The story of Cornerstone:

A brief history on the development of general practice accreditation in New Zealand

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Introduction

In the past decade, there have been a number of high profile cases relating to quality issues in the New Zealand health sector, such as the Stent report on Christchurch Hospital and the Gisborne cervical screening inquiry. The passing of the Health Practitioners Competence Assurance Act 2003 reinforced the legislative requirements of our publicly funded health system to be more accountable to the consumer. The concomitant rise of consumerism and mass education of health of the public via the media, the popular press and the Internet have all contributed to an increasing demand from the public regarding accountability, transparency, self-regulation, quality improvement, and better value for money from the medical profession.[1] It is also recognised that quality in general practice depends on more than just the competence or performance of each individual general practitioner acting in isolation.[2,3] The demand for effective quality assessment in general practice has therefore increased considerably. In the following article, I shall briefly describe the historical background of the development of accreditation in health care, general practice accreditation in New Zealand and the tool developed by The Royal New Zealand College of General Practitioner (RNZCGP) for such purpose which is now called 'Cornerstone'.

What is accreditation?

According to the International Society for Quality in Health Care (ISQua), *'Accreditation is a self-assessment and external peer review process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system.'*[4] In essence, accreditation begins with the setting of contemporary standards as defined and assessed by their peers. These standards address important organisational functions and then encourage organisations, through the awarding of accreditation, to comply with these standards. The assumption is that if organisations are doing the 'right things right' as reflected in the standards, then errors and adverse outcomes are less likely to happen than if there were no such standards.[5] The ultimate goal of accreditation is to encourage continuous improvement of the system.

History of accreditation

The history of accreditation in developed countries can be roughly divided into three periods. The first took place in the USA with the founding of the American College of Surgeons (ACS) in 1913. Following the initiative of EA Codman, surgeons decided that they would not operate in hospitals that did not provide them with a minimum standard of quality in their working conditions. Eventually this initiative developed into accreditation. This first period was the result of a professional initiative, dominated by doctors to influence providers (hospitals) to obtain satisfactory working conditions. It was also private, voluntary and mainly 'structure' oriented.

Giraud commented that the economic crisis of the 1970s attracted the attention of Western governments to the increasing costs of health care.[6] Subsequently, economists, epidemiologists, managers, and regulators (external users of health care) began to examine medical practices. They found that despite the continuing rise of health expenditures, there was little evidence that health indicators improved at the same time. Furthermore, widespread unexplained variation in doctors' practices was documented. Armed with such evidence, these external users of health care pushed for a 'professionally led quality assurance of medical practice'. The 'quality' argument, however, was viewed with scepticism by the medical profession. The latter felt that it was an excuse for rationalising health expen-

ditures through utilisation review, consensus conferences and practice guidelines. Not surprisingly it never gained professional legitimacy among doctors as opposed to other health professionals such as nurses. Doctors who did not like to relinquish control were the biggest barrier in implementing quality assurance of medical practices in most industrial countries. Nonetheless, there were some positive developments during this time such as the development of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The latter favoured a move from minimum to optimum achievable standards. Scrivens described it as the birth of professionalisation of the quality movement in health care.[7] In this second period of quality assurance, purchasers and regulators wanted to influence providers (doctors) to achieve better quality care for less money. It began to question doctors' decisions and practices. The focus had shifted from structure to process.

Accreditation today is concerned with both management and the more professional aspects of medical practice with the help of evidence-based practice guidelines. Different stakeholders are frequently involved in the development of accreditation programme to ensure relevance to those experiencing quality.[8] However, the composition of the stakeholders and the emphasis depends very much on the initiator of the programmes and, more importantly, the social, economic and political context of the country of the health services within which it operates.

Table 1. Brief history of accreditation

Year	Events
1913	American College of Surgeons (ACS) formed
1918	Minimal Standards for Hospitals produced by ACS
1951	Joint Commission on Accreditation of Hospitals formed; renamed Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1988
1953	Canadian Council on Hospital Accreditation formed; renamed Canadian Council on Health Facilities Accreditation (CCHFA) in 1988
1974	Australian Council on Hospitals Standards formed; later renamed Australian Council on Healthcare Standards (ACHS)
1987	New Zealand Private Hospitals Association began to pilot the ACHS accreditation programme
1990	New Zealand Council on Healthcare Standards (NZCHS) formed; now known as Quality Health New Zealand
1991	Royal Australian College of General Practitioners (RACGP), Australian Medical Association (AMA) and the Commonwealth Government began to develop a set of national standards for general practices
1994	NZCHS issued its own standards
1996	RACGP published entry standards for general practices
1997	Australian General Practice Accreditation Limited (AGPAL) incorporated an independent company that offers accreditation to general practices throughout Australia
1998	The Royal New Zealand College of General Practitioners (RNZCGP) established a Practice Standard Committee to develop a proposed set of standards for general practice
1999	Pre-test and pilot study of the standards as identified by the Goodfellow Unit
2000	RNZCGP published the 1st edition of *Aiming for Excellence*
2000	Health Care Aotearoa (HCA) published the final draft of the *Te Wana Quality Programme*
2000–1	Field trial of the general practice assessment tool
2001	Publication of the *RNZCGP Practice Standards Validation Field Trial Report*
2002	RNZCGP published the 2nd edition of *Aiming for Excellence*
2004	Re-branding of the accreditation programme to Cornerstone
2005	Te Puea Marae Medical Centre became the first Cornerstone practice

Development of GP accreditation in NZ

In the early 1990s, the then Health Funding Authority (HFA) was looking for a tool that could measure good quality in general practice. The driver was the increasing demand for accountability of HFA's spending of public money on purchasing primary health care service. Concomitantly, members of the Independent Practitioner Association (IPA) and the RNZCGP were interested in a tool to demonstrate quality and to develop standards for general practice. In May 1998, the HFA commissioned the Goodfellow Quality Assurance Unit at the University of Auckland to produce a quality measurement tool for use in general practice.[9]

The working party reviewed eight quality measurement tools used locally and internationally. A total of 311 quality indicators were examined. Most indicators were related to structure and process with only 37 indicators linked to outcomes. These indicators were scrutinised by the group in terms of clarity, relevance, validity and data availability. Sixty-eight indicators were deemed feasible for immediate use whereas another 41 indicators required better information management systems prior to use. Interestingly, no

outcome indicators survived the relevance and validity screen! In short, there were major differences between the tools as they reflected the different values and expectations held by the various stakeholders, and none was deemed to be suitable for immediate use in New Zealand without change and validation. The working party also identified that the existing tools did not achieve the right balance of quality assurance and continuous quality improvement (CQI) activities. Other important omissions were the cultural issues pertinent to New Zealand (e.g. the Treaty of Waitangi) and the crucial role that practice nurses play in the delivery of essential general practice services.

The RNZCGP Practice Standards Working Party then used the findings of Wellingham et al. and performed pre-testing and a pilot study in a total of twenty-four practices. It refined the draft standards to 49 indicators as published in the first edition of *Aiming for excellence in general practice*.[10] The indicators are grouped under five broad criteria:

1. Factors affecting patients
2. Physical factors affecting the practice
3. Practice systems
4. Practice and information management
5. Quality assurance and professional development

Subsequently, field testing of the standards in eighty-one practices were conducted and found the tool to be valid and reliable.[11] The field trial report revealed that the practices welcomed the assessment process with many practices scoring highly in most criteria. Some deficiencies were noted such as practice planning (preparing a strategic plan), health outcomes for Maori, and patient involvement in the services that practices provide.[12]

Further feedback from various key stakeholders after the field trial reduced the number of indicators to 46. In 2002, the second edition of *Aiming for excellence: an assessment tool for general practice* was released.[13] Since then the Ministry of Health has agreed to fund 85 practices all around the country to undergo practice accreditation. Many more practices have already registered their interest in going through the same process. In late 2004, the RNZCGP re-branded the accreditation process and called it the Cornerstone programme. Just prior to the launch of the programme and in keeping with the spirit of CQI, the process for examining one of the indicators relating to the review of medical records was refined. Rather than the assessors reading many medical records, the practice being assessed would perform a self-audit of the medical records prior to the assessment visit. The practice would than identify any gaps and submit a plan for future improvement using the Plan-Do-Study-Act (PDSA) cycle. The assessors would then discuss the plan with the practice team on the day of the assessment visit.

At the time of writing this article, six practices have successfully achieved accreditation and the Te Puea Medical Centre in Mangere Bridge was the first Cornerstone practice in New Zealand.

In summary, general practice accreditation in New Zealand has taken a long time to develop. The Cornerstone programme will probably be the most relevant and acceptable to most GPs.[14] The tool itself will undergo continuous review and refinement and will involve all stakeholders in the process. Finally, the Cornerstone programme will only flourish if there is strong clinical leadership and an organisational culture of quality and accountability for continuous improvement. It is only with such vision that we can truly aim for excellence in general practice.

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