



Contraception 79 (2009) 331-333

Editorial

Beyond education and training: making change stick

Medicine is in constant change, with new evidence continually replacing how we consider health and illness. In health care we are deluged with articles about change — how to accomplish it, how to measure it, how to sustain it. Patients have become more robust advocates. With the proliferation of new medications and data, both patients and clinicians must rely upon online information, as printed material is often out of date before leaving the mailroom. So, the paradoxical question is why, when we train individual clinicians to incorporate new evidence and procedures, is it so hard to overcome organizational, political, and financial barriers that limit their ability to implement such change in practice?

Data indicate that providing education and training to individual health care providers alone is not enough. Continuing medical education evaluations show didactic programs affect practice less than interactive learning opportunities [1]. Randomized intervention trials using the WHO electronic library based on Cochrane systematic reviews have found little evidence of consistent impact on clinician obstetric practice in several countries [2]. Clinicians are rarely exposed to existing models for implementing new practices [3–5] during their training, so their skills to negotiate change at their clinical site may be limited. We believe that interventions designed to target barriers and systems change will have more impact on improving contraceptive and abortion care than those focused only on individual professional knowledge. Implementing medical innovations should be viewed as requiring systems change, often needing buy-in from many levels of a practice or health care organization, not just training of the care provider.

As advocates for enhanced contraceptive quality of care and access, we are aware of many opportunities for improvement in how we deliver care. The complexities of incorporating new contraceptive evidence and skills into a practice setting are well documented. Despite growing evidence supporting advantages of providing hormonal contraception without mandatory physical exams [6,7], broader indications for long-acting reversible contraceptives [8,9], provision of more contraceptive supplies per visit [10] and managing miscarriage in outpatient settings [11,12], community reproductive health practice has lagged behind [13–15].

Research has also documented the difficulties of integrating abortion training into practice, which include

gaining and maintaining sufficient case numbers [16], overcoming organizational barriers [17] and addressing scope of practice limitations for primary care providers [18]. Although some organizations have begun to provide clinician mentoring, networking and online tools to improve integration into routine practice, the scope of these challenges is likely to require a broader collaborative effort.

There is no universal map for effectively expanding our focus beyond individual provider training. But we know from quality models that training to implement systems change has greater effect than individual efforts at improvement [3,5,19]. Attempting to introduce a service or make a change on a systemic level requires a few common steps: (1) aligning goals, (2) providing methods for training and piloting a program, (3) setting clear performance indicators and (4) communicating effectively.

1. Aligning goals

This means making a strong business and community case for a new intervention, whether it is for patient need, improved safety or efficacy, or cost considerations. If the innovation is sound and there was good reason for the initial training, there should be a related reason the service is compelling for a clinical site. One researcher highlights the importance of three influences on the rate of diffusion of health care innovations: the perceptions of the innovation, the characteristics of the individuals who adopt the change and the contextual and managerial factors within the health care organization [5]. To build perception, it is helpful to present data showing the intervention can improve continuity of care, build staff skills or address internal gaps in services. Systems change advocates should practice articulating the benefits and offer a clear path toward implementation. Introduction of controversial new reproductive services (such as abortion) may benefit from opportunities for staff to discuss concerns through values clarification [20,21].

One study highlights the complexity of integrating medication abortion services into a university setting [17] and outlines factors leading to success. Steps taken to build stakeholder buy-in included early outreach to nursing staff and many discussions that led to the development of departmental consensus statements, which proved critical

to refer back to when obstacles arose. Cultivating champions and supporting early innovators at various organizational levels help a pilot intervention become more rapidly and fully institutionalized [5,22]. Creating partnerships with reproductive health professionals from other organizations can also help build influence internally [23], especially if the champion has limited political capital in the organization to initiate the intervention. The Institute for Healthcare Improvement emphasizes that the spread of innovation must be the job of both an organization's leaders and the day-to-day management team [19,24]. After building buy-in with leadership, consider an approach for integrating a new service that encompasses input and roles of front desk, health education, clinical and billing staff.

2. Providing methods for training and piloting the service

There are many useful resources describing methods for training staff. One valuable approach used in family planning services is a clinic self-assessment technique called COPE (client-oriented, provider efficient) in which clinic staff learn to evaluate their services, identify internal problems and attempt to develop workable solutions. This method has been used in a variety of countries with long-lasting impact [25–27]. Involving staff in ongoing quality improvement systems has been effective even in resource-poor settings [4,25].

Mastering these processes can be challenging because they compel staff to commit to new ways of thinking and working. But intervention studies have demonstrated that full staff training and system-wide protocol changes can have a significant impact on the utilization of more highly effective contraceptive methods and subsequent rates of unintended pregnancies or repeat abortions [28–30]. Use of clinical guidelines and management protocols help to standardize the approach [31]. It is recommended that training materials be tailored to address knowledge gaps and misinformation of patients as well as providers, and should address cost implications of a new procedure or service [32].

3. Setting clear performance indicators

Collecting data and clarifying meaningful performance indicators from the outset help focus an intervention [33,34]. Chart or billing reviews can be beneficial, for example, to evaluate the number of months of contraceptive supplies, dedicated staff time and associated costs in light of outcomes markers such as contraceptive continuation or unintended pregnancy. Providing information on a few key indicators, perhaps in the form of a visible dashboard, can form the basis for regular feedback on progress.

Tangible goals allow team participants to understand the connections between their day-to-day work and compelling, longer-term aspirations [3]. Discussing the initiative's impact on access to reproductive health services can

reinforce the group's core values, such as patient-centered care [4]. In the absence of such an overarching vision, programs may address specific objectives but on their own are likely to fall short of cultivating a team's commitment to sustained change.

4. Communicate frequently and effectively

Various studies have suggested that quality improvement interventions involving audit and feedback, participatory planning activities and sharing of "best practice" approaches can have a robust impact in improving quality of care, not only in hospital settings but also in primary care clinics [35,36]. Communication is a vital part of any initiative. Messages should promote the champions of the intervention, reinforce the purpose and methods of the intervention and share specific goals and progress.

In this era of global economic disruption, a new progressive leadership and a guarded optimism that "change is possible" — now is the time to make positive change stick. We have highlighted steps to increase an intervention's success and to institutionalize change. We must build stronger support mechanisms for individual clinicians, gather and align a diverse leadership and work with our colleagues to create a culture of ongoing improvement. We also need more high-quality research evaluating how best to implement new evidence-based practices. Our goals in reproductive health training should focus beyond clinical knowledge to include methods of practice integration involving systems change. It is never easy, but it usually is well worth the effort.

Acknowledgment

We would like to acknowledge Marji Gold, M.D., Ruth Lesnewski, M.D., and Linda Prine, M.D., for their editorial support and guidance.

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