



Could improvement science be the game changer for quality improvement in primary care?

With increasing health care costs, an ageing population, new technologies and DHB budget constraints, the spotlight is increasingly on primary care to be the workhorse for population health gain in New Zealand. Associate Professor Sue Wells, University of Auckland and Clinical Advisor to the Health Quality & Safety Commission's primary care programme takes a look at how improvement science can help.

Without high functioning primary care, our health service would collapse. Every year, 80 percent of New Zealanders see their GP at least once, 62 percent will have one to five visits and 12 percent will visit six or more times per year.¹

General practice is typically owned by autonomous practice owners. The work is conducted in small teams caring for a defined population and there is much closer connection to the community and other services than is the case with hospitals. Huge amounts of patient data are collated in GP practice management systems. Therefore we have the e-data AND the 'team power' to make giant quality improvement strides.

So what's been happening in primary care quality improvement?

Over the past twenty years many innovative approaches to primary care quality improvement have pervaded our thinking and doing. These include the Primary Healthcare Strategy

(advent of PHOs, capitation and access funding to reduce health inequalities) and chronic disease management programmes such as Get Checked Diabetes and Care Plus. Explicit standards of practice (e.g., Foundation and Cornerstone standards) have been defined and national guidelines have been developed and translated into decision support systems, making them available at the time of a patient consultation. The emphasis shifted in the last decade to encouraging transparency through audits of care and organisational benchmarking, with performance targets increasing the push towards achieving national goals and reducing unwarranted variation.



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Recently the focus has shifted again towards system level measures, moving the locus of control away from the clinical microsystem (e.g., the general practice) towards a whole-of-system approach measured by downstream patient outcomes such as hospital admissions and amenable mortality. While some contributory measures have been identified for action at the local district alliance level, in this brave new world integration across social and health care sectors will be critical to success. Patients as partners in care is also in the spotlight. There has been a swing towards patient engagement in care delivery through approaches such as co-design, patient portal access and measuring patient experience of care.

What's holding us up then?

Is it possible that some of the biggest problems are working as an 'n of one' individual practice – reliant on the intrinsic motivation of individuals – combined with limited experience of successfully using QI science and processes?

Improvement is often seen more as an art than a science. When tackling a health care issue and designing improvement approaches, little effort is put into diagnosing the full extent of the problem using both qualitative and quantitative data and really understanding the context of care across community and other services. In addition, there is not enough emphasis on establishing who should be involved on this improvement journey (the team), identifying what you are trying to accomplish (and for whom), implementing improvement practice that is based on best evidence and measuring not only the outcomes but also the costs and unforeseen consequences.

Without systematically attending to these improvement basics, resources are wasted, the champion loses steam, enthusiasm wanes, side-effects are unnoticed and changes are not necessarily an improvement. As Sholtes pointed out nearly 30 years ago;

"Teams that proceed with an improvement project without careful planning are probably headed for disaster. Without planning, teams often collect the wrong kind of data, invest in unnecessary gadgets or machines, or ignore customer needs. As a result, their solutions may not be solutions at all. They end up with a process no better than at the start, an expensive investment that has done little good, or a product or service the customers don't want. Perhaps worst of all, these winless projects create a crowd of once-hopeful managers and operators who now conclude improvement projects don't work here."—Team Handbook- p. 5-1, Scholtes 1988

There is a way through though.

The Health Quality & Safety Commission has embarked on a primary care programme of work to lend a helping hand to general practice on improvement projects of their choice, to shine a light on how primary care can make a difference and advocate for positive change. There is a need to foster

undergraduate and postgraduate training in the science of improvement. It doesn't make sense to ask providers to initiate change without the knowledge, tools and means to make this a reality. At a postgraduate level, the Commission is supporting PHO quality improvement facilitator training to enhance primary care capacity. This is a nine-month professional development programme being delivered by Ko Awhatea for the Commission until 2019 with approximately 20 scholarships available per year. District Alliances are asked to nominate primary care quality improvement practitioners who are able to become a resource for their district to receive the Commission scholarships.

To date much of the improvement knowledge of what works has been conducted in hospital settings. We need to build an evidence-base for what works in primary care.

General practices and associated integrated services wanting to undertake quality improvement initiatives are encouraged to enter Whakakotahi, the Commission's primary care quality improvement challenge. Whakakotahi means: "To be as one" – uniting different health professionals for the purpose of hauora (health)."

The challenge sees the Commission partnering with general practice, community pharmacy, iwi providers, allied health services and NGOs to choose their own improvement projects. It then works with successful applicants to look at how those projects can deliver successful outcomes, and how learnings can be shared and spread on a larger scale. Early evaluation of the first three Whakakotahi projects will be shared in June.

Teams wishing to enter can send an expression of interest to primarycare@hqsc.govt.nz and they will be notified when entries are open in July, 2017 for the second round of projects.

References

1. Ministry of Health. Taking the Pulse. The 1996/97 New Zealand Health Survey. Wellington: Ministry of Health, 1999.

