Lessons from the Clinical Support Systems Program: facilitating better practice through leadership and team building

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ABSTRACT

- The increasing array of strategies and models for improving clinical practice and patient outcomes can be confusing for clinicians.
- The Clinical Support Systems (CSS) model has proved to be effective in local environments because it demystifies the design and implementation of evidence-based practice improvement projects.
- The CSS model is simple and has a wide scope. It provides a broad framework with minimalist specifications, enabling clinicians to design their own systems of care that cut across fragmented organisational structures.
- Implementing simple rules can be an effective strategy for change in complex care systems. These rules do not impose solutions on clinicians, but rather, help them to find creative solutions that have meaning for them and are contextually relevant.

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HEALTHCARE IS BECOMING increasingly complex, and patients, clinicians and healthcare administrators are continually faced with challenges in trying to cope with this complexity. New conceptual approaches have emerged to help clinicians understand and practise within this context.[1] These are based on understanding that clinical care involves dynamic interrelated systems that evolve as a result of the perceptions, attitudes, knowledge and experiences of patients and health practitioners, and the rules, customs, procedures and expectations that each develops in relation to the other. There is a need for a systems-based approach underpinned by appropriate infrastructure support.

The Clinical Support Systems (CSS) model is one such approach.[2] In this model, multidisciplinary teams focus on their practice in the light of the best available evidence. They then design interventions to ensure that the system of patient care is congruent with the evidence. This model was tested through the Clinical Support Systems Program (CSSP) in four consortium-based projects, each with different clinical settings and patient groups.[3-6]

Key lessons from the CSSP experience

Supporting practice improvement

The rapidly increasing array of strategies and models for improving clinical practice and patient outcomes may be confusing for clinicians. However, the CSS model, in demystifying design and implementation of evidence-based practice improvement projects,[7] has proven effective in local environments.

The model is effective because of its simplicity and scope. Instead of being tightly prescriptive, it provides a broad framework in which the specifications are sufficiently minimalist to enable application to a wide range of clinical settings and diseases. This has enabled clinicians to design their own systems of care that cut across prevailing fragmented organisational settings to implement evidence-based care within new systems.

Implementation of simple rules is increasingly recognised as an effective strategy for change in complex care systems.[8] These rules do not impose solutions on clinicians. Rather, they help clinicians to find creative solutions that have local ownership and are locally relevant.

Clinical leadership

Some clinicians are leaders by virtue of their position within an organisation; others are leaders because of personal attributes, such as the ability to influence others, galvanise involvement and generate change.

Clinical leaders are widely acknowledged as important facilitators of change,[9] but their high profile is often derived from involvement in multiple activities. They thus tend to be exceedingly busy and often absent from the clinical setting in which change is being implemented.

The CSSP experience has illustrated that good leadership is essential to improve clinical practice (Box 1). But, instead of being vested in a single individual, leadership should be a joint responsibility. Different members of the clinical team need to take on various components of the leadership role, according to skills, experience and the tasks required. That the doctor may not always be the appropriate team leader is an important realisation that may be difficult to rectify.

Working together in multidisciplinary teams

Improving patient care requires a team effort. All professional groups contributing to patient care need to be involved.

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1: Leadership, multidisciplinary teams and practice improvement

- Leadership is a collective responsibility, with individual team members making contributions at different times.
- Development of an effectively functioning team takes time and effort.
- A shared vision is critical to team success.
- Multiple strategies are needed to engage and maintain team membership.
- Investing in team development processes should return significant benefits throughout the project.
- Clinicians and team members are less likely to be resistant to change if they are personally involved in the development process.

The experience of clinicians involved in the CSSP has indicated that forming and maintaining teams requires effort. Even finding a time for team members to meet in a busy and fragmented work setting poses a challenge. Transforming a newly formed group of clinicians from different disciplines into an effective team takes time. Team members are likely to have different interests, opinions and interpretations of key terminology. These differences need to be worked through to develop a shared vision and mutual understanding between team members. Without this consensus, the full potential of the practice improvement initiative will be difficult to achieve. Improving skills in facilitation, negotiation and conflict resolution helps team members achieve consensus.

Multiple strategies to maintain the interest and commitment of team members are also necessary (Box 1). This can be particularly difficult in workplaces with high staff turnover. The role of long-term team members in orienting new staff is critical in sustaining the practice improvement initiative.

Evidence and better practice initiatives

The principle underpinning the CSS model was the integration of evidence-based medicine (EBM) and clinical practice improvement (CPI).[2] This integration proved to be challenging for multidisciplinary teams. As EBM and CPI are constructs that derive from different paradigms, their language and tools differ. Clinicians participating in the CSSP needed to grapple with what it actually meant for their practice to bring these two constructs together. Some clinicians were clearly more comfortable with one paradigm than the other, so negotiating for shared meaning took time.

EBM is the accepted approach in medicine for systematically defining and applying the best available evidence. The strongest level of evidence is regarded as that generated through systematic reviews of multiple randomised controlled trials. However, randomised controlled trials are more suitable for assessing some aspects of medical practice (eg, prescribing) than others (eg, effective communication with the patient). Moreover, randomised controlled trials have been applied with different levels of intensity across medical specialties. At the same time, the evidence base for clinical practice in other professional disciplines, such as nursing and allied health, does not always fit easily into the EBM paradigm. Multidisciplinary teams need to agree on the evidence base they will use to initiate better practice. There is little incentive for clinicians from a particular discipline to participate in improvement programs if their contribution to patient care is excluded from the evidence focus (Box 2).

Strategies to support local clinical teams

Strategies to support local practice improvement are likely to include aspects of education or training. For example, there is usually a need to disseminate the evidence for practice changes in the form of guidelines or to train staff in interventions such as the use of a decision-support tool. While education and training are not the sole remedy for changing entrenched structures, cultures and work practices, they are important components of the change process. Multifaceted approaches are needed for complex care systems.[10] Individual clinicians learn in different ways and also differ in the way they are linked into organisational structures.

Strategies are also likely to include some form of measurement and review of practice according to the agreed evidence base. The CSSP experience showed that clinicians are keen for meaningful feedback about the care they provide. Indeed, having access to such information can provide a strong motivation for clinicians to engage in a practice improvement project. However, there is a tendency to compensate for a lack of relevant clinical information in some areas by accumulating large amounts of data that are cumbersome to evaluate. This can hamper implementation of new projects. Practice improvement initiatives are best supported by a minimum evidence-based dataset that can be added to as needed.[11]

Partnerships with consumers

The dependence of evidence-based practice on effective partnerships between clinicians and consumers is increasingly recognised. Evidence moves from theory into practice when consumers encounter clinicians.[7] Both make decisions contributing to health outcomes, so both need access to the best available evidence to make informed decisions. The quality of this encounter influences the information

2: Use of evidence and data collection

If priorities are skewed too heavily towards one clinical discipline, there is a risk that members of other disciplines will disengage from the project. It is important to

- ensure that there is something for everybody (at least one indicator for each major discipline involved);
- realise that an endless search for perfect (instead of sufficiently good) data may jeopardise your project's momentum and cohesion (if an indicator is meaningful enough for clinicians to accept and act on it, then go with it);
- integrate decision support and data collection into one tool/document.

3: Consumer contributions to better practice

- Useful direct feedback about the quality of care received.
- Insights into problems in the care system from the patients' perspective.
- Assistance in design of patient information kits and brochures.
- Identification of potential problems for patients with new interventions.
- Strategic negotiation with administrators.
- Assistance in a range of tasks to support projects.
- Dissemination of information about projects to other consumers.

exchanged. This, in turn, influences decisions made by both parties and the resultant uptake of evidence.

Some clinicians participating in the CSSP were initially unconvinced about the requirement to involve consumers. They tended to have limited experience in working with consumers. Over time, scepticism was replaced by an appreciation of the valuable contribution consumers can make to practice improvement projects (Box 3).

Consumers were willing to assist clinicians in their efforts to improve the healthcare system. Clinicians have a responsibility to keep consumers informed about the influence of their involvement, particularly the changes that result from feedback they have provided.

Partnerships with health administrators

The success of clinical practice improvement projects is maximised if they are firmly based on partnerships between clinicians and administrators. A sponsoring senior administrator can make a valuable contribution, and inclusion of senior administrators in the project team can do much to minimise policy and organisational barriers to change. However, the CSSP experience showed that forging links between clinicians and administrators can be difficult. There are differences in orientation, language, priorities and ways of working that need to be overcome. Yet, persisting in this endeavour is worthwhile and can result in system improvements beyond the ability of either group to achieve on its own.

The CSSP itself was the outcome of collaboration between clinicians (the Royal Australasian College of Physicians [RACP]) and administrators (the Australian Government Department of Health and Ageing). Their experience showed that, although forming bridges takes time and can be frustrating, with persistence and by maintaining communication it is possible to establish common understanding and achieve productive outcomes for healthcare improvement.

The RACP's role in supporting clinicians

The direct involvement of the RACP in the CSSP has made an important contribution to increased interest in better practice initiatives by doctors.[7] At the same time, this involvement has been a new experience for the RACP, which has learned much about the practical role it can play in supporting its Fellows and trainees in developing their own CPI programs.

Clinicians are enthusiastic about improving the quality of clinical practice, but obtaining information to help develop a local project can be time-consuming. Even identifying where to begin the search for information can be difficult. The RACP is supporting busy clinicians through its "Achieving better practice" website (www.racp.edu.au/bp), which provides a wide range of information, practical advice and resources in one easy-to-find location. A major feature of the website is the "Initiating better practice" manual (www.improveyourpractice.com.au). The manual offers a simple, effective guide for clinicians seeking to improve the quality of their patient care. It provides a practical introduction to the CSS model and draws heavily on the experiences of clinicians involved in the CSSP. A step-by-step structure guides users through the process of designing a project, forming a team, involving consumers, designing interventions, measuring and reviewing practice and sustaining better practice. Case studies and tips to assist users, as well as traps to avoid, are included.

However, it is clear that support needs to extend beyond these practical initiatives. All professional bodies interested in improving healthcare need to ensure that the education and training provided support better practice. The quality of supervision, the on-the-job professional socialisation, the relevance and breadth of knowledge and skills acquired, the congruence between formal curricula and practical exposure, as well as the workload, are all important components of the training process that influence the ability of trainees to provide quality care now and into the future. There is also the potential to explore opportunities for collaboration between organisations. Current training processes tend to foster individualism and isolationism that counteract the team-based systems approaches necessary to support practice improvement.

The development of team-based systems of care based on best evidence will also depend upon integration of these concepts into undergraduate, postgraduate and continuing education programs.

The RACP, in association with the Australian Government Department of Health and Ageing and several state health departments, has led the way in developing the CSS model. The model has been used successfully to put into practice collaborative, evidence-based systems of care for the several specific disease processes or presentations studied in the program. The challenge now is to translate the lessons learnt and processes developed to the care of patients with other diseases and to progressively extend the use of the CSS model to other healthcare institutions or systems. Models of care and collaboration will need to vary to some degree according to the disease process and the environment in which the disease is being managed. However, the basic tenets of the CSS model remain — that is, access to and use of the best available evidence, and collaboration between healthcare professionals.

References

1. Plsek PE, Greenhalgh T. The challenge of complexity in health care. *BMJ* 2001; 323: 625-628.
2. Leigh J, Long PW, Phillips PA, Mortimer RH. The Clinical Support Systems Program. *Med J Aust* 2004; 180 (10 Suppl): S74-S75.
3. Ferry CT, Fitzpatrick MA, Long PW, et al. Towards a Safer Culture: clinical pathways in acute coronary syndromes and stroke. *Med J Aust* 2004; 180 (10 Suppl): S92-S96.
4. Mitchell PLR, White CA. Austin Bowel Cancer Consortium: changing culture in bowel cancer care. *Med J Aust* 2004; 180 (10 Suppl): S79-S82.
5. Scott IA, Denaro CP, Bennett CJ, et al. Achieving better in-hospital and after-hospital care of patients with acute cardiac disease. *Med J Aust* 2004; 180 (10 Suppl): S83-S88.
6. Horne MK. The Monash University Consortium: factors involved in the local implementation of clinical evidence into practice. *Med J Aust* 2004; 180 (10 Suppl): S89-S91.
7. Leigh J. Final evaluation report of the Clinical Support Systems Program (CSSP). Royal Australasian College of Physicians, 2003. Available at: www.racp.edu.au/bp/cssp/CSSP_final_report.pdf (accessed Mar 2004).
8. Committee on Quality Health Care in America, Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press, 2001.
9. Campbell D, Scott I, Anderson J, Greenberg P. Improving clinical practice: what works and what doesn't? *Intern Med J* 2001; 31: 536-540.
10. Grol R. Improving the quality of medical care. Building bridges among professional pride, payer profit, and patient satisfaction. *JAMA* 2001; 286: 2578-2601.
11. Berwick D. A primer on leading the improvement of systems. *BMJ* 1996; 312: 619-622. ❑