



## Strategies for Implementing Innovative Clinical Practices

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Clinical process innovations often fail, not because they are ineffective but because they are not implemented, that is, not put into practice. But reasons for implementation failure are not well understood, and successful strategies for diffusing innovations are not well established. The national initiative to implement Advanced Clinic Access (ACA) across VA provided an opportunity to increase our understanding of the factors that affect the implementation of clinical innovations.

In 2000, VA launched a national initiative to diffuse ACA in six target clinic areas (primary care, audiology, eye care, cardiology, orthopedics, and urology). An important component of the initiative was a comprehensive evaluation of the implementation and effectiveness of ACA. The chair of the ACA Steering Committee contracted with the Management Decision and Research Center (MDRC), part of VA's Health Services Research and Development Service, to conduct the evaluation.

This article presents the results for one evaluation question: What factors are associated with greater implementation of ACA?

### The ACA Initiative

ACA is a set of 10 key change principles for managing clinics so that veterans have access to medical care when they want it. The principles are: (1) work down the backlog, (2) reduce demand, (3) understand supply and demand, (4) reduce appointment types, (5) plan for contingencies, (6) manage the constraint, (7) optimize the care team, (8) synchronize patient, provider, and information, (9) predict and anticipate patient needs at the time of appointment, and (10) optimize rooms and equipment.

To encourage and support the diffusion of these principles, the ACA Initiative built an extensive infrastructure that includes: a national steering committee; a full-time national clinical director; a person designated to lead ACA in every VISN and most medical centers (called points of contact or POCs); and a network of clinical access coaches to catalyze peer networks of advocacy and support. The infrastructure, based on a spread model emphasizing information, communication, and social networks, supports a growing network of training, information exchange, coaching, and collaboration to

clinical staff in VA medical centers.

### A model of implementation and effectiveness

The conceptual model for the implementation and effectiveness of ACA is presented in Exhibit 1. According to this model, organizational structure and the particular activities used to introduce and then spread ACA will influence the extent to which ACA is implemented in a clinic area or across a medical center. In addition, certain aspects of facility context, and the awareness and operations of individuals responsible for implementing ACA, will also influence implementation. The implementation of ACA will in turn affect clinic waiting time and ultimately patients' satisfaction with their access to care. The model also posits that facility context will have a direct impact on both waiting time and satisfaction.

### Evaluation design

Taking advantage of the naturally occurring variation in clinic waiting times, we selected for study a sample of 78 VA medical centers stratified by wait time and size. Measures of the key variables in the change implementation model were drawn from data obtained by: (1) structured telephone interviews with facility ACA points of contact conducted between January and April 2003; (2) a mail survey completed by 3870 staff (42% response) in July and August 2003; and (3) VA administrative databases. ACA implementation was defined in terms of the use of the 10 key change principles, as reported by local ACA points of contact and as rated by staff in the six target clinic areas.

### Factors affecting ACA implementation

To identify the factors affecting ACA implementation, we conducted a series of regression analyses. The factors most strongly associated with greater implementation of ACA are reported in Exhibit 2. Two findings are noteworthy.

First, the profile of significant factors differed

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from clinic area to clinic area; no single set of variables emerged as significant predictors across all six areas.

Second, despite this variation, four variables emerged as significant predictors of ACA implementation in three or more of the six clinic areas:

- Greater length of time doing ACA;
- Greater management support for ACA;
- Clinic staff reviewing ACA performance data; and
- Clinic teams having the knowledge and skills needed to do their work well and make changes successfully.

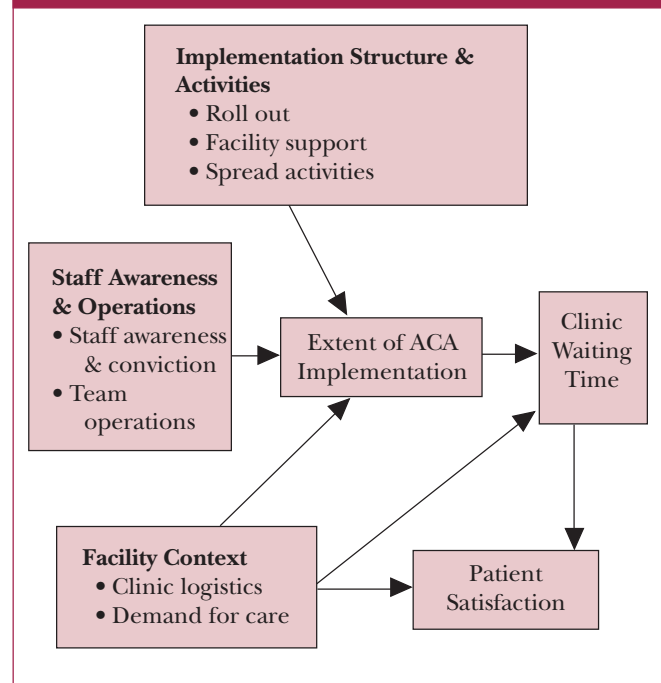
These results suggest that there is not a single formula for successful implementation of innovative clinical practices. However, there is a limited set of robust predictors that have a high likelihood of being important when considering clinical change in any venue.

### Implications

Knowledge about the factors affecting the implementation of ACA can be used to increase the success of diffusion of new clinical practices. These findings offer important lessons for VA managers and clinical leaders who are striving to diffuse effective new clinical practices successfully, and to VISN leaders who are working to transform their VISNs into learning organizations that can efficiently implement evidence-based practices.

The full evaluation report will be available later this spring on the MDRC web site at:  
[www.mdrc.research.med.va.gov](http://www.mdrc.research.med.va.gov)

### Exhibit 1. The Implementation and Effectiveness of Advanced Clinic Access



### Exhibit 2. Factors Significantly Associated with Extent of ACA Implementation

	Primary Care	Audiology	Cardiology	Eye Care	Orthopedics	Urology
▲ Positive association / ▼ Negative association						
<b>Implementation structure &amp; activities</b>						
• Time doing ACA				▲	▲	▲
• Management support for ACA	▲		▲		▲	
• Review of performance data		▲		▲		▲
• Local colleagues participate in access road show, consultations			▼			
• Availability of ACA resource materials					▲	▲
<b>Staff awareness and operations</b>						
• Team has needed knowledge and skills	▲		▲	▲	▲	
<b>Facility context</b>						
• Patients on waiting list	▲				▲	
• Exam rooms per clinician	▲					▲
• Use of consulting physicians		▲			▲	
Proportion of variance explained (adjusted R <sup>2</sup> )	35%	34%	22%*	21%	42%	39%

\* Note: The adjusted R<sup>2</sup> for cardiology increases to 42% when two variables not significant for other clinics are added: percent of clinic staff involved in the initial ACA implementation and collection of ACA data; also time doing ACA becomes significant when those variable are added.

# Providing Patient-Centered Care: System Redesign and Patient Involvement

*Joseph Restuccia, DrPH; Irene Cramer, PhD; Sally Holmes, MBA; Martin Charns, DBA*

In the last issue of *Transition Watch*, we described some of the ways health care organizations participating in the Robert Wood Johnson Foundation's *Pursuing Perfection* (P2) program are becoming patient-centered (see *Transition Watch*, January 2003 for a complete description of the P2 initiative). For the past two years, the Management Decision and Research Center (MDRC), with the Boston University Schools of Public Health and Management, has studied these organizations as part of an evaluation of the P2 effort. The MDRC research includes extensive on-site interviews with key staff at each organization and a survey of staff at participating sites. This article is the third in a series about the P2 project and what we are learning from the research.

Many health care organizations have conducted systematic patient satisfaction surveys and focus groups to listen to the voice of the patient. The true test of patient-centered care, however, is the extent to which organizations involve patients in their own care and redesign systems to be more patient-centered. For example, as in VA, Advanced Clinic Access is a major way that several P2 organizations are working to be more patient-centered. In this article we provide examples of patient involvement and delivery redesign in the seven P2 sites. We describe several innovative ways

they have rethought and redesigned care delivery and the impact of such programs on patients, family members, and clinicians.

## Visit Alternatives

In addition to patient preferences about appointment scheduling, P2 organizations have learned that some patients prefer to have their questions answered without coming in for an appointment. As a result, sites are experimenting with alternatives to traditional appointments such as e-mail or expanded telephone contact between patients and providers.

While some patients immediately see the benefit of phone or e-mail encounters, changing clinical practice to encompass such options requires major changes in infrastructure and clinician behavior. E-mail encounters must be handled in a secure, confidential IT environment (and usually require prior patient permission). An even more serious obstacle is that most insurers do not pay for physician time spent on either e-mail or telephone encounters. Nevertheless, some P2 sites, particularly those with some physicians on salary, are adopting these innovations because they increase care efficiency and patient satisfaction and, they believe, will result in better clinical quality overall. Moreover, some sites are negotiating with insurers to provide payment for e-mail and telephone visits.

An expanded use of telephone activity that all sites have found valuable is nurse or office staff calls to chronic care patients to remind them of the need for an appointment, often triggered by a screening algorithm in a patient registry containing patients' relevant clinical and encounter data.

## Transparency

Another patient preference P2 sites have addressed is removing access barriers to information about a patient's own care and about the organization's processes and outcomes of care. Sites have become much more transparent in sharing with patients information such as their own medical records, safety procedures, and clinical outcomes measures.

*Transition Watch* is a quarterly publication of the Office of Research and Development's Health Services Research and Development Service. Its goal is to provide timely, accessible health care change information and resources to aid VHA managers in their planning and decision making. Summaries and analysis of ongoing survey and management studies within VHA will be included, as well as organizational change resources from within and outside VA. For more information or to provide us with your questions or suggestions, please contact:

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## Patient Care

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Several organizations made public their promises around Pursuing Perfection activities and provided measures of performance indicating progress toward goals. In almost all our visits to P2 organizations, we have seen such progress reports prominently displayed on patient care units and other public areas where results can be reviewed by patients and families as well as staff. One organization even posts these on its public web site.

P2 sites are also giving patients access to their own medical records. Health care providers traditionally have seen the medical record as their property, generally unavailable to the patient. This perspective has been completely turned around. Medical records are now seen as belonging to the patient who may access his/her own record whenever requested, in some P2 sites, electronically via a secure Internet connection. Implementing this change entails changing not only administrative processes, but also attitudes and behaviors around record keeping, including the need to be accurate and sensitive in documenting the patient's condition and treatment.

Perhaps the highest degree of record transparency is represented by one P2 organization's "Shared Care Plan," which is developed jointly by the patient and his/her caregivers. In addition to a current listing of the patient's conditions, treatments, medications, and relevant medical history, it contains health-related goals, patient preferences, advanced directives, and a patient-designated list of family members or others who are authorized to access the Shared Care Plan. The Plan is available via a secure web-enabled network and can be edited by the patient as well as by his or her clinicians. In interviews, we have heard stories about how Shared Care Plans have saved valuable time in treating an emergency and enabled patients to better understand and self-manage their own conditions.

## Self-Management

Patient self-management is a cornerstone of patient-centeredness, particularly for chronic care patients whose condition is often more dependent on everyday behavior regarding diet, exercise, and appropriate use of medications than on their episodic medical encounters.

Family members are important caregivers for those with disabilities or chronic conditions; for such patients family members must be included in discussions about diagnosis, prognosis, and treatment. In several P2 sites, family members traditionally were whisked out of the patient's room when clinicians examined or treated the patient, and visiting hours for those in the ICU were severely limited. P2 sites now allow, and often encourage, close family members to stay with patients and participate in decisions about their care. One site has a special phone line to facilitate inquiries about the patient. Others provide materials explaining equipment used in the ICU and train family members to use some equipment when it is safe to do so.

One P2 site, a pediatric teaching hospital, has instituted family rounds. Parents participate in the rounds with teaching staff and residents. All participants ask and are asked questions about the child, the home environment, the family's resources, and anything else that may affect the capability to care for the patient in the hospital and at home. Prior to instituting family rounds, many physicians, particularly house staff, were fearful that they would need to work longer hours to answer families' questions and satisfy their demands. In fact, their hours decreased as the rounds led to more informed and less apprehensive families who were much less likely to call later in the day or post-discharge with questions and concerns. It also has led to much better informed physicians. One prominent professor of medicine told us that it was a revelation to him how much the family's insurance, finances, and other circumstances could affect treatment - admitting that, prior to family rounds, he thought he could count on his discharge orders being fulfilled completely.

## Conclusion

Patient-centeredness involves much more than administering patient satisfaction surveys, providing information on treatment options, and eliciting patient care preferences. It requires recognizing both the capabilities and limitations of the patient and reconfiguring care delivery to maximize the former and minimize the latter. It involves organizational learning about patients' needs and wants and system redesign to fulfill them. P2 sites have found this redesign to require major cultural as well as technical change, but believe it to be well worth the effort.