The shift to a value-driven delivery model hinges on a key element: patients' achieving the best possible outcomes. The linchpin to that is ensuring that clinicians regularly follow best practices and adhere to evidence-based protocols.

“If this [transformation] is about value and value equals quality divided by cost, then it makes sense that you look at the evidence,” says Joseph Pepe, M.D., CEO of Catholic Medical Center, Manchester, N.H. Pepe, who served as CMC’s chief medical officer for 12 years before moving into the chief executive role in 2012, acknowledges that one of the biggest stumbling blocks to instituting evidence-based practice more broadly is the fear that it is “cookbook medicine.” That’s a passé notion, he says. Evidence-based care is not only about following results from the most recent clinical studies, but blending that with a patient’s values and desires, as well as relying on a physician’s judgment.

“Physicians have gotten a bad rap,” says Jean Slutsky, director of the Center for Outcomes and Evidence at the Agency for Healthcare Research and Quality, when talking about the perception that doctors routinely reject the move toward evidence-based care. “Physicians are lifelong learners. The very nature of what they do is about learning.”

A 2008 AHRQ handbook on implementing evidence-based care supports the notion that this is not a completely rigid process. It defines evidence-based care as “the use of current best evidence in making decisions about the care of individual patients, while recognizing that this is not an exact science, and that there may be times when the evidence is incomplete.” There’s a great merit, he says, to evidence-based care not only being informed by the most recent clinical studies, but blending that with a patient’s values and desires, as well as relying on a physician’s judgment.
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Knowledge Transfer: A Framework for AHRQ Patient Safety Portfolio and Grants

1. Knowledge creation and distribution
2. Diffusion and dissemination
3. Adoption, implementation, and institutionalization

In conjunction with clinical expertise and patient input to guide health care decisions. That definition was propounded by Davidackett, a Canadian author, in 1945: ‘Medical Journal’ editorial. “Good doctors are those, both individually and collectively, who are most readily available and who volunteer to serve, even when asked to do.”

For example, readily, the evidence may suggest that a patient be placed on a certain medication. Sometimes it may be to prescribe one pill a day, 30 tablets a month. A dissection model, which is like a clinical partner of the patient, the physician and patient would discuss the fact that it is no available medication to prescribe new one. In the present, that’s more affordable but requires the patient to take the medication three days a day.

Another factor to consider: What level of risk does the patient willing to assume?” Shellenbarger adds.

The AHRQ advocates that when developing a process to implement evidence-based practices, hospitals ‘see’ through the clinician's perspective. In doing so, it accommodates selecting assets for improvement, rather than asking what changes ought to be demonstrated.”

This approach Kaiser Permanente follows.

“We spent a lot of time trying to figure out what clinical questions that we want to answer,” says Kent Young, M.D. associate chief medical officer, clinical care and innovation, at Permanente Medicine.

As part of a national initiative, Kaiser Permanente has a robust process for reviewing clinical guidelines and disseminating new evidence throughout the health system. Scott says topics come up for review by a variety of different issues (see case study). Perhaps the most important element of the process, he says, is physicians being able to see if the evidence-based protocols are put through a rigorous review; clinicians have confidence that following them is in the best interest of the patient. Reviewing physician champions who can effectively advocate for the use of evidence-based care improves the likelihood that protocols will be adopted widely. The AHRQ report highlights two levels of barriers.

• Opinion leaders. These people are ‘natural’ evidence seeks inform-container in the context of a group practice. They respect and explore new ways for healthcare delivery, and are adoptive of new changes. They have evidence-based practices and can influence others to adopt the change.

• Change Champion. These people are ‘organizational’ evidence leaders, committed to improving quality of care, and have a positive working relationship with other healthcare professionals. They influence information, wanting provide to adapt the innovation, announce dissemination, and cert the need for its innovation.”

So, with everything else in healthcare, senior leadership support is also important. The AHRQ report states that sooner leaders need to incorporate evidence-based care into the organization’s overall mission, vision, and strategic plan. It needs to be a fundamental part of the organization.

With post-paid physicians recruited toward an approach that rewards good outcomes and positions that help, hospitals will be assessing more than financial risk for patient care. That, reports say, demands greater attention to evidence-based care.

“What choice do we have?” Scott asks. “We want to see what is best for healthcare. We want to see what will help healthcare. We want to see what will save healthcare.”

We can create those environments in which reality to the evidence.”

Case Study:

Kaiser Permanente

Kaiser Permanente is a care delivery system that believes in evidence, says Kent Young, M.D., associate executive director for clinical care and innovation at the Permanente Federation, which represents Kaiser’s medical groups. The system has a dynamic process for instituting evidence-based practices and getting them to (Kaiser)’s internal population.” National and local groups around the state are looking at evidence, but protocols must be approved by the right medical groups before becoming the standard of practice.

For example, with diabetes and hypertension, the panel reviews the clinical guideline topic to better evolve every two years. Other protocols “build on top of each other,” some are being brought forward by clinical boards and in some cases, the health system looks at the “existing and sufficient of population.” Kaiser Permanente ‘s district evidence guidelines are reviewed and updated every two or three years. Changes to the guidelines give the patient the best care. Kaiser Permanente has also developed a system to track patient outcomes and evaluate the effectiveness of the guidelines.

III. COMPARATIVE EFFECTIVENESS RESEARCH

Education and implementation

1. Develop educational materials (Web, print, etc.)
2. Mass dissemination of tools and products
3. Evaluation of implementation of specific groups

IV. Ongoing and Implementation

1. Monitoring outcomes
2. Adjust and refine
3. Follow-up dissemination of tools and products
4. Evaluation of improvement in outcomes
The shift to a value-driven delivery model hinges on a key element: ensuring that clinicians regularly follow best practices and adhere to evidence-based protocols.

“Waste transformation is about value and value equals quality divided by cost, and it’s hard to talk about it in the context of the old paradigm,” says Joseph Pepe, M.D., CEO of Catholic Medical Center, Manchester, N.H.

Pepe, who served as CMC’s chief medical officer for 12 years before moving into the chief executive role in 2012, acknowledges that one of the biggest stumbling blocks to instituting evidence-based practice more broadly is the fear that it is “cookbook medicine.” That’s a passé notion, he says. Evidence-based care is not only about following results from the most recent clinical studies, but blending that with a patient’s values and desires, as well as relying on a physician’s judgment.

“Physicians have gotten a bad rap,” says Jean Slutsky, director of the Center for Outcomes and Evidence at the Agency for Healthcare Research and Quality, when talking about the perception that doctors routinely reject the move toward evidence-based care. “Physicians are lifelong learners. The very nature of what they do is about learning.”

A 2008 AHRQ handbook on implementing evidence-based care supports the notion that this is not a completely rigid process. It defines evidence-based care as the use of up-to-date evidence to make decisions. It’s about making care decisions that are tailored to the patient. In short, it’s about providing the best care possible for the patient, based on the best evidence available.

The Art & Science of Evidence-Based Care

RESEARCH BY MATTHEW WEINSTOCK

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