Part 2: Multi-level Approaches to Implementation and Quality Improvement

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Challenges in improving healthcare quality and implementing effective practices

- Changing clinician and organizational practices in health care is challenging
- Education is “necessary but not sufficient”

Question: What is sufficient? What is required?
Broad answers to the question

- Implementation research suggests that quality improvement / implementation efforts must be multi-faceted and multi-level, involving a coordinated package (campaign) of intensive interventions, to address the multiple influences on clinical practices – and multiple causes of quality/implementation gaps.
Selected barriers to implementation

- Insufficient information, knowledge, skill, time
- Too much information
- Evidence is not accepted as legitimate
- Implementation gaps not recognized
- Misaligned financial incentives
- Insufficient staff or systems support
- Lack of external pressure, expectations
Selected influences on clinical practices

- Point of care
- Microsystem, team (norms, policies, habits)
- Clinical, hospital, facility (culture, leadership, policies, resources/budget)
- Integrated delivery system
- Professional norms (local, regional, national)
- Patient, business, other stakeholder norms and influences (community, region, state, nation)
- Local, state, federal regulations
A short history of quality improvement in health care

- Most QI initiatives address no more than 2-3 causes of quality gaps at 1-2 levels;

- The result: considerable effort, occasional impact – typically on mediating factors – but limited change in practices

- The classic case: “intervention physicians displayed improved knowledge and attitudes but no change in clinical practices”
“Necessary but not sufficient conditions”

- Most health care practices are highly stable and embedded in a dense network of influences and constraints related to knowledge, beliefs, attitudes, norms, habits, systems, incentives, expectations, etc.

- Eliminating one or two constraints eliminates one or two constraints, leaving many others
Requirements for quality improvement

1. Valid, legitimate (accepted) evidence
2. Evidence of deviations
3. External expectations, interest (monitoring), pressure
4. Supportive professional norms
5. Etiology of practices, deviations
6. Information, evidence, education
7. Feasible methods/systems
Condition 1.
Evidence-based practice standards, guidelines, clinical recommendations

- legitimate, accepted (acceptable)
- appropriately developed, sponsored
- fully endorsed, supported
- not easily dismissed
Condition 2.
Evidence of deviations from recommended, appropriate clinical practices

- valid, accurate (casemix adjusted)
- credible
- accepted (acceptable)
- timely
- relevant
- appropriate benchmark
Condition 3.
External pressure, incentives and expectations for improvement

- “external” includes leadership/senior management and other influential entities
- adequate to overcome competing demands and to focus attention/interest
- meaningful consequences
- requires measurement, reporting
- broad, comprehensive, pervasive (supervisor to peer to patient)
Condition 4.
Professional norms and peer influence

- adherence is appropriate, legitimate, expected, normative
- non-adherence is improper, unacceptable, counter-normative
Condition 5.
Etiology of deviations (causes/influences, barriers, facilitators)

- provides guidance in addressing deviations
- thorough diagnosis of multifaceted influences on current practices, leading to causes of deviations
- *reliable broad spectrum interventions do not exist*
Condition 6.
Information, evidence, education

- needed to achieve clinician understanding of the desired practices (and their advantages over current practices), to facilitate acceptance, action
Condition 7.
Feasible, operational methods

- logistical arrangements/processes to implement and utilize recommended practices
- elimination of financial, organizational and operational constraints (staffing, time, technology)
- examples: collaborative care models (Chronic Care Model), reminders, group visits, re-engineering
Implications for QI initiatives

- Launch (or stimulate) and coordinate
  (a) mutually reinforcing efforts by
  (b) professional societies, government, business, voluntary health organizations, payors, etc. directed at
  (c) multiple levels (patient, clinic, delivery system, policy)

- Align existing QI elements, fill gaps
  - guidelines
  - performance indicators
  - care models