

Importance of Job Aids in Health and Quality Assurance by Dr. James Heiby, USAID

Ed Kelly: A funny story a friend told me yesterday is related to what we are going to be talking about here today. Her little daughter, I guess she's about in fourth grade or so, was asked to write a story about her family. She wrote a nice long paragraph about her dog, a nice long paragraph about her brother, and then she got to her parents. She said, "I love my parents very much, but the problem with parents is that we get them so old their habits are really set in."

To a certain extent this discussion about job aids today is not just about breaking poor performance habits, but also engendering performance improvement and a performance improvement mindset, but specifically from a self-help perspective.

The story is that there is this funny little plaque down at Barnes & Noble. They have plaques of different authors. One of them is an anonymous author who said, "Walked into the bookstore the other day and asked the lady where the self-help section was and she said, well, if I told you, that would defeat the purpose, now wouldn't it?"

Without further ado, I'll introduce Jim Heiby, the medical officer in the office of health and nutrition for USAID Global. Many of you know him, he's been one of the tireless advocates as well as experts in the field of quality improvement and performance improvement within AID, within the healthcare field, and we're glad to have him here with us today.

Jim Heiby: Thanks, Ed. My job, other than to warm you up for Tony, is to outline a little bit about why the Quality Assurance Project is so interested in the field of job aids, which has been around for a long time but really has not engendered a lot of focused attention. I think this meeting is the first major meeting, to my knowledge, to focus on the issue of job aids, at least as far as USAID is concerned.

Our interest in job aids really comes from a more basic change in international health. I'd like to make the case that the development of clinical guidelines, and I think IMCI is probably the classic example, has quietly created a revolution in international health and it's one that we haven't quite come to grips with. These guidelines, for the first time, define the performance desired of providers in international health programs. Not just that providers graduated from a certain training program, but what they do when they go to work. When they see a patient with rapid breathing, do they do all the things that need to be done according to the evidence?

That is the scientific basis for clinical guidelines. If we've come to accept the fact that science does indicate that there are certain right ways to manage certain kinds of health issues, we are understanding that treatment is not simply an art that is entirely up to the whims of the clinician. This understanding leads us to the conclusion that programs are responsible for the details of the performance of health providers. They could do a good job, a mediocre job, or an excellent job, and that is something that the managers of health programs increasingly need to take responsibility for. I think this is true in the United States and Europe and Australia as well as in developing countries, but it's a strong global trend that's not going to reverse. We simply have to learn to deal with the issues of the performance of health workers and how to improve it.

These clinical guidelines are well suited to most of the problems that we work with, because we tend to be concerned with relatively simple health issues that do not involve a wide range of decision making or possibilities. Most of these health issues come up in a program over and over again. Children that need immunizations, women who need family planning, so these same health issues are presenting themselves

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repeatedly, and one thing that we know very well from research in this field is that if there are no guidelines established, you can count on variation. Different providers will conduct care in a different way.

One of my favorite stories is that at the beginning of the national ARI program in Egypt, a baseline study was conducted by UNICEF and a university group to see what was the most common form of treatment of children with respiratory symptoms. They collected a series of 80 consecutive children with respiratory illness to identify the most common treatment. They discovered that for those 80 children, there were 80 different treatments provided. I don't think we're going to go back to that standard in health care.

I'd also like to just introduce the idea that same line of thinking applies to the administrative work of health care programs, the way, for example, that patients are referred from a clinic to a hospital, the way the drug supply system is organized. These are also activities carried out repeatedly, there probably are right ways and wrong ways to do it, perhaps not based on science, but the same idea applies, the idea of quality.

Those of you who have been working in this field will see this as a pretty simplistic set of possibilities for improving performance, but I think that traditionally training has always been at the top of my list. What we are discovering as we look at performance itself is that as we measure training by evaluating performance of health workers, we find that there are limits to how far training will take us. That's why we're having this symposium, we're proposing job aids as a major strategy for improving performance when knowledge and skills of health workers are a major issue.

There are other factors as well. Performance can be affected by motivation, and we've done very little in that field. We're not going to talk so much about that except to say that there are interventions that managers can make in terms of motivation such as incentives and providing feedback that are very poorly developed in most of these programs.

From the quality assurance perspective, many times the problems come from the way health services themselves are organized. We have tools that promote problem-solving and the redesign of systems. Sometimes you just need money or resources to make things better.

I think you can see that job aids are one of the basic strategies for improving health care worker performance. For those of you who aren't convinced that we need to be concerned about performance, there are many studies one could throw up here. I thought that the World Health Organization did a nice job by looking at the management of children with possible pneumonia in 17 different countries a few years ago. You can see the actual performance of trained health workers who have been through some kind of training course related to ARI. Overall, about 30 percent of them perform correctly, and they rise to the level of performance that is considered correct case management.

When it comes to preventive actions or actions, in this case, related to counseling, less than half are doing an unacceptable job. You can see that, in fact, about 30 percent of the antibiotics being used in these programs are completely inappropriate, even though everyone has been trained. This is a small sampling of performance issues, but there's no question that training courses or not, we have serious issues with performance. In some countries, adequate performance was as low as 2 percent of the tests.

I'm sure all of you have seen job aids in action; it's hard to miss them. Although I'm going to try to avoid defining job aid, I think we all know that it's something that helps health workers do their jobs. Usually in developing countries it's a piece of paper, a checklist, some kind of memory aid, or maybe a standard clinical form.

We've seen these in different variations in different countries. Most of them, I think, are the product of highly expert people, so they are developed by people who understand the content of a job aid. Few, if any of these job aids actually represent expertise in the design of job aids.

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There are people in this world who have focused on the process of designing an effective job aid, and that's going to be one of the major themes of our sessions today—you need to have more than content expertise, but also expertise in developing job aids.

We have had very little research and evaluation in developing countries on this topic. We've got lots of job aids, and more evaluation research in the U.S. healthcare system. I think even in that literature, one of the missing elements is that we have tended to focus on taking someone's job aid and evaluating it in a rigorous, scientific manner, but not really using it. The point of that research is not to develop or refine the methodology itself, it's just taking someone's job aid and testing what percentage of increase in performance it produces.

I think that literature has not actually been a very rich source of learning how to develop job aids, either. I suspect you'll find that most of what Tony will have to say to us today when it comes to methodologies, and a process for developing job aids, actually comes from industry.

To give you an example of the importance of designing something properly, these graphs show the evaluation of two job aids, one produced by a group called Flow and one produced by Path. The take-home lesson is that the yellow part is really perfect performance, and in this case, the performance is using a new malaria diagnostic test.

You can see that the group on the left has a perfect performance of just under half, and on the right they really look terrific. What has changed here is really only one factor, the process for designing the instruction sheets. The process is the kind you're going to be learning about today. There was no content expertise brought to this process; the job aids on the left were designed by experts, those who actually developed the technology. The process of job aid design resulted in the improvements you see on the right.

As excited and positive as we are, one of the issues that we're finding in our work on quality assurance is that our counterparts simply don't think about job aids in a serious way. In many respects I think this is a development challenge, that the state-of-the-art of job aids aren't widely appreciated among our counterparts. I think a second point to keep in mind is that providers require active support to use job aids, we can't just fly in a helicopter and drop out job aids and expect to influence provider behavior.

We've seen already that there are points of resistance to using these job aids. Health workers see this as something they shouldn't have to do, if they're a doctor or a nurse they find it humiliating, and the whole concept of clinical guidelines, defining a certain level of performance is still new. So the idea of performance itself is still new for many providers in developing countries.

I think that in the next few years, the guidelines for clinical care are going to become increasingly complex. Malaria resistance is going to make malaria treatment more complex, all of the ramifications of the AIDS epidemic are going to result in more complex demands on providers. I think IMCI is a challenge that is far from resolved.

There are many reasons to think that the demands on providers to perform well will increase rather than decrease, so the requirements for job aids, can only go up in the future. We are seeing more and more countries decentralized under health reform. More district-level managers with very little training or experience and not many skills are being asked to manage very complex programs. I challenge you to think about the opportunities for helping program management through job aids.

I think that you also have the challenge of the commercial private sector, which we've tended to pay too little attention to even though it's providing most of the care around the world. What are the opportunities for influencing the care of private providers through job aids?

Even though we think of job aids as something that someone's getting paid to use, this concept also has applications to patients themselves, who sometimes have relatively complex tasks like remembering how to give

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medications to the child who has just received a packet of drugs. This is an illustration from one of our operations research studies, and what you're looking for here is what's missing. Twenty-three local clinical teams were trained to use quality improvement techniques to analyze their own needs in IMCI and develop solutions to whatever problems they identified. Of these 23 teams, none thought of job aids. I think this is part of the challenge we face. This is a very important tool that is underutilized.

In conclusion, I'd like to suggest that although job aids are extremely promising and they can work very well, there's no guarantee that they're going to work. You can have poor job aids, ineffective job aids, job aids that are not used at all. They've got to be done right, and that's why part of our focus today is how to do it right get job aids that really do influence performance.

It seems too obvious to say that job aids should be developed to address the needs of the user. In fact, this implies some concrete steps that are often not taken and involves assessing the performance of the health worker, not just handing over a job aid that was developed in Geneva, for example. It also implies some kind of evaluation of the benefit of that job aid and a refinement process based on those evaluations. I'd like to emphasize that job aids are not just something that you pull off the shelf and hand to health workers and expect something to happen. There are a range of areas where they need active support. Finally, I think that the need for rigorous and well developed job aids is a growth industry in international health and this is just the beginning.