Turning an idea into reality to improve patient care: the development of the Clinical Support Systems Program

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ABSTRACT

- The concept of the Clinical Support Systems Program (CSSP) was transformed from an idea into reality through the efforts of representatives of the Australian Government Department of Health and Ageing and the Royal Australasian College of Physicians.
- This collaboration involved developing common ground between two different perspectives: those of the funder/policy/administrative sector and those of the clinical practice world.
- Bridging these differences to establish an agreed approach to moving forward was a lengthy and difficult process. The process is aided by tension for change.
- Compromise, persistence and commitment to the end-goal by the parties involved were important features in building and maintaining the momentum of the change process.
- Many of the difficulties experienced could be traced to differences in decision-making processes between the clinical and the administrative paradigms. Knowledge brokers can assist in bridging the different languages and perspectives of the groups involved.

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THE CLINICAL SUPPORT SYSTEMS PROGRAM (CSSP) resulted from direct collaboration between representatives from the Australian Government Department of Health and Ageing (the Department) and the Royal Australasian College of Physicians (RACP). This collaboration involved developing common ground between the two different perspectives and health priorities of these organisations: those of the funder/policy/administrative sector and those of the clinical practice world.

Examination of this collaborative experience provides useful insights into the processes of change associated with translating ideas into practical realities so as to improve patient care. These insights have immediate relevance both for clinical contexts and for other joint ventures between clinical organisations and government departments.

Developing program concepts

The development of program concepts was a challenging experience, demanding considerable time and effort on the part of representatives from both the RACP and the Department. Both parties started from the same position: concern that evidence was not making its way into routine clinical practice. They also shared the view that cultural change led by clinicians was the best way to integrate evidence into clinical practice. However, they differed on the most effective ways to implement and test different approaches to achieving this.

Departmental representatives were interested in using clinical practice improvement (CPI) methods as the basic implementation framework, whereas those from the RACP were primarily interested in evidence-based medicine (EBM) and establishing randomised controlled trials. These differences posed a challenge to the success of the collaboration. Each party saw problems with the other party's perspective: departmental representatives saw the RACP position as somewhat naïve, focusing too heavily on the "evidence" and not enough on practice change; and RACP representatives perceived a lack of clarity and rigour in the CPI approach.

Bridging these differences to establish an agreed approach for moving forward was a lengthy and difficult process. The differing parties encountered many barriers arising from their peculiar emphases, values and interpretation of language in their negotiating stance. It was only through a willingness to persist, and a commitment to the end-goal, that the general idea of clinical support systems was transformed into a potential program, based on a single implementation framework.[1-3]

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Compromising to move forward

The protracted and difficult negotiations resulted in a compromise position that linked the methodologies of EBM and CPI into one model — the Clinical Support Systems (CSS) model. This compromise enabled progression to the next stage — the call for expressions of interest for conducting CSS projects.

In conceptually linking EBM and CPI, the model brought together different languages, values, structures and processes. However, it was perceived by potential project implementers as somewhat ambiguous. At the same time, it created a productive tension from which local learning ensued.[1,2] Instead of following a tightly prescribed blueprint for change, clinicians needed to work through what it meant to integrate EBM and CPI in the context of their own model. It is interesting that the compromise

1: Key features of a successful collaboration

- Understand that the perspectives of the other parties in a collaboration come from a different cultural orientation, which may affect language, emphasis, and interpretation.
- Expect that it will take time and effort to achieve mutual understanding and shared goals.
- Be willing to persist when the going gets tough.
- Be prepared to try something new.

which the RACP and the departmental representatives struggled to reach, and with which neither was happy, proved, in implementation, to be a powerful model for local system change.

Trying something different

In collaborating on the development of the CSS model, both the Department and the RACP were entering new territory. Neither had previous experience of working together in this way, but, in planning for the new program, it was clear that both parties were willing to take risks to try something different (Box 1).

For the Department, these risks related not only to its level of program funding ($4.5 million), but also to adopting a "hands-off" approach to the actual implementation, with the projects being contracted to the RACP instead of directly to the Department. The Department was particularly interested in working with and through the RACP as a means of increasing doctors' involvement in quality initiatives.[4] For the RACP, the CSSP was a "first" experience of being directly involved in program sponsorship and management. This represented a willingness to take a risk in trying something new as a way of contributing to improvements in clinical care.

As the Program developed, it became clear that both parties' early willingness to be innovative in their approach had been beneficial. The RACP's active promotion of the CSSP was successful in increasing doctors' interest in evidence-based clinical practice improvement, not only among its own membership but also more widely.[1] It was a powerful stimulus for change.[1,3] Furthermore, the RACP successfully brokered additional funds from two state governments (each gave $500 000), allowing an additional project to the originally planned three projects.

Building the momentum for change

In response to the call for expressions of interest for conducting CSSP projects, a total of 53 submissions were received. The majority were from consortia with RACP members as lead clinicians. However, most of the submissions did not reflect an understanding of the CSSP intent — they were written more like submissions for research grants, rather than proposals to conduct projects focused on clinical practice change.

Because of this, the collaborating partners established an expert panel. Its purpose was to assist the 11 short-listed consortia to develop a competitive tender, with access to expertise in areas crucial to strengthening their submissions and aligning them more closely with the intent of the CSSP. These areas included:

- clinical information and data systems (development and implementation);
- health economics (articulating costs and quality improvement);
- organisational and cultural change;
- clinical and outcomes measurement, analysis and review;
- clinical process management;
- evaluation (project evaluation and clinical costing); and
- consumer participation processes.

The expert panel, which had expertise relevant to these critical elements of the CSS model, was itself an important component of change management within the CSSP.

The competitive tendering process generated considerable interest both among the RACP membership and more widely within medicine. During this time, the Department, the RACP and a consumer representative visited each state to provide feedback to the short-listed consortia on their proposal before final submission.

This "whirlwind tour" contributed to the build-up of momentum, having a general positive effect beyond its effect on those immediately involved in the development of the submissions. It generated interest and heightened awareness more widely. The expectation of a prompt announcement of the successful projects within a few weeks of the deadline for final submissions added to this momentum.

Encountering unexpected obstacles

The final announcement of the successful projects was delayed for several months beyond the expected December 1999 deadline — the first two of the final four successful projects were notified in late March 2000. There was an unrealistic expectation of the timing of the announcement, and no allowance had been made for delays caused by such things as the Christmas holiday period, administrative processes and changes in key personnel. The change momentum which had been building during the competitive tendering process was lost, and this had three consequences:

- Much of the interest and enthusiastic support that had been galvanised within each consortium during the tender-development process abated during the waiting phase. This had downstream effects for the successful projects — there was a need to reactivate local interest, and this delayed implementation of the projects. In some cases, key clinicians in the original tender were no longer available, having filled the time they had planned to devote to their CSSP project with other activities.
- The relationship between the RACP and its members became strained during the waiting phase. The RACP's Health Policy Unit played a crucial role at this time in brokering communication within the RACP, and between the Department and the RACP members who were frustrated by the delays.[1,5]
- The RACP and the Department were faced with the challenge of re-establishing a shared vision and negotiating

2: Strategies to support collaborative change management programs

- There needs to be tension for change — paradox and ambiguity create opportunities for change to happen and energise people to be involved.
- Endeavour to preserve the momentum of the change-management strategy. A stalling in the process (for whatever reason) necessitates reactivation, requiring additional effort to return to the point at which the stalling occurred.
- Ensure that mechanisms are established to preserve continuity of corporate memory within one's own organisation with respect to the collaborative venture. Consensus is difficult to achieve, and there is a risk that staff changes may undermine hard-won agreements, necessitating further negotiation to re-establish a mutual position.
- Manage any transition from collaborative partnership to funder/fundee arrangements carefully. This transition changes the dynamic of the relationship, and there is a risk that hard-won agreements and goodwill will be undermined during this process.
- Create opportunities to bring funders and project clinicians together. Generally there is little opportunity for funders and practising clinicians to engage directly with each other, and there is much to be gained, both in terms of generating funder interest and support and in invigorating projects, through mechanisms that provide this opportunity.
- Invest in brokers (organisations or individuals) to build relationships and facilitate effective knowledge transfer between groups. Knowledge brokers can assist in bridging the different languages, cultures and perspectives of groups that each contribute to patient care in different ways.

the formal agreements for project funding between new personnel, who themselves had different ideas and fresh interpretations of what could be achieved by the CSSP.

Many of the difficulties experienced at this time from both sides (Department and RACP) could be traced to differences in the decision-making processes between clinical and administrative paradigms. Clinicians are used to working at a faster pace, dealing with immediate issues and producing solutions quickly. Administrative processes, with appropriate checks and balances and internal requirements, affect the speed of decision-making.[1] While both reflect their different system orientations, effective change strategies that seek to forge links between these two systems need to take these cultural differences into account, and work through the frustrations that may ensue (Box 2).

Re-establishing the collaborative approach

During this stop–start phase in program establishment, the nature of the relationship between the Department and RACP moved away from the collaborative partnership evident earlier in the program development towards the more traditional relationship of funder and contracted program manager.

Gradually, as a result of the personal efforts of both parties, the collaborative approach was re-established. A major contributing factor was the direct connection forged by the RACP between the projects and the Department. Project visits for key senior stakeholders were organised, and a presentation by senior project clinicians was made to the Department. It was evident that benefits are to be gained (in terms of funder support) by creating mechanisms whereby program funders, who are removed from the clinical setting, have an opportunity to interact directly with the programs' clinician participants.[5] The participants also appreciated the opportunity to showcase their work directly to funders.

Conclusions

The many and varied improvements in patient care achieved by the clinicians and others involved in the CSSP projects have their origins in the collaborative efforts of the representatives of the Department and the RACP. Although the process was not easy for either party, the joint willingness to persist in turning ideas into a practical program to support evidence-based practice improvement was a major achievement. These experiences have provided important insights for similar future initiatives to build upon.

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