and colleagues (2021) reported on the effectiveness of champions in improving outcomes (defined as the goal or benefit resulting from adopting an innovation). Hall and colleagues (2021) reported that the use of champions as part of multicomponent interventions may reduce oral plaque, denture plaque, and oral debris (moderate certainty evidence across three clustered RCTs) or have little or no effect in agitation of long-term care home patients (low certainty evidence across two clustered RCTs). In addition, Hall, and colleagues (2021) reported that there is not enough evidence at this time to conclude whether the use of champions as part of a multicomponent interventions can improve the other clinical outcomes (e.g., pressure ulcer prevalence) they evaluated, decrease adverse outcomes (e.g., falls), quality of life, satisfaction of care, or resource use in long term care homes (operationalized as the number of times residents are hospitalized). Hence, the literature related to champions' effectiveness in improving outcomes has only been synthesized in the context of long-term care homes, and has mostly focused on patient outcomes (e.g., improvement in health status, quality of life, etc.). None of the review studies summarized the effectiveness of

champions in influencing provider level outcomes (e.g., providers 'satisfaction with practice) or system level outcomes (e.g., length of stay and cost). Therefore, there is a gap in the literature for a study that summarizes and differentiates the effectiveness of champions in improving patients' health status and experiences, providers' satisfaction with practice, and system/facility efficiency as the result of innovation use (i.e., outcomes of innovation use) across different health care settings.

Quality Appraisal of Published Review Studies on Champion Effectiveness

I used the AMSTAR 2 (A MeaSurement Tool to Assess systematic Reviews) (Shea et al., 2017) to evaluate the quality of the four review studies discussed above (Hall et al., 2021; Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020). The AMSTAR 2 is a practical and valid quality appraisal tool. It was developed to be used by health care professionals and policy makers to evaluate the quality of systematic reviews of randomized controlled trials or non-randomized controlled trials (Shea et al., 2017). The AMSTAR 2 is reported to have acceptable interrater reliability (Shea et al., 2017). The findings of the quality appraisal are outlined in **Table 2**. Shea and colleagues (2017) advised that a total score should not be calculated for the AMSTAR 2. Rather, they suggested that individuals should reflect on what critical flaws are present in each review and qualitatively rate them according to four overall confidence levels: high, moderate, low, or critically low as outlined in (Shea et al., 2017). The confidence levels reflect the extent that a review provides an accurate and comprehensive summary of the results extracted from the available primary studies (Shea et al., 2017).

Through conducting the quality appraisals, I determined that Hall and colleagues (2021)'s systematic review to be a well conducted systematic review of effectiveness (overall high confidence level). Hall and colleagues' (2021) systematic review only had one non-critical

weakness which is that they did not provide a list of all the full text studies excluded in their review with the reasons for their exclusion. The other three reviews (Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020) were not conducted according to many of the criteria outlined by the AMSTAR 2. I rated the other three reviews (Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020) to have critically low confidence levels because they had more than one critical flaw pertaining to: 1) not conducting study selection in duplicate, 2) not conducting extraction in duplicate, and 3) and not conducting quality appraisal.

Some of the questions from AMSTAR 2 may not be pertinent to Miech and colleagues (2018) and Shea and Belden (2016)'s study designs (e.g., quality appraisal is not required in conducting integrative reviews (Whittemore & Knafl, 2005) or scoping reviews (Levac et al., 2010)). Hence, I evaluated these two reviews using a valid generic quality appraisal tool for synthesis studies developed by JBI (Aromataris et al., 2015). Although, these reviews met more of the criteria in the JBI quality appraisal tool, the same issues around study selection and data extraction were still present (see quality appraisals in **Table 3**).

Due to the quality of these studies, the results that I presented previously with respect to these reviews may not provide an accurate and comprehensive summary of champions' effectiveness in health care contexts. However, since Hall and colleagues' (2021) systematic review has good methodological quality, their findings should be relied on to be an accurate and comprehensive summary of champions' effectiveness in increasing guideline adherence by providers and improving outcomes in long term care.

Thesis Rationale

Collectively, the findings of the four review studies discussed in this chapter (Hall et al., 2021; Miech et al., 2018; Shea & Belden, 2016; Wood et al., 2020) do not comprehensively

identify and synthesize the effectiveness of champions, differentiated from other implementation strategies, across different health care settings. First, three of the reviews were focused on examining the effectiveness of champions pertaining to only one specific innovation (HIT (Shea & Belden, 2016) or best practice guidelines (Hall et al., 2021)), or within a particular health care context (long-term care homes (Hall et al., 2021) or drug and mental health settings (Wood et al., 2020). These findings may not be generalizable to other contexts. Second, the four reviews included studies that did not isolate the effectiveness of champions from other implementation strategies such as other facilitator roles (opinion leader or super users) (Shea & Belden, 2016) or other strategies used in conjunction to champions such as educational workshops for staff (Hall et al., 2021; Miech et al., 2018; Wood et al., 2020). It might be difficult to determine the extent of which champions influenced innovation use or outcomes if their effectiveness is evaluated in combination with other strategies. Similarly, the inclusion of studies that examine different roles like champions may create confusion, as sometimes these roles are not used as synonyms (Cranley et al., 2017; Miech et al., 2018; Thompson et al., 2006). Third, two of the reviews were primarily based on qualitative studies (Shea & Belden, 2016; Wood et al., 2020), which can suggest possible relationships but not effectiveness. Lastly, despite Miech and colleague's (2018) broader examination of the effectiveness of champions in health care (i.e., within diverse contexts or differing types of innovations), they did not use rigorous methods in their review normally associated with systematic reviews as outlined by the JBI manual on systematic review of effectiveness (Tufanaru et al., 2020) or the Cochrane handbook for systematic review of interventions (Higgins et al., 2021). For instance, their search strategy was only applied to a single database. Further, only one individual performed title and abstract screening and full text

screening, and quality appraisal was not completed (Miech et al., 2018). Finally, Miech and colleagues (2018) excluded grey literature as well as theses and dissertations on champions.

Further supporting the need for my thesis study, I performed a search on The International Prospective Register of Systematic Reviews (PROSPERO) to identify registered systematic reviews that are in progress on champions. Excluding the two systematic reviews that finished during my study and discussed above (Hall et al., 2021; Wood et al., 2020), there are two additional reviews related to champions that remain in progress (Kovai et al., 2013; Welsh et al., 2016). Kolvai and colleagues' (2013) review is on understanding the role of vision champions in schools while Welsh and colleagues' (2016) review is on champions' effectiveness in long term care. Therefore, there was a need for a rigorous systematic review to synthesize the literature around the effectiveness of champions, independent of other implementation strategies, in improving patient, provider, and system/facility knowledge use and outcomes across diverse health care settings/institutions.

Study Objective and Questions

The objective of my thesis was to conduct a systematic review of the existing published literature and theses and dissertations that evaluated the effectiveness of champions, independent of other implementation strategies, in increasing the use of innovations or improving outcomes in health care settings/institutions. The research questions were: 1) How are champions described and operationalized in the articles that evaluate their effectiveness? 2) What are the effects of champions on the uptake of innovations (knowledge use) by patients, providers, and systems/facilities? 3) What are the effects of champions on patient, provider, and system/facility outcomes (i.e., the resulting benefit or detriment occurring from the use of the innovation)?

Significance of Thesis

My thesis is significant to nursing and the broader health care field because champions have been increasingly used as a strategy for implementing health care innovations in health care contexts in the last decade (Miech et al., 2018). Grol and Grimshaw (1999) and Powell and colleagues (2019) advocated for the importance of having evidence-based implementation to coincide with evidence-based practice (Grol & Grimshaw, 1999; Powell et al., 2019). They stated that implementation strategies should be tested for their effectiveness in addressing specific barriers to implementation or in achieving a particular goal. Hence, the effectiveness of champions needs to be determined so that decision makers can make evidence informed decisions pertaining to the appropriate circumstances or implementation goals that are addressed or achievable with the help of champions.

Personal Impetus

My interest in studying the implementation of innovations originates from my experiences as a registered nurse on a surgical oncology unit. There were isolated instances while practicing as a nurse when I would be informed by my colleagues of existing evidence suggesting that certain routine practices that we still performed were outdated. These situations sparked my interest in studying the processes involved in changing practices to align with best evidence. My interest in studying champions was sparked by attending an RNAO Best Spotlight Organization (BPSO) celebration at a nursing home in Ottawa, Canada. During this celebration, I was intrigued by how the success of the implementation of best practice guidelines was attributed to the work of nursing home staff with varying degrees of expertise and roles. For instance, they celebrated and identified the work that was done by registered nurses, registered practical nurses, and the personal support workers who acted as champions. I did the champions

training myself through the RNAO and attended champions' network sessions. From my experience as a champion, both at unit and hospital levels, I recognized that certain champions were more helpful than other champions, despite the expectations that they are performing the same role. For example, during the implementation of the electronic medical health record at the hospital I work at, many nurses commented on how they preferred working shifts with internal nurse champions rather than with external technology champions. These nurses stated that the nurse champions were able to understand their explanations of what task they performed and how to accurately document it in the new health record. These experiences sparked my interest in finding out whether champions are truly effective because I perceived champions' effectiveness to vary depending on who was performing the role during the electronic health record implementation. While on the other hand, I also perceived during the RNAO BPSO celebration that all champions are equally important in enacting change. This sparked my interest in studying champions' effectiveness for my thesis.

Conceptual Model

The integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care is a model that I developed to guide my thinking for my thesis. My intent in this model was to illustrate my thought processes on how champions can facilitate the use of innovations in health care and the outcomes or impacts resulting from the use of innovations. Three models/frameworks (Harvey & Kitson, 2016; Straus et al., 2013; Titler & Everett, 2001) informed the development of my framework. First, the Diffusion of Innovations in Health Care model (Titler & Everett, 2001) which is based on the germinal work of Everett Rogers (1962). The Diffusion of Innovations in Health Care model (Titler & Everett, 2001) was the base model for my integrated Conceptual Model of Champions Facilitation of Innovation Use in Health

Care. From this model (Titler & Everett, 2001), I adopted the idea that successful uptake of innovation is dependent on a social and active process driven by champions who introduce and promote an innovation to potential users and the system. Second, I adopted the concept of facilitation from the integrated Promoting Action on Research Implementation in Health Services (iPARIHS) to define the activities and roles conducted by champions (Harvey & Kitson, 2016). Further, I adopted from the iPARIHS framework the idea that champions can influence innovation use by patients, health care providers and systems/facilities, and that the uptake of the innovations occurs within a specified context (Harvey & Kitson, 2016). Also, I adopted the idea from the iPARIHS framework that innovations are tailored/adapted by facilitators and recipients so that they are usable within a particular context (Harvey & Kitson, 2016). Third, I adopted the concepts of knowledge use and outcomes from Straus and colleagues' (2013) framework to define patients', providers', and systems/facilities' use of innovations and outcomes. These three models/frameworks and my model are described next.

Diffusion of Innovations in Health Care (Titler & Everett, 2001)

The Diffusion of Innovations in Health Care model states that implementation of innovations is an active, social, and communicative process (Titler & Everett, 2001). According to this model, the adoption of innovation is based on the type of innovation, the communication processes used to disseminate new knowledge to health care professionals, the characteristics of health care professionals as the user of innovations, and the broader social system (Titler & Everett, 2001). The social system in Titler and Everett's (2001) model refers to the physical location and the social structure that makes up the health care context (e.g., hospital, health care unit, etc.) where an innovation is implemented. Titler and Everett (2001) believed that the adoption of an innovation (measured by the rate of adoption, the extent of the adoption, and the

barriers to adoption) is determined by the characteristics of health care providers and the health care setting, which are influenced by a communication process (e.g., champions). Titler and Everett (2001) posits that the characteristics of the health care providers and the health care context interact and influence each other. They defined health care provider characteristics that impact implementation to include professional education, practice speciality, knowledge, and attitude towards an innovation, and receptivity to change (Titler & Everett, 2001). They defined the social system impacting implementation to include the support of leaders, standards and expectations set by job descriptions, policies, and procedures, access to clinical researchers, authority to change practice, and an organizational culture supporting change (Titler & Everett, 2001).

Integrated Promoting Action on Research Implementation in Health Services (iPARIHS) (Harvey & Kitson, 2016)

The iPARIHS framework posits that successful implementation, defined as the attainment of a specified implementation goal, results from the facilitation of an innovation with the recipients in their (local, organizational, and system) context (Harvey & Kitson, 2016). Harvey and Kitson (2016) defined facilitation as the process undertaken by certain individuals to make implementation of innovations easier. They proposed facilitation as the active ingredient of implementation because facilitation allows individuals to evaluate and then resolve barriers to implementation related to the innovation, the recipients of the innovation, and the context. Harvey and Kitson (2016) defined innovations as knowledge developed according to research evidence, providers' expertise, and patients' experiences that is tailored and adopted by facilitators and recipients to be usable within a particular context. They defined recipients as the individuals or teams that are affected or influenced by implementation. Context within the

iPARIHS framework was defined to comprise the local, organization, and system level context (Harvey & Kitson, 2016).

Straus and Colleagues' Knowledge Use and Outcomes (Strauss and colleagues, 2013)

According to Straus and colleagues (2013), the use of innovations should be evaluated as either knowledge use or outcomes of knowledge use on patients, providers, and systems (i.e., impact of using the innovation). Knowledge use is subdivided as either conceptual or instrumental knowledge use. Conceptual knowledge use is defined as an increase in knowledge pertaining to an innovation (i.e., awareness, enlightenment) or shift in attitude favouring the use of an innovation (Straus et al., 2013). Instrumental knowledge use is defined as a change in behaviour or practice related to the innovation (i.e., actual use of the innovation) (Straus et al., 2013). Outcomes of knowledge use are defined as the resulting impact from using the innovation on patients, providers, and systems/facilities. Examples of patient level outcomes include improvement in patients' health status, quality of life, and their satisfaction with their care. Examples of a provider level outcome include provider satisfaction with practice, the time taken to perform the new practice, and the development of new skill sets by providers. Examples of system level outcomes includes organizational level quality measures such as length of stay and wait times, and cost (Straus et al., 2013).

Integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care

My conceptual model (**Figure 1**) begins with the identification of a particular innovation that addresses an identified clinical question or practice gap. Champions may participate in this gap analysis, or they may be identified after the innovation has been identified by other individuals (e.g., management). Champions are identified by management or volunteer within the social system/context.

Since authors often describe champions as individuals from the local context who perform another occupational role apart from being a champion (Cranley et al., 2017; Thompson et al., 2006), I posit that champions do not only influence the context (Titler & Everett, 2001), but can also be vulnerable to aspects of the context. For example, a champion can be an experienced nurse who has volunteered to become a champion in changing how nurses perform a specific dressing on their unit. Certain authors support this claim by stating that certain contextual factors such as support from leadership (Soo et al., 2009), the formality of the champion role (Luz et al., 2019), the effect of power (Ploeg et al., 2010), and the effects of conflicting expectations (Goedken et al., 2019) can affect how champions behave and the impact of their behaviours. Therefore, the champion role is situated within the health care context in my model, which is a modification made to the Titler and Everett (2001) model. However, a circle with broken lines was placed around the term champion to make it clear that champions are influenced by the social system (context) and that they typically arise from within the context but are a separate aspect of implementation (an implementation strategy).

After a champion or group of champions are identified, local stakeholders collaborate with champions to tailor or adapt the innovation so that is compatible with the local context (Harvey & Kitson, 2016). Champions facilitate the implementation of this tailored and adapted innovation. Facilitation refers to the active process that aids with making implementation easier or faster (Harvey & Kitson, 2016). The champions perform varied roles and activities that range from project specific tasks such as providing training to staff to broader roles such as developing a culture that is receptive to change (Harvey & Kitson, 2016). Champions plan and enact activities that target changes at the patient, provider, and health care facility/system level. The patients, health care providers and health care facility/system are depicted in my model as

overlapping circles because these three concepts intermingle and affect each other (Harvey & Kitson, 2016; Titler & Everett, 2001). For example, shared decision making between patients and providers allows patients to make difficult health care decisions that are informed by medical evidence and professional knowledge and are congruent with the patients' preferences and values (Stacey et al., 2010). Similarly, health care providers' attitudes and actions are believed to be highly influenced by the institutional climate, culture, and policies in which they work in (Harvey & Kitson, 2016). Lastly, patients can affect the health care system through patient advocacy and engagement, which assures and advocates for the involvement of patients and the consideration of their experiences, needs, priorities and values when planning implementation or change (Banner et al., 2019). Hence, I propose that even though champions tailor their activities towards a particular target, the resulting change in innovation use (Straus et al., 2013) could affect all three of levels (patient, provider, and system/facility) because of how interlinked these three levels are. The iPARIHS framework supports this view as its developers have denoted that facilitation is the central component of implementation which addresses and influences the innovation, the recipients, and the context (Harvey & Kitson, 2016)

The resulting knowledge use, whether at patient, provider, or system/facility level is the culminating result of champions' facilitation, the patients', and providers' decision to change their attitudes or behaviours, and the system/facility level changes required to implement the innovation (Harvey & Kitson, 2016; Titler & Everett, 2001). I represented these interrelations by drawing a brace symbol that outlines the three circles (patients, providers, and system/facility) and then points towards the box with three types of innovation use. The use of the innovation (whether conceptual or instrumental, or by patient, provider, or facility) results in outcomes (e.g.,

benefits or improvements in patients' status and experiences, providers' satisfaction with practice, or system efficiency) from the uptake of the innovation (Straus et al., 2013).

Thesis Outline

The format for the thesis is a thesis-by-article and is composed of three chapters:

- **Chapter one** includes the introduction to the thesis, the study rationale, study objectives and research questions, significance of the study, my personal impetus for conducting the study, and conceptual model guiding the thesis research.
- **Chapter two** is a manuscript entitled "Champions' Effectiveness in Implementing Innovations: A Systematic Review" formatted for submission to the journal: *Implementation Science*.
- **Chapter three contains the integrated discussion.** First, I present a summary of the findings from my manuscript (chapter two). Then I describe adaptations I made to my conceptual model (found in chapter one) due of my systematic review results and my increased knowledge of the literature on champions and implementation. In chapter three, I also include a discussion of the main methodological limitations of the studies included in my systematic review of champions' effectiveness and I identify key elements that should be included in any study that evaluates the effectiveness of champions. I conclude chapter three with a summary of the implications for nursing practice, education, leadership, and research from my thesis.

Table 1

Comparison of Reviews About Champion Effectiveness

Article (citation)	**(Hall et al., 2021)**	**(Miech et al., 2018)**	**(Shea & Belden, 2016)**	**(Wood et al., 2020)**
Study aim	To assess the effectiveness of champions as a component of a multifaceted intervention, in improving adherence to guidelines and subsequent resident outcomes in long-term care homes	To summarize the literature on champions in health care settings and to gain greater clarity of the champion construct	To collate and synthesize quantitative and qualitative studies that reports on the characteristics, behaviours and impacts of health information technology (HIT) champions	To examine the role and efficacy of clinical champions in facilitating the implementation of evidence-based practices (e.g., screening tools and processes or pharmacological therapy) in drug and alcohol use and mental health settings
Study design	Systematic review and metanalysis	Integrative review	Scoping review	Systematic review
Setting	Long term care homes	Across different health care contexts (e.g., schools, hospitals, primary care clinics)	Across multiple different health care contexts (e.g., telehealth, hospitals)	Health care settings that provide drug and alcohol use and mental health treatments (excluding dementia and geriatric and cognitive disorders). These settings can be inpatient, outpatient, community, or primary care settings.
Type of synthesis (meta-analysis or narrative synthesis)	Meta-analysis, if not possible a qualitative assessment of the effect	Narrative synthesis Metanalysis was stated to be not possible due to the broad diversity in settings, research questions, outcomes, and types of champions	Narrative synthesis The authors coded impact (influence) as either positive, negative, varied (positive and negative), or not assessed	Narrative synthesis The authors extracted and summarized findings for each included study pertaining to champions' influence on the process of implementation or uptake of evidence-based practices
Number of included studies in synthesis related to effectiveness.	*N* = 12 studies	*N* = 199 studies	*N* = 42 studies	*N* = 13 studies

Article (citation)	(Hall et al., 2021)	(Miech et al., 2018)	(Shea & Belden, 2016)	(Wood et al., 2020)
		n = 11 studies (subset of the 199 studies) that evaluates relationships between champions and innovation use).	*n* = 28 studies (subset of 42 studies) that the authors coded evaluated impact (influence) of HIT champions	*n* = 6 of the 13 studies evaluated champions influence on the implementation process. Four of these six studies evaluated champions influence on uptake of evidence-based practice *n* = 7 of the 13 studies did not evaluate champion's influence on implementation
Study designs	RCT = 1 of 12 studies CRCTs = 11 of 12 studies	RCTs = 3 of 11 studies CRCT = 1 of 11 studies Quasi-experimental = 1 of 11 studies Observational quantitative studies = 6 of 11studies	Qualitative studies = 25 of 28 studies Observational quantitative studies = 3 of 28 studies.	Qualitative studies = 10 of 13 studies Mixed study (qualitative and cross-sectional study) = 1 of 13 study Observational quantitative studies = 2 of 13 studies
Types of Innovation	Guidelines and best practice recommendations	Heterogenous (includes evidence-based practices, programs, and use of technology)	Health information technology	Evidence-based practices drug and alcohol use and mental health treatments (e.g., screening tools and processes or pharmacological therapy)
Champions' effectiveness related to **Innovation Use** Reported findings (review authors conclusion, number of studies informing the finding and magnitude of effectiveness if reported)	1) **Innovation Use:** Adherence to the use of a depression screening tool by providers **Reported finding:** Uncertain if champion was effective as only reported in one RCT (*N* = 69 staff) (*RD* = 23% [95% CI: 5%, 52%]). Very Low GRADE level of certainty 2) **Innovation Use:** Adherence to guidelines (pressure ulcer prevention, function-focused care, and depression identification) by providers	1) **Innovation Use:** Adherence to evidence-based practice and uptake of programs by providers **Reported findings:** a) Four of the 11 studies (range of number of settings = one to four; 23 to 93 individual units) included in the subset of articles randomly allocated the presence or absence of champions into an intervention and control groups	1) **Innovation Use:** Uptake of a health information technology by providers and facility (not differentiated by authors) **Reported findings**: a) The authors coded 22 of the 28 studies to demonstrate that champions had a positive impact (influence) in implementation of HIT	**Innovation Use:** Change in health care providers' practices to be in line with best evidence (e.g., increase of clozapine prescribing for treatment of resistant schizophrenia) **Reported findings:** a) In four qualitative studies, champions were reported to influence change in providers' practices. These

Article (citation)	(Hall et al., 2021)	(Miech et al., 2018)	(Shea & Belden, 2016)	(Wood et al., 2020)
	Reported finding: Champions may improve adherence according to 2 CRCTs and 1 RCT, 15 clusters (*N* = 260 staff) (unadjusted *RD* range from 4.1 % to 44%). Low GRADE level of certainty	i) Two of the four studies demonstrated that the presence of champion resulted in mixed findings (i.e., not every measure of innovation use improved after a champion was introduced) ii) The other two studies reported improvements in uptake of a physical activity program in an elementary school and an influenza vaccination program in a hospital in groups with a champion b) Seven of the 11 studies included in the subset of articles utilized primarily observational study designs (six of seven) and one was a CRCT. They all reported an odds ratio. i) Six of the seven studies demonstrated that champions have a positive influence in uptake of innovations (defined as 95% *CI* intervals not overlapping with 1.0). Across the six studies, the odds ratio ranged from 1.94 to 3.44	b) The authors coded 6 of the 28 studies to demonstrate variable findings (i.e., champions had a positive and negative impact (influence)) c) The remaining 14 studies of the 42 total studies included in the review did not assess champions' impact	practice changes included increased use of buprenorphine for opioid dependence, appropriate use of pharmacological treatment for alcohol use, consistent screening of substance use, depression and anxiety, and uptake of the Transitional Relationship Model
Types of Outcomes (patient, provider, system/facility)	Patient or resident outcomes	None reported	None reported	None reported
Champions' effectiveness related to **Outcomes** (patient, provider, system/facility). Reported findings (review authors conclusion, number of studies informing the	1) **Outcome**: Oral Hygiene (decrease in dental plaque, denture plaque and oral debris of residents) **Reported findings**: **Effective**. According to three CRCTs (37 clusters, *N* = 640 residents) the use of champions may reduce levels of dental plaque (adjusted	None reported	None reported	None reported

Article (citation)	(Hall et al., 2021)	(Miech et al., 2018)	(Shea & Belden, 2016)	(Wood et al., 2020)
finding and magnitude of effectiveness if reported)	*MD* = − 0.28 [95% *CI*: − 0.55, 0.00]; *n* = 167) and denture plaque (adjusted **MD** = − 0.34 [95% *CI*: − 0.50, − 0.18]; n =388), and oral debris (adjusted *MD* = − 0.2 [95% *CI*: − 7.3, 7.0]; n = 113). **Moderate GRADE** level of certainty 2) **Outcome**: Level of agitation of residents **Reported findings:** **Little or no effect** on residents' level of agitation 2 CRCTs (31 clusters, *N* = 503 residents) (adjusted *MD* = 0.49 [95% *CI*: − 2.39, 3.37]). **Low GRADE** level of certainty 3) **Outcome**: Other Clinical Outcomes (physical function, pressure ulcer prevalence, malnourishment, delirium, infections, and comfort) **Reported findings: Uncertain** based 6 CRCTs (Median = 12.5 clusters, range = 4 -47 clusters) because evidence was rated as **very low according to GRADE**. Clinical Physical Function (unadjusted *MD* = 4.77 [95% *CI*: 1.39, 8.15]), Pressure ulcer prevalence (unadjusted *RD* = 0.00 [95% *CI*: − 0.03, 0.02]), Moderate-severe malnourishment (adjusted OR = 1.6 [95% *CI*: 0.8, 3.1]), prevalence of delirium (unadjusted *RD* = − 0.03 [95% *CI*: − 0.10, 0.04]), infections (adjusted hazard ratio = 0.99 [95% *CI*: 0.87, 1.12]), comfort in the last week of dying (adjusted *MD* = 0.91 [95% *CI*: − 1.03, 2.85]). 4) **Outcome**: Adverse outcomes (injury, falls, ED visits related to falls)			

Article (citation)	(Hall et al., 2021)	(Miech et al., 2018)	(Shea & Belden, 2016)	(Wood et al., 2020)
	Reported findings: Uncertain based 1 CRCT (4 clusters, *N* = 169 residents) because evidence was rated as **very low according to GRADE**. Unadjusted *RD*s for (i) injury (*RD* = 7%; [95% *CI*: − 5%, 20%]), (ii) falls (*RD* = 1%; [95% *CI*: − 14, 16%]) and (iii) ED visits related to falls (*RD* = 4%; [95% *CI*: − 2%, 10%]). Very Low GRADE level of certainty 5) **Outcome**: Quality of life of residents **Reported findings: Uncertain** based 3 CRTCs (45 clusters, *N* = 653 residents). Unadjusted *MD* = 0.03 (95% *CI*: − 0.01, 0.07). **Very Low GRADE** level of certainty 6) **Outcome**: Residents' satisfaction with care **Reported findings: Uncertain** based 1 CRCT (73 clusters, *N* = 913 residents) because evidence was rated as **very low according to GRADE**. Adjusted *MD* = 1.72 (95% *CI*: − 0.15; 3.59) Very Low GRADE level of certainty 7) **Outcome**: Number times that residents are admitted to the hospital **Reported findings: Uncertain** based 2 CRCTs (18 clusters, *N* = 261 residents). Meta-analysis was not performed due to heterogeneity. Unadjusted *RD* ranged from 7% (95% *CI*: − 15%, 0%) to 22% (95% *CI*: − 37%, − 7%) for champion intervention group. **Very Low GRADE** level of certainty			

Note: CI = confidence interval; CRCT = clustered randomized controlled trial; ED = emergency department; MD = mean deviation; RCT = randomized controlled trials; RD = risk difference

Table 2

AMSTAR 2 Assessments of Reviews About Champion Effectiveness

AMSTAR 2 Questions	**(Hall et al., 2021)**	**(Miech et al., 2018)**	**(Shea & Belden, 2016)**	**(Wood et al., 2020)**
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Yes	No	No	No
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	Yes	No	No	Yes
3. Did the review authors explain their selection of the study designs for inclusion in the review?	Yes	Yes	Yes	No
4. Did the review authors use a comprehensive literature search strategy?	Yes	Partial Yes	Yes	Yes
5. Did the review authors perform study selection in duplicate?	Yes	No	Yes	No
6. Did the review authors perform data extraction in duplicate?	Yes	No	No	No
7. Did the review authors provide a list of excluded studies and justify the exclusions?	No	No	No	Yes
8. Did the review authors describe the included studies in adequate detail?	Yes	No	Partial Yes	Partial Yes
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	Yes	No	No	No
10. Did the review authors report on the sources of funding for the studies included in the review?	Yes	Yes	Yes	Yes
11. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results?	Yes	No meta-analysis	No meta-analysis	No meta-analysis
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	Yes	No meta-analysis	No meta-analysis	No meta-analysis
13. Did the review authors account for RoB in individual studies when interpreting/discussing the results of the review?	Yes	No	No	No
14. Did the review authors provide a satisfactory explanation for, and discussion of, any	Yes	Yes	Yes	Yes

AMSTAR 2 Questions	**(Hall et al., 2021)**	**(Miech et al., 2018)**	**(Shea & Belden, 2016)**	**(Wood et al., 2020)**
heterogeneity observed in the results of the review?				
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	Yes	No meta-analysis	No meta-analysis	No meta-analysis
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Yes	Yes	Yes	Yes
Overall confidence	High	Critically low	Critically low	Critically low

From: Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., ... & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *bmj*, *358*.

Table 3

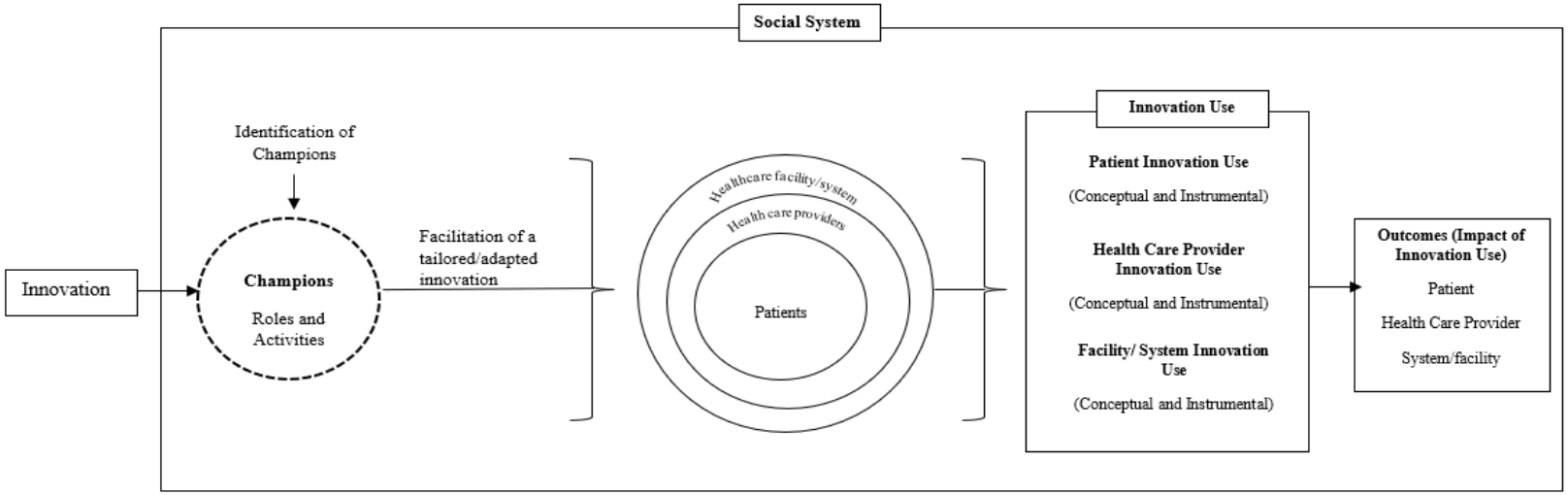
JBI Critical Appraisal of Non-systematic Reviews About Champion Effectiveness

Article (authors, year)	**(Miech et al., 2018)**	**(Shea & Belden, 2016)**
Critical appraisal tool question		
1) Is the review question clearly and explicitly stated?	YES	YES
2) Were the inclusion criteria appropriate for the review question?	Unclear	YES
3) Was the search strategy appropriate?	NO	YES
4) Were the sources and resources used to search for studies adequate?	NO	YES
5) Were the criteria for appraising studies appropriate?	N/A	N/A
6) Was critical appraisal conducted by two or more reviewers independently?	N/A	N/A
7) Were there methods to minimize errors in data extraction?	YES	NO
8) Were the methods used to combine studies appropriate?	YES	Unclear
9) Was the likelihood of publication bias assessed?	NO	NO
10) Were recommendations for policy and/or practice supported by the reported data?	YES	YES
11) Were the specific directives for new research appropriate?	YES	YES
Total Score	5/9	6/9
Comments	An additional search was completed for the terms: implementation leader, opinion leader, facilitator, and change agent. It was not well explained in the paper how the primary author who singularly conducted screening differentiated whether to include terms that did not use the term champion	Scoping review does not require quality appraisal

From: Aromataris, E., Fernandez, R., Godfrey, C. M., Holly, C., Khalil, H., & Tungpunkom, P. (2015, Sep). Summarizing systematic reviews: methodological development, conduct and reporting of an umbrella review approach. International Journal of Evidence-Based Healthcare, 13(3), 132-140. https://doi.org/10.1097/XEB.0000000000000055

Figure 1:

Integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care



Legend

--- (dotted line): Represents how champions are an implementation strategy utilized to make changes to the social system but are individuals from within the social system who are chosen or volunteer to become champions

→ (arrow): Influence or interaction

Based on: Titler, M. G., & Everett, L. Q. (2001). Translating Research into Practice. *Critical Care Nursing Clinics of North America*, *13*(4), 587-604. https://doi.org/10.1016/s0899-5885(18)30026-1; Straus, S. E., Tetroe, J., Bhattacharyya, O., Zwarenstein, M., & Graham, I. D. (2013). Chapter 3.5 Monitoring knowledge use and evaluating outcomes. In S. E. Straus, J. Tetroe, & I. D. Graham (Eds.), Knowledge Translation in Health Care: Moving from Evidence to Practice (2nd edition ed., pp. 227-236). John Wiley & Sons, Ltd.; Harvey, G., & Kitson, A. (2016, Mar 10). PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, *11*, 33. https://doi.org/10.1186/s13012-016-0398-2

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Chapter 2

Champions' Effectiveness in Implementing Innovations: A Systematic Review

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List of Abbreviations: 1) Preferred Reporting Items for Systematic Reviews and Meta-Analyses: PRISMA 2) peer review of the electronic search strategy: PRESS 3) medical subject headings: MESH 4) systematic review: SR

Abstract

Background: The implementation of innovations is integral in providing effective, safe, cost-effective health care services. The use of champions has been documented in the literature as an important strategy for successful use of innovations. However, the effectiveness of champions has not been well synthesized in the health care literature. The aim of our systematic review is to determine whether champions, tested in isolation from other knowledge translation strategies, are effective at increasing the use of innovations within health care settings/institutions.

Methods: The JBI systematic review method guided this study. A peer reviewed search strategy was applied to eight electronic databases to identify relevant articles. We included all published articles and unpublished thesis and dissertations that utilized a quantitative study design to evaluate the effectiveness of champions in implementing innovations within health care institutions. Two researchers independently completed title and abstract and full text screening, data extraction, and quality appraisal. We used both inductive and deductive content analysis to analyze our data and present our result through a narrative synthesis.

Results: After screening 7,566 records titles and abstracts and 2097 full text articles, we included 35 studies (37 articles) in our review. Most of the studies (74.3%) operationalized exposure to a champion as a single item evaluating the presence or absence of a champion. The presence of champions was related to increasing the use of programs or technological innovations by facilities or systems. However, the evidence that the presence of champions influenced the attitudes, knowledge, or use of innovations by health care providers, or improved patient outcomes is inconsistent. There is little evidence that the presence of champions is related to negative effects; champions were not related to poorer outcomes and only reported to decrease knowledge use in one study.

Conclusions: Our findings suggest that more research is needed to determine the relationship between champions and knowledge use and outcomes. Although there appears to be no adverse effects in using champions, their use should be undertaken cautiously until more evidence is generated on the relationships between the use of champions and knowledge use and outcomes. To further our understanding and differentiate why champions performed inconsistently across studies, future studies need to: 1) provide more detailed descriptions of the champions; 2) describe and evaluate champion activities; 3) use valid, reliable, and pragmatic tools to measure exposure to champions; 4) and use more robust study designs.

Introduction

Evidence-based practice (EBP) is the development and provision of health services according to best research evidence, health care providers' expertise, and patients' values and preferences (1). According to Varnell and colleagues (2), there has been increased interests by organizations to be more evidence based oriented because evidence-based practice can result into safer practices, better patient outcomes, and decreased health care costs. Similarly, technological advancements have created changes in how health care services are organized and provided in a manner that is cost effective, safe, and efficient (3, 4). Collectively, best evidence or technology, whether perceived to be new can be defined as an innovation (5, 6). However, according to some authors, current policies, systems, and health care practices are not based on best evidence (7, 8). For example, Braithwaite and colleagues summarized that 60% of health services in the USA, England and Australia are in line with best practice guidelines, that about 30% of health services are of low value, a waste, or redundant, and that 10% of patients globally experience iatrogenic harm or adverse events (9).

To implement innovations, research evidence must be synthesized, adapted, and applied into a specific health care context, and this adoption must be evaluated (10). This process is iterative and has been termed as implementation, also known as knowledge translation or knowledge transfer (10). According to a number of authors, the implementation of innovations is improved when devoted individuals aid with knowledge translation (5, 11, 12). Facilitation can be defined as the process undertaken by certain individuals to make implementation of new practices easier (11). Champions are individuals that facilitate knowledge translation (12, 13); champions have been defined as individuals, often health care professionals, who work beyond their job requirements to promote ideas or practices that they believe in (14). However, other

authors stated that champions can be formally appointed to the role by management (15, 16) and that managers can also be champions (15, 16).

In a recent 2019 integrative review about champions in health care, Miech and colleagues abstracted 11 out of the 199 included studies in their review to have evaluated the effectiveness of champions (17). A reason attributed to the dearth of studies is that champions are often evaluated in combination with other implementation strategies as part of a multifaceted approach (17-19). Further, some authors reported that the variety and lack of clarity between the terms used in the literature to describe individuals helping with knowledge translation (e.g., champions, local opinion leaders) creates confusion and makes it difficult to assess and compare the effectiveness of these roles (13, 20).

The subset of 11 studies on champions' effectiveness reported by Miech and colleagues evaluated whether exposure to champions result in higher likelihood of best practices being demonstrated by providers (17). Miech and colleagues reported that despite mixed findings in this subset of studies, the presence of champions was generally associated or related to the adoption of innovations. Hence, Miech and colleagues concluded that champions are necessary, but insufficient for implementation success (17). However, since Miech and colleagues followed an integrative review method (17), certain conventional systematic review (SR) steps (21) were not performed or reported. Particularly, the search strategy used in their review was only applied to a single database, and only one individual screened title and abstract and performed study selection. They did not assess the methodological quality of included studies (17). Further, Miech and colleagues (17) did not report on unpublished theses, and only included studies that randomly allocated champions or studies evaluating uptake of best practices by health care providers. Hence, their assessment of champion effectiveness is not comprehensive, and is

susceptible to publication bias because their review only consisted of published articles. Further, Miech and colleagues (17) included articles that did not isolate the champion's effectiveness from other knowledge translation strategies such as training programs (18, 19). Lastly, Miech and colleagues (17) did not synthesize the findings across the subset of 11 studies, rather the effectiveness of champions were described individually according to each study. Hence, Miech and colleagues' review (17) did not adequately review champion's effectiveness.

We aim to determine whether champions, tested in isolation from other implementation strategies, are effective at increasing the use of innovations within health care settings/institutions. The research questions are: 1) How are champions described and operationalized in the articles that evaluates their effectiveness? 2) What are the effects of champions on the uptake of innovations (knowledge use) by patients, providers, and systems/facilities? 3) What are the effects of champions on patient, provider, and system/facility outcomes?

Methods

The research team followed the JBI approach to conducting SR of effectiveness (22) and used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (21) to guide reporting of the study. The team registered the review in Open Science Framework as part of a broader scoping review (23). See **Additional file 1** for PRISMA checklist.

Search strategy and study selection

Search Strategy. The primary author (WJS) collaboratively devised a search strategy with a health science librarian for a larger scoping review that aimed to describe champions in health care. A second health science librarian assessed the search strategy using the Peer Review of the Electronic Search Strategy (PRESS) checklist (24). The refined search strategy consisted

of Boolean phrases and medical subject headings (MESH) terms for the following concepts: champions, implementation and related terms, and health care/health care context and related terms (see search strategy in **Additional file 2**). Eight electronic databases (Business Source Complete, CINAHL, EMBASE, Medline, Nursing and Allied Health, PsycINFO, ProQuest Thesis and Dissertations, and Scopus) were searched from inception to October 26, 2020, to identify relevant articles. Further, WJS identified and assessed additional retrieved from the reference lists and citations of included studies and synthesis studies that were captured by the search strategy.

Eligibility Criteria

Inclusion. We included all published studies and unpublished theses and dissertations that utilized a quantitative study design to evaluate the effectiveness of individuals explicitly referred to as champions at either increasing the use of innovations or in improving patient, provider, or system/facility outcomes within a health care setting. English language articles were included regardless of date of publication or type of quantitative study design.

Exclusion. Synthesis studies, qualitative studies, study protocols, conference abstracts, editorials and opinion papers, case studies, studies not published in English, articles without a full text available, and articles that are not about knowledge translation or evidence-based practice were excluded.

Study Selection

The title and abstract of all records were assessed by WJS and MDV using Covidence (25). Records were included if the title and abstract mentioned champions within health care settings. All potentially relevant articles and articles that had insufficient information were included for full text screening. The same SR team members independently assessed the

inclusion of full text articles in accordance with the eligibility criteria detailed above to determine the subset of articles that was related to champion's effectiveness. Discrepancies were resolved through consensus or if necessary, through consultation of a third senior SR team member. The same SR team members piloted the eligibility criteria on 100 titles and abstracts and 50 full text articles.

Data Extraction

WJS and MDV independently extracted articles using a standardized and piloted extraction form created by the SR team in DistillerSR (26). The following data were extracted: 1) study characteristics: first author, year of publication, study design, country, setting, details on the innovation being implemented, study limitations, funding, and conflict of interest; 2) study participant demographics: sample size, age, sex and gender identity, and professional role; 3) champion demographics: number of champions, age, sex and gender identity, and professional role; 4) operationalization of champions: quantitative measures relative to the presence or influence of champions, and the reliability and validity of these measures; and 5) study outcome: the study outcome evaluated for a relationship with champions in the primary study, method of measurement, reliability and validity of measure, statistical analysis/approach undertaken, and statistical results and significance at *p*-value of 0.05 or less. WJS and MDV resolved discrepancies during extraction through discussion or through consultation of a senior SR team member. WJS contacted authors for missing data integral to the analysis (e.g., to clarify statistical test results such as odd ratios when presented as a figure with no integers in the article).

Quality Appraisal

Study methodological quality was appraised by WJS and MDV independently using five JBI critical appraisal tools for: 1) case control studies (27), 2) cohort studies (27), 3) cross-sectional studies (27), 4) quasi-experimental (non-randomized experimental) studies (22), 5) randomized control trials (22). Non-controlled before and after studies and interrupted time series were assessed using the critical appraisal tool for quasi-experimental studies (22). Discrepancies were resolved through consensus. The JBI critical appraisal tools used in this study are composed of eight to 13 questions, depending on the tool. Each question response was attributed a score according to a scoring system from a recently published JBI systematic review (28) (Yes = 2; Unclear = 1; and No = 0). A quality score between 0 and 1 was calculated for each included study by dividing the total score with the total number of available scores. According to this quality score, the SR team classified each study as either weak (quality score < .5), moderate (quality score between .5 - .74), or strong (quality score between .75 – 1) (29). Studies were included in the data synthesis regardless of the quality score. The total percentage of "Yes" responses was also examined for each critical appraisal question to determine the areas of variability in quality between studies with the same study design.

Data Analysis

Due to methodological and heterogeneity of included studies, the research team performed a narrative synthesis of the included studies. WJS used both inductive and deductive content analysis (30) to aggregate study outcomes into categories as detailed below. Two senior SR team members (IDG and JES) evaluated and confirmed the accuracy of the performed categorization. WJS deductively categorized each extracted study outcome as either knowledge use or as patient, provider, and system/facility outcomes as described by Straus and colleagues (31). We specifically define knowledge use in this study as an improvement in knowledge

(enlightenment) or attitude towards an innovation (best practices, research use, or technology) or the use of an innovation. WJS categorized study outcomes as either patient, provider, and system/facility outcomes based on who or what benefits from the uptake of the innovation. Examples of patient outcomes included changes in patients' health status or quality of life. Provider outcomes included providers' satisfaction of the innovation. System/facility outcomes included system level indicators such as readmission rates, length of stays, and access to training (31). Differing from Straus and colleagues (31), we also stratified knowledge use into patient, provider, and system/facility knowledge use according to the level of analysis and intended target for change in the included study. Patient and provider knowledge use was defined as uptake of an innovation by patients and providers (31). System/facility knowledge use was defined as the adoption of an innovation throughout a whole system or facility; this included for example, adoption of programs which entailed changes in work culture, policies, and workflows (32-34). Knowledge use was further divided into two categories conceptual and instrumental knowledge use. Conceptual knowledge use was defined as improvement in individuals' knowledge and attitude towards an innovation (31). Instrumental knowledge use was defined as the use of innovation (i.e. pertaining to a change in practice) (31). Further, WJS used inductive content analysis to further categorize study outcomes within their respective category of knowledge use or outcome according to the innovation that was being implemented. For example, the implementation of transfer boards, hip protectors and technology were grouped together as these innovations pertain to the introduction of new equipment in clinical practice. Study outcomes that could not be classified as either knowledge use or outcomes of knowledge use were grouped into an "other outcomes" category (e.g., whether formal evaluations were more likely to be conducted).

To answer research question one, we inductively organized the measures used to identify exposure to champions into three categories: 1) studies that used a single dichotomous ("Yes or No") or Likert scale, 2) studies that appointed a champion for their study, and 3) studies that utilized more nuanced measures for champion exposure. To answer research questions two and three, we used a predetermined set of vote-counting rules used in published SRs (35-37) as outlined on **Table 1**. As previously suggested by Grimshaw and colleagues (7), we reported the study design, sample sizes, significant positive, significant negative and nonsignificant relationships, and the magnitude of effect (if reported by the study) for all the studies. This was done to help mitigate the limitations of vote-counting in considering the effect size and the sensitivity of each individual study in estimating these effect sizes (7). We also performed a sensitivity analysis to determine whether the number of categories for which a conclusion can be made, or the type of conclusions (effective, ineffective, or mixed effectiveness) for any category will change when weak studies are eliminated (36, 38).

Results

Search Results

As demonstrated in the flow chart (**Figure 1**), the database search identified 6,435 records and the additional citation analysis identified 3,946 records. Duplicates (n = 2,815) were removed using Covidence (25), leaving 7,566 to screen. After titles and abstracts were screened, 2,097 articles were identified that potentially met eligibility criteria. The full text of these 2,097 articles was reviewed, with 35 studies (37 articles) (32-34, 39-72) meeting all the inclusion criteria. (**Additional file 3** lists excluded full text articles and reasons for exclusion).

Characteristics of Included Studies

The included studies in our SR were primarily conducted in the last 10 years (2010 – 2020), with the highest proportion of studies conducted in North America (*n* = 28) or in acute care/tertiary settings (*n* = 20). The number of health care settings/institutions ranged from one to 1174 settings/institutions and sample sizes ranged from 80 to 6648 study participants. **Table 2** summarizes study characteristics and **Table 3** provides more detailed descriptions on each study.

Methodological Quality

Of the 35 included studies, 19 (54.3%) were rated as strong (39, 40, 44, 50-57, 59, 60, 65-72) , 11 (33.3%) were rated as moderate (32-34, 41, 42, 46, 48, 49, 62-64), and 5 (13.9%) were rated as weak (43, 45, 47, 58, 61) (See **Additional File 4).** Lower methodological quality was generally attributed to the lack of description of study participants and setting, lack of reliable and valid measures used to assess exposure to champions and study outcomes, and the lack of processes used for random allocation and concealment of participant allocation to groups.

Description and Operationalization of Champions

Overall, there is a scarcity of demographics reported on the champions. No included study reported the age of the champions, and only one study reported the sex of the champion (72). Nine studies identified the profession of the champions as either nursing or medicine (41, 43, 46, 47, 58, 62, 64, 66, 67).

Most studies (n = 26 out of 35, 74.3%) operationalized champions as the perceived presence or absence of champions by survey respondents measured by dichotomous (“Yes/No responses) or Likert single items. **Table 5 and 6** details operationalization of champions for each included study.

Four (11.4%) out of the 35 studies described the appointment of champions in their study setting (46, 64, 65, 72). There was a range of one champion (72) to six champions (46) per health

care setting in these studies. Two of these studies described the activities performed by the champions: 1) training nurses in Kangaroo – Mother Care and providing educational videos to mothers of neonatal intensive care patients (65) and 2) creating and implementing a protocol related to appropriate urinary catheter use and auditing urinary catheter use (72). The other two studies detailed the training provided to champions but not their activities (46, 64).

The remaining five (14.3%) out of 35 studies (51, 53, 60, 69-71) operationalized champions using tools that assessed the presence of a champion who possessed or performed particular attributes, roles, or activities. Overall, these measures demonstrates that champions can perform differing roles and activities from enthusiastically promoting or role modelling behaviour towards a particular innovation, to broader leadership roles (e.g., managing or acquiring resources). However, none of the included studies reported performing an evaluation on whether the champions' activities were perceived to be helpful by knowledge users. Further, none of the included studies assessed whether adequate exposure to champions for an effect was achieved.

Categorization of Study Outcomes

Across all 35 studies, we extracted and categorized 66 instances for which the relationships between champions and knowledge use or patient, provider, or facility/system outcome were evaluated. Some studies evaluated the relationships between champions and more than one dependent variable. **Table 4 and 5** respectively presents the relationships between champions and knowledge use and the resulting impact of knowledge use pertaining to patients, providers, and systems/facilities.

Champions' Effectiveness in Increasing Knowledge Use

Twenty-nine studies evaluated the effectiveness of champions in increasing knowledge use. Five studies evaluated the effectiveness of champions in increasing conceptual knowledge use (53, 56, 57, 60, 67, 69, 70), 25 studies evaluated the effectiveness of champions in increasing instrumental knowledge use (32-34, 39-42, 44, 46, 47, 49-51, 54, 55, 58, 59, 62-68, 72). One study evaluated both conceptual and instrumental knowledge use (67). None of the studies evaluated the effectiveness of champions at increasing patients' conceptual knowledge use. Based on our vote-counting rules, we were able to draw conclusions between the use of champions and the following three categories: 1) providers' knowledge and attitudes towards an innovation (conceptual knowledge use); 2) providers' use of an innovation (instrumental knowledge use); and 3) systems/facilities use of best practices, programs, and technology (instrumental knowledge use). A description of each conclusion relative to these three categories of knowledge use is detailed below. We present the study outcomes organized into their respective knowledge use categories, the statistical analysis and approach, test statistics and measure of magnitude supporting our conclusions in **Table 5**.

Champions' Effectiveness in Increasing Provider Conceptual Knowledge Use

Four studies evaluated the effectiveness of champions in improving providers' attitudes and awareness of new technology or equipment (conceptual knowledge use) (53, 56, 57, 60, 69, 70). One of the 4 studies used a quasi-experimental design (69, 70), while the other three studies were cross-sectional observational studies (53, 60, 69, 70). Two (50%) of the 4 studies reported that champions were effective at increasing provider conceptual knowledge use (53, 56, 57), and 2 of the 4 studies (50%) reported mixed findings regarding the effectiveness of champions at increasing provider conceptual knowledge use (60, 69, 70). Therefore, our findings suggests that

the use of champions was inconsistently related to providers' conceptual knowledge use of new technology or equipment.

Champions' Effectiveness in Increasing Provider Instrumental Knowledge Use

Seventeen studies evaluated the effectiveness of champions in increasing health care providers use of innovations (instrumental knowledge use) (39-41, 44, 46, 47, 49, 50, 54, 55, 58, 59, 62, 64, 66, 68, 72). One of the 17 studies was a clustered randomized controlled trial (44), while 2 of the 17 studies used a quasi-experimental design (46, 72), and the remaining 14 studies were observational studies (39-41, 47, 49, 50, 54, 55, 58, 59, 62, 64, 66, 68). Eight of the 17 studies (47.1%) reported that champions were effective at increasing provider's use of innovations (41, 44, 49, 54, 59, 64, 68, 72). Six of the 17 studies (35.3%) reported that mixed findings exist regarding the effectiveness of champions at increasing provider's use of innovations (39, 40, 46, 50, 55, 58). Two of the 17 (11.8%) studies reported that no relationship exists between champions and providers' use of innovations (47, 62) and one of the 17 (5.9%) studies reported that champions decreased provider's use of an innovation (66). Therefore, our findings suggests that the use of champions was inconsistently related to providers' use of best practice or technological innovations.

Champions' Effectiveness in Increasing System/Facility Instrumental Use

Seven studies evaluated the effectiveness of champions in increasing systems/facilities' adoption of technology, best practices, and programs (instrumental knowledge use) (32-34, 42, 51, 63, 67). One of the seven studies used a quasi-experimental design (32), while the remaining studies used observational study designs (33, 34, 42, 51, 63, 67). Five of the 7 (71.4%) studies reported that champions were effective at increasing the adoption of technology (32, 51), best practices (67), and programs (34, 63) by systems/facilities (32, 34, 51, 63, 67). One of the 7

(14.3%) studies reported that mixed findings exist regarding the effectiveness of champions in increasing the adoption of a depression program (33) and 1 of the 7 (14.3%) studies reported that champions had no effect on increasing system/facility uptake of electronic mail (42). Therefore, our findings suggest that the use of champions was related to increased use of technological innovations, best practices, and programs by systems/facilities.

Champions' Influence on Outcomes

Ten studies evaluated the effectiveness of champions at improving outcomes. Six of the 10 studies evaluated the effectiveness of champions at improving patient health status or experience (patient outcomes) (34, 43, 45, 49, 52, 68). One of the 10 studies evaluated the effectiveness of champions at improving provider's satisfaction with the innovation (69, 70), and three studies evaluated the effectiveness of champions at improving system/facility-wide outcomes such as quality indicators (48), the establishment of organizational training programs (61), or sustainability of programs (71). Based on our vote-counting rules, we were able to draw conclusions between the use of champions and patient outcomes.

Champions' Influence on Patient Outcomes

Six studies evaluated the effectiveness of champions in improving patient outcomes (34, 43, 45, 49, 52, 68). All six studies used observational study designs. Three of the 6 studies (50%) reported that champions were effective at decreasing adverse patient outcomes (43, 45) or improving patients quality of life (52), while the other three studies (50%) reported that champions did not have a significant effect on improving patients' standardized depression scale scores (34), patient's laboratory tests and other markers related to diabetes (68) or their satisfaction with health services (49). Therefore, the use of champions was inconsistently related to improvements in patient outcomes.

Champions' Effectiveness on Knowledge Use and Outcomes

Three of the 35 studies evaluated the effectiveness of champions in increasing both knowledge use and outcomes (34, 49, 68). In these three studies, the use of champions improved health care providers' use of best practices (49, 68) and the uptake of a depression program by facilities (34) but did not impact patient outcomes.

Sensitivity Analysis

We found that when weaker quality studies were removed, the number of categories that we can make conclusions on, or their respective conclusions did not change (Additional file 5).

Discussion

Study Findings

We aimed to summarize how champions are described and operationalized in studies that evaluate their effectiveness. Secondly, we wanted to assess whether champions are effective at increasing knowledge use or improving patient, provider, and system/facility outcomes.

Description and operationalization of champions. We found that most studies evaluating the effectiveness of champions operationalized exposure to champions using a single item scale that asked whether participants perceive there was a presence or absence of a champion. Furthermore, we found that there is minimal demographic information provided regarding the champions in the included studies. These findings coincide with Miech and colleagues' findings (17), as they commented on the need for more nuanced operationalization of champions. However, unlike Miech and colleagues (17), we captured studies that described the activities and roles of the champion or champions within their studies or utilized scales that measured the existence of champions who possessed specific attributes or roles.

Champions' effectiveness. We found that the use of champions is related to increased use of innovations at an organizational level. Our findings indicate that champions do not consistently improve provider's attitudes, knowledge, and use of innovations, nor consistently improve patient outcomes. However, we only found one study suggesting that the use of champions results in decreased knowledge use and none of the studies reported that the use of champions resulted in worse outcomes. Our systematic review findings dispute the findings by Miech and colleagues (17) that champions are a necessary but insufficient strategy for implementation success. Our findings do not suggest that champions are not important in implementation. Rather, our SR demonstrates that apart from facility/system instrumental knowledge use, there is not enough evidence at this time to conclude that the use of champions is related to improvements in knowledge use or outcomes. The distinction between our results and Miech and colleagues' findings (17) was made evident by our use of a framework to synthesize and clarify what champions influenced (knowledge use or outcomes) and who they influenced (patient, provider, or system/facility) during implementation. The myriad of mixed findings pertaining to the effectiveness of champions could be related to the lack of: 1) description of the champions; 2) evaluation of champion's activities and level of exposure to champions; and 3) assessments of confounding contextual factors affecting champions' performance. According to Shaw and colleagues (73), champions can undertake many roles and activities and that the assumption that champions operate in the similar manner may make comparisons difficult if these distinctions are not clarified. For example, Luz and colleagues reported that champions who volunteered to become champions had more tenure, performed more grassroots projects, were more enthusiastic and confident, and promoted more novel projects than champions formally appointed by management (14).

Implications of Study Findings

One implication of our study findings is that it provides a more comprehensive summary of studies that evaluate the effectiveness of champions in health care settings/institutions than any other existing studies. Furthermore, we identified areas for which the effectiveness of champions was not well examined: 1) patients' knowledge use (attitude and use), 2) organizational conceptual knowledge use (e.g., organizational readiness) 3) provider outcomes (e.g., satisfaction with an innovation); 4) system/facility outcomes (e.g., quality indicators). Furthermore, our SR findings suggests that individuals who are thinking of mobilizing champions should begin by reflecting on their intended implementation goal (knowledge use or outcomes by patients, providers, or by systems/facilities). If the goal is to increase organizational use of innovations, then there is evidence to support that the use of champions may be beneficial. However, if the goal is to improve knowledge use by providers and patients, or outcomes, individuals should use champions cautiously until more conclusive evidence exist to support the effectiveness of champions pertaining to these goals. Although there is a lack of evidence suggesting that the use of champions can be harmful, there are opportunity costs that come with deploying champions (e.g., clinician time and sometimes monetary cost) that may be better utilized using a different implementation strategy. Moreover, our study findings demonstrates that more nuanced measures exist in assessing the use of champions. However, future research should be focused on developing and utilizing valid, reliable, and pragmatic tools that evaluate champions' activities and exposure to champions. Lastly, future research should also focus on analyzing the optimal dose of champions required to achieve an implementation goal. For example, future studies should expand on qualitative findings of Damschroder and colleagues (73), who found through qualitative interviews that a single champion may be adequate at

implementing technological innovations, but a group of champions composed of individuals from different professions may be required for changing providers' behaviours.

Strengths and Limitations

Strengths

Our SR was conducted using rigorous, systematic, and transparent methods. For instance, we applied a PRESS-ed search strategy (24) to eight online databases, and two SR team members independently completed title and abstract, study selection, data extraction, and methodological quality appraisal for all the records or studies. Also, we only included studies that identified the presence of an individual who was explicitly stated to be a champion. By doing so, we removed the need to decipher whether other terms (e.g., superuser) should be considered synonymous or different concepts (13, 20).

Limitations

Limitations in the primary studies. One limitation of the included primary studies was that they were mostly conducted in North American or European countries; hence these findings may not be pertinent to other continents. Another limitation was the limited use of reliable and valid measures used to measure exposure to champions and study outcomes. Furthermore, only one study used a clustered randomized control trial design, and six studies used a quasi-experimental study design; the rest of included studies used an observational study design.

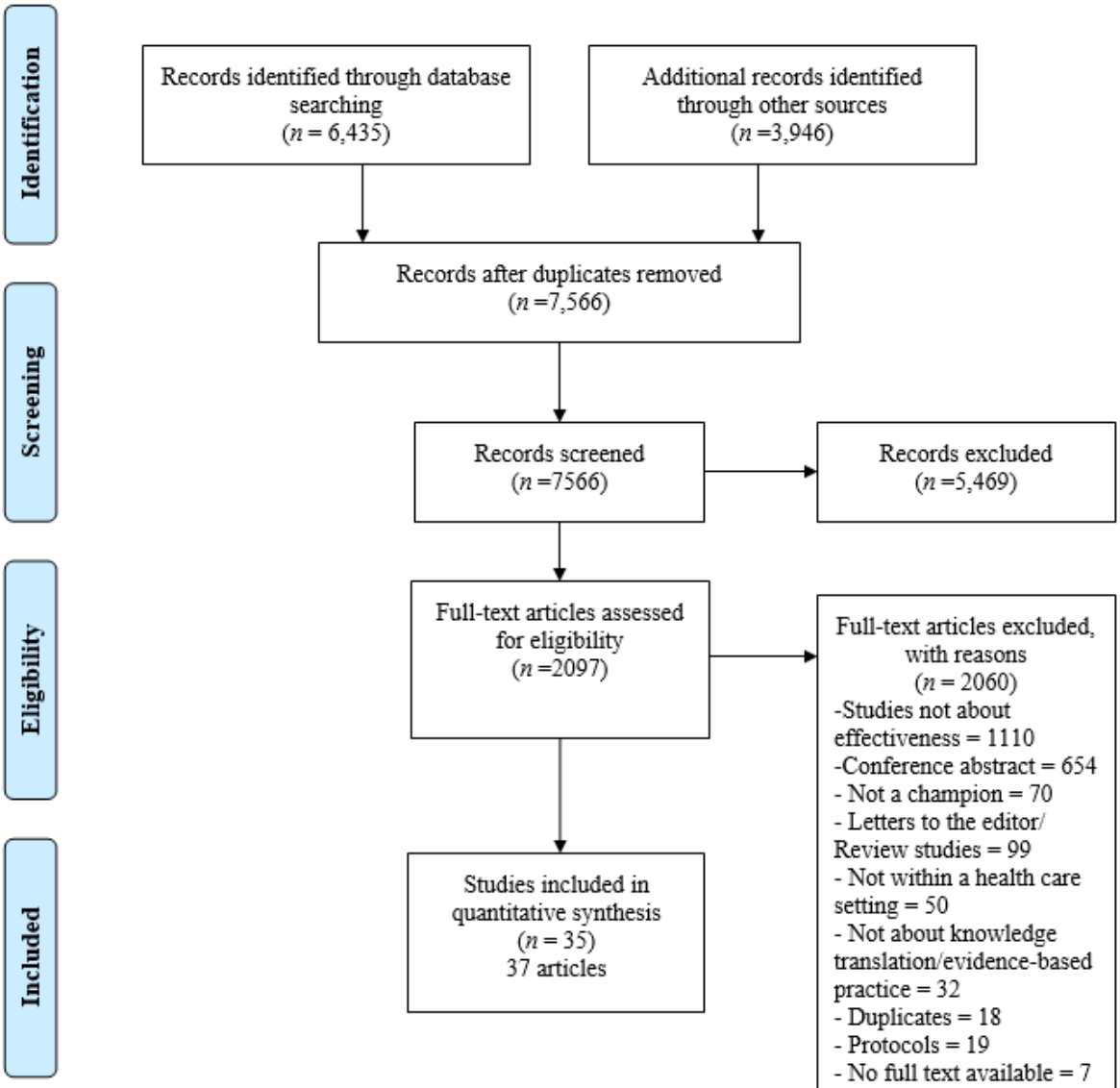
Limitations of our review. Due to the methodological and heterogeneity of included studies, we could not conduct a meta-analysis to calculate the magnitude of champions' effectiveness. In addition, grey literature apart from theses and dissertations were not considered in this study. Moreover, our eligibility criteria excluded studies that are pertinent to health care but are not set within health care settings or institutions, and articles that were not written in

English. Our SR was also unable to analyze how many champions is required to make an intended change due to the lack of reporting in the included studies.

Conclusions

Our SR aimed to evaluate the effectiveness of champions in improving knowledge use and patient, provider, and system/facility outcomes. Our findings could only conclusively determine that the use of champions is related to increased use of innovations by systems or facilities. Apart from this finding, the effectiveness of champions in improving knowledge use or outcomes is either inconclusive or unexamined. However, there is little evidence suggesting that champions are harmful to implementation. Despite this, individuals thinking of deploying champions should be cautious as there is still not enough evidence to suggest whether they are effective in increasing knowledge use or outcomes. The lack of description of champions' attributes, roles, activities, and the lack of evaluation of champions' activities makes it difficult to decipher why the effectiveness of champions in improving knowledge use or outcomes is primarily mixed. In addition, the minimal use of experimental research designs and use of reliable and valid measures to assess exposure to champions makes it impossible to draw causal conclusions. To advance our understanding of champions' effectiveness, future studies should utilize more robust experimental study designs, describe the champions' characteristics (number of champions, demographics, attributes, and roles), and use reliable and valid instruments to evaluate exposure to champions, the champions' activities and the resulting knowledge use or outcomes.

Figure 1: PRISMA Flow Diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Table 1: Vote counting rules

1) To conclude whether champions are effective at increasing the knowledge use or outcomes (patient, provider, or system/facility) four or more studies must have evaluated a relationship or correlation between champions and knowledge use or the outcome of knowledge use.

2) Champions' effectiveness at increasing knowledge use or outcomes of knowledge use were coded as follows:
    a. Champions are effective if 60% or more of the studies demonstrated a positive significant relationship between exposure to champions and either knowledge use or outcome of knowledge use.
    b. Champions are ineffective if 60% or more of the studies demonstrated a non-significant or significant negative relationship between exposure to champions and either knowledge use or outcome of knowledge use.
    c. Champions' effectiveness is mixed if less than 60% of the studies reported a non-significant/significant relationship between exposure champions and either knowledge use or outcome of knowledge use.

3) We applied the same rules as above to determine whether individual studies demonstrated a significant, non-significant, or mixed relationship between exposure to champions and either knowledge use or outcome of knowledge use. The analysis was based on percentage of statistical results reported in a study. We performed these evaluations to counteract double counting articles with multiple study outcomes.

4) When both bivariate and multivariate statistics are reported in a study, we used the more robust multivariate findings in our synthesis.

5) We assessed categories examined in three or less studies to determine trends in champion effectiveness using the same rules detailed above.

Table 2: Summary of Included Studies (n = 35)

Characteristic		N (%) of studies or Frequency (%)[1]
Publication Year	2010 – 2020 2000 - 2010 1997	24 (68.6%) 10 (28.6%) 1 (2.9%)
Country	United States of America Canada England India Israel Italy Taiwan Uganda United States of America and Puerto Rico 18 European countries	22 (62.9%) 5 (14.3%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%)
Setting*	Acute care/tertiary Primary Community/Home Long-term Care	20 (57.1%) 11 (31.4%) 4 (11.4%) 2 (5.7%)
Number of Settings/Institutions	One setting/institution 2 - 10 settings/institutions 11 – 50 settings/institutions 51 – 100 settings/institutions 101 – 500 settings/institutions > 500 settings/institutions Not reported	3 (8.6%) 2 (5.7%) 11 (31.4%) 3 (8.6%) 10 (28.6%) 2 (5.7%) 4 (11.4%)
Study Design	Cross-sectional Interrupted time series Non-controlled before and after Cohort Mixed methods (qualitative interview and cross-sectional) Case control Cluster randomised trial Mixed methods (qualitative interview and cohort)	23 (65.7%) 3 (8.6%) 3 (8.6%) 2 (5.7%) 1 (2.9%) 1 (2.9%) 1 (2.9%) 1 (2.9%)
Study Participants*	Health care providers Patients Managers or administrators Not reported	17 (48.6%) 8 (22.9%) 5 (14.3%) 7 (20%)
Sample Size	1- 100 101 - 500 501 - 1000 > 1000 Not reported	2 (5.6%) 13 (36.1%) 7 (19.4%) 6 (16.7%) 8 (22.2%)

Characteristic		N (%) of studies or Frequency (%)[1]
Sex and Gender of Study Participants	Reported Sex (n= # studies)	3 (8.3%)
	Female	5052/8305 (60.8%)[1]
	Male	3253/8305 (39.2%)[1]
	Sex category interpreted as sex by extractor	3/3 (100%)
	Reported Gender identity (n=# studies)	10 (27.8%)
	Female	5228/7026 (74.4%)[1]
	Male	1771/7026 (25.2%)[1]
	Non-binary	1/7026 (0.0%)[1]
	Missing/Not reported	26/7026 (0.4%)[1]
	Gender identity interpreted as sex by extractor	9/10 (90%)
	Gender identity interpreted as gender by extractor	1/10 (10%)
	Study did not specify if reported category was sex or gender identity (n= #studies)	2 (5.26%)
	Male	3992/7047 (56.6%)
	Female	3055/7047 (43.3%)
	Interpreted as sex	2/2 (100%)
	No report of Sex or Gender (n= #studies)	20 (57.1%)

Note: *Studies are present in more than one setting category; therefore, numbers do not add to n = 35 (100%)

Table 3: Description of Included Articles

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Albert, 2012	USA	Clinics (frequency not reported)	Cross-sectional study	Physicians who reported consistent use of standard order programs (SOPs) = 502 Age: Mean (SD) = 50.4 (10.1) years Sex and Gender: Not reported Physicians who consistently use SOPs for influenza Vaccine Only = 175 Age: Mean (SD) = 50.2 (9.4) years Sex and Gender: Not reported Physicians who consistently use SOPs for Influenza and pneumococcal polysaccharide vaccine = 203 Age: Mean (SD) = 51.8 (9.9) years Sex and Gender: Not reported	Innovation: SOPs are facility policies allowing non-physician health care providers to assess patient's immunization status and administer vaccines without a physician order. Study outcome measurement Measure: Single item asking how often non- physician staff utilize a SOP for administering influenza, pneumococcal polysaccharide vaccine, or both types of vaccines at their clinic. Options range from: a) inexistence or lack of interest in implementing SOPs; b) inexistence but interest in implementing SOPs; c) existence but inconsistent use of SOPs; or d) consistent use of SOPs. Reliability: Not reported; Validity: Not reported
Alidina, 2018	USA	Hospital (frequency not reported)	Cross-sectional study	Operating room staff = 368 Age: Not reported Sex & Gender: Not reported Professions: Anesthesiology = 311 (84.5%); Surgery = 13 (3.5%); OR staff = 24 (6.5%); Other = 20 (5.4%)	Innovation: Operating room cognitive aids are tools (e.g., checklist or emergency operating procedures) that provide information to facilitate and standardize decision making, action and information sharing between health care providers during crises. Outcome measurement Measure: Single survey item asking operating staff about the regular use of operating room cognitive aids at their facility on a 5-point Likert scale from "strongly disagree to strongly agree". Reliability: Not reported Validity: The survey was piloted survey with 21 operating room staff to assess readability and comprehensibility of questions.

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Anand, 2017	18 European countries	203 Neonatal intensive care units	Prospective cohort study	NICU patients = 6648 Age: Mean (SD) = 35.0 (4.6) weeks Not specified Sex or Gender: Male = 3753 (56.5%); Female = 2895 (44.5%) Interpreted as: Sex.	Innovation: The use of measurement scales that measure continuous pain proceeding invasive procedures may enhance the quality pain management in neonatal patients (e.g., prevents untreated pain, under or overdosing of analgesics, or the development of drug tolerance) Outcome measurement Measure: Chart audit to measure the use of pain assessments tools/scales designed to measure continuous pain (e.g., Echelle Douleur Inconfort Nouveau-ne (EDIN) scale, COMFORT scale) for one month in participating NICUs. Reliability: A random 10% of the data was double checked by a local data quality manager. If 1% or more errors is present, then another random 10% would be double checked. If 1% or more errors continued, then all data entries for that NICU would be double checked. Validity: Not reported
Ash, 1997	USA	65 academic health sciences centers	Cross-sectional study	Informatics professionals and library workers = 534* Age: Not reported Sex and Gender: Not reported Professions: Informatics professionals = 195 (31% of 629); library workers = 339 (48% of 706) *	Innovation: Electronic mail is a communication method whereby an individual sends a message to another individual through via a computer or other technological devices. Outcome measurement Measures: Two single items scales measuring electronic mail infusion (74) and diffusion (75) on a 4-point scale (low to high). Infusion is the extent of which an innovation is implemented, while diffusion is the breadth of implementation within an organization. Measures: Two single items scales measuring electronic mail infusion (74) and diffusion (75) on a 4-point scale (low to high). Infusion is the extent of which an innovation is implemented, while diffusion is the breadth of implementation within an organization.

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Ben-David, 2019	Israel	24 medical surgical intensive care units	Cross-sectional study	Sample information not reported	Reliability: Not reported; Validity: Not reported Innovation: Central-line associated bloodstream infection (CLABSI) prevention practice bundles consists of measures that decreases risk of infection during insertion (e.g., hand hygiene and use of maximal sterile barriers) and measures that minimize infection risk during ongoing catheter use (e.g., aseptic technique for tubing and dressing changes and the prompt removal of central line catheters when no longer necessary). Outcome measurement Measure: Monthly incidence rates of CLABSI collected as part of routine national surveillance in Israel hospitals. Reliability: Not reported; Validity: Not reported
Bentz, 2007	USA	19 (10 intervention, 9 control) clinics	Cluster randomised trial	1) Control clinic patients = Not reported Age: Mean (SD) = 50.7 (5.6) years Reported Gender: Male = 33.5% Female = 76.5% Interpreted as: Sex 2) Physicians in control clinics = 55 Age: Not reported Reported Gender: Male = 49.2%; Female = 50.8% Interpreted as: Sex 3) Intervention clinic patients = Not reported Age: Mean (SD) = 54.2 (6.7) years Reported Gender: Male = 34%, Female = 76% Interpreted as: Sex 4)Physicians in intervention clinics = 57 Age: Not reported Reported Gender: Male = 51.6 %; Female = 48.4 %	Innovation: The delivery of electronic health record generated feedback rather than peer feedback to health care providers to increase the delivery of tobacco cessation assistance and referrals to the Oregon Tobacco Quitline. Outcome measurement Measure: Monthly rates of clients referred, reached, or counseled regarding tobacco cessation using the Oregon Tobacco Quitline according to electronic health records. Reliability: Not reported; Validity: Not reported

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
				Interpreted as: Sex	
Bradley, 2012	USA	533 hospitals	Cross-sectional study	Hospitals' chief executive officers = 533 Age: Not reported Sex & Gender: Not reported Profession: Not reported	Innovation: There was no specific innovation in this study. The purpose of this study was to identify and determine the relationships between hospital strategies and hospital risk standardized mortality rates (RSMR). Outcome measurement Measure: Thirty-day RSMR: "predicted number of deaths within 30 of admission at a hospital divided by the expected number of deaths within 30 days of admission at the same hospital multiplied by the overall 30-day mortality rate of the cohort" (45) (p.3). Reliability: Not reported; Validity: Not reported
Campbell, 2008	USA	One hospital	Non-controlled before and after study	Intensive care unit (ICU) patients = 120 Age: Range = 32 - 93 years old Reported Gender: Male = 53%; Female = 47% Interpreted as: Sex.	Innovation: The Keystone ICU Sepsis project aims at improving the quality of care, decreasing length of stay, eliminating unnecessary cost, and creating a culture centered on safety in participating Michigan hospital's ICUs. The Keystone ICU Sepsis project seeks to increase the identification of patients with or at risk of sepsis and the implementation of appropriate of sepsis protocols. Outcome measurement Measures: Chart documentation of 1) ICU nurses' compliance with sepsis-screening protocols and 2) the proportion of patients with severe sepsis that physicians initiated the sepsis protocol on. Reliability: Not reported; Validity: Not reported
Chang, 2012	USA	225 Primary Care Practices	Cross-sectional study	Primary care directors: sample details not reported	Innovation: Depression care improvement models are evidence-based models that guides screening and management of common mental health disorders in a primary care setting.

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					These models include the collocation of mental health specialists, the Translating Initiatives in Depression (TIDES) model, and the Behavioural Health Laboratory (BHL) model. Outcome measurement Measure: Primary care directors' responses to a single item in the 2007 VA Clinical Practice Organization Survey (CPOS) Primary Care (76). This single item asks the degree of implementation of three depression care improvement models (collocation, TIDES, and BHL). The authors dichotomized the responses into fully or partially implemented versus planned but not yet implemented or not implemented. Some clinics may have implemented multiple depression improvement models. The authors used a hierarchal coding system to assign each clinic to only a single model; prioritizing BHL, then TIDES, then collocation. Reliability: Not reported; Validity: Not reported
Ellerbeck, 2006	USA	44 Hospitals	Cross-sectional study	Sample details not reported	Innovation: Consistent use of aspirin and beta blockers during the hospitalization or at the time of discharge in patients with acute myocardial infarction. Outcome measurement Measures: Audit of hospital records and supplemental Medicare billing records of a random sample of Medicare patients admitted between April 1, 1998, and May 31, 2001, with a principal diagnosis of acute myocardial infarction. Outcome data was the use of aspirin and beta-blockers at admission and at discharge. Reliability: Not reported; Validity: Not reported

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Foster, 2017	USA and Puerto Rico	1174 hospitals	Non-controlled before and after study	Sample details not reported	Innovation: Innovations were not clearly outlined in this paper. The purpose of the paper is to assess the relationships between engagement or knowledge translation strategies and the change in a composite measure of quality of care according to 10 harm topics (e.g., readmissions). Examples of these engagement or knowledge translation strategies includes improvement events targeted to staff, and improvement fellows (a subset of which comprises of champions). Outcome measurement Measure: A weighted composite score of quality of care calculated by adding a ratio of occurrence of the stated10 harm topics for one month. A low score means higher quality. These measures are based on self-reports submitted by hospitals. Reliability: Not reported; Validity: Not reported
Goff, 2019	USA	80 Pediatric primary care practices	Cross-sectional study	Practice leaders = 80 Age in years (n (%)): 26–35= 8 (10%); 36–45 = 17 (21.3%); 46–55= 17 (21.3%); 56–65 = 31 (38.8%); > 65 = 3 (3.75%); No response = 4 (5%) Reported Gender: Female = 66 (82.5%); Male = 10 (12.5%); Nonbinary = 1 (1.25%); No response = 3 (3.75%) Interpreted as: Gender Professions: Practice manager = 58 (72.5%); Nurse manager = 6 (7.5%); Physician owner = 1 (1.25%); Physician leader = 4 (5%); Other = 9 (11.3%); No response = 2 (2.5%)	Innovation: This study did not have an innovation, rather the study assessed the relationships between the organizational characteristics of primary care practices in the Massachusetts Health Quality Partners and their reported clinical quality and patient experience scores. Outcome measurement Measures: The authors translated clinical quality and patient experience scores from Massachusetts Health Quality Partners (MHQP) website to a scale from zero to three points. Average patient experience scores and clinical quality scores were calculated for practices reporting four or more patient experience or clinical quality scores. Reliability: Not reported; Validity: Not reported

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Granade, 2020	USA	Primary care clinics and pharmacies (frequencies not reported)	Cross-sectional study	1) Clinicians = 4911 Age in years (n (%)): < 40 = 1,497 (30.5%); 40–49 = 1,503 (26.8%); 50–59 = 1,156 (23.4%); ≥ 60 = 736 (19.3%) Reported Sex: Male = 1,858 (48.5%); Female = 3,053 (51.5%) Interpreted as: Sex Professions: Physician = 2,349 (71.5%); Nurse practitioner = 1,293 (15.7%); Physician assistant = 1,269 (12.8%) 2) Pharmacists = 793 Age in years (n (%)) :< 40 = 310 (45.3%); 40–49 = 194 (19.4%); 50–59 = 161 (17.5%); ≥ 60 = 125 (17.7%) Reported Sex: Male = 1,858 (48.5%); Female = 3,053 (51.5%) Interpreted as: Sex	Innovation: The Standards for Adult Immunization Practice emphasizes that health care providers should routinely perform assessments, strongly recommend, administer, or provide referrals, and document in electronic health care systems the administration of all necessary vaccines in adult patients. Outcome measurement Measure: A survey developed by Centers for Disease Control and Prevention (CDC) and Abt Associates Inc. to assess primary care clinicians and pharmacists' self reported adherence to the Standards for Adult Immunization Practice and factors (e.g., presence of champions) related to implementation of these standards. A composite score of vaccination process standard adherence was calculated by the authors. Reliability: Not reported Validity: Survey question phrasing were revised for better readability and comprehension.
Hsia, 2019	Taiwan	119 Hospitals	Cross-sectional study	Top managers = 119 Age: Not reported Sex and Gender: Not reported Professions: Not reported	Innovation: E-Health innovations are forms of information technology that are design to aid with the delivery of health care related activities. Examples of E-Health innovations are electronic health record computerized provider order entry, and picture archiving and communication systems. Outcome measurement Measure: A seven item subscale within a 28-item questionnaire that is intended to measure the extent that hospital medical services and work processes are performed using E-Health technologies. The questionnaire was created by the authors. Scoring of items were on a five-point Likert scale ranging from strongly disagree to strongly agree. Reliability: Composite reliability = 0.95; $\alpha = 0.934$

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					Validity: Factor loadings range = 0.728 -1.053, which is above the 0.707 threshold.
Hung, 2008	USA	57 Primary care practice-based research networks	Cross-sectional study	Patients = 4735 Age in years (n (%)): 18 – 39 = 1348 (28.9%); 40 – 54 = 1476 (31.6%); 55 – 64 = 925 (19.8%); ≥ 65 = 921 (19.7%). Reported Gender: Male = 1319 (27.9%); Female = 3377 (71.3%). Interpreted as: Sex	Innovation: The Chronic Care Model (CCM) is a system level framework consisting of six main areas with a focus on prevention and health behavior counseling in primary care practices. These six main areas include 1) establishing a health system and organization of care centered on chronic care, 2) supporting patient participation in their own care, 3) a proactive delivery system that identifies and addresses health needs, 4) availability of evidence-based decision supports for health care providers, 5) implementing an electronic health care information system, and 6) established networks with community resources to support continuity of care. This study was interested on understanding how the CCM related to quality-of-life measures. Outcome measurement Measures: Three survey items based on the Center for Disease Control and Prevention (CDC)'s Healthy Days core measures (77-79): 1) number of unhealthy days in the past 30 days, 2) number limiting days in the past 30 days, 3) general health status. Number of unhealthy days and limiting days was measured on a three-point ordinal scale (0 days, 1 – 13 days, and 14 – 30 days). General health status is rated on a five-point scale from poor to excellent. Reliability: Not reported; Validity: Not reported
Kabukye, 2020	Uganda	One tertiary oncology center	Cross-sectional study	Survey Participants = 146 Age in years (n (%)): ≤ 30 = 47 (32.2%);31–40 = 58 (39.7%);41–50 = 20 (13.7%); ≥ 50 = 13 (8.9%); Missing = 8 (5.5%) Reported Gender: Female = 86 (58.9%); Male = 53 (36.3%); Missing = 7 (4.8%)	Innovation: Electronic health record is the use of information technology to assist with health care related processes. Outcome measurement Measure: A four item subscale measuring organizational readiness in implementing electronic health records in low-

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
				Interpreted as: Sex Profession(s): Oncologist = 9 (6.2%); Doctor = 27 (18.5%); Nurse = 24 (16.4%); Allied health worker (lab, imaging, pharmacy, medical records officers) = 61 (41.8%); Biostatistics/Data manager/IT = 13 (8.9%); Administrator = 12 (8.2%)	and middle-income countries using a 5-point Likert scale ranging from strongly agree to strongly disagree adapted from a study by Paré et al. (60). Reliability: Dillon- Goldstein's rho = 0.79; α = 0.64 Validity: Convergent validity: Average variance extracted (AVE) = 0.48
Kenny, 2005	USA	Three army medical treatment facilities	Cross-sectional study	Registered nurses = 290 Age: Not reported Reported Gender: Male = 60 (20.7%); Female = 229 (79.0%); Missing: 1 (0.3%) Interpreted as: Sex	Innovation: This study did not have an explicit innovation. The purpose of this study was to examine individual and organization factors related to research use by nurses. Research use was defined as the use of research findings to guide nursing practice. Outcome measurement Measures: 1) Adapted Research Utilization survey by Estabrooks (80) to measure direct, persuasive, and overall research use. All types of research use were single survey items scored using a 7 - point Likert scale from "never" to "nearly every shift". Measures: 1) Adapted Research Utilization survey by Estabrooks (80) to measure direct, persuasive, and overall research use. All types of research use were single survey items scored using a 7 - point Likert scale from "never" to "nearly every shift". Reliability: α (range) = 0.77 – 0.91; Validity: Not reported
Khera, 2018	USA	108 transplant centers	Cross-sectional study	Physicians = 316 Age: Not reported Sex and Gender: Not reported Professions: Physicians = 230 (77.4); Program Medical Director = 67 (22.6)	Innovation: The findings of a phase three, multicenter randomized control trial titled Blood and Marrow Transplant Clinical Trials Network (BMT CTN) 0201 (81) found that the use of bone marrow stem cells for unrelated donor hematopoietic cell transplantation is related to similar survival rates and less chronic graft versus host disease in patients with hematologic malignancies than the use of peripheral blood stem cells. Innovation: The findings of a phase three, multicenter randomized control trial titled Blood and Marrow

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					Transplant Clinical Trials Network (BMT CTN) 0201 (81) found that the use of bone marrow stem cells for unrelated donor hematopoietic cell transplantation is related to similar survival rates and less chronic graft versus host disease in patients with hematologic malignancies than the use of peripheral blood stem cells. Outcome measurement: Measure: A 26 – item survey developed by the authors according to the literature and key informant interviews with three researchers from BMT CTN 0201 study (81). Outcome variables include physician reported personal and facility-level change in preference regarding unrelated donor graft use from peripheral blood source to bone marrow. These survey items were scored on a 5 -point Likert scale from very important to very unimportant. Reliability: Not reported; Validity: Not reported
Korall, 2017, 2018 One study – two reports	Canada	13 Long term care homes	Cross-sectional study	Paid care providers = 529 Age in years (n (%)): 20 – 29 = 42 (7.9%); 30 – 39 = 87 (16.4%); 40 – 49 = 149 (28.2%); 50 – 59 = 187 (35.3%); 60 – 69 = 46 (8.7%); Missing/unknown = 18 (3.4%) Reported Gender: Female = 474 (89.6%); Male = 40 (7.6%); Missing/unknown = 15 (2.8%) Interpreted as: Sex Professions: Health care assistant/resident care aide = 290 (54.8%); Licensed practical nurse = 84 (15.9%); Registered nurse = 40 (7.6%) Resident care coordinator = 13 (2.4%); Manager = 14 (2.6%); Recreational/occupational/physiotherapist	Innovation: Hip protectors are protective undergarments with either a hard shield or soft pads sewn into its sides to cover the skin over the lateral aspects of the proximal femur. The purpose of hip protectors is to minimize the injury to the hip resulting from a fall. Outcome measurement Measures: A 15- item questionnaire titled as C-Hip Index, developed, and tested for psychometric properties by authors (56) to measure affective and cognitive, behavioural, and overall hip protector commitment. Reliability: α (range) = 0.87 – 0.97 Validity: 1) Construct validity: affective and cognitive subscale, and behavioural subscale loaded to a commitment to hip protectors

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
				= 24 (4.5%); Unit/program clerk = 18 (3.4%); Missing/unknown = 49 (9.3%)	with an eigen value of 1.386. $R^2 = 0.693$. Both subscales had a factor matrix coefficient of 0.833. 2) Content validity index (CVI): Twelve items in C-Hip index had a CVI = 0.79 for both clarity and relevance. Range CVI = 0.55 – 0.82. 3) Convergent validity: Increase in self reported championing is associated significant increase in for the affective/cognitive, behavioural subscales, and entire C-Hip index ($p < 0.01$). 4) Concurrent validity: Significant lower median responses for individual subscales or entire C-Hip index and awareness of a resident breaking a hip while wearing a hip protector (p <0.01). Significant higher median responses for individual subscales or entire C-Hip index and presence of a champion at their LTC home.
Lago, 2013	Italy	103 Neonatal intensive care units	Cross-sectional study	Sample details not reported	Innovation: The implementation of effective neonatal pain prevention programs according to best practice guidelines. These programs should include training and strategies to routinize the assessment of pain and the appropriate use of pharmacological and nonpharmacological therapies to prevent and treat pain. Outcome measurement Measure: A 58- item questionnaire created by the authors assessing NICU characteristics, availability pain control guidelines and NICU's routine use of non-pharmacological and pharmacological pain-relieving interventions during invasive procedures. Frequency of pain-relieving interventions was measured on 4-point Likert scale from never (0–15%) to always (>90%). Reliability: Not reported; Validity: Not reported
Papadakis, 2014	Canada	40 family health team clinics	Cross-sectional study	1) Health care providers = 288 Age: Mean (SD) = 39.5 (17.3) years Sex and Gender: Not reported	Innovation: Evidence-based smoking cessation treatments is composed of five strategies (denoted as 5 As): ask patients about their smoking status, advise patients to quit smoking,

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
				Profession(s): Practising physician = 80.7%; Medical resident = 5%; Nurse practitioner = 12.7% 2) Patient = 2501 Age: Mean (SD) = 47.7 (14.7) years Reported Sex: Male = 952 (38.1%); Female = 1549 (61.9%) Interpreted as: Sex	assess patient's readiness to quit, assist with a quitting attempt using behavioural counselling or smoking cessation medications, and to arrange follow up pertaining to smoking cessation. Outcome measurement Measures: 1) A health care provider survey created by the authors to assess family health teams characteristics and providers' attitudes and believes towards evidence-based smoking cessation treatments. 2) A patient evaluation survey created by the authors asking on a binary scale (yes or no) if the patient's physician or other health care providers asked, advised, or assessed readiness to quit, and if the provider assisted, or arranged follow up regarding smoking cessation. Reliability: Not reported; Validity: Not reported
Paré, 2011	Canada	1) Study 1: 11 home care organizations 2) Study 2: one hospital	Cross-sectional study	1) Study 1: Registered nurses = 134 Age in years (%): ≤ 29: 14%; 30-39 = 23%; 40-49 = 35%; 50-59 = 26%; ≥ 60 years = 2% Reported Gender: Male = 2%; Female = 98% Interpreted as: Sex 2) Study 2: Clinicians = 237 Age (%): ≤ 29 years = 10%; 30 to 39 years = 21%; 40 to 49 years = 28% 50 to 59 years = 34%; ≥ 60 years: 7% Reported Gender: Male: 32%; Female: 68% Interpreted as: Sex Professions: Registered nurse = 57%; Social worker = 9%; Occupational	Innovation: The innovations in the two studies pertain to the implementation of clinical information system. In study one, the innovation was a mobile computing project. The mobile computing project contains home care nursing policies and procedures and allows home care nurses to create individualized care plans for their clients and to document the care they provided. The innovation in study two was the electronic medical record. The purpose of this study was to determine the factors related to the readiness of the staff in implementing these technological innovations. Outcome measurement Measures: The authors created a survey according to Holt and colleagues' conceptual model of organizational readiness (82). The questionnaire has 39 items. Organizational readiness was measured on 4- item subscale, scored on a 5-point Likert scale

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
				therapist = 4%; Clinician (others) = 19%; Physicians = 12%	ranging from strongly agree to strongly disagree adopted two studies (83, 84). Reliability: 1) Organizational readiness - α: Study 1 = 0.89; Study 2 = 0.88. Validity: 1) Construct validity: exploratory factor analyses showed that all scale items loaded highly (> 0.68) on a single factor. 2) Convergent validity: Average variance extracted (study 1 = 0.88; study 2 =0.86) was higher than inter-construct correlations 3) Discriminant validity: Cross-loadings (study1 range = 0.85 – 0.91; study 2 range = 0.78 – 0.89) loaded more highly on their own factor than on other factors.
Patton, 2013	England	153 emergency departments	Cross-sectional study	Lead clinicians = 153 Age: Not reported Sex and Gender: Not reported Professions: Not reported	Innovation: The assessment of alcohol consumption and provision of advice to decrease alcohol use by health care providers in the emergency department is an effective and cost-effective way of decreasing alcohol consumption and alcohol related harm. Outcome measurement Measure: A follow up survey based on questions from a national emergency survey distributed in England in 2006 (85).The dependent variables were two survey items asking about emergency staff's access to training for screening and brief advice regarding alcohol consumption. Reliability: Not reported; Validity: Not reported
Sharkey, 2013	USA	14 nursing Homes	Non-controlled before and after study	Sample details were not reported	Innovation: The On-Time pressure ulcer quality improvement based on the integration of health information technology tools has three primary objectives: 1) utilize the knowledge and train certified nursing assistants to document and communicate their assessments to licensed staff through an electronic health system; 2) support collaborative and

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					multidisciplinary clinical decision making through clinical decision support systems that summarize resident data from daily staff documentations; and 3) to establish a proactive practice focused on prevention and early treatment of pressure ulcers. Outcome measurement Measures: On-Time facilitators' reports tracked implementation milestones achieved every 9 months and documented facility team characteristics, team skills and capacity. Milestones were tracked according to three levels: levels 1 to 3. The level equates to the number of process improvements implemented facility wide. Reliability: Not reported; Validity: Not reported
Shea, 2016	USA	37 ambulatory clinics	Cross-sectional study	Health care providers = 596 Age: Not reported Sex and Gender: Not reported Professions: Not reported	Innovation: The innovation in this study was the meaningful use of electronic health records, or the ability to maximize the capacity of the electronic health record to improve quality, safety, and efficiency of health care services. Meaningful use of the electronic health records is implemented in three stages. However, the authors were interested in the Stage 1 meaningful use because Medicare services must attest to this level of meaningful use 90 days post implementation of the electronic health records to receive monetary incentives. Stage 1 meaningful objective criteria includes 14 required core objectives (e.g., having an updated medication lists for patients) and 5 menu objectives selected from a set of 10 options (e.g., providing patient- specific educational materials). Outcome measurement Measure: Survey created and administered by authors to clinics' senior leaders. Meaningful use of electronic health records was quantified as the percentage of eligible providers

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					in each clinic demonstrating all Stage 1 meaningful use objective criteria. Reliability: Not reported; Validity: Not reported
Sisodia, 2020	USA	205 medical, surgical, and mental and behavioral health clinics	Retrospective cohort study	Sample details not reported	Innovation: Patient-reported outcomes (PROs) are questionnaires that is distributed to patients to assess their general health, quality of life, or health/symptoms pertaining to a specific disease. Outcome measurement Measure: PRO collection rates were extracted from project logs within an enterprise data warehouse. These logs contained the number and type of patient related questionnaires administered to collect patient related outcomes by participating clinics in the most recent 6 months. Reliability: Not reported; Validity: Not reported
Slaunwhite, 2009	Canada	46 units within one acute care facility 23 units with champions 23 units with no champions	Case-control study	Sample details not reported	Innovation: The introduction of unit champions can facilitate the uptake of the influenza vaccine amount hospital staff. Study outcome measurement Measure: Annual influenza vaccination rates in matched hospital units (matched according to previous years influenza vaccination rates, physical size, and primary function). Secondly, the authors assessed the change in annual influenza vaccination rates from the previous year for each hospital unit. Reliability: Not reported; Validity: Not reported
Soni, 2016	India	One Neonatal intensive	Interrupted time series	NICU patients = 648 Percentage of sample when KMC champions were absent in the NICU: 43.1%	Innovation: Kangaroo Mother Care (KMC) has two main components: skin-to-skin care and breastfeeding. KMC is a safe and low-cost measure to reduce neonatal mortality.

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
		care unit (NICU)		Age: Not reported Not specified Sex and Gender: Female % = 37.3%; Male % = 62.7% Interpreted as: Sex	Study outcome measurement Measures: Chart audits to determine overall use and initiation rate (neonates/30 days) of skin-to-skin care and breastfeeding documented on standardized forms. Average duration (hours/day) was only measured for skin-to-skin care because of the difficulty in differentiating between breastfeeding attempts and successful breastfeeding. Reliability: Not reported; Validity: Not reported
Strasser, 2003	USA	203 cystic fibrosis (CF) care centers	Cross-sectional study	Clinic directors and coordinators of CF care centers = 289 Age: Not reported Reported Gender: Male: 114 (39.6%) Female: 174 (60.4%); Missing: 1 (0.3%) Interpreted as: Sex Profession(s): Director = 150 (52.1%); Nurse coordinator = 112 (38.9%); Nurse practitioner = 20 (6.9%); Nurse health educator = 6 (2.1%)	Innovation: The Agency for Healthcare Research and Quality (AHRQ) 5A Smoking Cessation Clinical Practice Guideline refers to five steps: ask, advise, assess readiness to quit, assist patients with quitting, and to arrange follow up regarding smoking cessation. Outcome measurement Measure: A survey developed by authors to examine factors reported by directors and coordinators of CF centers that may affect smoking cessation guideline implementation. The AHRQ 5 A (ask, advise, assess, assist, and arrange follow up) model smoking cessation guideline was the guideline assessed by the survey. The outcome variable was measured with a dichotomous (yes/no) question asking whether the AHRQ 5 A has been implemented to address CF patient's parentals smoking behaviours. Reliability: Test-retest survey reliability (*n* = first 30 respondents): Kendall's tau = 1.00, $p < .01$ Spearman's r = 1.00, $p < .01$ Validity: The survey was approved for content validity by an expert panel (a pulmonologist and two doctoral trained researchers in medical education and health behaviour)

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Tierney, 2003	USA	Public health clinics and pediatrician practices (frequency not reported)	Mixed study (generic qualitative and cross-sectional)	1) Public Health Clinics providers = 440 2) Pediatricians = 434 Age: Not reported Sex and Gender: Not reported Profession(s): Not reported	Innovation: Reminder and recall immunization systems are routine communication processes (via telephone or mail) with children's parents at preselected ages to remind them of an upcoming or past-due immunization or wellness check up. Routine immunization assessments refer to the measurement of immunization coverage rates at least every two years. Outcome measurement Measure: A 21-item survey created by the authors to assess five domains: messages to parents, barriers to implementation of reminder or recall messaging systems, other immunization practices (assessments, feedback), practice attitudes about immunization and characteristics and demographics. Reliability: Not reported; Validity: Not reported
Ward, 2004	USA	109 Veterans Affairs medical centers	Cross-sectional study	Quality managers = 109 Age: Not reported Sex and Gender: Not reported Profession(s): Not reported Patients = not reported Age: Mean (range) = 66 (59 -73) years. Gender: Males: 96% Females: 4%; Range of males in all centres = 90 - 99% Interpreted as: Sex	Innovation: The implementation and health care provider's adherence to diabetes guidelines pertains to glycemic, lipid, and blood pressure screening and control. Outcome measurement Measures: 1) A 31- item questionnaire distributed to quality managers assessing organizational context related to diabetes guideline implementation. Provider process measures included in the survey includes performing the following: HbA_{1c} screen (annually), foot screening (annually), lipid screening (biannually), renal screening (biannually), eye screen (annually). 2) Patient outcome measures include glycemic control (HbA_{1c} < 9.5%), non-smoker status, Lipid control (LDL ≤ 130 md/dL) and hypertension control < 140/90 mm Hg). These data were extracted from the 1999 Veterans Health Survey and the 2001 Veterans Satisfaction Survey.

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					Reliability: Not reported; Validity: Not reported
One study, two reports: Weiler, 2012, 2013	USA	3 private ambulance companies and 3 public fire departments	Interrupted time series	Emergency Medical Service workers = 190 (Weiler, 2012); 221 (Weiler, 2013) Age: Range: 18 – 65 years old Sex and Gender: Not reported Professions: Not reported	Innovation: Patient transfer-board or slide board is a foldable board that aids with lateral transfers by bridging the gap between the bed and hospital stretcher and facilitate sliding of the patient from the stretcher to the bed and vice versa. Outcome measurement Measures: This study used three survey instruments that the authors formulated according to existing validated instruments: 1) "Intention to use the transfer board" scale (3 item scale) was based on Dishaw and Strong (86).1) "Intention to use the transfer board" scale (3 item scale) was based on Dishaw and Strong (86). 2) Ergonomic advantage of transfer boards (5 item scale) was based on Moore and Benbasat (87).2) Ergonomic advantage of transfer boards (5 item scale) was based on Moore and Benbasat (87). Reliability: Not reported Validity: Ergonomic advantage- Factor loadings ranged from 0.62 – 0.81. Validity not reported for intention to use scale.
Westrick, 2009	USA	104 Community pharmacies	Cross-sectional study	Pharmacy staff = 104 Age: Not reported Reported Sex: Male = 65 (64.0%); Female = 35 (36.0%) Interpreted as: Sex Professions: Staff pharmacist = 13 (14.1 %); Manager = 67 (72.8 %) Owner/partner = 12 (13 %)	Innovation: Pharmacy based in-house immunization services is the administration of vaccines by pharmacists at their designated health care setting. Outcome measurement Measure: A questionnaire created by the authors that assesses pharmacy staff's perspectives regarding the following criteria relevant to the sustainability of an in-house pharmacy immunization services (5 subscales): champion effectiveness (strategic and operational), formal evaluation, degree of

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
					modification, compatibility, and sustainability of immunization services. The sustainability scale was based on Goodman and colleagues (88). The subscales composed of either 4 to 6 items or scored on a 5-point Likert scale except for formal evaluation, which is a single dichotomous item. The sustainability scale was based on Goodman and colleagues (88). The subscales composed of either 4 to 6 items or scored on a 5-point Likert scale except for formal evaluation, which is a single dichotomous item. Reliability: α (range for all five subscales except formal evaluation) = 0.71 – 0.85. Formal evaluation was not assessed for reliability. Validity: Not reported
Whitebird, 2014	USA	42 clinics from 14 medical groups	Mixed study (Generic qualitative and prospective cohort)	Patients in the Depression Improvement Across Minnesota: Offering a New Direction (DIAMOND) program at 6 months follow up = 5258 Age: Not reported Sex and Gender: Not reported	Innovation: The DIAMOND program aims to provide collaborative depression care and consultive support to primary care clinics throughout Minnesota and Western Wisconsin. The DIAMOND program is composed of six aspects: 1) the use of the Patient Health Questionnaire-9 (PHQ-9) (89) to assess and monitor patient's condition and progress; 2) systematic tracking of patients 3) use of evidence based guidelines to guide treatment 4) dissemination of relapse prevention education to health care staff; 5) the presence of a care manager whose role is to educate, coordinate and support care services; and 6) the presence of a consulting psychiatrist collaborating with the care manager to review cases and provide treatment change recommendations. Outcome measurement Measure: Standardized monthly data reports regarding the number of eligible patients enrolled into the DIAMOND program (patients with a PHQ-9 $\geq$ 10) and remission rates (patients with a PHQ-9 <5) every six months. Reliability: Not reported; Validity: Not reported

First author, year	Country	Setting	Design	Study participants (Age, sex & gender, and professions if applicable)	Innovation, Knowledge Translation Outcome Measurement (Measure Reliability & Validity)
Zavalkoff, 2015	Canada	1 pediatric intensive care unit (PICU)	Interrupted time series	Sample: Pediatric patients = 3100 Age: Not reported Sex and Gender: Not reported	Innovation: The introduction of a champion lead and the creation of an interdisciplinary policy dictating health care teams to systematically assess and discuss daily the appropriateness of continued use and the possibility of removal of urinary catheters in their patients. Outcome measurement Measures: Secondary data analysis of urinary catheter device utilization ratio in children admitted to the PICU between April 1, 2009, to June 29, 2013, according to hospital acquired surveillance database. Urinary catheter device utilization ratio was calculated by taking the number of days that a patient was exposed to a urinary catheter divided by the number of days that the patient was admitted in the PICU. Reliability: Not reported; Validity: Not reported

Notes: * This is a calculated sample size based on the reported response rate (31% and 48% response rate for informatics professionals (n = 629) and library workers (n = 706)). However, this calculated sample size only equates to 40% response rate, while the authors state having a 41% response rate

Table 4: Summary of Champions' Effectiveness in Increasing Knowledge Use and Improving Outcomes

First author, year	Knowledge Use		Outcome (impact)
	Conceptual (knowledge)	Instrumental (adherence)	
Albert, 2012		(?) H (Consistent use of standard orders)	
Alidina, 2018		(?) H (Regular use of operating cognitive aids)	
Anand, 2017		(+) H (Continuous pain assessments)	
Ash, 1997		(?) S (Implementation of electronic mail)	
Ben-David, 2019			(+) Patient (Decrease incidence of central-line associated blood stream infection)
Bentz, 2007		(+) H (Referrals of patients to the Oregon Tobacco Quitline)	
Bradley, 2012			(+) Patient (Decrease 30-day risk standardized mortality rate post myocardial infarction)
Campbell, 2008		(?) H (Adoption of sepsis protocol)	
Chang, 2012		(ø) S (Depression care programs in primary care)	
Ellerbeck, 2006		(ø) H (Medications prescribed during and after myocardial infarction)	

First author, year	Knowledge Use		Outcome (impact)
	Conceptual (knowledge)	Instrumental (adherence)	
Foster, 2017			(+) System (Decreased harm topics to quality of care (e.g., readmission)
Goff, 2019		(+) H (Adherence to best practices for medication/intervention prescribing)	(ø) Patient (Patient experience)
Granade, 2020		(?) H (Adherence to adult vaccination standards)	
Hsia, 2019		(+) S (Hospital medical services and processes performed using E-health technology)	
Hung, 2008			(+) P (Quality of life measures)
Kabukye, 2020	(+) H (Attitudes towards implementing electronic health record)		
Kenny, 2005		(+) H (Instrumental research use)	
Khera, 2018		(?) H (Preferred unrelated graft source for hematologic malignancies)	
One study, two reports: Korall, 2017, 2018	(+) H (Commitment to hip protectors)		
Lago, 2013		(?) H (Non-pharmacological and pharmacological interventions during invasive procedures)	
Papadakis, 2014		(+) H	

First author, year	Knowledge Use		Outcome (impact)
	Conceptual (knowledge)	Instrumental (adherence)	
		(Delivery of evidence-based smoking cessation treatments)	
Paré, 2011	(?) H (Attitudes towards implementing electronic health record)		
Patton, 2013			(+) S (Provider's access to training for screening and giving brief advice regarding alcohol use)
Sharkey, 2013		(+) S (Facility wide health information clinical decision support system for preventing pressure ulcers)	
Shea, 2016		(ø) H (Meaningful use of electronic health records)	
Sisodia, 2020		(+) S (Success of patient reported outcome collection program)	
Slaunwhite, 2009		(+) H (Uptake of influenza vaccine)	
Soni, 2016		(+) P (Kangaroo-Mother Care: Breastfeeding and Skin - skin)	
Strasser, 2003		(-) H (Application of smoking cessation guideline)	
Tierney, 2003	(+) S (Intent by pediatrician practices to adopt reminder recall and immunization coverage rates)	(+) S (Pediatrician practices' and public health clinics' use of reminder recall and immunization coverage rate assessments)	

First author, year	Knowledge Use		Outcome (impact)
	Conceptual (knowledge)	Instrumental (adherence)	
Ward, 2004		(+) H (Adherence to diabetes guidelines)	(ø) P (Improvement in patient parameters outlines by diabetes guideline)
One study, two reports: Weiler, 2012, 2013	(?) H (Intention to use transfer boards)		(+) H (Ergonomic advantage of transfer boards)
Westrick, 2009			(ø) S (Adaption and sustainability of in-house pharmacy immunization services)
Whitebird, 2014		(+) S (Uptake of depression program)	(ø) P (Improvement in depression remission rates)
Zavalkoff, 2015		(+) H (Urinary catheter use)	

Notes: P = patient, H = provider, S = system/facility; (+) = champions significantly increased knowledge use/outcome of knowledge use; (-) = champions significantly decreased knowledge use/outcome of knowledge use; (?) = mixed findings related to champions effect on knowledge use/outcome of knowledge use; ø = no significant effect in increasing or decreasing knowledge use/outcome of knowledge use.

Table 5: Champions Effectiveness in Increasing Patient, Provider, and System/Facility's Knowledge Use

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Conceptual Knowledge Use (knowledge/enlightenment)							
Provider (*n* = 4) **Conclusion**: There are mixed findings with respect to use of champions and improvement in providers' conceptual knowledge use.							
Implementation of new technology or equipment (*n* = 4)	One study two reports: Korall, 2017, 2018	Cross-sectional study	Existence of a champion of hip protectors (Single item scored on a 5-point Likert scale)	Overall commitment to hip protectors	Bayesian Model Averaging logistic model	Logistic regression coefficient (95% CI) = 0.24 (0.17 -0.31)	**< .05**
	Kabukye, 2020	Cross-sectional study	Presence of an effective champion (3-item survey scale by Paré et al.(60).	Organizational readiness in a low resource setting	Structural equation model using a partial least square method	Path coefficient = 0.15	**.0299**
	Paré, 2011	Cross-sectional study	Presence of an effective champion (3-item survey scale)	Organizational readiness in a large teaching hospital	Structural equation model using a partial least squares method	Path coefficient = 0.23	**< .05**
				Organizational readiness in implementing a mobile computing system for home care		Path coefficient = 0.05	> .05
	One study, two reports: Weiler, 2012, 2013	Interrupted time series	Endorsed by champions (three items rated at a 6-point Likert scale based on Mullins et al. (90).	Intention to use transfer boards 2 months post-introduction of transfer boards	Stepwise logistic regression	*C(p)* = -.041 *F* = 16.25	**<.0001**
					Structural equation model using a maximum likelihood method	Path coefficients (95 CI) = 0.27 (-.0156 - .5556)	> 0.05[1]
System/Facility (*n* =1) **Conclusion**: There is a study suggesting that the use of champions is related to system/facility's conceptual knowledge use.							

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Implementation of best practices related to vaccination processes (*n* = 1)	Tierney, 2003	Mixed study (generic qualitative and cross-sectional)	Presence of a champion lead ("Yes/No" survey item)	Pediatrician practices' likelihood or intent to adopt reminder and recall system in their practice in a year	Multivariable linear regression	Test statistic not reported	**< .03**
				Pediatrician practices' likelihood or intent to adopt immunization coverage rates assessments in their practice in a year		Test statistic not reported	**.002**
Instrumental Knowledge Use (adherence in using the innovation (evidence-based practice or technology))							
Patient (*n* = 1) **Conclusion**: There is a study suggesting that the use of champions is related to improving patients' instrumental knowledge use.							
Implementation of Kangaroo-Mother Care (*n* = 1)	Soni,2016	Interrupted time series	Absence of champions (Two champion were present from January 5, 2010 – July 31, 2011; transition period from August 1, 2011 – July 31, 2012; champion was absent from August 1, 2012 – October 7, 2014)	Initiation rate of skin to skin by mothers of NICU patients	Competing-risks regression model and observation-weighted linear polynomial test	Subhazard rate ratios (SHR)[3] (95 CI) = 0.62 (0.47 -0.82)	**< .001**[2]
				Overall use of skin to skin by mothers of NICU patients	Multivariate logistic regression and observation-weighted linear polynomial test	OR (95 CI) = 0.49 (0.34 – 0.70)	**.004**[2]
				Average duration of skin to skin provided by mothers of NICU patients	Multivariate linear regression and observation-weighted linear polynomial test	β (95 CI) = -1.47 (-2.07 to -0.86)	**< .001**[2]

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
				Initiation rate of breastfeeding by mothers of NICU patients	Competing-risks regression model and observation-weighted linear polynomial test	SHR (95 CI) = 0.88 (0.68 – 1.14)	.30[2]
				Overall use of "breastfeeding" by mothers of NICU patients	Multivariate logistic regression and observation-weighted linear polynomial test	OR (95 CI) = 0.89 (0.55 -1.44)	0.61[2]
Provider (*n* = 17) **Conclusion**: There are mixed findings with respect to use of champions and improvement in providers' instrumental knowledge use.							
Implementation of best practices for smoking cessation (*n* =3)	Bentz, 2007	Cluster randomised trial	Presence of a champion ("Yes/No" item determined through structured interviews with clinic managers or lead nurses)	Monthly rates of documented clients connected by health care providers to the Oregon Tobacco Quitline	Generalized estimating equations	OR (95 CI) = 3.44 (2.35 -5.03)	< **.05**
	Papadakis, 2014	Cross-sectional study	Presence of physician champion ("Yes/No" survey item)	Frequency of evidence-based smoking cessation treatments delivered by health care providers	Multivariable logistic regression	OR (95 CI) = 2.0 (1.1 - 3.6)	< **.01**
	Strasser, 2003	Cross-sectional study	Presence of a designated champion (Single item rated on a 6-point Likert scale)	Extent that health care providers apply smoking cessation guideline to help parents of cystic fibrosis patients quit smoking	Multivariable logistic regression	β (SE) = -.7570 (0.2110) OR (95 CI) = 0.469 (0.310 - 0.709)	**0.0003**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Implementation of best practices related to vaccination processes (*n* = 3)	Albert, 2012	Cross-sectional study	Presence of an immunization champion on site ("Yes/No" survey item)	Consistent use of standard orders for influenza vaccines only by non-physician staff	Multivariable logistic regression	OR (95% CI) = 1.12 (0.72 - 1.76)	> .05
				Consistent use of standard orders for both influenza vaccine and PPV by non-physician staff		OR (95% CI) = 1.67 (1.01 - 4.54)	**.046**
	Granade, 2020	Cross-sectional study	Presence of immunization champions ("Yes/No" survey item)	Primary care clinicians' adherence to adult vaccination standards	Multivariable logistic regression	APR (95% CI) = 1.40 (1.26 - 1.54)	< **.05**
				Pharmacist's adherence to adult vaccination standards		APR (95% CI) = 1.20 (0.96 - 1.49)	> .05
	Slaunwhite, 2009	Case-control study	23 champions randomly allocated to 23 hospital units versus 23 matched units with no champion	Difference in overall health care providers vaccination rates between champion and non champion units	*t* -test	*t* (22) = 2.86 (11% higher vaccination rate in champion units)	< **.03**
				Percentage change in health care provider vaccination rates from previous year in champion units		*t* (21) = 4.38 (increase from 44% to 54%)	< **.001**
Implementation of new technology/equipment (n = 2)	Alidina, 2018	Cross-sectional study	Presence of an implementation champion for cognitive aids (selected as an important facilitator from a list of facilitators)	Regular use of operating cognitive aids during applicable clinical events	Chi square	Test statistic not reported	0.8968

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
			Absence of an implementation champion for cognitive aids (selected as important barrier from a list of barriers)	Regular use of operating cognitive aids during applicable clinical events	Multivariable logistic regression	OR (95% CI) = 0.44 (0.23 - 0.84)	**.0126**
	Shea, 2016	Cross-sectional study	Presence of nurse champions ("Yes/No" survey item)	Percentage of providers in a clinic demonstrating Stage 1 meaningful use of electronic health records	Multivariable logistic regression	OR (95 CI) = 0.99 (0.60-1.65)	.983
Implementation of best practices related to pain management in neonatal intensive care units (*n* = 2)	Anand, 2017	Prospective cohort study	Presence of a nurse[4] champion ("Yes/No" survey item)	Number of continuous pain assessments performed and documented by nurses per day for one month in neonatal intensive care units	Generalized estimating equations	OR (95 CI) = 2.54 (1.27–5.11)	**0.009**
	Lago, 2013	Cross-sectional study	Presence of a local champion (Single item asking whether a physician champion, a nurse champion, both types of champions, or no champion was present)	Routine use (> 90% of the time) of non-pharmacological and pharmacological interventions during invasive procedures in neonatal intensive care units	Stepwise logistic regression	Six out of 11 interventions: 1) Heel prick: OR (95 CI) = 2.78 (1.2 -6.43) 2) Venipuncture: OR (95 CI) = 2.59 (1.13 - 5.96) 3) PICC insertion: OR (95 CI) = 3.33 (1.38 – 8.02) 4) Tracheal intubation: OR (95 CI) = 2.68 (1.17 – 6.16) 5) Mechanical ventilation: OR (95	**< 0.05**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
						CI) = 3.74 (1.5 – 9.32) 6) Chest tube insertion: OR (95 CI) = 3.26 (1.31 – 8.1).	
						Five out of 11 interventions: 1) Tracheal Aspiration: OR (95 CI) = 1.96 (0.82 - 4.66) 2) Nasal CPAP: OR (95 CI) = 1.98 (0.87 – 4.53) 3) Lumbar puncture: OR (95 CI) = 1.99 (0.86 -4.59) 4) ROP screening: OR (95 CI) = 2.35 (0.96 – 5.8) 5) Postoperative pain: OR (95 CI) =1.58 (0.56 – 4.43)	> 0.05
Implementation of best practices related to prevention, identification, and management	Campbell, 2008	Non-controlled before and after study	Appointment of six nurses (two for each shift) champions for four weeks	Intensive care unit nurses' compliance with sepsis-screening protocols	Chi square	$\chi^2 = 30.86$	**<.001**
				Physician's initiation of sepsis protocol for patients with severe sepsis		$\chi 2 = 0.563$	.453

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
of infections (*n* = 2)	Zavalkoff, 2015	Interrupted time series	Appointment of a single physician champion to lead projects decreasing catheter associated urinary tract infections	Urinary catheter-use ratio in a pediatric intensive care	Binomial regression (PROC GENMOD, binomial distribution, canonical link)	OR (95% CI) = 0.83 (0.77 - 0.90)	< **.05**
Generic implementation of best research evidence (*n* = 2)	Kenny, 2005	Cross-sectional study	Presence of a champion ("Yes/No" survey item)	Nurses' direct (instrumental) research use	Pearson's correlation coefficient	*r* = .250	**.001**
	Goff, 2019	Cross-sectional study	Presence of a designated quality champion ("Yes/No" survey item)	Average clinical quality scores (adherence of providers to best practices in prescribing treatments for diseases (e.g., asthma, diabetes)	ANOVA	Test statistics not reported (Mean difference = 0.2 favouring presence of a champion)	**.03**
Implementation of diabetes guideline (*n* = 1)	Ward, 2004	Cross-sectional study	Presence of champion (Single item rated on a 5-point Likert scale)	Provider process measures relative to guideline-based diabetes management	Multivariable predictor generalized estimating equation	β (SE) = 1.24 (0.51)	**.02**
Implementation of best practices related to medications prescribed during or after an acute	Ellerbeck, 2006	Cross-sectional study	Presence of a physician champion ("Yes/No" survey item)	Aspirin use at admission	Generalized estimating equations	OR (95% CI) = 1.31 (0.87-2.01)	> .05
				Aspirin use at discharge		OR (95% CI) = 1.17 (0.69-2.02)	> .05
				Beta-blockers use at admission		OR (95% CI) = 1.45 (0.91-2.31)	> .05

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
myocardial infarction (*n* = 1)				Beta-blockers use at discharge		OR (95% CI) = 4.14 (1.66-11.66)	< **.05**
Implementation of the findings of a phase III, multicenter randomized control trial (BMT CTN 0201) (81) study *(n* =1)Implementation of the findings of a phase III, multicenter randomized control trial (BMT CTN 0201) (81) study *(n* =1)	Khera, 2018	Cross-sectional study	Engagement of local champions (Single item scored on a 5- point Likert scale)	Physician reported personal change in preferred unrelated donor graft source for patients with hematologic malignancies from peripheral blood source to bone marrow	Multivariable logistic regression	OR (95 CI) = 1.91 (.87-4.19)	.11
				Physician reported transplant center change in preferred unrelated donor graft source for patients with hematologic malignancies from peripheral blood source to bone marrow		OR (95 CI) = 3.18 (1.29-7.85)	**.01**
System/Facility (*n* = 7) **Conclusion:** The use of champions was related to increase in system/facility instrumental knowledge use.							
Implementation of technology/equipment (n = 3)	Ash, 1997	Cross-sectional study	Presence of champions (Single survey item rated on a 5-point Likert scale)	Infusion of electronic mail	Multivariable linear regression	β = 0.09	.52
				Diffusion of electronic mail		β = 0.34	**.01**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
	Hsia, 2019	Cross-sectional study	Presence of leadership's e-health championing behaviour (6-item survey scale)	Extent of hospital medical services and work processes are performed by health care providers using E-health technologies	Structural equation model using a partial least square method	Path Coefficient = 0.280	**< .05**
	Sharkey, 2013	Non-controlled before and after study	Presence of an internal champion ("Yes/No" question in facilitator reports)	Facility wide implementation of at least two process improvements focused on using health information technology as a medium for clinical decision support to prevent pressure ulcers in nursing homes (labelled as "Level 2 outcome" by authors)	Nonparametric Spearman correlation	ρ = 0.65	**.013**
				Facility wide implementation of three or more two process improvements focused on using health information technology as a medium for clinical decision support to prevent pressure ulcers in nursing homes (labelled as "Level 3 outcome" by authors)		ρ = 0.75	**0.002**
Implementation of a depression care	Chang, 2012	Cross-sectional study	Presence of clinical champion ("Yes/No" survey item)	Collocation model implemented	Multivariable logistic regression models	OR (95 CI) =2.36 (1.14 -4.88)	**<.05**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
programs (*n* = 2)				TIDES model implemented	Bivariate regression analysis	OR (95 CI) = 0.59 (0.20 -1.78)	>.05
				BHL model implemented		OR (95 CI) = 0.65 (0.14 - 2.98)	>.05
				No depression care improvement model implemented		OR (95 CI) = 0.63 (0.31 - 1.29)	>.05
	Whitebird, 2014	Mixed study (Generic qualitative and prospective cohort)	Presence of a strong primary care provider champion ("Yes/No" extracted from quality improvement narrative reports)	Average monthly activation rate (patients entering the program per number of full-time health care provider)	Pearson's correlation coefficient	*r* (95 CI) = 0.60 (0.10 - 0.86)	**<.05**
Implementation of patient reported outcomes collection program (*n* = 1)	Sisodia, 2020	Retrospective cohort study	Presence of a clinician champion ("Yes/No" survey item)	Patient reported outcomes (PRO) collection rate per clinic in the most recent 6 months	Multivariable linear regression	Collection rate change (95 CI) = 11.2 (2.5 - 20.0)	**.01**
				PRO successful collection rate (50 % or greater) in a 6-month period	Multivariable logistic regression	OR (95 CI) = 3.36 (1.06 - 10.61)	**.04**
Implementation of best practices related to vaccination processes (*n* = 1)	Tierney, 2003	Mixed study (generic qualitative and cross-sectional)	Presence of a champion lead ("Yes/No" survey item)	Pediatrician practices' current use of reminder and recall systems	Multivariable logistic regression	OR (95% CI) = 1.85 (1.08 - 3.18)	< **.05**
				Public health clinic's current use reminder and recall systems		OR (95% CI) = 3.01 (1.34 - 6.73)	< **.05**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
				Pediatrician practices' current use of immunization coverage rates assessments	Multivariable logistic regression	OR (95% CI) = 1.38 (0.89 - 2.13)	**< .05**
				Public health clinic's current use of immunization coverage rates assessments		OR (95% CI) = Not reported	> .05

Notes:[1] - The authors reported a path coefficient that they stated is significant at a p-value of 0.1. Manual calculation of the 95% CI was done by JES to determine significance of both ergonomic advantage and intention to use at a p value of .05.[2] – These *p*-values were denoted as *p*(trend) by authors because an observation-weighted linear polynomial test was conducted to determine trends for differences in estimates across all the different models. [3]- Subhazard rate ratios were calculated separately using separate competing risk regression models to consider discharge against medical advice prior to initiation of breast feeding and skin to skin. 4- In bivariate testing, both physician and nurse champions were significantly correlated with continuous pain assessments; the physician champion variable was not included in the multivariate testing because it was highly correlated with the nurse champion variable.

Table 6: Champions Effectiveness on Patient, Provider, and System/Facility's Outcomes

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Patient Outcomes (*n* = 6) **Conclusion**: There are mixed findings with respect to use of champions and improvement in patients' outcomes related to knowledge use.							
Improvement in patient's health outcomes (*n* = 4)	Ben-David, 2019	Cross-sectional study	Presence of ward infection control champions (Survey item asking if a nurse or/and physician champion was present)	Monthly incidence rates of central-line associated bloodstream infection	Negative binomial regression	Incidence Rate Ratio (95% CI) = 0.47 (0.31 - 0.71)	**<.001**
	Bradley, 2012	Cross-sectional study	Presence of one or more physician/nurse/ both/no champions (Two "Yes/No" survey items asking the presence of physician/nurse champions)	30 days risk standardized mortality rate post acute myocardial infarction in hospitals	Multivariate linear regression	β (95% CI) = −0.695 (−1.253- −0.137) (No champion vs nurse champion only)[1]	**.015**
						β (95% CI) = −0.731 (−1.404 to −0.059) (Physician champions vs nurse champion only)	**.033**
						β (95% CI) = −0.880 (−1.442 - −0.318) (Both physician and nurse champions vs nurse champion only)	**.002**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
	Ward, 2004	Cross-sectional study	Presence of champion (Single item rated on a 5-point Likert scale)	Patient outcome measures relative to guideline-based diabetes management	Single predictor generalized estimating equations	β (SE) = -0.38 (0.39)	.3202
	Whitebird, 2014	Prospective cohort	Presence of a strong primary care provider champion ("Yes/No" extracted from quality improvement narrative reports)	Average monthly remission rates at 6 months (number of patients with a score of < 5 on the PHQ-9)	Pearson's correlation coefficient	*r* (95 CI) = 0.40 (-0.16 to 0.77)	> .05
Quality of life (*n* = 1)	Hung, 2008	Cross-sectional study	Presence of practice (health promotion) champions (Single item rated on a 5-point Likert scale)	Fewer numbers of unhealthy days in the past 30 days	Hierarchal generalized linear modeling	β (SE): 0.34 (0.07) OR (95 CI) = 1.41 (1.22 -1.64)	< **.001**
				Fewer numbers of limiting days in the past 30 days		β (SE): 0.53 (0.19) OR (95 CI) = 1.71 (1.16 - 2.53)	< **.01**
				General health status		β (SE): 0.38 (0.09) OR (95 CI) = 1.47 (1.20-1.79)	< **.001**
Patient Experience (*n* = 1)	Goff, 2019	Cross-sectional study	Presence of a designated quality champion ("Yes/No" survey item)	Average patient experience scores of clinics that are part of the Massachusetts Health Quality Partners (MHQP)	ANOVA	Test statistics not reported (Mean difference = 0.09 favouring presence of a champion)	.29

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Provider Outcomes (*n* = 1) **Conclusion**: There is a single study suggesting that the use champions is related to improvements in provider outcomes related to knowledge use.							
Satisfaction with practice (*n* =1)	One study, two reports: Weiler, 2012, 2013	Interrupted time series	Endorsed by champions (three items rated at a 6-point Likert scale based on Mullins et al. (90).	Reported ergonomic advantage 1-month post-introduction of transfer boards	Structural equation model using a maximum likelihood method	Path coefficients (95 CI) = 0.63 (.0664 -1.1936)	**< 0.05**[2]
System/Facility Outcomes (*n* = 3) **Conclusion:** There is a trend suggesting that the use of champions is related to improvement in system/facility outcomes related to knowledge use.							
Hospital quality of care indicators (*n* = 1)	Foster, 2017	Non-controlled before and after study	An average of 0.1 champion fellows in 1160 hospitals (number of champion fellows)	Weighted composite score of quality of care - occurrence of 10 harm topics (e.g., readmissions) for one month.	Multivariate linear regression	Adjusted effect over time: $\beta = -0.9$ (negative β = more effective in this study)	**.008**
Access to training for alcohol cessation screening and advice (*n* =1)	Patton, 2013	Cross-sectional study	Presence of champion ("Yes/No" survey item)	Emergency staff's access to training for screening for alcohol consumption	Chi square	$\chi^2 = 36.64$	**<0.001**
				Emergency staff's access to training for providing brief advice regarding alcohol consumption		$\chi^2 = 29.93$	**<0.001**
Compatibility and sustainability of in-house pharmacy immunization services (*n* = 1)	Westrick, 2009	Cross-sectional study	Strategic champion effectiveness (4-item scale on champion's commitment, advocacy, and ability to manage and acquire resources) adapted from Hays et al. (91)	Compatibility between immunization services and host pharmacy	Multivariable linear regression	$\beta = 0.12$	.300
				Sustainability of in-house pharmacy immunization services		$\beta = 0.00$	.978
			Operational champion effectiveness (4-item scale on champion's	Compatibility between immunization services and host pharmacy	Multivariable linear regression	$\beta = 0.31$	**.005**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
			knowledge, ability to manage an in-house immunization service, and to resolve conflicts) adapted from Hays et al. (91)	Sustainability of in-house pharmacy immunization services		β = 0.09	.419
Other Outcomes (n = 1)[3]							
Adaptation and evaluation of in-house pharmacy immunization services (n = 1)	Westrick, 2009	Cross-sectional study	Strategic champion effectiveness (4-item scale on champion's commitment, advocacy, and ability to manage and acquire resources) adapted from Hays et al. (91)	Degree of modifications made to in-house pharmacy immunization services	Multivariable linear regression	β = 0.05	.705
				Formal evaluation of in-house pharmacy immunization services		β = 0.26	**.038**
			Operational champion effectiveness (4-item scale on champion's knowledge, ability to manage an in-house immunization service, and to resolve conflicts) adapted from Hays et al. (91).	Degree of modifications made to in-house pharmacy immunization services	Multivariable linear regression	β = 0.05	.698
				Formal evaluation of in-house pharmacy immunization services		β = 0.09	.419

Notes: [1]- In this study, groups exposed to only nurse champions had the highest RSMR (RSMR = 16.2), hence it was the reference variable. [2]- The authors reported a path coefficient that they stated is significant at a p-value of 0.1. Manual calculation of the 95% CI was done by JES to determine significance of both ergonomic advantage and intention to use at a p value of .05. [3]- Other outcomes were not considered in analysis.

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Additional Files

Additional File 1: PRISMA Checklist

Section and Topic	Item #	Checklist item	Thesis page number
TITLE			
Title	1	Identify the report as a systematic review.	p.52
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.53
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.56-57
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.57
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.58-59
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.58
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.128
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.58 -59
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.59
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.56

Section and Topic	Item #	Checklist item	Thesis page number
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.59
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.59-60
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	p.99-113
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.60-62
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	p.60-62
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.60-62
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.60-62
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	p.61/p.66
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	p.58 –59
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	p.58 –59 and p.61
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.72
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	

Section and Topic	Item #	Checklist item	Thesis page number
Study characteristics	17	Cite each included study and present its characteristics.	p.73 -95
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.247
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	p. 96 - 113
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.62 – 63
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Summary: p.64- 67 Table 4/5/6 (p.96-113)
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	p.360
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.67-69
	23b	Discuss any limitations of the evidence included in the review.	p.69-70
	23c	Discuss any limitations of the review processes used.	p.69-70
	23d	Discuss implications of the results for practice, policy, and future research.	p.69 and p.71
OTHER INFORMATION			

Section and Topic	Item #	Checklist item	Thesis page number
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.57
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.57
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	p.53
Competing interests	26	Declare any competing interests of review authors.	p.53
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	p.53

Additional File 2: Search Strategy

OVID Medline 10.26.2020 (1946 to October 01, 2020)

PCC (Population, Concept, Context)	Search terms	Results
Population: Champions	1. (champion*).mp.	7192
	2. Peer Influence/	612
	3. Leadership/	41564
	4. peer group/	20832
	5. 3 and 4	341
	6. 1 OR 2 or 5	8141
Concept: Knowledge translation/evidence base practice	7. (ebp or ebm or ebn or cpg* or best practice* or (evidence adj2 practice*)).mp.	97979
	8. (guideline* adj2 (implement* or adher*)).mp.	38927
	9. (quality adj1 (improv* or manag*)).mp.	98951
	10. (research adj2 (‘use’ or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp.	9249429
	11. (knowledge adj2 (‘use’ or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp.	17452

12. (evidence adj2 (‘use’ or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp.	50289
13. ((innovation adj2 (adopt* or diffus*)) or (implementation adj2 (science* or research)) or (innovation or diffusion)).mp	298347
14. exp Evidence-Based Practice/ or Information Dissemination/	104811
15. guideline adherence/ or quality assurance, health care/ or quality improvement/ or Outcome Assessment, Health Care/ or Process Assessment, Health Care/ or "Outcome and Process Assessment, Health Care"/ or Safety Management/	225565
16. "diffusion of innovation"/ or implementation science/ or technology transfer/ or Organizational Innovation/	43244
17. OR/7-16	9781948

Context: Healthcare	18. (health adj2 care or healthcare).mp.	990507
	19. ((health care adj2 (professional* or personnel* or provider* or occupation*)) or (healthcare adj2 (professional* or personnel* or provider* or occupation*)) or nurse* or physician* or dentist* or (allied adj2 profession*)).mp.	1104944
	20. Patient care/ or "Delivery of Health Care"/ or Health Services Administration/ or Quality of Health Care/ or health resources/ or "health services needs and demand"/ or Health Services/ or Health Services Research/ or Hospitals/ or Ambulatory Care Facilities/	365331
	21. Health Personnel/ or Health Occupations/ or practice patterns, dentists'/ or practice patterns, nurses'/ or practice patterns, physicians'/ or professional practice gaps/ or "attitude of health personnel"/ or Interprofessional Relations/ or Health Knowledge, Attitudes, Practice/	431637
	22. OR/18-21	

		2099889
Combinations	25. 6 AND 17 AND 22	1498

OVID Psych Info APA (1806 to October Week 3 2020) 10.26.2020

1 champion*.mp. (3795)

2 interpersonal influences/ (6032)

3 Leadership/ (34935)

4 exp peers/ (13051)

5 3 and 4 (171)

6 1 or 2 or 5 (9983)

7 (ebp or ebm or ebn or cpg* or best practice* or (evidence adj2 practice*)).mp. (42383)

8 (guideline* adj2 (implement* or adher*)).mp. (1681)

9 (quality adj1 (improv* or manag*)).mp. (12329)

10 (research adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (24271)

11 (knowledge adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (13587)

12 (evidence adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (18320)

13 ((innovation adj2 (adopt* or diffus*)) or (implementation adj2 (science* or research)) or (innovation or diffusion)).mp. (47221)

14 Evidence Based Practice/ or Information Dissemination/ (19788)

15 treatment guidelines/ or quality control/ or "treatment process and outcome measures"/ or patient safety/ or Program Evaluation/ (23436)

16 innovation/ (14003)

17 or/7-16 (166248)

18 ((health adj2 care) or healthcare).mp. (212797)

19 ((health care adj2 (professional* or personnel* or provider* or occupation*)) or (healthcare adj2 (professional* or personnel* or provider* or occupation*)) or nurse* or physician* or dentist* or (allied adj2 profession*)).mp. (175468)

20 Health Care Delivery/ or Health Care Services/ or Health Care Administration/ or Health Care Administration/ or Hospitals/ or Outpatient Treatment/ (82534)

21 Health Personnel Attitudes/ or Health Personnel/ (35993)

22 or/18-21 (344095)

23 6 and 17 and 22 (199)

OVID Embase 10.26.2020

1 champion*.mp. (9734)

2 peer pressure/ (2584)

3 leadership/ (69681)

4 peer group/ (24180)

5 3 and 4 (553)

6 1 or 2 or 5 (12849)

7 (ebp or ebm or ebn or cpg* or best practice* or (evidence adj2 practice*)).mp. (191909)

8 (guideline* adj2 (implement* or adher*)).mp. (15599)

9 (quality adj1 (improv* or manag*)).mp. (144271)

10 (research adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (63323)

11 (knowledge adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (23055)

12 (evidence adj2 ('use' or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support)).mp. (63915)

13 ((innovation adj2 (adopt* or diffus*)) or (implementation adj2 (science* or research)) or (innovation or diffusion)).mp. (353964)

14 evidence based practice/ or information dissemination/ (87660)

15 protocol compliance/ or quality control/ or total quality management/ or outcome assessment/ or safety/ (1054843)

16 implementation science/ (1418)

17 or/7-16 (1767408)

18 ((health adj2 care) or healthcare).mp. (1840718)

19 ((health care adj2 (professional* or personnel* or provider* or occupation*)) or (healthcare adj2 (professional* or personnel* or provider* or occupation*)) or nurse* or physician* or dentist* or (allied adj2 profession*)).mp. (1385992)

20 patient care/ or health care/ or health service/ or health care quality/ or health care planning/ or hospital/ or ambulatory care/ or health services research/ (1209612)

21 health care personnel/ or medical profession/ or practice gap/ or health personnel attitude/ or clinical practice/ or public relations/ or attitude to health/ (692041)

22 or/18-21 (3501254)

23 6 and 17 and 22 (1946)

CINAHL 10.26.2020

#	Query	Results
S23	S6 AND S17 AND S22	851
S22	S18 OR S19 OR S20 OR S21	1,404,487
S21	(MH "Health Personnel") OR (MH "Health Occupations") OR (MH "Attitude of Health Personnel") OR (MH "Practice Patterns") OR (MH "Interprofessional Relations")	118,133
S20	(MH "Patient Care") OR (MH "Health Care Delivery") OR (MH "Health Care Delivery, Integrated") OR (MH "Health Services Administration") OR (MH "Health Care Supervision (Omaha)") OR (MH "Health Services Needs and Demand") OR (MH "Health Services") OR (MH "Quality of Health Care") OR (MH "Health Services Research") OR (MH "Hospitals") OR (MH "Ambulatory Care")	275,787
S19	(((health care n2 (professional* or personnel* or provider* or occupation*)) OR ((healthcare n2 (professional* or personnel* or provider* or occupation*)) OR (nurse* or physician* or dentist* or (allied n2 profession*))	813,843
S18	(healthcare OR health n2 care)	666,707
S17	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16	410,447

S16	(MH "Diffusion of Innovation") OR (MH "Implementation Science")	15,458
S15	((MH "Quality Assurance") OR (MH "Quality Assessment") OR (MH "Quality Improvement")) OR ((MH "Guideline Adherence") OR (MH "Process Assessment (Health Care)") OR (MH "Outcome Assessment"))	140,803
S14	(MH "Evidence-Based Dental Practice") OR (MH "Medical Practice, Evidence-Based") OR (MH "Nursing Practice, Evidence-Based") OR (MH "Professional Practice, Evidence-Based") OR (MH "Occupational Therapy Practice, Evidence-Based") OR (MH "Physical Therapy Practice, Evidence-Based") OR (MH "Professional Practice, Evidence-Based") OR (MH "Professional Practice, Research-Based") OR (MH "Information Management")	84,351
S13	((innovation n2 (adopt* or diffus*)) or (implementation n2 (science* or research)) or (innovation or diffusion)	59,670
S12	(evidence n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	36,420
S11	(knowledge n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	12,831

S10	(research n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	41,622
S9	(quality n1 (improv* or manag*))	102,809
S8	(guideline* n2 (implement* or adher*))	21,077
S7	(ebp or ebm or ebn or cpg* or best practice* or (evidence n2 practice*))	109,076
S6	S1 OR S2 OR S5	6,662
S5	S3 AND S4	239
S4	(MH "Peer Group")	13,419
S3	(MH "Leadership")	43,397
S2	(MH "Peer Pressure")	946
S1	(champion*)	5,483

ProQuest: Nursing and Allied 10.26.2020

S1: noft((champion*))- Results: 9538

S2: mainsubject.Exact("peer influence") - Results: 38

S3: mainsubject.Exact("leadership")- Results: 23456

S4: mainsubject.Exact("peer group") - Results: 1711

S5: S3 AND S4 - Results: 33

S6: S1 OR S2 OR S5 - Results: 9609

S7: noft((ebp or ebm or ebn or cpg* or best practice* or (evidence Near/2 practice*))) –

Results: 89797

S8: noft((guideline* Near/2 (implement* or adher*))) - Results: 7254

S9: noft((quality Near/1 (improv* or manag*))) - Results: 47049

S10: noft((research Near/2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))) - Results: 50631

S11: noft((knowledge Near/2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))) - Results: 7913

S12: noft((evidence Near/2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))) - Results: 22716

S13: noft(((innovation Near/2 (adopt* or diffus*)) or (implementation Near/2 (science* or research)) or (innovation or diffusion))) - Results: 76766

S14: mainsubject.Exact("evidence-based practice" OR "evidence-based nursing" OR "information dissemination" OR "evidence based practice" OR "evidence based" OR "evidence-based medicine")- Results: 29036

S15: mainsubject.Exact("process assessment (health care)" OR "safety management" OR "outcome & process assessment (health care)" OR "guideline adherence" OR "quality improvement" OR "outcome assessment (health care)" OR "quality assurance, health care") -Results: 21658

S16: mainsubject.Exact("organizational innovation" OR "implementation" OR "diffusion of innovation") - Results: 6045

S17: S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 - Results: 310192

S18: noft((healthcare OR health Near/2 care)) - Results: 668296

S19: noft(((health care Near/2 (professional* or personnel* or provider* or occupation*))) OR ((healthcare Near/2 (professional* or personnel* or provider* or occupation*))) OR (nurse* or physician* or dentist* or (allied Near/2 profession*))) - Results: 625394

S20: mainsubject.Exact("health services research" OR "hospitals" OR "quality of health care" OR "ambulatory care facilities" OR "health resources" OR "health services needs & demand" OR "health services administration" OR "health services" OR "patient care" OR "delivery of health care") - Results: 230358

S21: mainsubject.Exact("health knowledge, attitudes, practice" OR "health occupations" OR "attitude of health personnel" OR "interprofessional relations" OR "health personnel") - Results: 25378

S22: S18 OR S19 OR S20 OR S21 - Results: 1215547

S23: S6 AND S17 AND S22 - Results: 635

ProQuest Dissertations and Theses Global

S1: noft(champion*) - Results: 4975

S2: noft((ebp or ebm or ebn or cpg* or best practice* or (evidence Near/2 practice*))) - Results: 89725

S3: noft((guideline* Near/2 (implement* OR adher*))) - Results: 1607

S4: noft((quality Near/1 (improv* OR manag*))) - Results: 34540

S5: noft((research Near/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support))) - Results: 59277

S6: noft((knowledge Near/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support))) - Results: 16978

S7: noft((evidence Near/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support))) - Results: 19347

S8: noft(((innovation Near/2 (adopt* OR diffus*)) OR (implementation Near/2 (science* OR research)) OR (innovation OR diffusion))) - Results: 133870

S9: S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 - Results: 323847

S10: noft((healthcare OR health Near/2 care)) - Results: 72243

S11: noft(((health care Near/2 (professional* or personnel* or provider* or occupation*))) OR ((healthcare Near/2 (professional* or personnel* or provider* or occupation*))) OR (nurse* or physician* or dentist* or (allied Near/2 profession*))) - Results: 74797

S12: S10 OR S11 - Results: 118765

S13: S1 AND S9 AND S12 - Results: 104

Scopus 10.26.2020

1. TITLE-ABS-KEY ((champion*)) - 24,276 document results

2. TITLE-ABS-KEY (((ebp OR ebm OR ebn OR cpg* OR "best practice*" OR (evidence W/2 practice*)))) - 239,243 document results

3. TITLE-ABS-KEY (((guideline* W/2 (implement* OR adher*)))) - 47,176 document results

4. TITLE-ABS-KEY (((quality W/1 (improv* OR manag*)))) - 390,089 document results

5. TITLE-ABS-KEY (((research W/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support)))) - 160,148 document results

6. TITLE-ABS-KEY (((knowledge W/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support)))) -71,312 document results

7. TITLE-ABS-KEY (((evidence W/2 (use OR utili* OR adopt* OR implement* OR disseminat* OR uptake OR transfer* OR translat* OR support)))) - 117,191 document results

8. TITLE-ABS-KEY ((((innovation W/2 (adopt* OR diffus*)) OR (implementation W/2 (science* OR research)) OR (innovation OR diffusion)))) - 1,415,950 document results

9. #2 OR # 3 OR #4 OR #5 OR #6 OR #7 OR #8 - 2,337,377 document results

10. TITLE-ABS-KEY (((healthcare OR health W/2 care))) - 1,742,498 document results

11. TITLE-ABS-KEY (((health AND care W/2 (professional* OR personnel* OR provider* OR occupation*)) OR (healthcare W/2 (professional* OR personnel* OR provider* OR occupation*)) OR nurse* OR physician* OR dentist* OR (allied W/2 profession*))) - 1,537,780 document results

12. #10 OR #11- 2,781,641 document results

13. #1 AND #9 AND #12 - 1,104 document results

Business Source Complete

#	Query	Results
S22	S5 AND S16 AND S21	93
S21	S17 OR S18 OR S19 OR S20	607,907
S20	(DE "MEDICAL personnel") OR (DE "HOSPITAL personnel")	14,962
S19	(((DE "MEDICAL care") OR (DE "HEALTH facilities")) OR (DE "HEALTH services administrators")) OR (DE "HOSPITALS") OR (DE "MEDICAL offices")	136,941
S18	((health care n2 (professional* or personnel* or provider* or occupation*))) OR ((healthcare n2 (professional* or personnel* or provider* or occupation*))) OR (nurse* or physician* or dentist* or allied profession*)	198,239
S17	(healthcare OR health n2 care)	486,635
S16	S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15	596,150
S15	DE "DIFFUSION of innovations" OR DE "INNOVATION adoption"	9,911
S14	DE "QUALITY assurance"	8,021
S13	DE "INFORMATION resources management" OR DE "EVIDENCE-based management"	29,407

S12	((innovation n2 (adopt* or diffus*)) or (implementation n2 (science* or research)) or (innovation or diffusion)	417,653
S11	(evidence n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	11,527
S10	(knowledge n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	16,109
S9	(research n2 (use or utili* or adopt* or implement* or disseminat* or uptake or transfer* or translat* or support))	27,572
S8	(quality n1 (improv* or manag*))	59,356
S7	(guideline* n2 (implement* or adher*))	1,857
S6	(ebp or ebm or ebn or cpg* or best practice* or (evidence n2 practice*))	52,381
S5	S1 OR S4	44,348
S4	S2 AND S3	219
S3	DE "LEADERSHIP"	71,145
S2	DE "PROFESSIONAL relationships" OR DE "COWORKER relationships"	3,369
S1	(champion*)	44,129

Additional File 3: List of Excluded Articles and Reasons for Exclusion

Number	Reference	Exclusion Reason
1	Aagaard EM, Gonzales R, Camargo Jr CA, Auten R, Levin SK, Maselli J, Metlay J. Physician champions are key to improving antibiotic prescribing quality. The Joint Commission Journal on Quality and Patient Safety. 2010 Mar 1;36(3):109-16.	Study not about effectiveness
2	Aarons GA, Green AE, Trott E, Willging CE, Torres EM, Ehrhart MG, Roesch SC. The roles of system and organizational leadership in system-wide evidence-based intervention sustainment: a mixed-method study. Administration and Policy in Mental Health and Mental Health Services Research. 2016 Nov;43(6):991-1008.	Not within a health care setting
3	Aarts M, Conn LG, Govindarajan A, Mccluskey S, McKenzie M, Okrainec A, Pearsall E, Rotstein O, McLeod R. Improved outcomes following implementation of an enhanced recovery after surgery (eras) program across the province of Ontario. Indiseases of the colon & rectum 2016 may 1 (vol. 59, no. 5, pp. E374-e375). Two commerce sq, 2001 market st, Philadelphia, pa 19103 USA: Lippincott Williams & Wilkins.	Conference abstract
4	Abejirinde IO, Zweekhorst M, Bardají A, Abugnaba-Abanga R, Apentibadek N, De Brouwere V, van Roosmalen J, Marchal B. Unveiling the black box of diagnostic and clinical decision support systems for antenatal care: realist evaluation. JMIR mHealth and uHealth. 2018 Dec 21;6(12):e11468.	Study not about effectiveness
5	Abendstern M, Hughes J, Tucker S, Clarkson P, Challis D. Self-assessment and personalization in occupational therapy services: a managerial perspective on the challenges and opportunities of a service innovation. British Journal of Occupational Therapy. 2014 Oct;77(10):499-506.	Study not about effectiveness
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129	Beddingfield H., Sutton K., Kim E., Batara D., Hirsch K. The role for neuro champions in a mixed intensive care unit. Neurocritical Care / 2017;27(2 Supplement 1):S304	Conference abstract
130	Bee P, Lovell K, Airnes Z, Pruszynska A. Embedding telephone therapy in statutory mental health services: a qualitative, theory-driven analysis. BMC psychiatry. 2016 Dec;16(1):1-1.	Study not about effectiveness
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234	Byers JF, Beaudin CL. The relationship between continuous quality improvement and research. Journal for healthcare quality: official publication of the National Association for Healthcare Quality. 2002 Jan 1;24(1):4-8.	Study not about effectiveness
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1026	Leung V., Lloyd-Smith E., Romney M. Physician hand hygiene champions. Canadian Journal of Infectious Diseases and Medical Microbiology / 2012;23(SUPPL. SB):35B	Conference abstract
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1035	Liaw KR. Integrated Family Stress Screening and Response in Pediatric Intensive Care. In64th Annual Meeting 2017 Oct 24. AACAP.	Conference abstract
1036	Liaw RL. Family Emotional Well-Being and Resiliency in Pediatric Diabetes Care: Early Learning From the Roadmap Pilot Collaborative. In2020 Virtual Meeting 2020 Oct 24. AACAP.	Conference abstract
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1041	Liersch S, Tobias T, Brady L. Strengthening the provision of supportive care for adolescents and young adults (Aya's) with cancer in Southern Melbourne: 274. Asia-pacific Journal of Clinical Oncology. 2011 Nov;7.	Conference abstract
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1044	Lim ZJ, Nagle D, McAllan F, Ramanan R, Dendle C, Stuart RL, Egerton-Warburton D. Evaluating the sustained effectiveness of a multimodal intervention aimed at influencing PIVC insertion practices in the emergency department. Emergency Medicine Journal. 2020 Jul 1;37(7):444-9.	Not a champion
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1398	Pannucci CJ, Jaber RM, Zumsteg JM, Golgotiu V, Spratke LM, Wilkins EG. Changing practice: implementation of a venous thromboembolism prophylaxis protocol at an academic medical center. Plastic and reconstructive surgery. 2011 Nov;128(5):1085.	Study not about effectiveness

Number	Reference	Exclusion Reason
1399	Paone D. Implementation of evidence-based practice in 2 states: Lessons from the Chronic Disease Self-Management Program.	Study not about effectiveness
1400	Paone D. Implementation of evidence-based practice in 2 states: Lessons from the Chronic Disease Self-Management Program.	Duplicate
1401	Papadakis S, Gharib M, Hambleton J, Reid RD, Assi R, Pipe AL. Delivering evidence-based smoking cessation treatment in primary care practice: experience of Ontario family health teams. Canadian Family Physician. 2014 Jul 1;60(7):e362-71.	Duplicate
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1403	Pappas JM, Flaherty KE, Wooldridge B. Tapping into hospital champions-strategic middle managers. Health care management review. 2004 Jan 1;29(1):8-16.	Not a champion
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1406	Parish E, Runnacles J, Davey N, Roueché A. 102 Developing effective leaders: creating change champions in children's healthcare.	Conference abstract
1407	Park HW. Improving quality of healthcare in Korea. Journal of the Korean Medical Association. 2012 Oct 1;55(10):969-77.	Not English
1408	Parker CN, Shuter P, Maresco-Pennisi D, Sargent J, Collins L, Edwards HE, Finlayson KJ. Implementation of the Champions for Skin Integrity model to improve leg and foot ulcer care in the primary healthcare setting. Journal of clinical nursing. 2019 Jul;28(13-14):2517-25.	Study not about effectiveness
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Number	Reference	Exclusion Reason
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1412	Parris S, Cochrane G, Marjanovic S, Ling T, Chataway J. Galvanising the nhs to adopt innovation: the feasibility and practicality of recommendations from the interim report of the accelerated access review. Rand health quarterly. 2016 Jun 20;6(1).	Study not about effectiveness
1413	Pasio KS, Mash R, Naledi T. Development of a family physician impact assessment tool in the district health system of the Western Cape Province, South Africa. BMC family practice. 2014 Dec;15(1):1-9.	Not about knowledge translation/evidence-based practice
1414	Patel B, Usherwood T, Harris M, Panaretto K, Redfern J, Jansen J, McKinn S, Lyford M, Patel A, Peiris D. PT253 Understanding the impact of a multifaceted quality improvement intervention to improve cardiovascular disease risk management in Australian Primary Health Care: The TORPEDO study process evaluation. Global Heart. 2014;1(9):e214-5.	Conference abstract
1415	Pathania S, Slater LZ, Vose C, Navarra AM. Music therapy and pain management in patients with end-stage liver disease: An evidence-based practice quality improvement project. Pain Management Nursing. 2019 Feb 1;20(1):10-6.	Study not about effectiveness
1416	Patterson J.A.; Olson B.H.; Keuler N.S. Improving the culture of breastfeeding support in primary care practices: A pilot of the outpatient breastfeeding champion program. Breastfeeding Medicine. 2018;13(7):A-31	Conference abstract
1417	Patterson JA, Keuler NS, Eglash AR, Olson BH. Outpatient breastfeeding champion program: Breastfeeding support in primary care. Breastfeeding Medicine. 2020 Jan 1;15(1):44-8.	Study not about effectiveness
1418	Patterson PD, Anderson MS, Zionts ND, Paris PM. The emergency medical services safety champions. American journal of medical quality. 2013 Jul;28(4):286-91.	Not about knowledge translation/evidence-based practice
1419	Patwardhan MB, Matchar DB, Samsa GP, Haley WE. Utility of the advanced chronic kidney disease patient management tools: case studies. American Journal of Medical Quality. 2008 Mar;23(2):105-14.	Study not about effectiveness
1420	Paulsen MM, Varsi C, Paur I, Tangvik RJ, Andersen LF. Barriers and facilitators for implementing a decision support system to prevent and treat disease-related malnutrition in a hospital setting: qualitative study. JMIR formative research. 2019 May 9;3(2):e11890.	Study not about effectiveness

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1423	Peace D. A Multi-disciplinary approach to improving environmental hygiene in a pediatric system American Journal of Infection Control. 2010;38(5):E100-E10	Conference abstract
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1427	Pek JH, Kang HM, Wong E. Improving apnoeic oxygenation use for rapid sequence intubation in an emergency department. Trends in Anaesthesia and Critical Care. 2017 Apr 1;13:25-31.	Study not about effectiveness
1428	Pekkala J, Cross-Barnet C, Kirkegaard M, Silow-Carroll S, Courtot B, Hill I. Key considerations for implementing group prenatal care: lessons from 60 practices. Journal of midwifery & women's health. 2020 Mar;65(2):208-15.	Study not about effectiveness
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1430	Peritore NR. Communicating social support: Understanding complexities of breastfeeding communication among African American mothers.	Not about knowledge translation/evidence-based practice

Number	Reference	Exclusion Reason
1431	Perkins A, Nicholls K, Shaw T, Liu G, Molokhia E. Attitudes toward colorectal cancer screening in the digital age: a survey of practices and attitudes among screening-eligible Alabamians. Southern medical journal. 2013 Aug 1;106(8):462-7.	Study not about effectiveness
1432	Perlin JB, Hickok JD, Septimus EJ, Moody JA, Englebright JD, Bracken RM. A bundled approach to reduce methicillin-resistant Staphylococcus aureus infections in a system of community hospitals. Journal for Healthcare Quality. 2013 May;35(3):57-69.	Study not about effectiveness
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1435	Peterson JC, Rogers EM, Cunningham-Sabo L, Davis SM. A framework for research utilization applied to seven case studies. American journal of preventive medicine. 2007 Jul 1;33(1):S21-34.	Not within a health care setting
1436	Peterson KA, Radosevich DM, O'Connor PJ, Nyman JA, Prineas RJ, Smith SA, Arneson TJ, Corbett VA, Weinhandl JC, Lange CJ, Hannan PJ. Improving diabetes care in practice: findings from the TRANSLATE trial. Diabetes care. 2008 Dec 1;31(12):2238-43.	Study not about effectiveness
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1438	Petrescu-Prahova M, Belza B, Kohn M, Miyawaki C. Implementation and maintenance of a community-based older adult physical activity program. The Gerontologist. 2016 Aug 1;56(4):677-86.	Not within a health care setting
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1441	Phillips G, Ker J. Champion students! Experience with a standardized infection control training package in medical students. Journal of Hospital Infection. 2006 Apr 1;62(4):518-9.	Letters to the editor/ Review studies
1442	Phillips SJ, Stevens A, Cao H, Simpkin W, Payne J, Gill N. Improving stroke care in Nova Scotia, Canada: a population-based project spanning 14 years. BMJ Open Quality. 2021 Sep 1;10(3):e001368.	Conference abstract
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1446	Pilling LB, Bogen J, Simmons R. Building Interprofessional Global Health Infrastructure at a University and Health System: Navigating Challenges and Scaling Successes. Annals of Global Health. 2017 Apr 7;83(1).	Conference abstract
1447	Pinderup P. Improving the knowledge, attitudes, and practices of mental health professionals regarding dual diagnosis treatment–a mixed methods study of an intervention. Issues in mental health nursing. 2018 Apr 3;39(4):292-303.	Study not about effectiveness
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1450	Piver-Renna JM. The adoption and implementation of alcohol screening, brief intervention, and referral to treatment programs in mid-Atlantic Level I trauma centers. The Johns Hopkins University; 2009.	Study not about effectiveness

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1453	Ploeg J, Markle-Reid M, Davies B, Higuchi K, Gifford W, Bajnok I, McConnell H, Plenderleith J, Foster S, Bookey-Bassett S. Spreading and sustaining best practices for home care of older adults: a grounded theory study. Implementation Science. 2014 Dec;9(1):1-7.	Study not about effectiveness
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1455	Plunkett A, Kelly N, Scott D. G549 (P) Learning from excellence: a new paradigm of safety reporting. 2015	Conference abstract
1456	Polaha J, Smith JD, Sunderji N. A recipe for assessing fidelity in family and health systems. 2019	Letters to the editor/ Review studies
1457	Poland B, Graham H, Walsh E, Williams P, Fell L, Lum JM, Polzer J, Syed S, Tobin S, Kim G, Yardy G. 'Working at the margins' or 'leading from behind'?: a Canadian study of hospital− community collaboration. Health & social care in the community. 2005 Mar;13(2):125-35.	Study not about effectiveness
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1463	Poremski D.; Kahan D.; Pauly D.; Stergiopoulos V. Challenges in continuity of care: The experience of frequent users of emergency departments in a large metropolitan center in Canada. Annals of the Academy of Medicine Singapore. 2015;44(10 SUPPL. 1):S227	Conference abstract
1464	Porter SC, Johnston P, Parry G, Damian F, Hoppa EC, Stack AM. Improving parent-provider communication in the pediatric emergency department: results from the clear and concise communication campaign. Pediatric emergency care. 2011 Feb 1;27(2):75-80.	Study not about effectiveness
1465	Portnoy B, Lee SJ, Kincheloe J, Breen N, Olson JL, McCormally J, Brown ER. Independent state health surveys: responding to the need for local population health data. Journal of public health management and practice: JPHMP. 2014 Sep;20(5):E21.	Study not about effectiveness
1466	Postema TR, Peeters JM, Friele RD. Key factors influencing the implementation success of a home telecare application. International journal of medical informatics. 2012 Jun 1;81(6):415-23.	Study not about effectiveness
1467	Poulos RG, Lord SR, Zwi AB. Towards enhancing national capacity for evidence informed policy and practice in falls management: a role for a" Translation Task Group"?. Australia and New Zealand Health Policy. 2007;4(1).	Study not about effectiveness
1468	Powers MA, Cuddihy RM, Bergenstal RM, Tompos P, Pearson J, Morgan B. Improving blood pressure control in individuals with diabetes: a quality improvement collaborative. The Joint Commission Journal on Quality and Patient Safety. 2011 Mar 1;37(3):110-AP1.	Protocol
1469	Powers, M. How to create the best appeal strategy for coding denials. Healthcare Financial Management 2020;74(3):30-31	Not about knowledge translation/evidence-based practice
1470	Pradarelli JC, Yule S, Panda N, Craig M, Lowery KW, Ashley SW, Gee DW, Waters PM, Knight J, Smink DS. Optimizing the implementation of surgical coaching through feedback from practicing surgeons. JAMA surgery. 2021 Jan 1;156(1):42-9.	Study not about effectiveness
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1472	Prata N, Gessessew A, Abraha AK, Holston M, Potts M. Prevention of postpartum hemorrhage: options for home births in rural Ethiopia. African Journal of Reproductive Health. 2009;13(2).	Study not about effectiveness
1473	Preas MA, Custer M, Rew C, Hebden J, Thom K, Cafeo C. Economic Impact of a Dedicated Nurse Champion in Reducing Catheter Associated Bloodstream Infections (CLABSIs). American Journal of Infection Control. 2011 Jun 1;39(5):E207.	Conference abstract
1474	Preas MA, Emerick M, Harris-Williams M, Filippell M, Hebden J, Thom K, Harris A, Leekha S. Culture Change and CLABSI Reduction: Achieving Success in a Medical Center with 10 Distinctively Different Intensive Care Units. American Journal of Infection Control. 2012 Jun 1;40(5):e194-5.	Conference abstract
1475	Prebble K, Kidd J, O'Brien A, Carlyle D, McKenna B, Crowe M, Deering D, Gooder C. Implementing and maintaining nurse-led healthy living programs in forensic inpatient settings: an illustrative case study. Journal of the American Psychiatric Nurses Association. 2011 Mar;17(2):127-38.	Study not about effectiveness
1476	Prendergast M, Honey M. The barriers and facilitators for nurse educators using telehealth for education. InMEDINFO 2019: Health and Wellbeing e-Networks for All 2019 (pp. 1323-1326). IOS Press.	Study not about effectiveness
1477	Prescribing Technology to Increase Uptake of Depression Treatment in Primary Care: A Pre-implementation Focus Group Study of SOVA (Supporting Our Valued Adolescents)	Study not about effectiveness
1478	Preshaw J, Evans K, Attilia B. Revolutionising sepsis management within maternity at Musgrove Park Hospital, Taunton. BJOG: An International Journal of Obstetrics and Gynaecology / 2016;123(Supplement 4):5	Conference abstract
1479	Preslaski CR, Lat I, MacLaren R, Poston J. Pharmacist contributions as members of the multidisciplinary ICU team. Chest. 2013 Nov 1;144(5):1687-95.	Study not about effectiveness
1480	Price K, Kennedy KJ, Rando TL, Dyer AR, Boylan J. Education and process change to improve skin health in a residential aged care facility. International wound journal. 2017 Dec;14(6):1140-7.	Study not about effectiveness
1481	Priest KC, Englander H, McCarty D. “Now hospital leaders are paying attention”: a qualitative study of internal and external factors influencing addiction consult services. Journal of substance abuse treatment. 2020 Mar 1;110:59-65.	Study not about effectiveness

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1483	Pronovost P, Weast B, Rosenstein B, Sexton JB, Holzmueller CG, Paine L, Davis R, Rubin HR. Implementing and validating a comprehensive unit-based safety program. Journal of Patient Safety. 2005 Mar 1;1(1):33-40.	Study not about effectiveness
1484	Provaznik J, Ahmad M. Early identification of delirium in elderly hospitalized patients. Journal of general internal medicine. 2018;33: S173-S173.	Conference abstract
1485	Pruden J. PICU's Mission to Eliminate CA-BSI by Joining a National Collaborative. American Journal of Infection Control. 2011 Jun 1;39(5):E156.	Conference abstract
1486	Puleo E, Zapka J, White MJ, Mouchawar J, Somkin C, Taplin S. Caffeine, cajoling, and other strategies to maximize clinician survey response rates. Evaluation & the health professions. 2002 Jun;25(2):169-84.	Study not about effectiveness
1487	Pulia M, Redwood R, May L. Antimicrobial stewardship in the emergency department. Emergency Medicine Clinics. 2018 Nov 1;36(4):853-72.	Study not about effectiveness
1488	Purvis T, Marion V, Andrew NE, Kilkenny MF, Breen S, Cadilhac DA. Reducing clinical variation: process evaluation of the Shared Team Efforts Leading to Adherence Results (STELAR) project. International Journal of Stroke 2019 Aug 1;14: 8-8.	Conference abstract
1489	Qamruddin A, Duran G, Stefanescu A, Boehm E, Parashette V, Stefanescu B. NEWBORN INTERVENTION PROMOTING PRETERM INFANT EATING READINESS: 415. Journal of Investigative Medicine. 2019 Jan;67(1).	No full text available
1490	Qu H, Hu X, Singh JA. Factors influencing implementation of a computerized, individualized, culturally tailored lupus decision aid in lupus clinics: a qualitative semi-structured interview study. Clinical rheumatology. 2019 Oct;38(10):2793-801.	Study not about effectiveness
1491	Quicke JG, Cottrell E, Duffy H, Somerville S, Oxtoby J, Wallbanks A, Campbell L, Blackburn S, Stevenson K, Cooper V, Finney A. Implementing and evaluating a pilot physiotherapist-led osteoarthritis clinic in general practice. Physiotherapy. 2019 Jan 1;105:e33-4.	Conference abstract

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1492	Quinn KG, Christenson E, Spector A, Amirkhanian Y, Kelly JA. The influence of peers on PrEP perceptions and use among young black gay, bisexual, and other men who have sex with men: a qualitative examination. Archives of sexual behavior. 2020 Feb 3:1-5.	Study not about effectiveness
1493	Quraishi F, Cheung V, Sharp S, Avinoam G. Collaboratively moving knowledge into practice: AP. 99. International Journal of Stroke. 2015 Sep;10.	Conference abstract
1494	Raab S, Currens H, Woodman D. IMPLEMENTATION OF LEAN STRATEGIES IN CYTOPATHOLOGY: S3-019. Cytopathology. 2011 Oct;22.	Conference abstract
1495	Raff E, Campbell C, Wei E. Added value: Quality improvement in radiology Emergency Radiology. 2016;23(6):571	Conference abstract
1496	Rafferty MR, MacDonald J, Byskosh A, Sloan L, Toledo S, Marciniak C, Simuni T. Using implementation frameworks to provide proactive physical therapy for people with Parkinson disease: case report. Physical therapy. 2019 Dec 16;99(12):1644-55.	Study not about effectiveness
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1498	Ragazzi, H., Keller, A., Ehrensberger, R., Irani, A.-M. (2011). Evaluation of a practice-based intervention to Ragazzi H, Keller A, Ehrensberger R, Irani AM. Evaluation of a practice-based intervention to improve the management of pediatric asthma. Journal of Urban Health. 2011 Feb 1;88(1):38-48.	Study not about effectiveness
1499	Rajaraman M, Urquhart R, Kendell C, Geldenhuys L, Ross A, Folkes A, Sullivan V, Rayson D, Porter GA. 218 How Scientific Evidence is Used to Adopt Complex Innovations in Cancer Care: A Multiple-Case Study from Nova Scotia, Canada. Radiotherapy and Oncology. 2019 Oct 1;139:S91.	Conference abstract
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1501	Rand CM, Concannon C, Wallace-Brodeur R, Davis W, Albertin CS, Humiston SG, Szilagyi PG. Identifying Strategies to Reduce Missed Opportunities for HPV Vaccination in Primary Care: A Qualitative Study of Positive Deviants. Clinical pediatrics. 2020 Oct;59(12):1058-68.	Study not about effectiveness

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1503	Randall, A, Lieberthal, B. One size does not fit all. Health Management Technology 2012;33(10):26-7	Letters to the editor/ Review studies
1504	Randell TV, Madeira T, Pavlovic NV, Abshire M. Mechanical Circulatory Support Driveline Infection Reduction through Nursing Quality Improvement. Journal of Cardiac Failure. 2019 Aug 1;25(8):S123.	Conference abstract
1505	Rangachari P, Dellsperger KC, Rethemeyer RK. Network analysis of the structure of inter-professional knowledge exchange related to Electronic Health Record Medication Reconciliation within a Social Knowledge Networking system. Journal of healthcare leadership. 2019;11:87.	Study not about effectiveness
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1508	Rangachari P, Rethemeyer RK. Impact of Periodic Top-down Communications on Infection Prevention Practices & Outcomes in Two Units. InAcademy of Management Proceedings 2014 (Vol. 2014, No. 1, p. 11039). Briarcliff Manor, NY 10510: Academy of Management.	Conference abstract
1509	Rangan K, Bava L, Bailan C, Carcich S, Green S, Vingelen MB, O'Connell J, Thomas S. Nurs-18. Development of a multidisciplinary care service for adolescent and young adult oncology patients at an urban pediatric academic center. Neuro-oncology. 2018; 20(Suppl 2):i154.	Conference abstract
1510	Rankin NM, Shaw T, York S, Mcgregor D, Butow P, Young J, White K, Barnes D, Zielinski R, Stone E. Improving Pathways to Early Lung Cancer Diagnosis: Process Mapping and Qualitative Analysis. Journal of thoracic oncology.2015;10 (9):S398-S398.	Conference abstract

Number	Reference	Exclusion Reason
1511	Rantz MJ, Grando V, Conn V, Zwygart-Staffacher M, Hicks L, Flesner M, Scott J, Manion P, Minner D, Porter R, Maas M. Getting the basics right: Care delivery in nursing homes.	Not a champion
1512	Rantz MJ, Grando V, Conn V, Zwygart-Staffacher M, Hicks L, Flesner M, Scott J, Manion P, Minner D, Porter R, Maas M. Getting the basics right: Care delivery in nursing homes.	Duplicate
1513	Rantz MJ, Zwygart-Stauffacher M, Flesner M, Hicks L, Mehr D, Russell T, Minner D. Challenges of using quality improvement methods in nursing homes that "need improvement". Journal of the American Medical Directors Association. 2012 Oct 1;13(8):732-8.	Study not about effectiveness
1514	Rao SK, Turner SM, Ferris TG. Reducing the burden of quality improvement through the abms maintenance of certification portfolio sponsor program. Journal of general internal medicine. 2017;32: S792-S792.	Conference abstract
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Number	Reference	Exclusion Reason
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Number	Reference	Exclusion Reason
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1600	Rutledge AB, McLeod N, Mehan N, Regan TW, Ainsworth P, Chong P, Doyle T, White M, Sanson-Fisher RW, Martin JM. A clinician-centred programme for behaviour change in the optimal use of staging investigations for newly diagnosed prostate cancer. BJU international. 2018 May;121:22-7.	Study not about effectiveness
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1603	Sabella J, Williams TS. Developing Breastfeeding Champions: A Quality Improvement Project to Increase Provider Knowledge, Skills and Comfort with Supporting Exclusive Breastfeeding in the Pediatric Office.	Conference abstract
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1605	Sacco TL, LaRiccia B. Interprofessional implementation of a pain/sedation guideline on a trauma intensive care unit. Journal of Trauma Nursing. 2016 May 1;23(3):156-64.	Study not about effectiveness
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1610	Saint S, Kowalski CP, Banaszak-Holl J, Forman J, Damschroder L, Krein SL. How active resisters and organizational constipators affect health care–acquired infection prevention efforts. The Joint Commission Journal on Quality and Patient Safety. 2009 May 1;35(5):239-46.	Not a champion
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1618	Santiago C, Delaurier B. Conversations Matter: Attitudes and Perceptions about Family Presence in the Medical-Surgical ICU. Canadian Journal of Critical Care Nursing. 2017 Jun 1;28(2).	Conference abstract
1619	Santoy IV J, Jost GB, Zhang X, Delgado DR, Cross JM, Huzar TF, Wade CE. 459 Identification of Characteristics of Patients Admitted to the Burn Unit for One Day. Journal of Burn Care & Research. 2019 Mar 9;40(Supplement_1):S202-3.	Conference abstract
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1854	Tolson D; Irene S; Booth J; Kelly TB; James L. Constructing a new approach to developing evidence-based practice with nurses and older people. Worldviews on Evidence-Based Nursing ;3(2):62-72	Study not about effectiveness
1855	Tomayko EJ, Godlewski B, Bowman S, Settersten RA, Weber RB, Krahn G. Leveraging public health research to inform state legislative policy that promotes health for children and families. Maternal and child health journal. 2019 Jun;23(6):733-8.	Not within a health care setting
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1868	Trevino K. Designing for dissemination: Applying the Consolidated Framework for Implementation Research (CFIR) to development of an implementable anxiety intervention. InPSYCHO-ONCOLOGY 2019 Feb 1 (Vol. 28, pp. 30-31).	Conference abstract
1869	Trotochaud K, Fitzgerald H, Knackstedt AD. Ethics champion programs. AJN The American Journal of Nursing. 2018 Jul 1;118(7):46-54.	Not about knowledge translation/evidence-based practice
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Number	Reference	Exclusion Reason
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1873	Tseung V, Jaglal SB, Salbach NM, Yoshida K, Cameron JI. Key informants' perspectives on implementing caregiver programs in an organized system of stroke care. Disability and rehabilitation. 2021 Apr 10;43(8):1145-52.	Study not about effectiveness
1874	Tucker H. Integrating Care in Norfolk-Progress of a National Pilot. Journal of Integrated Care. 2010 Feb 4.	Letters to the editor/ Review studies
1875	Tuell DS, Jaishankar G, Click I, Fox B, Polaha J. Lone Ranger or Pit Crew? Evaluating the Impact of a Team-Based Care Curriculum for Pediatric Residents. Academic Pediatrics. 2018 Jul 1;18(5):e27.	Conference abstract
1876	Tuepker A, Elnitsky C, Newell S, Zaugg T, Henry JA. A qualitative study of implementation and adaptations to Progressive Tinnitus Management (PTM) delivery. PloS one. 2018 May 16;13(5):e0196105.	Study not about effectiveness
1877	Tuffrey-Wijne I, Davidson J. Excellence in palliative and end-of-life care provision for people with intellectual disability. International journal of palliative nursing. 2018 Dec 2;24(12):598-610.	Study not about effectiveness
1878	Turner K.; Jyothish D. Global health partnerships: Role of nursing collaborations in education and quality improvement. Archives of Disease in Childhood. 2019;104(Supplement 2):A122-A123	Conference abstract
1879	Turner LC. Translation of a health policy innovation: An analysis of the actors, factors and processes that enabled the emergence and translation of Diagnosis Related Groups into and within Australia, 1970-2000. University of New South Wales; 2002.	Not within a health care setting
1880	Turner MA, Johnson SJ, Kopari NM. 472 A Fifteen Month Perspective on Achieving Early Enteral Nutrition in Burn Patients. Journal of Burn Care & Research. 2018 Apr 9;39(suppl_1):S209-.	Conference abstract
1881	Turpening P, Glover T, Kittelson S, Garvan C. Striving to Improve Primary Palliative Care: The Palliative Care Resource Nurse Survey (S753). Journal of Pain and Symptom Management. 2017 Feb 1;53(2):439.	Conference abstract
1882	Tyler MD, Singh N. Improving the Quality of Care and Oxygen Utilization for Premature Infants.2018	Conference abstract

Number	Reference	Exclusion Reason
1883	Tynan A, Draper DA. Getting what we pay for: innovations lacking in provider payment reform for chronic disease care. Center for Studying Health System Change; 2008 Jun 6.	Not about knowledge translation/evidence-based practice
1884	Udwin, MR. Thought leaders. Cultivating a great physician champion. Health Management Technology. 2015;36(10):24-24	Letters to the editor/ Review studies
1885	Ugolini S, Davis E, Phillips K, Ung S, Stamos L, Thompson B, Zollinger C, Dalpiaz A, Smith L, Carlson A, Chandna S. Successful Nurse-Driven Implementation of Hepatitis C Virus (HCV) Ab+/NAT+ Donor Acceptance Guideline for Heart Transplant: Single-Center Experience. Journal of Cardiac Failure. 2019 Aug 1;25(8):S125.	Conference abstract
1886	Ukabiala O, Alkureishi L, Isaacson JH, Mayer M, Arora VM, Lee WW. Impact of faculty training on patient satisfaction with patient-centered electronic medical record use. InJOURNAL OF GENERAL INTERNAL MEDICINE 2016 May 1 (Vol. 31, pp. S825-S826).	Conference abstract
1887	Uko C. Implementing Evidence-Based Vitamin D Protocol in the Dialysis Clinic: An Educational Approach. Nephrology Nursing Journal. 2020 May 1;47(3).	Study not about effectiveness
1888	Uko C. Implementing Evidence-Based Vitamin D Protocol in the Dialysis Clinic: An Educational Approach. Nephrology Nursing Journal. 2020 May 1;47(3).	Study not about effectiveness
1889	Ulhassan W, von Thiele Schwarz U, Westerlund H, Sandahl C, Thor J. How visual management for continuous improvement might guide and affect hospital staff: A case study. Quality management in health care. 2015 Oct 1;24(4):222-8.	Not a champion
1890	Ung YC, Evans W, Gatto A, Gollnow A, Martelli-Reid L, Kiteley C, Chen A. Implementing dyspnea management: a quality improvement project for patients with lung cancer in Ontario, Canada. InJournal of Thoracic Oncology 2013 Nov 1 (Vol. 8, pp. S1010-S1010).	Conference abstract
1891	Unsworth J. Make or break: factors influencing the development of nursing practice within the UK National Health Service (Doctoral dissertation).	Study not about effectiveness
1892	Uplinger N, Turkel MC, Adams PC, Nelson-Slemmer D, Pierce S. Development of a DiaBEATes nurse champion program. The Diabetes Educator. 2009 Sep;35(5):713-26.	Study not about effectiveness
1893	Urbanski J, Baskel M, Martelli M. Strategic Planning—A Plan for Excellence for South Haven Health System. Nursing administration quarterly. 2011 Jul 1;35(3):227-34.	Study not about effectiveness

Number	Reference	Exclusion Reason
1894	Urimubenshi G. Implementing stroke unit care in selected hospitals in Rwanda (Doctoral dissertation, University of Glasgow).	Study not about effectiveness
1895	Urquhart R, Kendell C, Cornelissen E, Madden LL, Powell BJ, Kissmann G, Richmond SA, Willis C, Bender JL. Defining sustainability in practice: views from implementing real-world innovations in health care. BMC health services research. 2020 Dec;20(1):1-7.	Study not about effectiveness
1896	Urquhart R, Kendell C, Geldenhuys L, Ross A, Rajaraman M, Folkes A, Madden LL, Sullivan V, Rayson D, Porter GA. The role of scientific evidence in decisions to adopt complex innovations in cancer care settings: a multiple case study in Nova Scotia, Canada. Implementation Science. 2019 Dec;14(1):1-2.	Study not about effectiveness
1897	Urquhart R, Porter GA, Sargeant J, Jackson L, Grunfeld E. Multi-level factors influence the implementation and use of complex innovations in cancer care: a multiple case study of synoptic reporting. Implementation Science. 2014 Dec;9(1):1-6.	Study not about effectiveness
1898	Urquhart R, Sargeant J, Porterm GA. Factors related to the implementation and use of an innovation in cancer surgery. Current Oncology. 2011 Dec;18(6):271-9.	Study not about effectiveness
1899	Urrutia, R. A Team of Champions. Pancreatology 2011;10(6):III-IV	Not about knowledge translation/evidence-based practice
1900	Uscher-Pines L.; Kahn J.M. Barriers and facilitators to pediatric emergency telemedicine in the United States Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2014;20(11):990-996	Study not about effectiveness
1901	Ustianov J.; Feldman-Winter L.; Heinrich P.; Homer C. Using qi to increase breastfeeding rates. Breastfeeding Medicine / 2013;8(SUPPL. 1):S-11	Conference abstract
1902	Uzochukwu B, Onyedinma C, Okeke C, Onwujekwe O, Manzano A, Ebenso B, Etiaba E, Ezuma N, Mirzoev T. What makes advocacy work? Stakeholders' voices and insights from prioritisation of maternal and child health programme in Nigeria. BMC health services research. 2020 Dec;20(1):1-6.	Not within a health care setting
1903	Vajravelu ME, Lord K, Gaines S, Jacobstein C, Lavelle J, Patel N, Orenstein M, Palladino AA, Kelley J, Ackermann AM. Reducing Time to Treatment of Diabetic Ketoacidosis in the Emergency Department Setting. In99th Annual Meeting of the Endocrine Society 2017 Apr 2. Endocrine Society.	Conference abstract

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1904	Valaitis R, Meagher-Stewart D, Martin-Misener R, Wong ST, MacDonald M, O'Mara L. Organizational factors influencing successful primary care and public health collaboration. BMC health services research. 2018 Dec;18(1):1-7.	Study not about effectiveness
1905	Vamos S, Rootman I, Shohet L, Donnell L. Health literacy policies: National examples from Canada. INTERNATIONAL HANDBOOK OF HEALTH LITERACY. 2019 Jul 31:435.	Not about knowledge translation/evidence-based practice
1906	Van Camp L.; Kessenich A.; Tcheng J.; Kroll R.; Chesebro A. A duke heart network affiliate collaborative performance improvement project: Reducing contrast-induced acute kidney injury. Catheterization and Cardiovascular Interventions / 2017;89(Supplement 2):S154-S155	Conference abstract
1907	van Deventer C, Golden L, Du Plessis E, Lion-Cachet C. Optimal management of children on antiretroviral therapy (ART) in primary care: a quality improvement project. South African Family Practice. 2017 Mar 8;59(1):29-34.	Study not about effectiveness
1908	van Laere J, Aggestam L. Understanding champion behaviour in a health-care information system development project–how multiple champions and champion behaviours build a coherent whole. European Journal of Information Systems. 2016 Jan 1;25(1):47-63.	Study not about effectiveness
1909	Van Oers HA, Teela L, Schepers SA, Grootenhuis MA, Haverman L. A retrospective assessment of the KLIK PROM portal implementation using the Consolidated Framework for Implementation Research (CFIR). Quality of Life Research. 2020 Aug 15:1-3.	Study not about effectiveness
1910	Van Scoyoc S.K. How To Be a Champion. Journal of Evidence-Based Dental Practice. 2009;9(3):151-153	Letters to the editor/ Review studies
1911	Vardanian MM, Horwitz SM, Storfer-Isser A, Wang N, Gleacher A, Hoagwood K, Olin SS. A second look at dropout rates from state-sponsored MAP trainings: Can targeted adaptations improve retention in evidence-based practice trainings?. the Behavior Therapist. 2017 Oct.	Study not about effectiveness
1912	Varnell G; Haas B; Duke G; Hudson K. Effect of an educational intervention on attitudes toward and implementation of evidence-based practice. Worldviews on Evidence-Based Nursing ;5(4):172-181	Not within a health care setting
1913	Vedel I, Le Berre M, Sourial N, Arsenault-Lapierre G, Bergman H, Lapointe L. Shedding light on conditions for the successful passive dissemination of recommendations in primary care: a mixed methods study. Implementation Science. 2018 Dec;13(1):1-2.	Study not about effectiveness

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1914	Velji K, Baker GR, Fancott C, Andreoli A, Boaro N, Tardif G, Aimone E, Sinclair L. Effectiveness of an adapted SBAR communication tool for a rehabilitation setting. Healthc Q. 2008 Mar 15;11(3):72-9.	Not a champion
1915	Venkat A, Rickard-Aasen S, Shank G, Pringle J. A Qualitative Analysis of the Incorporation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) into the Normal Workflow of the Emergency Department for Patients with At-Risk Behavior Related to Drug and Alcohol Abuse: 722. Academic Emergency Medicine. 2014 May;21.	Conference abstract
1916	Venkataraman V, Browning T, Pedrosa I, Abbara S, Fetzer D, Toomay S, Peshock RM. Implementing shared, standardized imaging protocols to improve cross-enterprise workflow and quality. Journal of digital imaging. 2019 Oct;32(5):880-7.	Study not about effectiveness
1917	Venketasubramanian N. Stroke pathways. Annals of the Academy of Medicine, Singapore / 2001;30(4 Suppl):27-35	Study not about effectiveness
1918	Venter C, Vlieg-Boerstra B, Skypala I. INDANA-International Network for Diet And Nutrition in Allergy. Clinical and Translational Allergy. 2011 Dec;1(1):1-.	Conference abstract
1919	Verma P, Saleem Z, Vantra A, Ladak B, Bhaduri A. G13 Timely completion of discharge letters in a busy paediatric assessment unit (PAU): A challenge overcomed.	Conference abstract
1920	Vickery KD, Rindfleisch K, Benson J, Furlong J, Martinez-Bianchi V, Richardson CR. Preparing the Next Generation of Family Physicians to Improve Population Health. Family medicine. 2015 Nov;47(10):782-8.	Not within a health care setting
1921	Visram S, Hunter DJ, Kuchenmüller T. Capacity for evidence-informed policymaking across Europe: development and piloting of a multistakeholder survey. Public health. 2018 Oct 1;163:54-60.	Study not about effectiveness
1922	Viswanathan M, Nerz P, Dalberth B, Voisin C, Lohr KN, Tant E, Jonas DE, Carey T. Assessing the impact of systematic reviews on future research: two case studies. Journal of comparative effectiveness research. 2012 Jul;1(4):329-46.	Study not about effectiveness
1923	Vohra S, Feldman K, Johnston B, Waters K, Boon H. Integrating complementary and alternative medicine into academic medical centers: experience and perceptions of nine leading centers in North America. BMC health services research. 2005 Dec;5(1):1-7.	Study not about effectiveness
1924	Voigt J, Waltzman M, Lottenberg L. Intraosseous vascular access for in-hospital emergency use: a systematic clinical review of the literature and analysis. Pediatric emergency care. 2012 Feb 1;28(2):185-99.	Letters to the editor/ Review studies

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1925	Vollers WJ, Wright A, Mall A. Sustaining Zero: Central Line Associated Bloodstream Infection Prevention through Innovation, Accountability and Evidence-Based Practice. American Journal of Infection Control. 2011 Jun 1;39(5):E48-9.	Conference abstract
1926	Vousden N, Lawley E, Seed PT, Gidiri MF, Charantimath U, Makonyola G, Brown A, Yadeta L, Best R, Chinkoyo S, Vwalika B. Exploring the effect of implementation and context on a stepped-wedge randomised controlled trial of a vital sign triage device in routine maternity care in low-resource settings. Implementation Science. 2019 Dec;14(1):1-6.	Study not about effectiveness
1927	Wager KA, Lee FW, White AW, Ward DM, Ornstein SM. Impact of an electronic medical record system on community-based primary care practices. The Journal of the American Board of Family Practice. 2000 Sep 1;13(5):338-48.	Study not about effectiveness
1928	Wagner KM. Exploring the use of social network analysis in identifying physician engagement in quality improvement in the hospital setting. Central Michigan University; 2013.	Study not about effectiveness
1929	Wakefield BJ, Drwal K, Paez M, Grover S, Franciscus C, Reisinger HS, Kaboli PJ, El Accaoui R. Creating and disseminating a home-based cardiac rehabilitation program: experience from the Veterans Health Administration. BMC cardiovascular disorders. 2019 Dec;19(1):1-7.	Study not about effectiveness
1930	Wakerman J, Chalmers EM, Clarence CL, Humphreys JS, Bell AI, Larson A, Lyle D, Pashen DR. Sustainable chronic disease management in remote Australia. Medical Journal of Australia. 2005 Nov;183:S64-8.	Study not about effectiveness
1931	Wale JL, Belizán M, Nadel J, Jeffrey C, Vij SL. The Cochrane Library review titles that are important to users of health care, a Cochrane Consumer Network project. Health Expectations. 2013 Dec;16(4):e146-63.	Study not about effectiveness
1932	Walke L, Robinson S, Perkal M. Implementation and Dissemination of a Clinical Algorithm for Geriatric Hip Fracture Patients: Lessons learned.: D136. Journal of the American Geriatrics Society. 2011 Apr;59.	Conference abstract
1933	Walker C.A.; Oborne C.A.; Burmiston S.; Thomas S. Use of failure severity and frequency to reduce insulin risk in secondary care. Clinical Pharmacist. 2011;3(4):S4-S5	Conference abstract
1934	Walker I, Kiwanuka J, Ngonzi J. Introducing monitoring of vital signs and the WHO Checklist at Mbarara University teaching hospital, Uganda: an observational study. InBritish Journal of Anaesthesia 2012 Mar 1 (Vol. 108, pp. 210-211).	Conference abstract

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1935	Walker JA, Hashim Y, Oranye N. Impact of Muslim opinion leaders' training of healthcare providers on the uptake of MNCH services in Northern Nigeria. Global public health. 2019 Feb 1;14(2):200-13.	Study not about effectiveness
1936	Walker M, Doiron RC, French SD, Feldman-Stewart D, Siemens DR, Mackillop WJ, Booth CM. Bladder-sparing radiotherapy for muscle-invasive bladder cancer: A qualitative study to identify barriers and enablers. Clinical Oncology. 2017 Dec 1;29(12):818-26.	Study not about effectiveness
1937	Walker N, Lehman J, Tanqueray T. Using NELA data to produce sustained improvements in patient outcomes: data analysis and feedback strategies at Homerton University Hospital. InANAESTHESIA 2017 Jan 1 (Vol. 72, pp. 92-92).	Conference abstract
1938	Walker R, Ballentine V. Improved Birth Outcomes With Implementation of a Perinatal Quality and Patient Safety Collaborative. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2014 Jun 1;43:S53-4.	Conference abstract
1939	Walker, T. AHIP long-term care initiative heightens quality. Managed Healthcare Executive 09// 2004;14(9):12-12	Conference abstract
1940	Wallace S, Maxey K, Iyer LS. A multi-case investigation of electronic health record implementation in small-and medium-size physician practices. Journal of Information Technology Case and Application Research. 2014 Jan 2;16(1):27-48.	Study not about effectiveness
1941	Wallace SM, Doy LE, Kedgley EN, Ricketts WM. P87 Evidence-based emergency oxygen guidelines are not being followed in the emergency department. Thorax. 2010 Dec 1;65(Suppl 4):A114-5.	Conference abstract
1942	Walling A, Beron P, Wenger N, Kaprealian T, McCloskey S, King C, Murrell-Diedric K. A Provider-Based Quality Improvement Intervention Aimed at Increasing Appropriateness of Radiation Therapy Regimens for Patients with Advanced Cancer and Painful Bone Metastases (TH320A). Journal of Pain and Symptom Management. 2017 Feb 1;53(2):324-5.	Conference abstract
1943	Walling A.M.; Beron P.; Wenger N.; Kupelian P.; Kaprealian T.B.; Mc Closkey S.A.; King C.R.; Steinberg M.L. A provider-based quality improvement intervention aimed at improving appropriateness of radiation therapy regimens for patients with advanced cancer and painful bone metastases. Journal of Clinical. Oncology2019;34(26 Supplement 1):176	Conference abstract

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1944	Wallis M, Marsden E, Taylor A, Craswell A, Broadbent M, Barnett A, Nguyen KH, Johnston C, Glenwright A, Crilly J. The geriatric emergency department intervention model of care: a pragmatic trial. BMC geriatrics. 2018 Dec;18(1):1-9.	Study not about effectiveness
1945	Walsh KE, Secor JL, Matsumura JS, Schwarze ML, Potter BE, Newcomer P, Kim MK, Bartels CM. Promoting secure provider-to-provider communication with electronic health record messaging: an educational outreach study. Journal for healthcare quality: official publication of the National Association for Healthcare Quality. 2018 Sep;40(5):283.	Study not about effectiveness
1946	Walshe C, Caress A, Chew-Graham C, Todd C. Implementation and impact of the Gold Standards Framework in community palliative care: a qualitative study of three primary care trusts. Palliative Medicine. 2008 Sep;22(6):736-43.	Study not about effectiveness
1947	Walter FL, Bass N, Bock G, Markel DC. Success of clinical pathways for total joint arthroplasty in a community hospital. Clinical Orthopaedics and Related Research®. 2007 Apr 1;457:133-7.	Study not about effectiveness
1948	Wang A, Wolf M, Carlyle R, Wilkerson J, Porterfield D, Reaves J. The North Carolina experience with the diabetes health disparities collaboratives. The Joint Commission Journal on Quality and Safety. 2004 Jul 1;30(7):396-404.	Study not about effectiveness
1949	Wang M.; Hsieh D.; Son D.; Losonczy L.; Tahara K.; Alter H.; Gregory B. Highland health advocates: A resident-led, multidisciplinary advocacy program addressing social determinants of health. Journal of General Internal Medicine. 2015;30(SUPPL. 2):S534-S535	Conference abstract
1950	Wang MC, Hyun JK, Harrison MI, Shortell SM, Fraser I. Redesigning health systems for quality: lessons from emerging practices. The Joint Commission Journal on Quality and Patient Safety. 2006 Nov 1;32(11):599-611.	Study not about effectiveness
1951	Wang V, Allen K, Van Houtven CH, Coffman C, Sperber N, Mahanna EP, Colón-Emeric C, Hoenig H, Jackson GL, Damush TM, Price E. Supporting teams to optimize function and independence in Veterans: a multi-study program and mixed methods protocol. Implementation Science. 2018 Dec;13(1):1-4.	Protocol
1952	Ward AJ, Bell JL, Jerkins L. A model for survivorship care plans (SCP) at a large academic institution.	Conference abstract

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1953	Warner EL, Hacking CC, Wu Y, Kirchhoff AC. Improving quality of pediatric cancer survivor care: Providers' support of and experience with survivor care plans.2014	Conference abstract
1954	Warren CE, Ndwiga C, Sripad P, Medich M, Njeru A, Maranga A, Odhiambo G, Abuya T. Sowing the seeds of transformative practice to actualize women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research. BMC women's health. 2017 Dec;17(1):1-8.	Not within a health care setting
1955	Watson LL, Bluml BM. Integrating pharmacists into diverse diabetes care teams: implementation tactics from Project IMPACT: Diabetes. Journal of the American Pharmacists Association. 2014 Sep 1;54(5):538-41.	Not within a health care setting
1956	Watts B, Drawz P, Stalnaker R, Carter C, Lawrence R, Kern E. Locally-tailored registries: a novel application of the electronic medical record to support quality improvement interventions. Journal of general internal medicine 2011 may 1 (vol. 26, pp. S308-s308).	Conference abstract
1957	Wazneh LM, Tsimicalis A, Loiselle CG. Young Adults' Perceptions of the Venturing Out Pack Program as a Tangible Cancer Support Service. InOncology nursing forum 2016 Jan 1 (Vol. 43, No. 1).	Study not about effectiveness
1958	Weagraff JB. Health Care Leaders' Experiences of Electronic Medical Record Adoption and Use. 2016	Study not about effectiveness
1959	Weatherby H, Woolner V, Chartier L, Casey S, Ong C, Gaylord E. LO37: Reducing hemolysis of coagulation blood samples in the emergency department. Canadian Journal of Emergency Medicine. 2020 May;22(S1):S20-.	Conference abstract
1960	Weaver FM, Goldstein B, Evans CT, Legro MW, LaVela S, Smith B, Miskevics S, Hammond MC. Influenza vaccination among veterans with spinal cord injury: Part 2. Increasing vaccination rates. The journal of spinal cord medicine. 2003 Jan 1;26(3):210-8.	Study not about effectiveness
1961	Webster SN, Unger HW, El-Nouri A, El Halawani M, Black B, Sobhy S, Uygur D, Unger GD, Wright A. Changing practice: role of the RCOG'Quality and Safety in the Second Stage of labour'(QSSS) initiative. Bjog-an international journal of obstetrics and gynaecology 2019 Jun 1 (Vol. 126, pp. 74-75).	Conference abstract
1962	Weiner BJ, Haynes-Maslow L, Campbell MK, Kahwati LC, Kinsinger LS. Implementing the MOVE! weight-management program in the Veterans Health Administration, 2007-2010: a qualitative study. Preventing chronic disease. 2012;9.	Study not about effectiveness

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1963	Weingart SN, Price J, Duncombe D, Connor M, Conley K, Conlin GJ, Sullivan AM, Powell M, Ponte PR, Bierer BE. Enhancing safety reporting in adult ambulatory oncology with a clinician champion: a practice innovation. Journal of nursing care quality. 2009 Jul 1;24(3):203-10.	Study not about effectiveness
1964	Weissman DE. Champions, leaders, and the future of palliative care.2003	Letters to the editor/ Review studies
1965	Wells S, Shermont H, Hockman G, Hamilton S, Abecassis L, Blanchette S, Munhall D. Standardized tracheostomy education across the enterprise. Journal of pediatric nursing. 2018 Nov 1;43:120-6.	Study not about effectiveness
1966	Welsh CA, Flanagan ME, Hoke SC, Doebbeling BN, Herwaldt L. Reducing health care-associated infections (HAIs): lessons learned from a national collaborative of regional HAI programs. American journal of infection control. 2012 Feb 1;40(1):29-34.	Study not about effectiveness
1967	Welsh SM, Sherriff A, Flodgren G. The champion for improved delivery of care to older people in long-term care settings: effects on professional practice, quality of care and resident outcomes. The Cochrane Database of Systematic Reviews. 2015 Apr;2015(4).	Protocol
1968	Welton C, Baudisch M. HOW CAN RESPIRATORY THERAPISTS SOLVE ALARM FATIGUE?. Canadian Journal of Respiratory Therapy. 2017 Mar 1;53(2).	Conference abstract
1969	Werner-Wasik M, Harrison AS, Wilson K, Clancy D, DiNome JW, Shi W, Babinsky L, Hurwitz MD. Impact Assessment of a Comprehensive Department Quality Improvement Program Reporting System. International Journal of Radiation Oncology, Biology, Physics. 2019 Sep 1;105(1):E611.	Conference abstract
1970	Werth SL, Justice R. Prevalence of Moisture-Associated Skin Damage in an acute care setting: outcomes from a quality improvement Project. Journal of Wound Ostomy & Continence Nursing. 2019 Jan 1;46(1):51-4.	Study not about effectiveness
1971	West BJ, Macduff C, McBain M, Gass J. Evaluation of a national educational programme for healthcare workers on prevention and control of healthcare associated infections. Journal of Research in Nursing. 2006 Nov;11(6):543-57.	Study not about effectiveness
1972	Westbury JA, Johnson MJ, Pond JP, Toy CF, Anderson LS, Blake E, Leaf AA. Developing the role of the nurse as a link advisor for research and a champion for nutrition in the neonatal intensive care unit. Journal of Neonatal Nursing. 2013 Aug 1;19(4):198-205.	Study not about effectiveness

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1973	West-Pollak A, Then EP, Podesta C, Hedelt A, Perry ML, Izarnotegui WV, Perez M, Villegas A, Baez NI, Bassa R, Mendez G. Impact of a novel community-based lifestyle intervention program on type 2 diabetes and cardiovascular risk in a resource-poor setting in the Dominican Republic. International health. 2014 Jun 1;6(2):118-24.	Not within a health care setting
1974	Whicker MA. Bedside Nurses' Influence on Patients' Continuum of Care Through Effective Discharge Teaching (Doctoral dissertation, Walden University).	Protocol
1975	**White C.M., Statile A.M., Conway P.H., Schoettker P.J., Solan L.G., Unaka N.I., Vidwan N., Warrick S.D., Yau C., Connelly B.L.** (2012). Utilizing improvement science methods to improve physician compliance with proper hand hygiene *#journal#*, 129(4), e1042	Study not about effectiveness
1976	White CL. Nurse champions: A key role in bridging the gap between research and practice. Journal of Emergency Nursing. 2011 Jul 1;37(4):386-7.	Letters to the editor/ Review studies
1977	White CM, GD SS, Butler M, Wang Z, Robinson K, Mitchell MD, Berkman N, Henderson J, Fiordalisi C, Hartling L, Newberry SJ. Understanding health-systems' use of and need for evidence to inform decisionmaking.	Study not about effectiveness
1978	White DE, Norris JM, Jackson K, Khandwala F. Barriers and facilitators of Canadian quality and safety teams: a mixed-methods study exploring the views of health care leaders. Journal of healthcare leadership. 2016;8:127.	Study not about effectiveness
1979	White JP, Deborah Bransford BS, CDEd KG, Song VL. Hawaii's statewide evidence-based practice program. Integrating Evidence into Practice for Impact, An Issue of Nursing Clinics of North America, E-Book. 2014 Jul 31;49(3):275.	Study not about effectiveness
1980	White K. IBS17. 01 Undertaking Nursing and Allied Health Research—How to Survive It and Get Published. Journal of Thoracic Oncology. 2019 Oct 1;14(10):S108.	Conference abstract
1981	Whittemore R. A multicomponent intervention improved diabetes care in primary care practicesCommentary. Evidence-based nursing. 2009 Jul 1;12(3):89-.	Conference abstract
1982	Wichmann R, Gardner J, Hagestuen R. Struthers Parkinson's Center Network (SPCN): Improving PD care through growth and development of sustainable partnerships Journal of Parkinson's Disease. 2016;6(Supplement 1):118-119	Conference abstract

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1983	Wick K, Hildebrandt B, Peterson A, Bernard J, Rashid A, Larson C. Developing a Culture of Safety around Hand Hygiene. American Journal of Infection Control. 2015 Jun 2;43(6):S54-5.	Conference abstract
1984	Wiedemann, LA. CPOE Lessons Learned. Journal of AHIMA. 2010;81(10):54-64	Letters to the editor/ Review studies
1985	Wilcox ME, Singh JM, Chung K, Lazar NM, McIntaggart S, Stewart TE. Improving quality, safety and costs by implementing a performance measurement and management approach for common investigations in the icu. Intensive care medicine 2009 Sep 1 (Vol. 35, pp. 174-174).	Conference abstract
1986	Wilder T, Harris N. Pre-exposure Prophylaxis (PrEP) in Clinical Settings: Are Medical Providers PrEPared?. InAIDS RESEARCH AND HUMAN RETROVIRUSES 2016 Oct 1 (Vol. 32, pp. 293-293).	Conference abstract
1987	Wiley W, McQueen A, Stewart H. N037 Improving Quality and Safety in a Regional Cardiac Care Program: Implementation of a Quality and Safety Huddle to Engage the Multi-Disciplinary Team to Improve Patient Care. Canadian Journal of Cardiology. 2012 Sep 1;28(5):S431.	Conference abstract
1988	Wilkinson KN. A year of change: Nurse unit champions reduce CLABSI on 5 medical/surgical units. American Journal of Infection Control. 2013 Jun 1;41(6):S18.	Conference abstract
1989	Wilkinson S, Borycki E, Kushniruk A. Best practices for EHR implementation: A BC First Nations community's experience. InHealthcare management forum 2020 Jan (Vol. 33, No. 1, pp. 39-46). Sage CA: Los Angeles, CA: SAGE Publications.	Study not about effectiveness
1990	Wilkinson-Houston KN, Reeves T, Zuckerman J. Beyond Critical Care: Reducing CABSI on Medical-Surgical and Long Term Care Units. American Journal of Infection Control. 2011 Jun 1;39(5):E56-7.	Conference abstract
1991	Williams AM, Crooks VA, Whitfield K, Kelley ML, Richards JL, DeMiglio L, Dykeman S. Tracking the evolution of hospice palliative care in Canada: a comparative case study analysis of seven provinces. BMC Health Services Research. 2010 Dec;10(1):1-5.	Not within a health care setting
1992	Williams AM, Dawson SS, Kristjanson LJ. Translating theory into practice: using action research to introduce a coordinated approach to emotional care. Patient education and counseling. 2008 Oct 1;73(1):82-90.	Study not about effectiveness
1993	Williams AM, Toye C, Deas K, Fairclough D, Curro K, Oldham L. Evaluating the feasibility and effect of using a hospital-wide coordinated approach to introduce evidence-based changes for pain management. Pain Management Nursing. 2012 Dec 1;13(4):202-14.	Study not about effectiveness

Number	Reference	Exclusion Reason
1994	Williams GM. Physician, management, and hospital influence on the adoption of electronic health records: A qualitative study of influencing factors that impact EHR adoption (Doctoral dissertation, Capella University).	Study not about effectiveness
1995	Williams J, Sachdev N, Moin T, Duru OK. 2239-PUB: Best Practices for Implementing Diabetes Prevention in Health Care Settings.	Conference abstract
1996	Williams K. Evaluating successful disease management programs using Kotter's eight-step change model as a theoretical framework for understanding (Doctoral dissertation, Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses.(UMI 3648365)).	Study not about effectiveness
1997	Williams K. Implementing an Osteoporosis Program into Your Practice, Hospital, or Organization: What Works and What Doesn't Work. InJOURNAL OF BONE AND MINERAL RESEARCH 2019 Dec 1 (Vol. 34, pp. 354-354).	Conference abstract
1998	Williams KM. Evaluating successful disease management programs. Osteoporosis international 2016 Nov 1 (Vol. 27, pp. S733-S734)..	Conference abstract
1999	Williams L, Woodward-Hagg H, Bravata D, Daggett V, Plue L, Damush T. Healthcare Engineering Methods Can Improve Inpatient Stroke Care Quality. InSTROKE 2010 Apr 1 (Vol. 41, No. 4, pp. E288-E289).	Conference abstract
2000	Williams TA, Leslie GD, Leen T, Mills L, Dobb GJ. Reducing interruptions to continuous enteral nutrition in the intensive care unit: a comparative study. Journal of clinical nursing. 2013 Oct;22(19-20):2838-48.	Study not about effectiveness
2001	Williams VN. A Mixed-Methods Approach to Characterizing Cross-Sector Collaboration and its Effects in Nurse-Family Partnership (Doctoral dissertation, University of Colorado Denver, Anschutz Medical Campus).	Study not about effectiveness
2002	Williams, J. "Enthused Houston dentist firs in line to apply for evidence-based Dentistry Champions Conference." American Dental Association News 44(5): 10-10.	Letters to the editor/ Review studies
2003	Williams, J. Time to champion evidence-based dentistry. American Dental Association News ;44(2):12-13	Letters to the editor/ Review studies
2004	Williams, Jean. Dentists learn new tools at EBD champions conference. American Dental Association News ;43(7):22-22	Letters to the editor/ Review studies

Number	Reference	Exclusion Reason
2005	Williamson JE, Logan AY, Reinke EK, Jarrett S, Clarke C, Davidson LE. The First Step is Always the Hardest: Building a Framework for Stewardship Across a Large, Diverse Healthcare System. InOpen Forum Infectious Diseases 2016 Dec 1 (Vol. 3, No. suppl_1, p. 967). Oxford University Press.	Conference abstract
2006	Wilne S, Liu JF, Trusler J, Lundsell S, Kennedy C, Clough L, Dickson N, Lakhanpaul M, Baker M, Dudley J, Grundy R. THE UK" HEADSMART-BE BRAIN TUMOUR AWARE" CAMPAIGN. InNeuro-Oncology 2012 Jun 1 (Vol. 14, pp. 131-131).	Conference abstract
2007	Wilson D, Redman RW, Talsma A, Aebersold M. Differences in perceptions of patient safety culture between charge and noncharge nurses: implications for effectiveness outcomes research. Nursing Research and Practice. 2012 Oct;2012.	Study not about effectiveness
2008	Wilson M, Chen HS, Wood M. Impact of nurse champion on quality of care and outcomes in type 2 diabetes patients. JBI Evidence Implementation. 2019 Mar 1;17(1):3-13.	Letters to the editor/ Review studies
2009	Winterbottom AE, Jha V, Melville C, Corrado O, Symons J, Torgerson D, Watt I, Wright J. A randomised controlled trial of patient led training in medical education: protocol. BMC medical education. 2010 Dec;10(1):1-5.	Protocol
2010	Wise HH, Frost JS, Resnik C, Davis BP, Iglarsh AZ. Interprofessional education: An exploration in physical therapist education. Journal of Physical Therapy Education. 2015 Jan 1;29(2):72-83.	Study not about effectiveness
2011	Witham M, Rochester L, Nestor G, Dark P, Down K, Hall A, Hancock H, Knee J, Maier R, Mountain G, Tortice A. 'Better healthcare through more inclusive research'-an NIHR workstream to improve trial delivery for underserved groups. InTRIALS 2019 Oct 1 (Vol. 20).	Conference abstract
2012	Witkamp FE, van Zuylen L, Van der Maas PJ, Van Dijk H, Van der Rijt CC, Van der Heide A. Improving the quality of palliative and terminal care in the hospital by a network of palliative care nurse champions: the study protocol of the PalTeC-H project. BMC health services research. 2013 Dec;13(1):1-7.	Protocol
2013	Witkamp FE, van Zuylen L, van der Rijt CC, van der Heide A. Effect of palliative care nurse champions on the quality of dying in the hospital according to bereaved relatives: a controlled before-and-after study. Palliative medicine. 2016 Feb;30(2):180-8.	Study not about effectiveness

Number	Reference	Exclusion Reason
2014	Woelk G, Daniels K, Cliff J, Lewin S, Sevene E, Fernandes B, Mariano A, Matinhure S, Oxman AD, Lavis JN, Lundborg CS. Translating research into policy: lessons learned from eclampsia treatment and malaria control in three southern African countries. Health Research Policy and Systems. 2009 Dec;7(1):1-4.	Study not about effectiveness
2015	Wolff AM, Bourke J. Reducing medical errors: a practical guide. The Medical Journal of Australia. 2000 Sep 1;173(5):247-51.	Letters to the editor/ Review studies
2016	Wolfson D, Bernabeo E, Leas B, Sofaer S, Pawlson G, Pillittere D. Quality improvement in small office settings: an examination of successful practices. BMC Family Practice. 2009 Dec;10(1):1-2.	Study not about effectiveness
2017	Wollenhaup CA, Stevenson EL, Thompson J, Gordon HA, Nunn G. Implementation of a modified bedside handoff for a postpartum unit. JONA: The Journal of Nursing Administration. 2017 Jun 1;47(6):320-6.	Study not about effectiveness
2018	Wondimagegn D, Cornelson B, Rouleau K, Janakiram P, Ghavam-Rassoul A, Rodas J, Zemenfes D. Toronto Addis Ababa Academic Collaboration in Family Medicine: an overview of the dawn of family medicine in Ethiopia through an inter-institutional model. Annals of Global Health. 2016 Aug 20;82(3).	Conference abstract
2019	Wong J.J.; Houghton E.; D'Orton-Gibson P.; Fadden E.; Whitmore D.; Morton B. A six-month quality improvement project to improve adherence to optimal physiological parameters for patients in Aintree University Hospital Critical Care Unit. Journal of the Intensive Care Society .2019;20(2 Supplement):69-70	Conference abstract
2020	Wong P, Helsinger D, Petry J. Providing the right infrastructure to lead the culture change for patient safety. The Joint Commission journal on quality improvement. 2002 Jul 1;28(7):363-72.	Study not about effectiveness
2021	Woo K, Milworm G, Dowding D. Characteristics of quality improvement champions in nursing homes: a systematic review with implications for evidence-based practice. Worldviews on Evidence-Based Nursing. 2017 Dec;14(6):440-6.	Letters to the editor/ Review studies
2022	Wood Dauphinee S.L.; Bayley M.; Mokry J.; Salbach N.; Thorpe K. Stroke Canada optimization of rehabilitation by evidence: Implementation trial (SCORE: IT). Cerebrovascular Diseases .2011;31(SUPPL. 2):43	Conference abstract
2023	Woodhead T, Campbell F, Muszynska K. ISQUA18-1798 Using a National Registry and Structured Collaboration to Improve the Care of Children and Young People with Diabetes. International Journal for Quality in Health Care. 2018 Sep;30(suppl_2):48-9.	Conference abstract

Number	Reference	Exclusion Reason
2024	Woody II EW. MHS Genesis Implementation: Strategies in Support of Successful EHR Conversion. Military Medicine. 2020 Sep 18;185(9-10):e1520-7.	Letters to the editor/ Review studies
2025	Wright FC, Gagliardi AR, Fraser N, Quan ML. Adoption of surgical innovations: factors influencing use of sentinel lymph node biopsy for breast cancer. Surgical innovation. 2011 Dec;18(4):379-86.	Study not about effectiveness
2026	Wright J, Fiocchi F, Kehoe K, Mitchell K, Thrutchley D, Breeding T, Gupte S, Buchanan D, Spertus J, Rumsfeld J. Building Quality Improvement from the Ground Up: Lessons from the Design and Implementation of the IC3 Program National Practice-Based Quality Improvement Program. InCIRCULATION 2010 Jul 13 (Vol. 122, No. 2, pp. E84-E84).	Conference abstract
2027	Wroth TH, Boals JC. Application of quality-improvement methods in a community practice: the Sandhills Pediatrics Asthma Initiative. North Carolina medical journal. 2005 May 1;66(3):218-20.	Not a champion
2028	Wyman MF, Schmidt J, Flood M, Gleason C. A WHOLE-FACILITY APPROACH: IMPLEMENTING AN INNOVATIVE MODEL OF "DEMENTIA FRIENDLY HOSPITAL" AT THE MADISON VA MEDICAL CENTER. Innovation in Aging. 2018 Nov;2(Suppl 1):208.	Conference abstract
2029	Xiang X, Robinson-Lane SG, Rosenberg W, Alvarez R. Implementing and sustaining evidence-based practice in health care: The Bridge Model experience. Journal of gerontological social work. 2018 Apr 3;61(3):280-94.	Study not about effectiveness
2030	Xiao LD, Ullah S, Morey W, Jeffers L, De Bellis A, Willis E, Harrington A, Gillham D. Evaluation of a nurse-led education program to improve cross-cultural care for older people in aged care. Nurse education today. 2020 Apr 1;87:104356.	Study not about effectiveness
2031	Xie A, Koontz DW, Voskertchian A, Fackler JC, Milstone AM, Woods-Hill CZ. Survey-based Work System Assessment to Facilitate Large-scale Dissemination of Healthcare Quality Improvement Programs. Pediatric Quality & Safety. 2020 Mar;5(2).	Study not about effectiveness
2032	Yackanicz L, Kerr R, Levick D. Physician buy-in for EMRs. Journal of healthcare information management: JHIM. 2010 Jan 1;24(2):41-4.	Study not about effectiveness
2033	Yadav K, Stahmer A, Mistry RD, May L. An implementation science approach to antibiotic stewardship in emergency departments and urgent care centers. Academic Emergency Medicine. 2020 Jan;27(1):31-42.	Study not about effectiveness

Number	Reference	Exclusion Reason
2034	Yakovchenko V, DeSotto K, Drainoni ML, Lukesh W, Miller DR, Park A, Shao Q, Thornton DJ, Gifford AL. Using Lean-Facilitation to Improve Quality of Hepatitis C Testing in Primary Care. Journal of General Internal Medicine. 2021 Feb;36(2):349-57.	Study not about effectiveness
2035	Yanagizawa-Drott L, Kurland L, Schuur JD. Infection prevention practices in Swedish emergency departments: results from a cross-sectional survey. European Journal of Emergency Medicine. 2015 Oct 1;22(5):338-42.	Conference abstract
2036	Yang L, Brown-Johnson CG, Miller-Kuhlmann R, Kling SM, Saliba-Gustafsson EA, Shaw JG, Gold CA, Winget M. Accelerated launch of video visits in ambulatory neurology during COVID-19: Key lessons from the Stanford experience. Neurology. 2020 Aug 18;95(7):305-11.	Study not about effectiveness
2037	Yang RS, Chao CT, Huang WJ, Chan DC. A multicentre cohort study of risk factors for mortality, falls, and recurrent fractures among patients under fracture liaison service. Osteoporosis international 2019 may 1 (Vol. 30, pp. S82-S82).	Conference abstract
2038	Yevchak AM, Fick DM, McDowell J, Monroe T, May K, Grove L, Kolanowski AM, Waller JL, Inouye SK. Barriers and facilitators to implementing delirium rounds in a clinical trial across three diverse hospital settings. Clinical Nursing Research. 2014 Apr;23(2):201-15.	Study not about effectiveness
2039	Yip S, Fleming J, Shepherd HL, Walczak A, Clark J, Butow P. "As Long as You Ask": A Qualitative Study of Biobanking Consent—Oncology Patients' and Health Care Professionals' Attitudes, Motivations, and Experiences—the B-PPAE Study. The oncologist. 2019 Jun;24(6):844.	Study not about effectiveness
2040	Yoder L.H.; Kirkley D.; McFall D.C.; Kirksey K.M.; StalBaum A.L.; Sellers D. CE: Original Research: Staff nurses' use of research to facilitate evidence-based practice. The American journal of nursing . 2014;114(9)	Study not about effectiveness
2041	Young AM, Keller HH, Barnes R, Bell JJ. Clinicians as novice facilitators: a SIMPLE case study. Journal of health organization and management. 2019 Mar 18.	Study not about effectiveness
2042	Young BC, Hacker MR, Dodge LE, Golen TH. Timing of antibiotic administration and infectious morbidity following cesarean delivery: incorporating policy change into workflow. Archives of gynecology and obstetrics. 2012 May;285(5):1219-24.	Study not about effectiveness
2043	Young J.; MacGinley K.; Bines E.; Heald V. Parkinson's service - A collaborative approach in the emergency department (ED). Age and Ageing . 2018;47(Supplement 3):	Conference abstract

Number	Reference	Exclusion Reason
2044	Yourman L, Nguyen K, Gupta R. Quality Improvement for Quality Improvement Education in Geriatrics. JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 2019 Apr 1 (Vol. 67, pp. S231-S231).	Conference abstract
2045	Yusof MM. A case study evaluation of a critical care information system adoption using the socio-technical and fit approach. International journal of medical informatics. 2015 Jul 1;84(7):486-99.	Study not about effectiveness
2046	Zachariah F, Gallo M, Loscalzo M, Crocitto LE. Embedding palliative care into care coordination.2014	Conference abstract
2047	Zakocs R, Freire KE. The DELTA PREP initiative: Accelerating coalition capacity for intimate partner violence prevention. Health Education & Behavior. 2015 Aug;42(4):458-70.	Study not about effectiveness
2048	Zandieh SO, Yoon-Flannery K, Kuperman GJ, Langsam DJ, Hyman D, Kaushal R. Challenges to EHR implementation in electronic-versus paper-based office practices. Journal of general internal medicine. 2008 Jun;23(6):755-61.	Study not about effectiveness
2049	Zarzour MH. How Can We Improve Our Understanding of Successful Implementations in EHealth? (Doctoral dissertation, University of Manchester).	Study not about effectiveness
2050	Zecevic AA, Li AH, Ngo C, Halligan M, Kothari A. Improving safety culture in hospitals: facilitators and barriers to implementation of Systemic Falls Investigative Method (SFIM). International Journal for Quality in Health Care. 2017 Jun 1;29(3):371-7.	Duplicate
2051	Zecevic AA, Li AH, Ngo C, Halligan M, Kothari A. Improving safety culture in hospitals: facilitators and barriers to implementation of Systemic Falls Investigative Method (SFIM). International Journal for Quality in Health Care. 2017 Jun 1;29(3):371-7.	Study not about effectiveness
2052	Zeitouni R, Saha A, Gettys KE, Avey K, Burdon TD. Improving transition of care for patients with high risk for readmission. Journal of general internal medicine 2014 Apr 1 (Vol. 29, pp. S486-S487).	Conference abstract
2053	Zhu H, Ponnusamy V, Broster S, Ogilvy-Stuart A. G198 (P) A New NICU Bedside Procedures Safety Checklist. Archives of Disease in Childhood. 2014 Apr 1;99(Suppl 1):A87-8.	Conference abstract
2054	Zhukovsky DS, Haider A, Naqvi SM, Joshi N, Soliman PT, Mathew B, Bodurka DC, Meyer L, Westin SN, Frumovitz MM, Archie L. A systematic process to enhance selection of a prepared medical decision maker.	Conference abstract

Number	Reference	Exclusion Reason
2055	Zimmerman RK, Brown AE, Pavlik VN, Moehling KK, Raviotta JM, Lin CJ, Zhang S, Hawk M, Kyle S, Patel S, Ahmed F. Using the 4 pillars practice transformation program to increase pneumococcal immunizations for older adults: a cluster-randomized trial. Journal of the American Geriatrics Society. 2017 Jan;65(1):114-22.	Study not about effectiveness
2056	Zingg W, Holmes A, Dettenkofer M, Goetting T, Secci F, Clack L, Allegranzi B, Magiorakos AP, Pittet D. Hospital organisation, management, and structure for prevention of health-care-associated infection: a systematic review and expert consensus. The Lancet Infectious Diseases. 2015 Feb 1;15(2):212-24.	Letters to the editor/ Review studies
2057	Zorbas H. The australian experience - Consumer involvement across the continuum of cancer control Asia-Pacific Journal of Clinical Oncology.2011;7(SUPPL. 4):85	Conference abstract
2058	Zoutman DE, Ford BD. Quality improvement in hospitals: barriers and facilitators. International journal of health care quality assurance. 2017 Feb 13.	Study not about effectiveness
2059	Zuber CD, Moody L. Creativity and innovation in health care. Nursing administration quarterly. 2018 Jan 1;42(1):62-75.	Study not about effectiveness
2060	Zuber CD. Empowering champions of innovation and change in large healthcare organisations using human-centred design (Doctoral dissertation, Coventry University).	Study not about effectiveness

Additional File 4: Quality Appraisal Assessments

Supplemental Table 1: Quality Appraisal of Included Cross-sectional Studies (*n* = 24)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total Score	Quality Score	Quality
Albert, 2012	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Alidina, 2018	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Ash, 1997	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Moderate
Ben-David, 2019	Yes	No	No	Yes	No	No	Yes	No	6	.38	Weak
Bradley, 2012	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	7	.44	Weak
Chang, 2012	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Moderate
Ellerbeck, 2006	No	No	No	Yes	Yes	No	No	No	4	.25	Weak
Goff, 2019	Yes	Yes	No	Yes	Yes	No	No	No	8	.5	Moderate
Granade, 2020	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Hsia, 2019	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Hung, 2008	No	Yes	No	Yes	Yes	Yes	No	Yes	10	.63	Strong
Kabukye, 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	16	1	Strong
Kenny,2005	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Khera, 2018	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Strong
Korall, 2017, 2018[1]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Lago, 2013	Yes	Yes	No	Yes	No	No	No	No	6	.38	Weak
Papadakis, 2014	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Pare, 2011	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Patton, 2013	Yes	No	No	Yes	No	No	No	Yes	6	.38	Weak
Shea, 2016	No	No	No	Yes	Yes	Yes	Yes	Yes	10	.63	Moderate
Strasser, 2003	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Tierney, 2003	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Ward, 2004	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Westrick, 2009	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	16	1	Strong
% of Yes	80	68	16	100	88	80	36	88			

Notes: Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1- Were the criteria for inclusion in the sample clearly defined?; Q2- Were the study subjects and the setting described in detail?; Q3- Was the exposure measured in a valid and reliable way?; Q4 - Were objective, standard criteria used for measurement of the condition?; Q5- Were confounding factors identified?; Q6 - Were strategies to deal with confounding factors stated?; Q7 - Were the outcomes measured in a valid and reliable way?; Q8- Was appropriate statistical analysis used?; [1] - Korall, 2017 and Korall, 2018 are from one study but had two reports.

Supplemental Table 2: Quality Appraisal of Included Cross-sectional Studies without Weak Studies (*n* = 20)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total Score	Quality Score	Quality
Albert, 2012	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Alidina, 2018	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Ash, 1997	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Moderate
Chang, 2012	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Moderate
Goff, 2019	Yes	Yes	No	Yes	Yes	No	No	No	8	.5	Moderate
Granade, 2020	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Hsia, 2019	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Hung, 2008	No	Yes	No	Yes	Yes	Yes	No	Yes	10	.63	Strong
Kabukye, 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	16	1	Strong
Kenny,2005	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Khera, 2018	Yes	No	No	Yes	Yes	Yes	No	Yes	10	.63	Strong
Korall, 2017, 2018[1]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Papadakis, 2014	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Pare, 2011	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	14	.88	Strong
Shea, 2016	No	No	No	Yes	Yes	Yes	Yes	Yes	10	.63	Moderate
Strasser, 2003	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Tierney, 2003	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Ward, 2004	Yes	Yes	No	Yes	Yes	Yes	No	Yes	12	.75	Strong
Westrick, 2009	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	16	1	Strong
% of Yes	80	75	20	100	100	95	35	95			

Notes: Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1- Were the criteria for inclusion in the sample clearly defined?; Q2- Were the study subjects and the setting described in detail?; Q3- Was the exposure measured in a valid and reliable way?; Q4 - Were objective, standard criteria used for measurement of the condition?; Q5- Were confounding factors identified?; Q6 - Were strategies to deal with confounding factors stated?; Q7 - Were the outcomes measured in a valid and reliable way?; Q8- Was appropriate statistical analysis used?; [1] - Korall, 2017 and Korall, 2018 are from one study but had two reports.

Supplemental Table 3: Quality Appraisal of Included Non-controlled Before and After and Interrupted Time Series Studies (*n* = 6)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Total Score	Quality Score	Quality
Campbell, 2008	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	12	.67	Moderate
Foster, 2017	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	12	.67	Moderate
Sharkey, 2013	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	12	.67	Moderate
Soni, 2016	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	14	.78	Strong
Weiler, 2012, 2013 [1]	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	14	.78	Strong
Zavalkoff, 2015	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	14	.78	Strong
% of Yes	100	100	100	0	50	100	100	0	100			

Notes: Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1: Is it clear in the study what is the 'cause' and what is the 'effect' (i.e., there is no confusion about which variable comes first)?; Q2: Were the participants included in any comparisons similar?; Q3: Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest? Q4: Was there a control group?; Q5: Were there multiple measurements of the outcome both pre and post the intervention/exposure?; Q6: Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?; Q7: Were the outcomes of participants included in any comparisons measured in the same way?; Q8: Were outcomes measured in a reliable way?; Q9: Was appropriate statistical analysis used? [1] - Weiler, 2012 and Weiler, 2013 are one study with two reports.

Supplemental Table 4: Quality Appraisal of Included Cohort Studies (*n* =3)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Total Score	Quality Score	Quality
Anand, 2017	Yes	Yes	No	Yes	Yes	Unclear	Yes	Yes	Yes	N/A	Yes	17	.77	Moderate
Sisodia, 2020	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	N/A	Yes	16	.72	Moderate
Whitebird, 2014	Unclear	Yes	No	Yes	No	Yes	No	Yes	Yes	N/A	No	11	.5	Moderate
% of Yes	66.7	100	0	100	66.7	66.7	33.3	100	100	N/A	66.7			

Notes: Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1: Were the two groups similar and recruited from the same population? Q2: Were the exposures measured similarly to assign people to both exposed and unexposed groups? Q3: Was the exposure measured in a valid and reliable way? Q4: Were confounding factors identified? Q5: Were strategies to deal with confounding factors stated? Q6: Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)? Q7: Were the outcomes measured in a valid and reliable way? Q8: Was the follow up time reported and sufficient to be long enough for outcomes to occur? Q9: Was follow up complete, and if not, were the reasons to loss to follow up described and explored? Q10: Were strategies to address incomplete follow up utilized? Q11: Was appropriate statistical analysis used?

Supplemental Table 5: Quality Appraisal of Included Case Control Studies (*n* =1)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total Score	Quality Score	Quality
Slaunwhite, 2009	Yes	No	No	No	Yes	No	Yes	No	Yes	Yes	10	.5	Moderate
% of Yes	100	0	0	0	100	0	100	0	100	100			

Notes: Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1: Were the groups comparable other than presence of the exposure of interest in cases or absence of disease in controls? Q2: Were the study subjects and the setting described in detail? Q3: Was the exposure measured in a valid and reliable way? Q4: Was exposure measured in a standard, valid and reliable way? Q5: Was exposure measured in the same way for cases and controls? Q6: Were confounding factors identified? Q7: Were strategies to deal with confounding factors stated? Q8: Were outcomes assessed in a standard, valid and reliable way for cases and controls? Q9: Was the exposure period of interest long enough to be meaningful? Q10: Was the exposure period of interest long enough to be meaningful?

Supplemental Table 6: Quality Appraisal of Included Randomized Controlled Trials (*n* =1)

Author, Year	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Total Score*	Quality Score	Quality
Bentz, 2007	Unclear	Unclear	Yes	Unclear	Yes	Unclear	Yes	Yes	Yes	Yes	No	Yes	Yes	20	.87	Strong
% of Yes	0	0	100	0	100	0	100	100	100	100	0	100	100			

Notes: *Scoring system: Yes = 2 points, Unclear = 1 point, and No = 0 point; Q1: Was true randomization used for assignment of participants to treatment groups? Q2: Was allocation to groups concealed? Q3: Were treatment groups similar at the baseline? Q4: Were participants blind to treatment assignment? Q5: Were those delivering treatment blind to treatment assignment? Q6: Were outcomes assessors blind to treatment assignment? Q7: Were treatment groups treated identically other than the intervention of interest? Q8: Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed? Q9: Were participants analyzed in the groups to which they were randomized? Q10: Were outcomes measured in the same way for treatment groups? Q11: Were outcomes measured in a reliable way? Q12: Was appropriate statistical analysis used? Q13: Was the trial design appropriate for the topic, and any deviations from the standard RCT design accounted for in the conduct and analysis?

Additional File 5: Champions' Effectiveness Sensitivity Analysis

Supplemental Table: Champions Effectiveness in Increasing Patient, Provider, and System/Facility's Knowledge Use

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Conceptual Knowledge Use							
			Provider (*n* = 4)				
			Conclusion: There are mixed findings with respect to champion effectiveness at improving providers' conceptual knowledge use.				
Implementation of new technology or equipment (*n* = 4)	One study two reports: Korall, 2017, 2018	Cross-sectional study	Existence of a champion of hip protectors (Single item scored on a 5-point Likert scale)	Overall commitment to hip protectors	Bayesian Model Averaging logistic model	Logistic regression coefficient (95% CI) = 0.24 (0.17 -0.31)	**< .05**
	Kabukye, 2020	Cross-sectional study	Presence of an effective champion (3-item survey scale by Paré et al.(1).	Organizational readiness in a low resource setting	Structural equation model using a partial least square method	Path coefficient = 0.15	**.0299**
	Paré, 2011	Cross-sectional study	Presence of an effective champion (3-item survey scale)	Organizational readiness in a large teaching hospital	Structural equation model using a partial least squares method	Path coefficient = 0.23	**< .05**
				Organizational readiness in implementing a mobile computing system for home care		Path coefficient = 0.05	> .05
	One study, two reports: Weiler, 2012, 2013	Interrupted time series	Endorsed by champions (three items rated at a 6-point Likert scale based on Mullins et al. (2).	Intention to use transfer boards 2 months post-introduction of transfer boards	Stepwise logistic regression	*C(p)* = -.041 *F* = 16.25	**<.0001**
					Structural equation model using a	Path coefficients (95 CI) = 0.27 (-.0156 - .5556)	> 0.05[1]

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
					maximum likelihood method		
System/Facility (*n* =1) **Conclusion**: There is a study suggesting that champions are effective at improving system/facility's conceptual knowledge use.							
Implementation of best practices related to vaccination processes (*n* = 1)	Tierney, 2003	Mixed study (generic qualitative and cross-sectional)	Presence of a champion lead ("Yes/No" survey item)	Pediatrician practices' likelihood or intent to adopt reminder and recall system in their practice in a year	Multivariable linear regression	Test statistic not reported	**< .03**
				Pediatrician practices' likelihood or intent to adopt immunization coverage rates assessments in their practice in a year		Test statistic not reported	**.002**
Instrumental Knowledge Use							
Patient (*n* = 1) **Conclusion**: There is a trend suggesting that champions are effective at improving patients' instrumental knowledge use.							
Implementation of Kangaroo-Mother Care (*n* = 1)	Soni,2016	Interrupted time series	Absence of champions (Two champion were present from January 5, 2010 – July 31, 2011; transition period from August 1, 2011 – July 31, 2012; champion was absent from August 1, 2012 – October 7, 2014)	Initiation rate of skin to skin by mothers of NICU patients	Competing-risks regression model and observation-weighted linear polynomial test	Subhazard rate ratios (SHR)[3] (95 CI) = 0.62 (0.47 -0.82)	**< .001[2]**
				Overall use of skin to skin by mothers of NICU patients	Multivariate logistic regression and observation-weighted linear polynomial test	OR (95 CI) = 0.49 (0.34 – 0.70)	**.004[2]**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
				Average duration of skin to skin provided by mothers of NICU patients	Multivariate linear regression and observation-weighted linear polynomial test	β (95 CI) = -1.47 (-2.07 to -0.86)	< **.001**[2]
				Initiation rate of breastfeeding by mothers of NICU patients	Competing-risks regression model and observation-weighted linear polynomial test	SHR (95 CI) = 0.88 (0.68 – 1.14)	.30[2]
				Overall use of "breastfeeding" by mothers of NICU patients	Multivariate logistic regression and observation-weighted linear polynomial test	OR (95 CI) = 0.89 (0.55 -1.44)	0.61[2]
Provider (*n* = 15) **Conclusion**: There are mixed findings with respect to champion effectiveness at improving providers' instrumental knowledge use.							
Implementation of best practices for smoking cessation (*n* =3)	Bentz, 2007	Cluster randomised trial	Presence of a champion ("Yes/No" item determined through structured interviews with clinic managers or lead nurses)	Monthly rates of documented clients connected by health care providers to the Oregon Tobacco Quitline	Generalized estimating equations	OR (95 CI) = 3.44 (2.35 -5.03)	< **.05**
	Papadakis, 2014	Cross-sectional study	Presence of physician champion ("Yes/No" survey item)	Frequency of evidence-based smoking cessation treatments delivered by health care providers	Multivariable logistic regression	OR (95 CI) = 2.0 (1.1 - 3.6)	< **.01**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
	Strasser, 2003	Cross-sectional study	Presence of a designated champion (Single item rated on a 6-point Likert scale)	Extent that health care providers apply smoking cessation guideline to help parents of cystic fibrosis patients quit smoking	Multivariable logistic regression	β (SE) = -.7570 (0.2110) OR (95 CI) = 0.469 (0.310 - 0.709)	**0.0003**
Implementation of best practices related to vaccination processes (*n* = 3)	Albert, 2012	Cross-sectional study	Presence of an immunization champion on site ("Yes/No" survey item)	Consistent use of standard orders for influenza vaccines only by non-physician staff	Multivariable logistic regression	OR (95% CI) = 1.12 (0.72 - 1.76)	> .05
				Consistent use of standard orders for both influenza vaccine and PPV by non-physician staff		OR (95% CI) = 1.67 (1.01 - 4.54)	**.046**
	Granade, 2020	Cross-sectional study	Presence of immunization champions ("Yes/No" survey item)	Primary care clinicians' adherence to adult vaccination standards	Multivariable logistic regression	APR (95% CI) = 1.40 (1.26 - 1.54)	< **.05**
				Pharmacist's adherence to adult vaccination standards		APR (95% CI) = 1.20 (0.96 - 1.49)	> .05
	Slaunwhite, 2009	Case-control study	23 champions randomly allocated to 23 hospital units versus 23 matched units with no champion	Difference in overall health care providers vaccination rates between champion and non champion units	*t* -test	*t* (22) = 2.86 (11% higher vaccination rate in champion units)	< **.03**
				Percentage change in health care provider vaccination rates from previous year in champion units		*t* (21) = 4.38 (increase from 44% to 54%)	< **.001**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Implementation of new technology/equipment (n = 2)	Alidina, 2018	Cross-sectional study	Presence of an implementation champion for cognitive aids (selected as an important facilitator from a list of facilitators)	Regular use of operating cognitive aids during applicable clinical events	Chi square	Test statistic not reported	0.8968
			Absence of an implementation champion for cognitive aids (selected as important barrier from a list of barriers)	Regular use of operating cognitive aids during applicable clinical events	Multivariable logistic regression	OR (95% CI) = 0.44 (0.23 - 0.84)	**.0126**
	Shea, 2016	Cross-sectional study	Presence of nurse champions ("Yes/No" survey item)	Percentage of providers in a clinic demonstrating Stage 1 meaningful use of electronic health records	Multivariable logistic regression	OR (95 CI) = 0.99 (0.60-1.65)	.983
Implementation of best practices related to pain management in neonatal intensive care units (*n* = 1)	Anand, 2017	Prospective cohort study	Presence of a nurse[4] champion ("Yes/No" survey item)	Number of continuous pain assessments performed and documented by nurses per day for one month in neonatal intensive care units	Generalized estimating equations	OR (95 CI) = 2.54 (1.27–5.11)	**0.009**
Implementation of best practices related to	Campbell, 2008	Non-controlled before and after study	Appointment of six nurses (two for each shift) champions for four weeks	Intensive care unit nurses' compliance with sepsis-screening protocols	Chi square	$\chi^2 = 30.86$	**<.001**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
prevention, identification, and management of infections (*n* = 2)				Physician's initiation of sepsis protocol for patients with severe sepsis		$\chi 2 = 0.563$	.453
	Zavalkoff, 2015	Interrupted time series	Appointment of a single physician champion to lead projects decreasing catheter associated urinary tract infections	Urinary catheter-use ratio in a pediatric intensive care	Binomial regression (PROC GENMOD, binomial distribution, canonical link)	OR (95% CI) = 0.83 (0.77 - 0.90)	< **.05**
Generic implementation of best research evidence (*n* = 2)	Kenny, 2005	Cross-sectional study	Presence of a champion ("Yes/No" survey item)	Nurses' direct (instrumental) research use	Pearson's correlation coefficient	*r* = .250	**.001**
	Goff, 2019	Cross-sectional study	Presence of a designated quality champion ("Yes/No" survey item)	Average clinical quality scores (adherence of providers to best practices in prescribing treatments for diseases (e.g., asthma, diabetes)	ANOVA	Test statistics not reported (Mean difference = 0.2 favouring presence of a champion)	**.03**
Implementation of diabetes guideline (*n* = 1)	Ward, 2004	Cross-sectional study	Presence of champion (Single item rated on a 5-point Likert scale)	Provider process measures relative to guideline-based diabetes management	Multivariable predictor generalized estimating equation	β (SE) = 1.24 (0.51)	**.02**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Implementation of the findings of a phase III, multicenter randomized control trial (BMT CTN 0201) (3) study (*n* =1)	Khera, 2018	Cross-sectional study	Engagement of local champions (Single item scored on a 5- point Likert scale)	Physician reported personal change in preferred unrelated donor graft source for patients with hematologic malignancies from peripheral blood source to bone marrow	Multivariable logistic regression	OR (95 CI) = 1.91 (.87-4.19)	.11
				Physician reported transplant center change in preferred unrelated donor graft source for patients with hematologic malignancies from peripheral blood source to bone marrow		OR (95 CI) = 3.18 (1.29-7.85)	**.01**
System/Facility (*n* = 6) **Conclusion:** Champions were overall effective in increasing system/facility instrumental knowledge use.							
Implementation of technology/equipment (n = 3)	Ash, 1997	Cross-sectional study	Presence of champions (Single survey item rated on a 5-point Likert scale)	Infusion of electronic mail	Multivariable linear regression	β = 0.09	.52
				Diffusion of electronic mail		β = 0.34	**.01**
	Hsia, 2019	Cross-sectional study	Presence of leadership's e-health championing behaviour (6-item survey scale)	Extent of hospital medical services and work processes are performed by health care providers using E-health technologies	Structural equation model using a partial least square method	Path Coefficient = 0.280	< **.05**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
	Sharkey, 2013	Non-controlled before and after study	Presence of an internal champion ("Yes/No" question in facilitator reports)	Facility wide implementation of at least two process improvements focused on using health information technology as a medium for clinical decision support to prevent pressure ulcers in nursing homes (labelled as "Level 2 outcome" by authors)	Nonparametric Spearman correlation	ρ = 0.65	**.013**
				Facility wide implementation of three or more two process improvements focused on using health information technology as a medium for clinical decision support to prevent pressure ulcers in nursing homes (labelled as "Level 3 outcome" by authors)		ρ = 0.75	**0.002**
Implementation of a depression care programs (*n* = 2)	Chang, 2012	Cross-sectional study	Presence of clinical champion ("Yes/No" survey item)	Collocation model implemented	Multivariable logistic regression models	OR (95 CI) =2.36 (1.14 -4.88)	**<.05**
				TIDES model implemented	Bivariate regression analysis	OR (95 CI) = 0.59 (0.20 -1.78)	>.05
				BHL model implemented		OR (95 CI) = 0.65 (0.14 - 2.98)	>.05

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
				No depression care improvement model implemented		OR (95 CI) = 0.63 (0.31 - 1.29)	>.05
	Whitebird, 2014	Mixed study (Generic qualitative and prospective cohort)	Presence of a strong primary care provider champion ("Yes/No" extracted from quality improvement narrative reports)	Average monthly activation rate (patients entering the program per number of full-time health care provider)	Pearson's correlation coefficient	*r* (95 CI) = 0.60 (0.10 - 0.86)	**<.05**
Implementation of best practices related to vaccination processes (*n* = 1)	Tierney, 2003	Mixed study (generic qualitative and cross-sectional)	Presence of a champion lead ("Yes/No" survey item)	Pediatrician practices' current use of reminder and recall systems	Multivariable logistic regression	OR (95% CI) = 1.85 (1.08 - 3.18)	**< .05**
				Public health clinic's current use reminder and recall systems		OR (95% CI) = 3.01 (1.34 - 6.73)	**< .05**
				Pediatrician practices' current use of immunization coverage rates assessments	Multivariable logistic regression	OR (95% CI) = 1.38 (0.89 - 2.13)	**< .05**
				Public health clinic's current use of immunization coverage rates assessments		OR (95% CI) = Not reported	> .05
Implementation of patient	Sisodia, 2020	Retrospective cohort study	Presence of a clinician champion ("Yes/No" survey item)	Patient reported outcomes (PRO) collection rate per	Multivariable linear regression	Collection rate change (95 CI) = 11.2 (2.5 - 20.0)	**.01**

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
reported outcomes collection program (*n* = 1)				clinic in the most recent 6 months PRO successful collection rate (50 % or greater) in a 6-month period	Multivariable logistic regression	OR (95 CI) = 3.36 (1.06 - 10.61)	**.04**
Persuasive Knowledge Use							
Provider (*n* = 1) **Conclusion**: There is no trend suggesting that champions are effective at improving provider's persuasive knowledge use.							
Generic implementation of best research evidence (*n* = 1)	Kenny, 2005	Cross-sectional study	Presence of a champion ("Yes/No" survey item)	Nurses' persuasive research use		*r* = .158	.39

Notes: [1] - The authors reported a path coefficient that they stated is significant at a p-value of 0.1. Manual calculation of the 95% CI was done by JES to determine significance of both ergonomic advantage and intention to use at a p value of .05.[2] – These *p*-values were denoted as *p*(trend) by authors because an observation-weighted linear polynomial test was conducted to determine trends for differences in estimates across all the different models. [3]- Subhazard rate ratios were calculated separately using separate competing risk regression models to consider discharge against medical advice prior to initiation of breast feeding and skin to skin. 4- In bivariate testing, both physician and nurse champions were significantly correlated with continuous pain assessments; the physician champion variable was not included in the multivariate testing because it was highly correlated with the nurse champion variable.

Supplemental Table: Champions Effectiveness on Patient, Provider, and System/Facility's Outcomes

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
Patient (*n* = 4) **Conclusion**: Champions were found to be overall not significant in improving patient's outcomes related to knowledge use.							
Improvement in patient's health outcomes (*n* = 2)	Ward, 2004	Cross-sectional study	Presence of champion (Single item rated on a 5-point Likert scale)	Patient outcome measures relative to guideline-based diabetes management	Single predictor generalized estimating equations	β (SE) = -0.38 (0.39)	.3202
	Whitebird, 2014	Prospective cohort	Presence of a strong primary care provider champion ("Yes/No" extracted from quality improvement narrative reports)	Average monthly remission rates at 6 months (number of patients with a score of < 5 on the PHQ-9)	Pearson's correlation coefficient	*r* (95 CI) = 0.40 (-0.16 to 0.77)	> .05
Quality of life (*n* = 1)	Hung, 2008	Cross-sectional study	Presence of practice (health promotion) champions (Single item rated on a 5-point Likert scale)	Fewer numbers of unhealthy days in the past 30 days	Hierarchal generalized linear modeling	β (SE): 0.34 (0.07) OR (95 CI) = 1.41 (1.22 -1.64)	< **.001**
				Fewer numbers of limiting days in the past 30 days		β (SE): 0.53 (0.19) OR (95 CI) = 1.71 (1.16 - 2.53)	< **.01**
				General health status		β (SE): 0.38 (0.09) OR (95 CI) = 1.47 (1.20-1.79)	< **.001**
Patient Experience (*n* = 1)	Goff, 2019	Cross-sectional study	Presence of a designated quality champion ("Yes/No" survey item)	Average patient experience scores of clinics that are part	ANOVA	Test statistics not reported (Mean difference = 0.09	.29

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
				of the Massachusetts Health Quality Partners (MHQP)		favouring presence of a champion)	
Provider (*n* = 1) **Conclusion**: There is a trend suggesting that champions are effective at improving provider outcomes related to knowledge use.							
Satisfaction with practice (*n* =1)	One study, two reports: Weiler, 2012, 2013	Interrupted time series	Endorsed by champions (three items rated at a 6-point Likert scale based on Mullins et al. (2).	Reported ergonomic advantage 1-month post-introduction of transfer boards	Structural equation model using a maximum likelihood method	Path coefficients (95 CI) = 0.63 (.0664 -1.1936)	**< 0.05**[2]
System/Facility (*n* = 3) **Conclusion:** There is a trend suggesting there are mixed findings with respect to champions' effectiveness in improving system/facility outcomes related to knowledge use							
Hospital quality of care indicators (*n* = 1)	Foster, 2017	Non-controlled before and after study	An average of 0.1 champion fellows in 1160 hospitals (number of champion fellows)	Weighted composite score of quality of care - occurrence of 10 harm topics (e.g., readmissions) for one month.	Multivariate linear regression	Adjusted effect over time: β = −0.9 (negative β = more effective in this study)	**.008**
Compatibility and sustainability of in-house pharmacy immunization services (*n* = 1)	Westrick, 2009	Cross-sectional study	Strategic champion effectiveness (4-item scale on champion's commitment, advocacy, and ability to manage and acquire resources) adapted from Hays et al. (4)	Compatibility between immunization services and host pharmacy	Multivariable linear regression	$\beta = 0.12$	.300
				Sustainability of in-house pharmacy immunization services		$\beta = 0.00$	.978
			Operational champion effectiveness (4-item scale on champion's knowledge, ability to manage an in-house immunization service, and to resolve conflicts)	Compatibility between immunization services and host pharmacy	Multivariable linear regression	$\beta = 0.31$	**.005**
				Sustainability of in-house pharmacy immunization services		$\beta = 0.09$	.419

Subcategory (# of studies)	First author, year	Study Design	Champion operationalization*	Outcome extracted from included study	Statistical analysis/approach	Test statistic (Measure of magnitude)	*p* - value
			adapted from Hays et al. (4)				
Other Outcomes (*n* = 1)							
Adaptation and evaluation of in-house pharmacy immunization services (*n* = 1)	Westrick, 2009	Cross-sectional study	Strategic champion effectiveness (4-item scale on champion's commitment, advocacy, and ability to manage and acquire resources) adapted from Hays et al. (4)	Degree of modifications made to in-house pharmacy immunization services	Multivariable linear regression	β = 0.05	.705
				Formal evaluation of in-house pharmacy immunization services		β = 0.26	**.038**
			Operational champion effectiveness (4-item scale on champion's knowledge, ability to manage an in-house immunization service, and to resolve conflicts) adapted from Hays et al. (4).	Degree of modifications made to in-house pharmacy immunization services	Multivariable linear regression	β = 0.05	.698
				Formal evaluation of in-house pharmacy immunization services		β = 0.09	.419

Notes: [1]- In this study, groups exposed to only nurse champions had the highest RSMR (RSMR = 16.2), hence it was the reference variable. 2- The authors reported a path coefficient that they stated is significant at a p-value of 0.1. Manual calculation of the 95% CI was done by JES to determine significance of both ergonomic advantage and intention to use at a p value of .05.

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Chapter 3: Integrated Discussion

This integrated discussion chapter has five objectives. First, I summarize the results of the systematic review. Second, I summarize the conceptual model that guided the thesis. Then describe adaptations required to my conceptual model (detailed in Chapter One) based on the findings of the systematic review of champions' effectiveness (Chapter Two). Third, I outline the main methodological issues of the studies included in the systematic review and illustrate the key elements that should be incorporated in champion effectiveness studies going forward. Lastly, I discuss the implications of the thesis for nursing practice, education, leadership, and research that resulted from my thesis.

In this integrated discussion chapter, my use of the term "innovation use" is equivalent to the term "knowledge use" that I used in Chapter 2.

Objective 1: Systematic Review Results

The aim of my systematic review was to synthesize the independent effect of champions on patient, provider, and system/facility innovation use and outcomes. The systematic review was modelled on the JBI approach (Tufanaru et al., 2020), and I used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021) to guide reporting of the study. The systematic review had three research questions: 1) How are champions described and operationalized in the articles that evaluate their effectiveness? 2) What are the effects of champions on the uptake of innovations (knowledge use) by patients, providers, and systems/facilities? 3) What are the effects of champions on patient, provider, and system/facility outcomes? The research team reviewed 7,566 titles and abstracts; of these, 35 studies (37 articles) met all the inclusion criteria and were included in the review. The findings relative to the research questions are summarized below.

How are champions described and operationalized in the articles that evaluates their effectiveness?

In my systematic review, I found that there was limited description of champions' demographics (sex, gender identity, age, and professional roles), their activities, and roles. Most of the studies included in my review (25 out of the 35 studies; 74.3%) simply operationalized the concept of champions as either the presence or absence of champions, measured with a single dichotomous (Yes or No) questionnaire item. Four of the 35 studies (11.4%) provided some details on the activities and roles that the appointed champion performed during their study (Campbell, 2008; Slaunwhite et al., 2009; Soni et al., 2016; Zavalkoff et al., 2015). Five of the 35 studies (14.3%) studies used scales that assessed the presence of a champion that possessed or performed specific attributes, roles, or activities (Hsia et al., 2019; Kabukye et al., 2020; Paré et al., 2011; Weiler et al., 2012, 2013; Westrick & Breland, 2009). In the systematic review, I did not locate any studies that evaluated the effectiveness of champions' activities and the length of exposure or number of champions required to have an effect (i.e., dose-effect ratio).

What are the effects of champions on the uptake of innovations (knowledge use) by patients, providers, and systems/facilities?

In the systematic review, I utilized a vote-counting rule that indicated that four or more studies are required to make conclusions related to champions' effectiveness. For a relationship between champions and innovation use or outcomes to be significant, 60% or more of studies had to demonstrate a significant positive relationship. I operationalized categories of innovation use or outcomes to have mixed findings if less than 60% of the studies reported a non-significant/significant relationship between exposure champions and either innovation use or outcome of innovation use (Dilig-Ruiz et al., 2018; Squires et al., 2011; Squires et al., 2015). I

found 29 studies that evaluated the effectiveness of champions on innovation use. Applying the described voting rules, I concluded that the use of champions is related to increased use of technological innovations, best practices, and programs by systems/facilities in 5 of 7 studies (71.4%) (Hsia et al., 2019; Sharkey et al., 2013; Sisodia et al., 2020; Tierney et al., 2003; Whitebird et al., 2014)). Authors evaluated the relationship between exposure to champions and provider conceptual use in four studies (Kabukye et al., 2020; Korall et al., 2017; Korall et al., 2018; Paré et al., 2011; Weiler et al., 2012, 2013)). I concluded that there are mixed findings with respect to use of champions and provider conceptual use because only 2 of the 4 studies (50%) demonstrated a significant positive relationship (Kabukye et al., 2020; Korall et al., 2017; Korall et al., 2018). Similarly, I concluded that there are mixed findings related to use of champions and provider instrumental knowledge use because only 8 of the 17 studies (47.1%) demonstrated a significant positive relationship (Anand et al., 2017; Bentz et al., 2007; Goff et al., 2019; Kenny, 2005; Papadakis et al., 2014; Slaunwhite et al., 2009; Ward et al., 2004; Zavalkoff et al., 2015).

When the relationships between exposure to champions and innovation use or outcomes was only evaluated in three or less studies, I applied the same vote counting rules to identify trends (Dilig-Ruiz et al., 2018; Squires et al., 2011; Squires et al., 2015). I found singular studies that suggested that the use of champions is related to improving patients' instrumental knowledge use (Soni et al., 2016) and system/facility conceptual innovation use (Tierney et al., 2003). Because only one study was found for each of the category, I was unable to draw any trends. None of the primary studies included in the systematic review evaluated the use of champions and patients' conceptual innovation use.

What are the effects of champions on patient, provider, and system/facility outcomes?

In the systematic review, I extracted 10 studies that evaluated the effectiveness of champions at improving outcomes. There is not enough evidence to confirm or refute a relationship between deployment of champions and patient, provider, and system/facility outcomes. Six studies evaluated the relationship between use of champions and improvement in patient outcomes (Ben-David et al., 2019; Bradley et al., 2012; Goff et al., 2019; Hung et al., 2008; Ward et al., 2004; Whitebird et al., 2014). But only three of the six studies (50%) demonstrated that use of champions was related to patient outcomes (Ben-David et al., 2019; Bradley et al., 2012; Hung et al., 2008), which is lower than the 60% required to declare a relationship (Dilig-Ruiz et al., 2018; Squires et al., 2011; Squires et al., 2015). There were not enough studies to make conclusions about champions' effectiveness in improving provider and system/facility outcomes. There is a single study suggesting that the use champions is related to improvements in provider outcomes related to knowledge use (Weiler et al., 2012, 2013). Three studies evaluated the relationships between using champions and system/facility outcomes (Foster et al., 2017; Patton & O'Hara, 2013; Westrick & Breland, 2009). In 2 of the 3 (66.7%) studies, the use of champions was reported to be related to improvements in system/facility outcomes (Foster et al., 2017; Patton & O'Hara, 2013), which indicates a trend.

Objective Two: Adaptations to My Conceptual Model

Summary of My Conceptual Model

I developed the Integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care model (Figure 2, Chapter 1) to illustrate how champions can facilitate the implementation of a tailored and adapted innovation, thereby resulting in patient, provider, and system/facility innovation use and outcomes. I constructed the Integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care by taking and combining pieces from

three existing frameworks/models: 1) the Diffusion of Innovations in Health Care model (Titler & Everett, 2001), 2) the integrated Promoting Action on Research Implementation in Health Services (iPARIHS) framework (Harvey & Kitson, 2016), and 3) a framework by Straus and colleagues (2013) on knowledge use and outcomes of knowledge use.

The Integrated Conceptual Model of Champions Facilitation of Innovation Use in Health Care model depicts use of champions as a strategy during implementation of health care innovations. Champions, in this model, are tasked with facilitating the implementation of innovations in a social system (i.e., context). Champions enact activities that makes implementation easier and faster thereby influencing patients, health care providers, facilities/systems use/adoption of innovations, which then results into patient, provider, and facility/system outcomes.

Modifications to My Conceptual Model

The systematic review and the literature pertaining to context in implementation demonstrated (as outlined below) that my original Integrated Conceptual Model of Champions Facilitation of Innovation Use failed consider two elements. First, the original model did not consider the influence of the external context on implementation. And second, the original model did not illustrate the effect that the patient, providers, system/facility, and the external context has on champions' facilitation of innovations. Therefore, I modified my model to integrate the external context and to outline the influence that patients, providers, system/facility, and the external context has on champions' attributes, roles, and activities. Below I will outline the evidence from the systematic review and the literature on context in implementation that justifies the modifications I performed on my conceptual model. Then I will detail the modification made to my conceptual model.

Evidence from Systematic Review

Context can be defined as the setting where an innovation is intended to be implemented (Harvey & Kitson, 2016). In my systematic review, some authors reported that contextual factors potentially confounded or mediated their findings (Bentz et al., 2007; Campbell, 2008; Ellerbeck et al., 2006; Hsia et al., 2019; Kenny, 2005; Korall et al., 2017; Shea et al., 2016; Slaunwhite et al., 2009). First, Bentz and colleagues (2007) stated that patients' age and health comorbidities can increase the likelihood that health care providers refer patients to smoking cessation programs, and that older patients are more receptive to quiting irregardless of the champions' influence. Second, Shea and colleagues (2016) reported that providers' characteristics (e.g., age) and providers' perception of how well the champions performed their activities could have potentially influenced providers' use of the electronic health record. Third, authors of several included studies reported how organizational factors could have influenced their findings (Ellerbeck et al., 2006; Slaunwhite et al., 2009). Slaunwhite and colleagues (2009) posit that varying management support of the champion strategy attributed to 10 of 23 champions not attending the champions' training in their study. Hence, 10 of the champions that promoted the influenza vaccines in that study were untrained in administering the vaccines. Furthermore, Ellerbeck and colleagues (2016) reported that the presence/or lack of system processes to optimize standardization of practice (e.g. standardized order forms or clinicial pathways) for prescribing aspirin and beta-blockers for patients hospitalized for acute myocardial could have potentially confounded their results. Fourth, authors of some included articles (Bentz et al., 2007; Hsia et al., 2019) reported that contextual factors beyond an organization (e.g. societal, political) influenced implementation. Bentz and colleagues (2007) reported that existing health system efforts to systematically addess tobacco use could have confounded the increase in the number of

patients referred, reached and counselled through the Oregon Tobacco Quitline after the introduction of champions. Furthermore, Hsia and colleagues (2019) reported that peer organizations' successful implementation of electronic health technologies will influence champions in management roles to promote electronic health technologies at their organization. These examples demonstrated how patient characteristics, provider characteristics, system/facility, and contextual factors external to organizations can potentially influence champions, their facilitation of implementation, and hence the resulting use of innovations and outcomes.

Evidence from Literature about Context in Implementation

To gain conceptual clarity of context in implementation, Squires and colleagues (2019) conducted a concept analysis (N = 70 articles) to develop a preliminary framework of the domains, attributes, and features of context in implementation. They found 89 features of context that were reported in at least two articles; these 89 features were grouped into 21 attributes and then six domains of context. The six domains according to this concept analysis consisted of: a) users of context (e.g. patient characteristics, patient preferences); b) providers/workers in context (e.g., providers' skill set and education) ; c) internal arrangements of context (e.g. leadership and governance); d) internal infrastructures/networks (e.g. social and physical infrastructure); e) responsiveness to change (e.g. receptivity to change and climate); and f) broader system related to context (e.g. market influence such as competitive pressure from peer organizations).

Squires and colleagues (2021) also conducted semi-structured interviews with change agent/implementation specialists and implementation researchers (N = 39 participants) from Australia, Canada, United Kingdom, and the United States to inform their context framework according to their participants' tacit knowledge of implementation. Through conducting the

interviews, they identified 66 features that are organized into 16 broader attributes of context. An important finding reported by Squires and colleagues (2021) was that participants percieved context to consists of different attributes that interrelate with each other to create complex structures and systems.According to these studies by Squires and colleages (2019) and Squires and colleages (2021), context consists of many features, attributes, and domains that span across individual/groups (patient or providers), the organization, and the broader external context. Further, the qualitative study by Squires and colleagues (2021) and studies included in my systematic review (Bentz et al., 2007; Campbell, 2008; Ellerbeck et al., 2006; Hsia et al., 2019; Kenny, 2005; Korall et al., 2017; Shea et al., 2016; Slaunwhite et al., 2009), suggest that contextual factors can influence champions' facilitation of implementation.

Explanation of Modifications to My Model

As described I made two modifications to my conceptual model based on the evidence, I described above. First, I added another circle surrounding the system/ facility, providers and patients called the external context. The extenal context is defined as factors that influence implementation that are outside the setting or organization where the innovation is being implemented. This includes aspects such as economic, political, policy regulatory and societal influences (Squires et al., 2019). This definition of external context is congruent with the definition used for the external context in the iPARISH framework by Harvey and Kitson (2016), and the definition of the outer setting in the Consolidated Framework for Implementation Research by Damschroder and colleagues (2009). Second, based on the outlined systematic review findings above and the interrelation between contextual factors reported by Squires and colleagues (2021), I changed the unidirectional arrows from champions to patients, providers, and system/facility to a bi-directional arrows. This change demonstrates how patients, providers,

and system/facility also influence champions' facilitation of implementation. Third, I added an unidirectional arrow pointing from external context to champions to demonstrate how the external context can affect champions' facilitation. I used a unidirectional arrow between the external context and champions because in my sytematic review I did not evaluate nor searched articles that evaluated champions' effectiveness in facilitating innovation use or outcomes in a broader external context. The modified Integrated Conceptual Model of Champions Facilitation of Innovation Use is illustrated in **Figure 1**.

Objective Three: Key Elements of Champion Effectiveness Studies

In this section I describe the methodological weaknesses present in many of the studies included in the systematic review. Then I outline three elements that should be incorporated in future champion effectiveness studies to address the methodological weaknesses identified in the systematic review and improve the quality of the findings of future champion effectiveness studies. These three elements include: 1) the use of causal pathway models to identify the strategy, its components, and its relationships to other model elements and how these relationships result in innovation use and outcomes; 2) the use of experimental study designs in conjunction with process evaluations; and 3) conducting a cost-effectiveness analysis.

Methodological Weaknesses of Primary Included Studies

In the systematic review, I rated the methodological quality of 19 of 35 (54.3%) studies to be strong, 11 of 35 (33.3%) as moderate, and 5 of 35 (13.9%) as weak using the JBI quality appraisal tools (Moola et al., 2020; Tufanaru et al., 2020). Even though more than half of the studies were rated as strong, there were critical weaknesses present across most studies related to evaluating effectiveness of implementation strategies. First, 28 of the 35 studies (80%) of the

included studies in the review used observational study designs, which makes it difficult to ascertain the extent to which the resulting innovation use, or outcomes were influenced by champions versus other possible confounding factors. Second, most of the included studies operationalized champions as either the presence or absence of champions (n = 26 out of 35, 74.3%) and did not provide any details on the activities conducted by these champions. Third, none of the studies evaluated whether the number of champions and length of exposure to champions impacted findings. Fourth, none of the studies evaluated whether the champion activities were perceived to be beneficial at addressing barriers to implementation, attaining the implementation goal, and the type of knowledge use and outcomes of interest. The lack of description of the champion strategy in many of the included studies makes its difficult to determine how champions affect innovation use or outcomes, the required amount of exposure to champions to influence innovation use or outcomes, and the extent that the identified change can be attributed to the deploying champions.

Implementation Causal Pathways Models

As described above, I found in my systematic review that studies evaluating champions' effectiveness poorly described the characteristics of champions, the activities that champions performed, and how exposure to champions and their activities influenced innovation use or outcomes. Powell and colleagues (2019) emphasized the need for studies examining implementation strategies to increasingly focus on understanding and identifying the processes and mechanisms underlying strategies' effectiveness. There are at least two approaches existing in the literature that researchers should use to plan studies that: 1) examines and evaluates the theoretical mechanisms and processes that determines how implementation strategies work and 2) the factors (e.g., contextual factors) that mediate their effectiveness in increasing innovation

use or outcomes (Fernandez et al., 2019; Lewis et al., 2018). To demonstrate how these approaches can be used, I described the causal pathway models as described by Lewis and colleagues (2018) and applied it to champions.

Description of Implementation Causal Pathway Models

Lewis and colleagues (2018) advocated for the use of Agile Science causal pathway models as a method of developing testable and robust theories pertaining to implementation processes. Causal pathway models represent the interrelations between implementation strategies/interventions, contextual factors, and outcomes of interest (Lewis et al., 2018). These causal pathway models would allow researchers to empirically test and clearly delineate three things related to champion effectiveness studies: 1) whether champions function according to a theoretical mechanism of action; 2) the extent that contextual factors modulate the causal pathways of the champion strategy; and 3) the extent that the resulting change in innovation use or outcome can be attributed to the champions' mechanism of action (Lewis et al., 2018).

Application of the Casual Pathway Model to Champion Effectiveness.

Lewis and colleagues (2018) outlined four steps necessary for using causal pathway models: 1) specifying implementation strategies, 2) generating strategy-mechanism linkages, 3) identifying proximal and distal outcomes, and 4) articulating effect modifiers.

Step One: Specifying implementation strategies. Lewis and colleagues (2018) denoted the importance of having clearly defined and specified implementation strategies. An implementation strategy is required to have an empirical or hypothetical rationale verifying their ability to improve the adoption, implementation, sustainment or scale up of an evidence-based practice. The strategy needs to be: 1) specifically and clearly defined; 2) represent the smallest

component while retaining the same mechanism of action; 3) observable; 4) replicable; 5) have a measurable impact on the process of implementation; 6) and can exert its effect on its own, or when used in conjunction with other strategies (Lewis et al., 2018).

To apply the first step (as demonstrated in **Figure 2,**), researchers must identify and define: 1) the roles, attributes, and the number of champions; 2) the activities that the champions perform; 3) the amount of exposure to champions; 4) the other strategies being used in conjunction to champions in their champion effectiveness studies; and 5) the fidelity of the champion strategy across settings. Through providing more detailed descriptions of the champion strategy, researchers can compare or replicate champion effectiveness studies easier.

Miech and colleagues (2018) illustrated in their integrative review (N = 199 included studies) that champions possess varying attributes and perform different roles and activities across the studies included in their review. Miech and colleagues described activities that were task-based (e.g., making pamphlets, stickers, and posters) and activities that pertained to building relationships and support across an organization (e.g., engaging stakeholders, boundary spanning across different groups of health care provider groups). This description of champions defines them as a multifaceted strategy explained according to the: 1) attributes and characteristics possessed by the champions and 2) the activities they perform to help with implementation, which coincides with another concept in implementation science called facilitation. Harvey and Kitson (2016) defined facilitation as the presence of an individual whose role is to enact activities that is tailored to address barriers and reinforce facilitators to implementation. Facilitation activities range from practical tasks (e.g., providing skills training to staff) to ones that enable and engage users of the innovation to take ownership of the change (Harvey & Kitson, 2016). Based on the similarities

between champions and facilitation, I posit that champions perform facilitation. This proposition is echoed by Cranley and colleagues (2017) who defined champions as a facilitation role.

Step Two: Generating strategy-mechanism linkages. Lewis and colleagues (2018) stated that once the strategy has been specified, then individuals need to specify the mechanism of action of the strategy. Mechanism of action refers to the process or action by which the strategy can influence the implementation goals. As implementation strategies can have multiple mechanisms of action, Lewis and colleagues (2018) advised that mechanisms of action should be chosen according to their ability to reinforce existing facilitators or address barriers to implementation.

To apply step two (as demonstrated in **Figure 2,**), researchers must identify the mechanism of action of the champion strategy. In the literature (Cranley et al., 2017; Thompson et al., 2006), champions are believed to function through the mechanism of action of the social influence process (Zimbardo & Leippe, 1991). Social influence process is defined as the actions of an individual or group that has the intent or ability to change how another person or group behave, feel, or think about a particular stimulus. Zimbardo and Lieppe (1991) defined stimulus as any beliefs, ideas, behaviours, or objects that an individual is attempting to persuade another individual to accept or perform or use.

Step Three: Identifying proximal and distal outcomes. Lewis and colleagues (2018) stated that there are two types of implementation outcomes. First, there are proximal outcomes which are immediate and the direct result of the mechanism of action. On the other hand, distal outcomes are the end goal of implementation, occurring after the proximal outcome has been met. Relative to Straus and colleagues' (2003) framework of knowledge use and outcomes, proximal outcomes would be defined as adherence or use of evidence that contributes or affects

the distal outcomes, and not an outcome (i.e., the benefits of adopting an innovation such as improvements in patients' health status).

To apply step three (as demonstrated in **Figure 2,**), researchers must first identify what level of change (i.e., patient, provider, or facility/system) they seek to produce and measure during and after implementation and whether the champions' activities will help in achieving their implementation goal. Proximal outcomes in champion effectiveness studies pertain to the use of innovations (knowledge use). As defined by Straus and colleagues (2013), knowledge use can be conceptual (attainment of knowledge or improved attitude towards the innovation or intention to use) or instrumental (applying or using the innovation as reflected in behavior change or action). Distal outcomes in champion effectiveness studies are defined as outcomes, or the resulting impact of using the innovation (i.e., resulting benefit or detriment and magnitude of impact) to either the patient, provider, or the facility/system as the result of implementing the innovation (Straus et al., 2013).

Step Four: Articulating effect modifiers. Lewis and colleagues (2018) identified two types of factors that can amplify or weaken the effect of implementation causal pathways: 1) preconditions and 2) moderators. Preconditions are contextual factors that are necessary for the mechanism to be active during implementation (e.g., availability of resources required for implementation). Moderators are contextual factors that can increase or decrease the effect of strategies in actualizing the desired outcomes. Moderators can be at an intra-individual or at the organizational level. Intra-individual moderators are individual factors that mediate implementation strategies (such as providers' buy in to change), while organizational are social and structural factors occurring within the context (for example workload) (Lewis et al., 2018).

To apply step four (as demonstrated in **Figure 2,**), researchers must investigate what contextual factors are necessary (preconditions):1) to recruit and deploy effective champions; and 2) to allow champions to enact activities that facilitate implementation. Examples of a precondition for recruitment or deploying champions include having individuals present who are passionate about an innovation or the existence of champion training programs. Examples of preconditions for champions' activities include the availability of technology or other resources, and the assurance that champions are scheduled for every shift.

Researchers performing champion effectiveness studies must also evaluate the contextual factors that may moderate the effect of champions and their activities. An example of an intra-individual moderator is an individual's level of trust/acceptance of the champions' knowledge and enthusiasm towards an innovation. Another example of an intra-individual moderator is the extent that a champion believes in the innovation. Examples of organizational moderators include protected time away from clinical tasks to perform implementation activities and the presence of incentives (e.g., monetary) for champions.

Use of Experimental Design in Conjunction with Process Evaluation

In my systematic review, I found that most of the studies (28 of the 35, 80%) used observational study designs, while six studies used quasi-experimental study designs and one study was a cluster randomized controlled trial. The cluster randomized controlled trial found that there is a relationship between exposure to champions and providers' uptake of the influenza vaccine (provider instrumental innovation use) (Bentz et al., 2007). This relationship was reinforced by six observational studies and a quasi-experimental study that also demonstrated a positive significant relationship between use of champions and provider instrumental innovation use (Anand et al., 2017; Goff et al., 2019; Kenny, 2005; Papadakis et al., 2014; Slaunwhite et al.,

2009; Ward et al., 2004; Zavalkoff et al., 2015). However, the findings from the cluster randomized controlled trial differed from the six studies (five observational, and one quasi-experimental) that reported mixed findings (Albert et al., 2012; Alidina et al., 2018; Campbell, 2008; Granade et al., 2020; Khera et al., 2018; Lago et al., 2013), two studies that reported no relationship (Ellerbeck et al., 2006; Shea et al., 2016), and one study that reported that using champions is related to decrease use of the innovation (Strasser, 2003). The use of experimental designs (randomized control trials) in evaluating the effectiveness of implementation strategies will result in findings that have high internal validity, as these study designs control possible confounding factors across heterogenous settings that may bias the results (Brown et al., 2017; Straus et al., 2013). Hence, there should be more confidence in the findings from the cluster randomized control trial. However, as one study is not adequate at constructing conclusions (Dilig-Ruiz et al., 2018; Squires et al., 2011; Squires et al., 2015), I concluded that there are mixed findings supporting the relationship between use of champions and provider instrumental innovation use (i.e., only 8 of 17 (47.1%) reported significant positive relationships).

Straus and colleagues (2013) suggested that experimental studies should be conducted in conjunction with process evaluations. Process evaluations are often conducted using qualitative study or mixed method designs to describe of how implementation occurred, and the experiences and perceptions of the individuals present during implementation (e.g., patients and providers) (Straus et al., 2013). For example, process evaluation could be used to confirm whether individuals were exposed to champions during the study, whether individuals perceived the activities performed by champions to be helpful, and the extent (i.e., dose) to which they were exposed to champions. In the systematic review, only 2 of the 35 studies (5.7%) conducted a process evaluation (Tierney et al., 2003; Whitebird et al., 2014). Tierney and colleagues (2003)

and Whitebird and colleagues (2014) conducted qualitative interviews with health care staff and management to determine what factors acted as barriers and facilitators to implementation. The factors identified informed the questionnaires they used in their subsequent cross-sectional study (Tierney et al., 2003; Whitebird et al., 2014). Michie and colleagues (2009) highlighted the idea that triangulating qualitative process evaluations with experimental studies should increase the validity that the observed change was related to the applied strategy. Hence, researchers who want to understand the effectiveness of champions should use experimental designs in conjunction with process evaluations.

Even though experimental designs are preferred for conducting effectiveness studies, observational studies can still be useful as they can provide more specific and naturalistic data pertaining to the implementation strategies within a particular context (Brown et al., 2017; Straus et al., 2013). For example, observational studies can be used to further our understanding of the roles, attributes, and activities that champions can perform. Handley and colleagues (2018) suggested that quasi-experimental designs (e.g., interrupted time series and pre-post with non-equivalent control group) can be used when randomization of participants and settings is not possible (e.g., ethical, practical, or political concerns). Quasi-experimental studies examine relationships of causality between variables without using random assignment (Handley et al., 2018). Miech and colleagues (2018) presented four studies that conducted random allocation of champions across different areas of health care (school health, public health, and pediatrics) (Acolet et al., 2011; McCabe et al., 2013; Naylor et al., 2006; Slaunwhite et al., 2009). Hence demonstrating that ethical, practical, or political concerns related to randomly allocating champions may not exist. However, Bärnighausen and colleagues (2017) argued that researchers should still consider quasi-experimental designs even when random allocation is possible, as

they often generate evidence faster and at a lower cost than experimental studies. And although they are still not as rigorous as experimental studies, the findings from quasi-experimental studies may be more reflective of the "real world" settings in which implementation occurs (Bärnighausen et al., 2017).

Cost- Effectiveness Analysis

Hoomans and Severens (2014) defined cost-effectiveness analysis as the comparison between implementation strategies relative to the use of the innovation and the outcomes resulting from its use. In my systematic review, I did not find any articles that performed cost-effectiveness analysis related to use of champions versus other strategies.

Hoomans and Severens (2014) and Quinn and colleagues (2013) advocated that decision makers should integrate cost-effectiveness analysis when deciding on what strategies to use during implementation. Quinn and colleagues (2013) reported that there are two main economic principles that should be considered in implementation. First, "opportunity cost" is the idea that allocating resources towards one implementation strategy, diverts these resources away from other strategies. Second, "marginal analysis" is the idea that the decision makers should allocate resources towards implementation strategies that would maximize innovation use or outcomes compared to other strategies (Quinn et al., 2013). Further, Quinn and colleagues (2013) stated that decision makers should consider both direct costs (e.g., cost of technology) and indirect costs of strategies (e.g., removing clinicians from clinical work to become champions) and the total budget in deciding what strategies should be used.

Although no cost-effectiveness analysis was conducted in any of the included studies in my review, four studies included in the systematic review described that champions were taken

out of their usual clinical roles to enact implementation activities (Campbell, 2008; Slaunwhite et al., 2009; Soni et al., 2016; Zavalkoff et al., 2015) and in two of these four studies were provided time off for training (Campbell, 2008; Slaunwhite et al., 2009). Other authors of studies not included in my systematic review also emphasized the importance of protected time provided to clinician champions for training and learning about the innovation, planning, and enacting implementation activities (Gagnon et al., 2010; Holland et al., 2010; Tappen et al., 2017; Westbury et al., 2013). These studies indicated that there is cost associated with the deployment of champions. Therefore, the findings from cost-effectiveness analyses will help decision makers allocate resources towards implementation strategies that are worth the investment based on evidence.

Objective Four: Implications

In Ontario, Canada, the College of Nurses of Ontario (CNO) (2002) outlined professional standards that all nurses, regardless of specialty or role are expected to meet. These professional expectations set by the CNO, and the findings of my systematic review informed the implications outlined below pertaining to nursing practice, education, leadership, and research.

Implications to Nursing Practice

According to the CNO (2002), nurses are accountable for "providing, facilitating, advocating and promoting the best possible care for clients" (p.4). Champions can be defined as individuals who advocate, facilitate, and promote the implementation of innovations that are able to improve health care services and outcomes (Cranley et al., 2017). Hence, by becoming champions, nurses can fulfill a professional expectation set by the CNO. While I did not find sufficient evidence to suggest that champions can improve the uptake of innovations by patients

and providers or improve outcomes in my systematic review, I did find evidence to conclude that the use of champions is related to organizational use of innovations. For example, the presence of champions was correlated to facility wide implementation of electronic clinical decision support focused on pressure ulcer prevention (Sharkey et al., 2013). However, this finding does not indicate causality as most of the studies (four of five) supporting this conclusion were observational studies. Therefore, nurses who want to be champions or are already champions should reflect on whether the activities they perform as champions are having an impact in practices or outcomes. By being reflective, nurse champions can develop tacit knowledge on what activities are cost-effective and effective at creating change within their context. Nurse champions can then disseminate their tacit knowledge to other champions through champion networks (Palmer et al., 2019).

Implications to Nursing Education

According to the CNO (2002), nurses are accountable for "advocating for quality practice improvements in the workplace" and "working together to create quality practice settings that promote continuing competence" (p.5). McComb and Kirkpatrick (2017) proposed a strategy for scaffolding learning activities across a four-year nursing baccalaureate program that allows nursing students to develop the skills required for quality improvement initiatives (e.g., conducting a literature review, stakeholder engagement, and planning and executing a project). Karagory and McComb (2014) and McComb and Kirkpatrick (2017) believed that by providing nursing students an opportunity to learn and enact quality improvement projects will develop their critical thinking, leadership, and problem-solving skills. Cullen and colleagues (2020) reported that nurses who participated in their champion training program (n = 12) had greater understanding of implementation, the innovation they were intended to implement, and

stimulated innovative thinking. Similarly, Spalding and colleagues (2016) reported that nurses (*n* = 30) who participated in their research champions program had increased confidence in comprehending and critiquing research articles and in applying research knowledge. The CNO (2002) stated that nurses in education roles are accountable for "using standards of practice and evidence-based knowledge to educate students" (p.5) and to "critically analyzing and evaluating nursing practice and education" (p.5). Therefore, if a nursing faculty decides to integrate champion/quality improvement training within a baccalaureate nursing program, they need to create opportunities for students to apply the skills through actual implementation and evaluate innovation use and/or outcomes.

Implications for Nursing Leaders

According to CNO's (2002) professional standards, nurses in administrator roles should be "establishing and maintaining communication systems to support quality service and research" (p.8) and "articulating an evidence base for all decisions and measuring the impact on practice" (p.8). Champions' increased knowledge of quality improvement, implementation, and evidence-based practice can be beneficial for quality improvement teams (Cullen et al., 2020), despite the lack of evidence supporting their effectiveness. Although there is no evidence of harm from using champions, there may be costs associated with deploying them. Hence, nurse managers and administrators who are interested in deploying champions should consider the following: 1) have a clear rationale and plan on how the use of champions can address barriers to implementation or impact the goals of implementation; 2) plan to assess fidelity of what champions' do; and 3) plan how they will evaluate champions' effectiveness.

Implications to Nursing Research

According to the CNO's (2002) professional standards, nurses in researcher roles should be "supporting and evaluating practice through research" (p.9) and "ensuring that high standards are used in the research process" (p.9). In my systematic review, I identified areas of research that should be further evaluated pertaining to the effectiveness of champions because they were either seldomly or not examined at all (e.g., patient knowledge use, provider outcomes and system outcomes). As described in detail in the "objective three" section of the integrated discussion, there is a need for more robust studies that evaluates the effectiveness of champions in increasing innovation use and outcomes. As already argued above, champion effectiveness studies should use causal pathway models, experimental designs in conjunction to process evaluations, and cost-effectiveness evaluations. The use of experimental study designs in conducting champion effectiveness studies decreases the likelihood that the results are influenced by other confounding factors, thereby producing results with higher internal validity and generalizability (Brown et al., 2017; Straus et al., 2013). However, as implementation processes can vary by context (e.g., strategies are required to be tailored to each context), experimental studies need to be accompanied with clear and detailed description of the champion strategy, the implementation process, the fidelity of the intervention and implementation, the context, and the implementation goals (Michie et al., 2009).

Conclusion

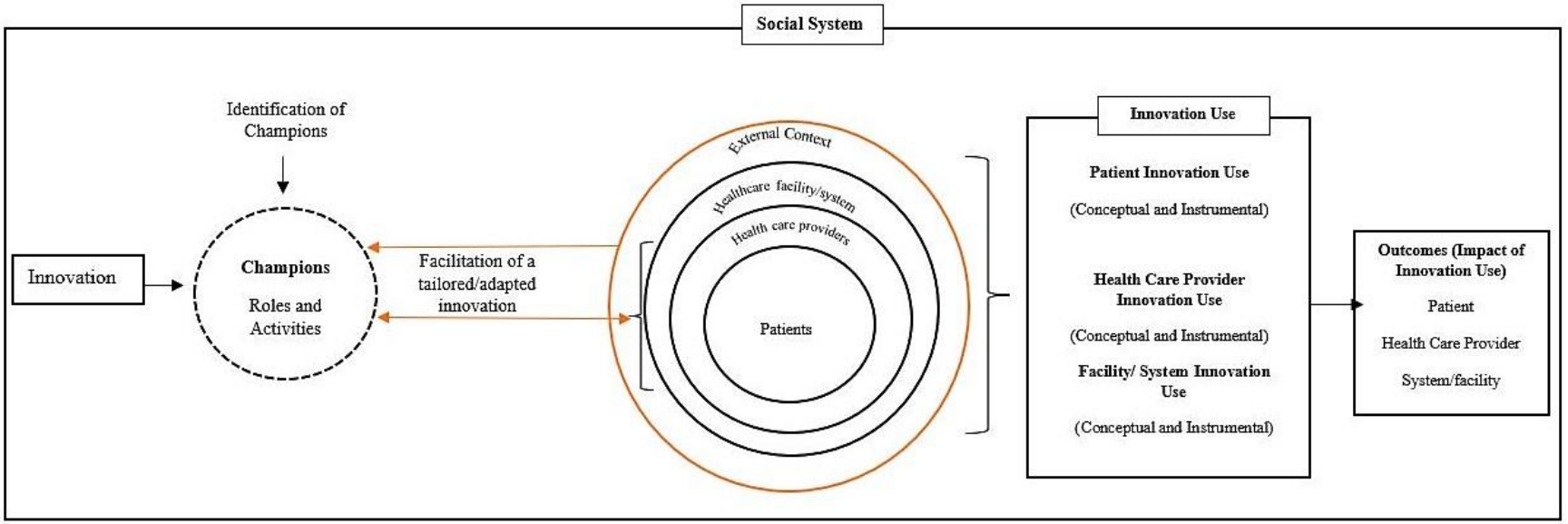
The conducted literature review illustrated that a systematic review on the effectiveness of champions, isolated from other strategies, in facilitating innovation use and improving outcomes in health care settings/institutions is needed. My systematic review indicated that the deployment of champions is overall associated to increased use of technological innovations, clinical programs, and practices at the organizational level across seven studies. The systematic

review also indicated that there are mixed findings pertaining to the use of champions and increased in provider conceptual and instrumental use, and improvements in patient outcomes. The findings were mixed because less than 60% of the studies evaluating the effects of champions on these categories of innovation demonstrated a positive significant relationship. Furthermore, there was insufficient evidence found in the systematic to conclude that causal relationships exist between deployment of champions and improvements in innovation use or outcomes on patients, providers, or facility/systems as most studies were observational. Regardless, the systematic review outlined limitations existing in the primary studies that evaluated the relationship between champion use and innovation use or outcomes. These limitations include the lack of description of the champion strategy, the lack of use of experimental designs, and the lack of cost-effectiveness evaluations. It is important to address these limitations in future studies as champions are being promoted by organizations, and because there is evidence suggesting that champions have increasingly been used in implementation studies in the last decade.

Future studies evaluating champions' effectiveness in increasing innovation use or outcomes should be based on precise and testable theories such as causal pathway models, use experimental designs in conjunction to process evaluation, and should include evaluation cost-effectiveness of the champion strategy. Improving the quality of studies evaluating champions' effectiveness studies will result in the availability of more credible evidence that decision makers can use to inform implementation.

Figure 1

Modified Integrated Conceptual Model of Champions Facilitation of Innovation Use



Legend

--- (dotted line): Represents how champions are an implementation strategy utilized to make changes to the social system but are individuals from within the social system who are chosen or volunteer to become champions

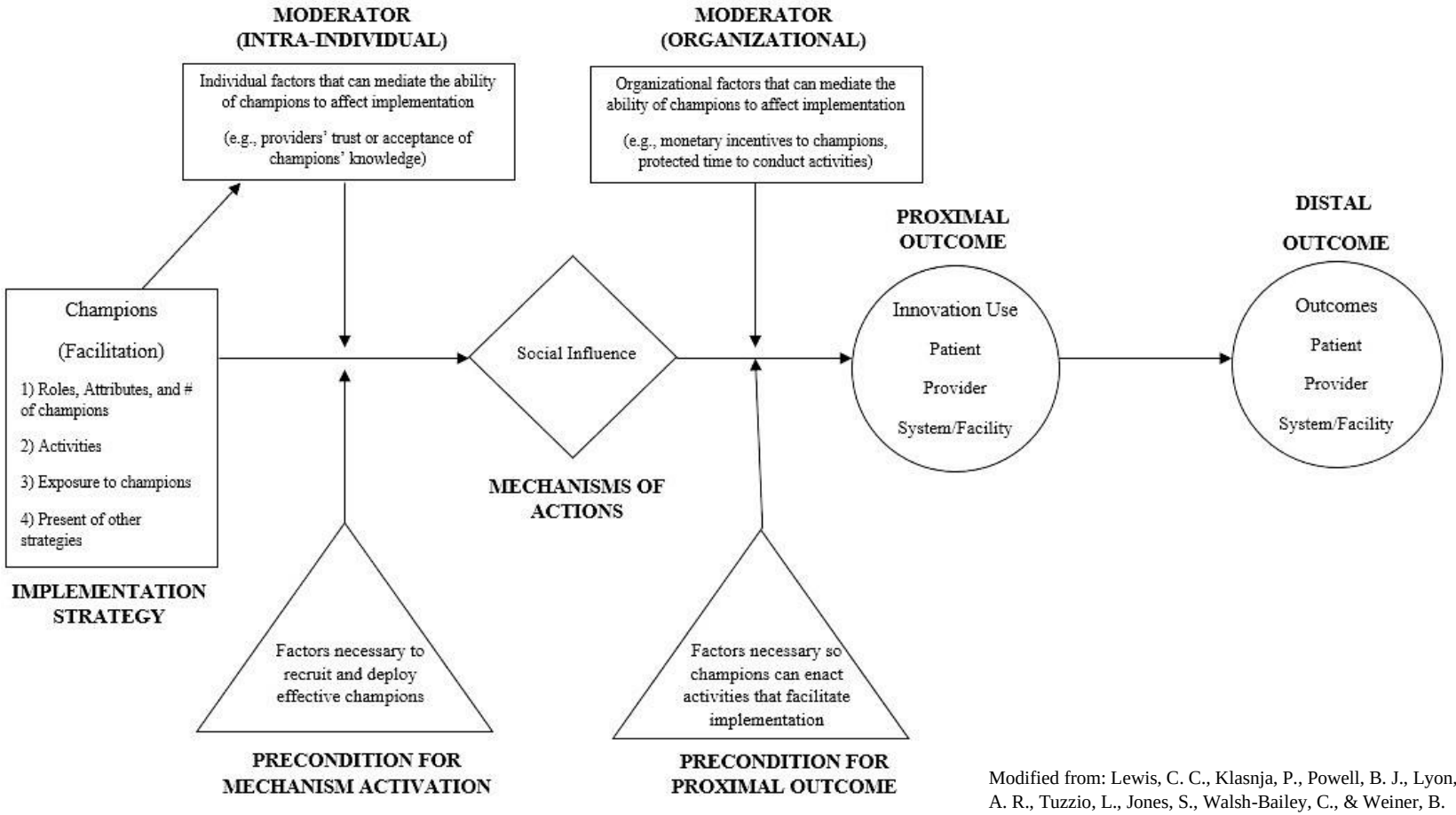
→ (arrow): Influence or interaction

Orange lines: Modifications made to original "Integrated Conceptual Model of Champions Facilitation of Innovation Use".

Based on: Titler, M. G., & Everett, L. Q. (2001). Translating Research into Practice. *Critical Care Nursing Clinics of North America*, *13*(4), 587-604. https://doi.org/10.1016/s0899-5885(18)30026-1; Straus, S. E., Tetroe, J., Bhattacharyya, O., Zwarenstein, M., & Graham, I. D. (2013). Chapter 3.5 Monitoring knowledge use and evaluating outcomes. In S. E. Straus, J. Tetroe, & I. D. Graham (Eds.), Knowledge Translation in Health Care: Moving from Evidence to Practice (2nd edition ed., pp. 227-236). John Wiley & Sons, Ltd.; Harvey, G., & Kitson, A. (2016, Mar 10). PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, *11*, 33. https://doi.org/10.1186/s13012-016-0398-2

Figure 2:

Application of the Casual Pathway Model to Champion Effectiveness



Modified from: Lewis, C. C., Klasnja, P., Powell, B. J., Lyon, A. R., Tuzzio, L., Jones, S., Walsh-Bailey, C., & Weiner, B. (2018). From Classification to Causality: Advancing Understanding of Mechanisms of Change in Implementation Science. *Front Public Health*, *6*, 1-6. https://doi.org/10.3389/fpubh.2018.00136

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