



Escape Fire Improving the Quality of Pain Care

Jean Guveyan Memorial Lecture 2008

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Berwick outlines new designs and suggests practical tools for change:

- Name the problem
- Build on success
- Take leaps of faith
- Understand systems
- Make action lists
- Look outside of the medical field, set aims
- And the most fundamental of all — never lose sight of the patient as the central figure

Our Fire-Quality Pain Care

- Appropriate assessment (routine screening, comprehensive initial assessment, and frequent reassessments)
- Interdisciplinary, collaborative care planning that includes patient input
- Appropriate treatment that is efficacious, cost conscious, culturally and developmentally appropriate and safe
- Access to specialty care as needed

Culture

- **A system of shared beliefs, values, and practices (customs and rules)**
 - Provides security, integrity, belonging
 - Constantly evolving
 - Determines
 - Meaning of illness and their causes
 - How decisions are made
 - What role individuals play
 - How news is communicated
 - How emotions are demonstrated
 - What rituals are important

Where Have We Been?

- **25 years ago:**
 - Who decided whether the patient was in pain?
 - What was the most common opioid analgesic?
 - What was the typical dose?
 - What was the usual route of administration?
 - What was the usual frequency of delivery?

Nothing would have a greater impact on improving cancer pain treatment than implementing existing knowledge

WHO, 1986

How Do We Bring Knowledge to Practice?

- **Understand background factors**
 - lack of visibility
 - lack of accountability
 - absence of practical tools
 - traditional outcomes of QA not useful
- **Examine the context and process**

Max, Annals of Internal Medicine 1990; 113:885-9

Impetus for Updating QI Guidelines

- **Pressing issues of quality**
- **Pain management remains inconsistent at best**
- **Inadequate development and implementation of pain QI activities**
- **Increase in knowledge and experience**

•Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press:2001:1.

•AHRQ in press National Healthcare Quality Report. Prepublication copy available: <http://www.ahrq.gov/qual/nhrq03/nhrqsum03.htm>

•Gordon DB & Dahl JL. Pain 2004; 107(1-2):1-4.

2005 APS Recommendations for Improving the Quality of Acute and Cancer Pain Management

All care settings should formulate structured, multi-level systems approaches (sensitive to the type of pain, population served and setting of care) that ensure:

- 1) **Prompt recognition and treatment of pain**
- 2) **Involvement of patients and families in the pain management plan**
- 3) **Improved treatment patterns**
- 4) **Regular reassessment and adjustment of the pain management plan as needed, and**
- 5) **Measurement of processes and outcomes of pain management.**

Archives of Internal Medicine 2005;165

Key Structural Elements

- **An interdisciplinary workgroup**
- **Analysis of current pain management practices**
- **A written standard of practice**
- **Explicit policies and procedures**
- **Clearly defined accountability**
- **Information about pharmacologic and nonpharmacologic interventions**
- **Patient and family education**
- **Orientation and continuing education**
- **An ongoing process**

Why Do Some Hospitals Succeed?

- **Shared Goal**
- **Substantial Administrative Support**
- **Strong Medical Staff Leadership**
- **Use of Credible Data and Feedback**

Bradley EH, et al. A Qualitative Study of Increasing B-Blocker Use After Myocardial Infarction JAMA 2001;285:2604-11

But HOW did they Succeed?

Common strategies to change practice

- **Education**
- **Feedback**
- **Doctor Participation**
- **Administrative Rules**
- **Financial Incentives/Penalties**
- **Academic Detailing**
- **Quality Improvement**

"Our present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a model T Ford" --radical new vehicles are needed

IOM, 1998

Effectiveness and Efficiency of Guideline Disseminations and Implementation Strategies

- Review of 235 rigorous evals of different strategies
- 86% of studies with improvements
- Median effect size across all studies 10% improvement in process indicators (wide range)
 - 14% reminders (range -1.0%-34%)
 - 8% dissemination education materials
 - 7% audit and feedback
 - 6% educational outreach
- Multifaceted interventions did not appear more effective

Grimshaw et al. Health Technol Assess 2004;8(6):iii-iv, 1-72

So What now?

Newer methods

- Problem based education or portfolio learning
- Breakthrough projects
- Risk management methods
- Business process redesign
- Leadership enhancement
- Shared decisions with patients

What the IOM said:

- There are serious problems in quality
 - *Between the health care we have and the care we could have lies not just a gap but a chasm.*
- The problems come from poor systems...not bad people
 - *In its current form, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves.*
- We can fix it... but it will require changes

Quality is a system property

Translate the Chasm Vision into Action

Changes Needed at 4 Levels

- **Clinician and patient relationships**
- **Small practice settings (microsystems)**
- **Organizations**
- **Environment**

The Chain of Effect in Improving Health Care Quality

Patient and Community	Experience	Aims (safe, effective, patient-centered, timely, efficient, equitable)
↓		
Microsystem	Process	Simple rules/design concepts (knowledge-based, customized, cooperative)
↓		
Organizational Context	Facilitator of processes	Design concepts (HR, IT, finance, leadership)
↓		
Environmental Context	Facilitator of facilitators	Design concepts (financing, regulation, accreditation, education)

Source: Institute for Healthcare Improvement

Changing the Organizations that Deliver Care

- **Redesign care based on best practices**
- **Use information technology to improve access to information and to support clinical decision-making**
- **Improve workforce knowledge and skills**
- **Develop effective teams**
- **Coordinate care among services and settings**
- **Measure performance and outcomes**

Three Guiding Frameworks

- Knowledge-based

- Patient-centered

- System-minded

“New Rules” for Health Care

- **Care based on continuous healing relationships**
- **Customization based on patient needs and values**
- **The patient as the source of control**
- **Shared knowledge and the free flow of information**
- **Evidence-based decision making**

“New Rules” for Health Care

- Safety as a system property
- The need for transparency
- Anticipation of needs
- Continuous decrease in waste
- Cooperation

Three Messages

- Focus on suffering
- Build and use knowledge
- Cooperate

Carol Ashton

Factors that helped LDS Hospital succeed:

1. The ability to involve people—front-line people—in the decision to change
2. Science (research based clinical practice)- the ability to find and communicate sound reasons for change
3. A willingness to “just get started” and to trust the capacity of people to make mid-course corrections
4. Support from the organization

Why Focus on Physicians

- **Physician's primary professional and business focus in their own practice**
 - Priorities MDs face may be out of alignment with larger system in which they work
- **The fact about hospitals; little happens in the system without a physician order**
- **Personal responsibility for quality is powerfully engrained in physician professional culture**
 - Fierce attachment to individual autonomy is in conflict with core tenet of QI

<http://www.ihl.org/IHI/Results/WhitePapers/EngagingPhysiciansWhitePaper.htm>

IHI Framework for Engaging Physicians

1. Discover Common Purpose
2. Reframe Values and Beliefs
3. Segment the Engagement Plan
4. Use "Engaging" Improvement Methods
5. Show Courage
6. Adopt an Engaging Style

1. Discover Common Purpose

- **How can the hospital engage in the *physicians' quality agenda?***
 - Improved patient outcomes
 - Reduce hassles and wasted time
- **Be brutally honest about the organization's culture**
 - Culture is the beliefs, norms and values—spoken or unspoken
 - Grudges, past tensions and scars
 - Legal opportunities and barriers

2. Reframe Values and Beliefs

- **Make physicians partners, not customers (ask them to lead)**
- **Help physicians give up personal autonomy and see "systems science"**

3. Segment the Engagement Plan

- **Clarify specifically what physicians need to engage in**
- **20 percent of medical staff usually perform 80% of clinical services**
- **Understand roles**
 - Project leader
 - Structural leader
 - Adopters (early and late)
 - Cautious laggards

4. Use "Engaging" Improvement Methods

- **Standardize what is standardizable, no more**
- **Generate light, not heat, with data**
- **Make the right thing easy to try**
- **Make the right thing easy to do**

5. Show Courage

- **Quality problems are criticisms of some physicians within a group of colleagues**
- **Demonstrate backbone all the way to the board**
- **Organizational silence is toxic to QI**

6. Adopt an Engaging Style

- **Involve physicians from the beginning**
- **Physicians hear, process, and respond to data based on how they are trained**
 - Treat patients one at a time
 - Bear personal accountability for life and death
 - Vastly overestimate their risk of malpractice
 - Strong sense of collegiality
 - Although supreme empiricists, believe what they have seen or experienced first
 - Place strong faith on “due process”

Let me leave you with a story...
