VIEWPOINT

INNOVATIONS IN HEALTH CARE DELIVERY

Development and Implementation of Expected Practices to Reduce Inappropriate Variations in Clinical Practice

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Variation in clinical practice is substantial and is associated with poorer health outcomes, increased costs, and disparities in care.[1,2] Substantial attention has been given to reducing unnecessary differences in practice patterns.[3] Despite these efforts, practice variation has been difficult to overcome. Challenges to reducing variation include heterogeneity and gaps in clinicians' knowledge; economic incentives for undesired clinical behaviors; concerns about malpractice risk; physicians' value of autonomy and personal preference; inadequate communication and decision support tools; and imbalances between clinical demand and resource capacity. Another fundamental barrier to practice standardization is that good clinical practice must sometimes vary to reflect a patient's specific social, environmental, and biological situation. Sometimes a standard practice would not be best for a given patient. Hence, efforts to legislate or establish policies governing care have been limited because they impede the common sense that there are nearly always exceptions to a given rule.

> The expected practices model addresses educational, economic, legal, cultural, infrastructural, and organizational barriers to practice standardization that have affected US health care.

The Los Angeles Department of Health Services (LADHS), the nation's second largest public health care system, is composed of 4 hospitals and 19 community-based clinics that are affiliated with 195 community-partner clinics and 3 medical schools. Approximately 500 000 predominantly uninsured or Medicaid-insured patients are empaneled, with approximately 2300 primary care practitioners requesting 160 000 specialty consultations annually. The LADHS has been challenged to reduce practice variation, but as a health care safety net system with high demand, limited resources, organizational mission, and the substantial changes associated with health reform, innovative approaches are needed for reducing practice variation.

Development and Implementation of Expected Practices

This Viewpoint describes a clinician- and health care organization–informed approach to reduce clinical practice variation across the LADHS through development and implementation of expected practices (EPs) that systematically address the key barriers to standardization. The approach to reducing variation in clinical practice is composed of the following steps:

1. Establishment of Specialty–Primary Care (SPC) work groups
2. Development of system-wide EPs by work groups
3. Vetting of EPs by a Governance Committee and Primary Care Advisory Council
4. Dissemination and reinforcement via electronic specialty consultations, a web-based Clinical Care Library, integration into the electronic medical record, and a regular electronic newsletter

Each SPC work group is composed of representative clinically-active specialists and primary care practitioners from across the LADHS and focuses on a single clinical specialty. The composition of the 25 SPC work groups ensures the real-world feasibility of the EPs in this heterogeneous and resource-limited health care system by being informed by the genuine needs of primary care practitioners, not only the perspectives of specialists.

The term "expected practice" is used because it is expected that physicians and other health care professionals will follow this standard approach except in rare cases with a compelling justification to deviate based on a specific patient's clinical situation. Expected practice topics, such as diabetes-related kidney disease, thrombocytosis, use of brain-type natriuretic peptide, and clinical breast examination, are developed to address important and common clinical conditions. The SPC work groups are instructed to weigh evidence from primary literature, medical association guidelines, and knowledge of real-world practice conditions within the health care system (eg, patient circumstances and clinic resources). An EP is neither a policy nor a guideline. Guiding principles underlying EPs are that there must be consensus among representative primary care practitioners and specialists, and that any recommendation must be available to every patient that enters the LADHS system. Expected practices can be accessed

via the electronic health record and a web-accessible Clinical Care Library (similar in concept to Kaiser's Clinical Library[4]), are incorporated into the electronic consultation system, and are reinforced through primary care practitioner forums, site-specific lecture series, grand rounds for house staff, webinars with clinic care managers, and a regular electronic newsletter. Examples of the EPs are available in the Supplement.

The EP as a Tool to Reduce Variation

Expected practices have addressed, at least in part, each of the barriers to practice standardization. The EPs provide succinct, consistent, and targeted decision support to primary care practitioners and specialists and are built into the daily clinical workflow. SPC work group members craft EPs recognizing that salaried clinical workforce members need not be influenced by financial incentives or disincentives. Expected practices likely reduce perceived and real risk of litigation as they are reviewed by the risk management team and de facto become the formalized community standard of practice. Collaboration between specialists and primary care practitioners encourages and facilitates negotiation of feasible and sensible practices that confront traditional barriers to standardization. The participation of frontline practitioners facilitates success by ensuring the acceptance of these recommendations by those who are seeing the daily challenges firsthand and can disseminate system changes to their colleagues. Because primary care practitioners and specialists have ownership of the document, there is personal investment in the final product and subsequently better adoption and adherence. In addition, the fact that EPs permit limited variation when necessary for provision of good clinical care addresses the strongly held belief that practice cannot be driven by top-down policy or legislation.

Use of EPs

To date, 22 SPC work groups have established more than 120 EPs on diverse topics such as rheumatoid arthritis, hepatitis C, and safe use of controlled substances. From July 2015 to May 2016, there have been more than 6700 downloads of EPs, with accelerating monthly use. The most successful EPs serve not only as reference documents but as tools to radically affect access and delivery of specialty care. For example, historically, different clinics in the system were approaching colorectal cancer screening in multiple ways. Some clinicians referred all patients for colonoscopy; others used fecal occult blood testing, barium enema, or flexible sigmoidoscopy; and many did not perform screening. The colorectal cancer screening EP outlines that within the LADHS, for average-risk adults aged 50 years or older, the expectation is that fecal immunochemical testing will be used annually. The EP also outlines when a higher-risk patient should proceed directly to colonoscopy and, conversely, when a patient with an elevated procedural risk might forgo colon cancer screening after a well-documented discussion with the patient about risks and benefits. Although this approach varies from prevailing thought in the United States and the typical approach of gastroenterologists, it has allowed better alignment of demand and resources, thus facilitating equity and quality.

Conclusions

Preliminary data, yet unpublished, suggest that these EPs have helped reduce clinical practice variation in an extremely large and complex health care system. An evaluation that includes both patient outcomes and cost will be necessary to assess its overall success. The EP model systematically addresses educational, economic, legal, cultural, infrastructural, and organizational barriers to practice standardization that have adversely affected US health care.

Although this approach was facilitated by a health care system that is predominantly managed care (ie, >70%) and in which the primary care practitioners and specialists are salaried, recent health care payment reforms suggest that the public system may represent the future landscape in US health care financing. The LADHS leadership gives the SPC work groups the autonomy and responsibility to develop and implement EPs. Although other organizations may be more traditional, with specialists dominating specialty care decision making and clinicians existing outside of the health care system reporting structure, without active engagement with frontline staff in a collaborative manner, extensive practice variation will continue to exist.

Inability to reduce clinical practice variation has contributed to inconsistent, inequitable, ineffective, and inefficient care, which has worked against achieving the triple aim of better care, better health, and lower cost. To achieve standardization, the clinician-driven process created at the LADHS has been informed by feasibility and equity and potentially could be replicated across other clinical settings.

ARTICLE INFORMATION

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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