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Balancing tensions

Improved chronic disease management

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The Triple Aim of better care, better health, and lower cost challenges clinicians and care systems to constantly improve. Pursuing these aims often uncovers underlying tensions; seemingly opposing forces that complicate how best to accomplish these goals, too often leaving care systems frustrated with their ability to improve outcomes, and physicians and others feeling blamed for slowing progress.

The Institute for Clinical Systems Improvement (ICSI) has experienced first hand how these tensions manifest themselves. Over the last several years, practice facilitators from ICSI teamed with clinics throughout Minnesota on a number of special projects, all targeted to improve clinical care for patients with chronic disease. As we partnered with these clinics, we identified five recurring tensions:

- Standardization vs. adaptation
- Single disease management vs. chronic disease management
- Quality improvement (transformation) vs. quality reporting (compliance)
- Commitment to innovation vs. capacity for change
- Leadership nimbleness vs. constancy of purpose

This article describes these tensions, why they exist, and what steps clinics took to manage these tensions to make steady progress in improving care.

Standardization vs. adaptation

The first tension is between the benefits of standardization through the use of evidence-based medicine and systems of care vs. the need to adapt care recommendations based on the needs and values of each individual patient. This creates a tension sometimes expressed as “cookbook medicine” on one side and

physician "autonomy" on the other. Administration and staff with mandates to improve quality, or implement a specific care pathway, sometimes attempt to create standardized processes without involving physicians, resulting in requirements that did not get the needed "buy-in," which creates discord between the system and individual practice.

How clinics addressed this: Modern guidelines include specific steps in care processes where customization of care should occur, such as through the use of shared decision-making and other patient engagement strategies. Standardization can be used to assure that these discussions reliably and effectively occur and that the decisions made are accurately and reliably implemented. For example, this entails systematically assuring that patients have the information they need about statins, having a discussion to understand the risks and benefits they might see from starting the medication, and ensuring that the decision is systematically implemented, including routine follow-up.

Chronic disease management is a continually expanding component of medical care.

To make progress toward this end, clinics created a forum to engage physicians in collaborative conversations about evidence-based recommendations and models of care. This forum included processes to be systematized and a structure for physician consensus for approving and implementing practice changes. All staff engaged in discussions on implementing evidence-based care to assure that roles and responsibilities were understood and all team members were able to participate at the top of their license.

Single disease management vs. chronic disease management

Chronic disease management is a continually expanding component of medical care, with an ever-increasing number of care improvement programs, guidelines, and accountability measures being presented to clinics, primarily focused on single disease states. Clinics are constantly expected to implement specific disease programs that have been proven effective in other settings. Clinics may be able to say, "Here's what we do for a hypertension patient," and "Here's what we do for a patient with depression," and show separate registries used for each condition. However, they have not taken advantage of or even understood their ability to build care pathways that can be used for multiple conditions. A single pathway for all chronic conditions is seen as too complex to design and too complicated to implement.

How clinics addressed this: Clinics used process mapping to understand the care processes they had in place for chronic conditions, identifying similarities and commonalities. This helped them see that a "system" for chronic condition management includes the common steps of pre-visit planning, rooming protocols, office visit activities, between visit care, registry work, and patient self-management plans. Using and reusing well-established disease-specific processes (e.g., what works well with diabetes or asthma) and adding new chronic condition care processes (e.g., for hypertension) sped up implementation. A single registry for all conditions eases work and better supports the care of patients with multiple chronic conditions.

Quality improvement (transformation) vs. quality reporting (compliance)

Another identified tension is between the data and reports required by various organizations for accountability and payment vs. the data and reports needed to support care improvement activities. Producing reports to comply with myriad external obligations has taken up a major portion of "quality department" work. This move toward compliance reporting leaves less capacity for collecting and analyzing data needed to evaluate improvement activities and change efforts. In many smaller clinics, the quality department is a single person or small team held accountable for accomplishing all improvement work in addition to compliance reporting.

How clinics addressed this: With the help of practice facilitators, clinics undertook "refresher" courses in improvement science, to understand how to build local improvement teams, design and conduct small tests of change, and collect and analyze the real-time data needed to understand if the tested change resulted in an improvement. Clinics reviewed the data that was available from various sources and determined what was and wasn't valuable for understanding these tests of change. Clinics developed simple, but useful data collection tools and used run charts and other foundational analytics to show improvement and share success with other improvement teams.

Commitment to innovation vs. capacity for change

This tension causes strain, especially for leadership, as they strive to balance resources needed for innovation, including positioning themselves for new payment models and mandated quality improvement vs. the resources needed to care for patients and conduct business as usual. Our participating clinics are all doing more with less. People are stretched, and dealing with various types of transitions along with changing and competing priorities. Burnout and resource availability have a significant impact. Physicians and other staff may understand and support the need to make change, but feel that they do not have any additional capacity to support the efforts.

How clinics addressed this: Leaders began by developing a clear understanding of their priorities and, with operational staff, a clear understanding of current capacity to undertake change. This included the workforce's base understanding of the knowledge, skills, and tools needed to undertake a change effort. Clinics took the time to lay the needed foundation, with training on improvement science and structures to agree on models of care, as well as other identified needs. Once improvement projects were begun, reasonable goals were set and the teams held accountable for steady progress. The pace was adjusted in real time, based on anticipated and unanticipated changes that had an effect on the teams (staff turnover, new regulations, holidays, etc.), but continual movement toward goals was expected.

[Leaders] … need to be both nimble and constant.

Leadership nimbleness vs. constancy of purpose

In this time of uncertainty for all of health care, clinic leadership has a responsibility to be prepared for multiple eventualities, and quickly make changes in response to environmental pressures. At the same time, leadership must, to quote W. Edwards Deming, "Create constancy of purpose toward improvement of product and service, with the aim to become competitive and to stay in business, and to provide jobs." This constancy is particularly important to staff as they experience the discomfort caused by the unsettled environment. The need to be both nimble and constant, creates communication challenges for leaders at all levels.

How clinics addressed this: Leaders engaged in thoughtful conversation about the improvement support that ICSI offered. Two key questions were discussed: First, was the offered opportunity in alignment with and clearly supportive of current priorities? Second, did leadership have the capacity to engage in and support the work? The answers to these questions determined whether the clinics chose to engage in the work at all, and if they chose to participate, when they could begin. Answers to these questions were also used when communicating to staff to ensure their understanding of how the change would support organizational goals, and the realization that the change wasn't a standalone "flavor of the month" initiative. Continual leadership support reinforced the importance and connectedness of the work to the organization's success.

Conclusion

ICSI continues to actively work with clinics across the state and finds these five tensions to be present across varied clinical settings. We found that it is beneficial for clinics to identify these and other tensions affecting their systems and understand the burden they place on staff and how they can limit system improvement. The strategies described here were helpful for multiple clinics as they pursued improvements in care, and have broad application. When clinics are able to work creatively *with* tensions rather than see them as barriers, it results in changes that are supportive of physicians and staff while improving care for patients with chronic diseases.

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