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We need to talk about quality in general practice

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This article is the latest in a monthly series from members of the GPs Down Under (GPDU) Facebook group, a not-for-profit GP community-led group with over 6000 members, which is based on GP-led learning, peer support and GP advocacy.

WE ARE a mix of academic and full time clinical GPs. Along with our practice colleagues, we are enthusiastic about delivering high quality care. We teach medical students and registrars, meet regularly in our practice teams to discuss challenging clinical scenarios, undertake in-practice small group learning, and bicker over our patient recall systems with a fervour usually reserved for debating who will win the State of Origin.

We hoped that perhaps the Australian Government was interested in quality general practice too when they announced the Practice Incentive PaymentQuality Improvement (PIP QI), which begins on 1 August 2019. So why were we left feeling puzzled and somewhat disempowered?

General practice care is a complex system. Even something notionally simple such as antihypertensive therapy is actually a complicated balancing act. We consider not only the blood pressure reading but also the patient's cardiovascular risk factors, medication tolerability, cost, and the patient's lifestyle. We think about what is behind the readings (the second cup of coffee after a sleepless night, the argument with their spouse). We think about whether starting a new medication is the most important thing we can do for this person today, and whether we need to explore and manage what is really going on with them (the hidden agenda behind presenting for a blood pressure check). And we understand that how we interact with this patient, and the choices we make in designing our clinical practice workflows, feeds back and influences the running of the practice in ways that can be unexpected.

Defining general practice quality is not as simple as comparing numbers, as **Mary Beth MacIsaac has written before**. Naively, we could do trivial comparisons of, say, diabetes control in one practice to the next. But without deeply understanding the local contexts, the mechanisms, the why, we are likely just measuring bias rather than quality.

At the heart of any high quality practice, there are committed and energetic people who really care about what they are doing. Getting those people engaged in driving quality improvement benefits not only practices but entire communities. We must empower these people; they need to feel that they have a role in driving the improvement.

Implementing quality improvement in our own practices has been a challenge. We care about our patients and take pride in our outcomes. But working as a full-time clinical GP, quality improvement projects are essentially a hobby. Not only is there no funding, it takes time away from direct patient care, which is the only income stream for a non-owner GP. We have been told by my senior GP colleagues that this wasn't always the case.

The Australian Primary Care Collaboratives Program, which started in 2005, invested in GP ability, capacity, and leadership. This program upskilled GPs in quality improvement methodology, including change management and data use. There was evidence of clinical benefit – the Collaboratives demonstrated improvement in diabetes care and cardiovascular outcomes. Reduction in funding to this program meant a gradual decline in its impact.

Other countries have seen the value in a return to a Collaboratives-type approach. In Scotland, where the Quality and Outcomes Framework pay for performance scheme was withdrawn in 2016, a Collaboratives-type approach was implemented as GP Clusters. Key recommendations in the implementation have been local autonomy in the clinical area of focus, local GP leadership, and administrative support.

In contrast, PIP QI is a top-down quality improvement strategy. Funding is based on data extraction for 10 quantitative measures that are shared with the local Primary Health Networks (PHNs). The practice then must engage in a quality improvement project, with vague descriptors of qualifying activities. The secretive nature of negotiations about the content of PIP QI has excluded the medical profession and the people we are trying to treat. The 10 measures are relatively crude, including percentage of patients who smoke, patients with diabetes with recent glycated haemoglobin recording, and patient weight recordings.

These limited measures are far too narrow to assess a complex system such as general practice. Rather than driving quality improvement, the focus becomes one of coding for the purposes of data extraction.

We need to be careful of what we are incentivising. Pay-for-data is a small step from pay-for-performance and public benchmarking, with all the unintended consequences of distorted clinical decision making and reduced patient autonomy. Even if the PIP QI remains pay-for-data, with these defined measures already being extracted, what incentive exists for practices to engage in a more challenging and important project such as promoting a culture of safety, communicating with hard to reach groups, or rethinking chronic pain management?

Quality improvement in these areas remains a hobby, something that is nice to do, potentially undertaken in spite of PIP QI, rather than being supported by a cohesive policy. The rationale and purpose for a top-down PIP QI needs to be defined; it's not acceptable to simply say it seems like a good idea.

As we prepare to embark towards a top-down data driven quality improvement framework there are some gaping holes in the path ahead. Practice-based electronic records need to be repurposed to become high quality, trusted data collection tools. GPs must be comfortable with the governance in place for their individual and practice data; this topic alone sparks frequent discussions within the GPDU forum. In negotiating agreements with PHNs, the power differential is significant. GP clinics need to be supported to move towards financially viable models in which non-clinical time to focus on learning and reflective practice is valued.

An alternative is a bottom-up strategy. Inspired by the idea that grassroots GPs can design projects that will benefit their practices and communities, we ran a workshop at the WONCA (World Organisation of Family Doctors) Asia Pacific Conference in May 2019. Although the participant GPs came from many different countries, they raised common themes – the burden of health costs on their patients, the need for system reform, and bureaucratic inertia. We were amazed by the passion and enthusiasm of the participants. These GPs were motivated to change not only their own practices but entire health care systems. Bottom-up strategies have the advantage of engagement – they involve empowering those at the grassroots level to make changes.

The PIP QI could be reimagined as a bottom-up strategy; it could fund a collaborative process that involved practices identifying their own areas for change, based on their community needs. The activity of collaboration, rather than the data, is the basis for the funding. The participants themselves are funded for the activity. The collaborative activity, with its results, are reported and submitted for review to the Colleges, much in the same way that independent activities are submitted for continuing professional development. The emphasis is changed from simply measuring “quality” to supporting localised, contextually appropriate quality improvement. In essence, for the activity to be meaningful, invest and support the people who need to actually do and lead the improvement.

We need to talk about quality.

Dr Mary Beth MacIsaac is a GP in south east Sydney. She has also worked as a locum in the Northern Territory and Tasmania. Before coming to Australia, she trained and worked as a GP in rural Canada. She is involved in GP registrar supervision and training. She is passionate about the vital role of general practice in the community, having been inspired by her supervisors while working as a medical student on a rural placement. She is a member of the Royal Australian College of General Practitioners Expert Committee – Quality Care.

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