Paving Clinical Pathways
Using a trusted change management model to establish standardized, evidence-based care across the continuum

by Leigh A. Resnick, M.H.A., R.R.T.

Healthcare spending was estimated to top $2.8 trillion in the United States\textsuperscript{1} in 2013, according to \textit{U.S. News and World Report}. Increased spending occurs due to multiple factors, namely variation in care. Cost drivers include overtreatment (or defensive medicine), advances in technology and individuals living longer with chronic diseases. In inpatient settings, care variation leads to adverse health outcomes and longer hospital stays.

Creating and implementing clinical pathways is an effective way to curb healthcare spending. Clinical pathways are structured, multidisciplinary plans of care surrounding an intervention. The pathway provides an evidence-based and detailed step-by-step treatment course arranged in an algorithm, guideline or protocol, which is accompanied by a timeframe or criteria-based progression.\textsuperscript{2} The concept of reducing variation through standardization was first demonstrated in the engineering field as early as 1950. It was later adopted by healthcare in the 1980s.\textsuperscript{3}

A study of six health organizations in Italy showed pathway use resulted in reduced variation in aspects such as length of stay, testing and therapeutic prescriptions.\textsuperscript{4} This study also found that patients suffering from heart failure showed decreased mortality and reduced outcome variation when treated using pathways. After implementing the care pathway, health outcomes for left ventricular assessment, a clinical core process, increased from 40\% of patients receiving the assessment to 100\%.\textsuperscript{5} Total inpatient mortality decreased from more than 17\% to less than 5\%, with the same effect observed in
readmissions rates. Before the use of the pathways, readmissions occurred for about 7% of patients. Post-intervention, this decreased to less than 3%.

Although pathways are not a new concept, there remains a wide bandwidth of provider acceptance. In Liverpool, England, two reports were published focusing on provider perception of clinical pathways. These reports focused on the Liverpool Care Pathway (LCP), which were used throughout the United Kingdom and developed to enhance end-of-life treatment with the goal of allowing patients to die with dignity. This care pathway was developed in the 1990s as concerns grew within the U.K. medical community that end-of-life care was fragmented and not provided consistently throughout the nation, resulting in patients who were not being treated according to best hospice practices. Patients may have spent their final days suffering from pain, hunger and possibly dehydration. The controversy over LCP arose from reports stating patients were placed on the pathway without their or their family’s knowledge. The reports also alleged that other patients may have been enrolled too soon (imminent death was not near).

Published studies validated the effectiveness of the LCP as a standard to treat patients. Issues regarding the perception of its use remained, however. Relatives and clinicians were unaware their family member or patient remained on the pathway for weeks without review or reevaluation of care, according to Mark Pickering, M.D. The reports implanted fear in the general public about end-of-life care using the LCP. Physicians were less likely to place their patients on the LCP in light of public concern.

Cookbook medicine?
Aside from concerns over how patients are treated once a pathway is initiated, some medical providers feel that standardization leads to “cookbook” medicine or medical care that is prescriptive and restricts
creativity, intuition and clinical judgment. Although some physicians feel standardization will stifle innovation, the optimal way to treat patients is through standardized care models, according to an article published in *Modern Healthcare*. Kedar Mate, M.D., vice president of the Institute for Healthcare Improvement, stated that standardizing parts, processes and individual roles results in a reduction of errors and patient harm.

Creating pathways involves the collaboration of individuals from diverse backgrounds, such as physicians, nurses, case managers, pharmacists and others. The tactical development of pathways must be supported through a change management model that ensures successful development, implementation and sustainability of pathways. Understanding why transformation efforts fail improves the likelihood of developing a successful pathway. John Kotter, professor at the Harvard Business School and head of research at Kotter International, identifies eight reasons why transformation efforts fail in Table 1.

### Table 1: 8 reasons why transformation efforts fail

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<th>Reason</th>
<th>Description and general considerations during transformation efforts</th>
<th>Considerations during clinical pathway program development</th>
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| 1. Not creating a large enough sense of urgency. | Without motivation, individuals are not likely to help, causing the effort to fail.  
   - Examine the market and competitive realities.  
   - Identify and discuss crises or major opportunities. | Communicate market or industry changes that impact reimbursement (such as pay-for-performance) and consumer-driven choices.  
   - Explain the importance of treatment standardization as a key tool to reduce variation and improve outcomes. |
| 2. Not creating a strong guiding coalition. | Only having a few individuals within an organization see the potential in a new transformation effort. | Identify key leaders (clinical and administrative) who have the authority and influence to drive the effort.  
   - Include those who understand |
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<td><strong>ASQ’s Healthcare Update</strong></td>
<td><strong>published in collaboration with the ASQ Healthcare Division</strong></td>
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### 3. Lacking a clear vision.
- If individuals are unaware of what the outcome is supposed to look like, they likely will not participate in the new effort.
  - Create a vision to help direct the change effort.
  - Develop strategies for achieving that vision.

### 4. Not communicating the vision effectively.
- Before individuals can understand the new vision, they must hear it more than five times using various methods of delivery.
  - Use every delivery option possible to communicate the new vision or strategies.
  - Teach new behaviors by the example of the guiding coalition.

### 5. Not removing obstacles.
- Obstacles or road blocks must be removed for the transformation to occur.
  - Change systems or structures that undermine the vision.
  - Encourage risk taking and nontraditional ideas, activities or actions.

- Most individuals are not willing to go on a long march unless they see that the journey will produce expected results within one to two years.
  - Plan for visible performance improvements.

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### 7. Declaring victory too soon.

- Implementing new systems, structures and policies that do not fit the vision.
  - Hire, promote or develop employees who fit the vision.
  - Reinvigorate the process with new projects, themes and change agents.
- Use caution in declaring victories during the creation and implementation phases. For example, simply creating the pathway is a small win but does not complete the overall goal. Having all providers use the pathway for all appropriate patients is the ultimate objective.

### 8. Not embedding changes into an organizational culture.

- Ensuring all individuals within an organization understands the new vision and approaches needed to meet the new vision.
  - Articulate the connections between new behaviors and corporate success.
  - Develop the means to ensure leadership development and succession.
- Embed pathway development and use into the care delivery model.
- Incorporate pathways in training and continuous education.
- Report pathways outcomes regularly to leadership and the broader organization.


This systematic change management approach addresses the common reasons initiatives fail and ensures diverse groups can meet goals and deliver high-quality outcomes with limited resistance.

When starting any initiative, there first must be a sense of urgency—a reason that suggests the status quo is more dangerous than the unknown. Along with urgency comes a guiding coalition of like-minded individuals that can be leveraged to initiate momentum away from the current state. Having a clear and communicable vision provides an end point or destination for individuals. During the implementation or change journey, several barriers and obstacles may arise. Frustration occurs when these roadblocks are not removed. Leadership must be willing and committed to resolve them as they occur. Generating
short-term wins injects bursts of energy in teams, rewarding quick turnarounds and small gains amidst a larger effort.

Changing the culture

Although short-term wins are important to maintain momentum, it is critical not to declare victory too soon. Progress must be celebrated, but teams must focus on the end goal. Lastly, sustainability occurs when changes are hardwired into an organization’s culture. The future state resembles the initial vision, and individuals incorporate the implemented changes in their daily responsibilities.

Although data supports the use of clinical pathways, medical providers may remain resistant to adopt this approach. To position a pathway effort for success, a systematic change management model should be applied. As discussed, Kotter’s model provides a framework for shaping, communicating, executing and hardwiring change. This model can be adapted for the effective creation and implementation of clinical pathways.

References:


5. Ibid.

6. Ibid.


8. Ibid.

9. Ibid.


About the author:

Leigh A. Resnick, M.H.A., R.R.T., is a manager for operations support for Thomas Jefferson University Hospital in Philadelphia. Leigh Resnick became a certified lean leader through Thomas Jefferson University Hospitals and a trained examiner for the Keystone Alliance for Performance Excellence, Resnick co-leads Thomas Jefferson’s Performance Excellence program using the Malcolm Baldrige National Quality Award criteria. Resnick is responsible for the strategic deployment and education of performance excellence tools and methods throughout the enterprise. Resnick is also responsible for supporting the one-year operating plan, which ultimately supports the three-year strategic plan and
uses the balanced scorecard format. Resnick has led and co-led numerous lean projects throughout the enterprise, which have resulted in improved workflows, decreased turnaround times and improved patient flow. A registered respiratory therapist, Resnick received a bachelor’s degree in health science from Gwyneddd Mercy University in Gwyneddd Valley, PA, and a master’s of health administration from Saint Joseph’s University in Philadelphia.