Cornerstone: building quality practice systems

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***John Wellingham** was a general practitioner in Waitemata for 19 years, during which he worked part-time for seven years as the Director of the Goodfellow Quality Assurance Unit, in the Faculty of Medicine and Health Science, University of Auckland. Initially a member of the RNZCGP Professional Development Committee (Practice) he now chairs the RNZCGP Practice Accreditation Advisory Group, which provides advice to the College on the Cornerstone programme. John believes high quality general practice is a key component of any future integrated health delivery system. He is planning to return to part-time general practice in the near future.*

Cornerstone is a combined quality improvement and quality assurance process which uses a set of measurements collated in a booklet titled *Aiming for Excellence*. It is a natural evolution from the continuous quality improvement work of the mid-1990s by the Goodfellow Unit in the University of Auckland, in partnership with the RNZCGP Quality Assurance Unit.

As part of this work, the Goodfellow Unit undertook a needs analysis of practices' views on their main blocks to quality improvement, and found that the key issues for GPs were finding time, and managing staff issues, but not issues of knowledge and competencies. At the same time, Lawrence and Packwood[1] from Oxford, UK, were evaluating their 1994 work on Total Quality Management (TQM) in general practice. They had trained practice leaders in TQM processes, including quality cycles, and then used the external facilitators from the UK system of local Medical Audit Advisory Groups (MAAG) to support the practices in an ongoing process.

The needs of general practice teams and the experience in the UK informed the initial design of facilitated practice workshops and the birth of the Practice Consultancy Programme (PCP). Over 60 practices used this service, and common issues addressed were: appointment systems, waiting times, telephone support systems, practice meetings and communication systems. These were, as anticipated, systems issues and not ones of knowledge and competencies.

Sweden was also testing these ideas and Eliasson et al. published an evaluation of using practice visiting for quality improvement processes,[2] noting that *'the feedback session is essential'*. It was this session, and not the self-assessment audit, which motivated practices to create achievable action plans to solve their problems. The PCP was soon to make the same observation.

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Both the Swedish and New Zealand practices were also asking some fundamental questions. *'Are these the right issues that we should be aiming to improve?'* and *'how are we doing in comparison with other practices?'* Without some benchmarks of best practice, or performance priorities, these questions could not be answered. The Goodfellow Unit therefore sought a way to establish and measure the key characteristics of primary care teams which deliver high quality medical services.

As described by Dr Kenneth Tong elsewhere in this issue, the Health Funding Agency, the funder of the time, was also seeking to establish measurements of quality and best practice at a team level. This overlap of needs enabled a package of work to be funded and undertaken to identify those components used by organisations in New Zealand and in health systems that are similar to New Zealand, as key indicators of a health team's ability to deliver quality services.

To do this work it was recognised that the definition of quality varied depending on which perspective one viewed it from. In other words, quality in the eyes of a patient has a different series of priorities from that seen by a clinician. It was therefore apparent that this work would need to be undertaken by a group that represented the views of a wide variety of stakeholders. This included patients, clinicians, practice managers, Maori, funders and ACC.

This group reviewed quality indicators from New Zealand, Australia, Britain, and North America. It identified several hundred of these and then added another 50 that the group felt were important in the New Zealand setting. From all of these a core set of 50 were chosen which were regarded as being relevant, reliable, were able to measure improvement over a period of time and for which information was reasonably easy to obtain.

Cornerstone was thus developed from this quality improvement philosophy. It was built around a set of indicators that have reasonable validity for New Zealand practices to use as benchmarks for quality improvement processes. It was also necessary to be able to identify for practices those key process deliverables that are required by legislation, mostly concerning patient and staff safety. In essence, these are some of the minimum standards that practices must achieve to be able to show that they work in a safe environment. Whereas the earlier indicators referred to above are to support continuous quality improvement, these safety issues indicators are about quality assurance.

Combining quality improvement and quality assurance in a single process is a challenge. This challenge was discussed in a paper by Buetow and Wellingham in 2003.[3] Cornerstone recognises that even large general practices are still small businesses and cannot afford to partake in multiple quality programmes. It therefore combines quality improvement and quality assurance, whilst acknowledging the challenges that this goal faces and accepting the compromise that this entails.

As part of its continuous quality improvement heritage, Cornerstone emphasises the critical processes identified by Lawrence, Eliasson and the Goodfellow Unit as being of most value. It is therefore built more obviously around the one-hour facilitated review workshop involving the whole practice, during which success is acknowledged and action plans are developed for the key improvement opportunities, than it is around the report.

The process is not necessarily pain free. Quality improvement requires measurements of the current situation, efforts to improve it, and remeasurement to see if improvement has occurred. The Cornerstone process requires practices to review themselves against the indicators established by the multi-disciplinary group that advised the College, and which are now found in the booklet *Aiming for Excellence*. This self-assessment process is probably the hardest part of the programme, although the review on 'the day of assessment' is probably the most unsettling time for first time participants, both practice members under assessment and reviewers alike! Of course, afterwards people wonder what the anxiety was about.

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However the benefit is that a process has been designed which is useful and achievable in a general practice setting, provides quality improvement goals, key quality assurance minimum standards, a process based on the best available evidence and one supported throughout by the College. And although the work involved in improving quality attracts no extra funding, the external processes are currently funded by external agencies. This covers the establishment of the key indicators, designing and packaging the process, providing facilitators and giving them training and quality oversight. Practices or Primary Health Organisations that have endeavoured to set up similar processes themselves will recognise that this design and development work is huge in volume and in responsibility.

Not only do indicators need to reflect either evidence, or consensus around best available evidence, of best practice, but the design of criteria is an academic exercise in itself. One of the benefits of Cornerstone is that the indicators and criteria in the *Aiming for Excellence* booklet are not only constructed according to best practice, but they have been subjected first to a pilot and then to a fully evaluated field trial.

The overall benefit of this to practices is that there is now a process available that enables measurements that describe a position on a quality improvement and quality assurance map, where the map has been defined by the many views of the wide variety of stakeholders involved in the general practice setting. In addition, an external review process is currently sponsored by funding agencies, which have accepted that the continuous quality improvement benefits of this programme, as well as the quality assurance ones, apply to all the stakeholders.

There is indeed something in Cornerstone for all practices. New practices can test whether they comply with key legislation, and more mature practices can identify and validate new goals for achieving ever higher levels of quality.

The performance of a team, or a system that supports the team, cannot replace the requirement for each team member to be an expert in his or her own role. Practice accreditation, through the Cornerstone process, will therefore never be able, nor was intended, to replace the require-

ment for individual ongoing professional development such as that involved in the RNZCGP Maintenance Of Professional Standards. Furthermore, as Grol pointed out in 2001,[4] for successful quality improvement in the health care system, *'There is a need for integrated methods and comprehensive programs that combine, for instance, evidence-based guidelines, clinical pathways, indicators for continuous assessment, and quality improvement projects embedded within a wider quality system of a hospital or practice.'*

The two processes of Cornerstone and MOPs, together with the combined and integrated Primary Health Organisation and DHB provider arm quality processes, can complete the complex integrated package which Grol describes. This is what is needed to support the building of technical excellence, in the setting of a patient focused service delivery system, and to develop a strong, capable, functional and hopefully happy and satisfied delivery team.

There are clearly some unknowns in the future. These involve direct risks to practices and also some assumptions that currently lack robust evidence. Will the full cost, not only of the quality improvement work, but also of the external facilitation and support, be left to the practices themselves? Will the aspirational goals in the *Aiming for Excellence* booklet become legislated expectations in the future? Can we be sure that three years is the appropriate time before undergoing the whole process again? Will the quality improvement opportunities be embraced? Will the other parts of the integrated team involved in quality systems be supportive of the whole? We must also ask ourselves, what will happen next if we do not use these tools to, at least, confirm that we have safe practice environments and processes, and preferably to demonstrate that we are aiming for, and achieving, increased levels of excellence?

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Whilst there is no definitive answer to some of these questions, the benefits of the process clearly apply to practice teams themselves, the patients who will experience a delivery system which continuously improves its own quality delivery, and the funder who can be assured of safe and patient-centred processes. Surely, this is a very strong argument for all three parties to contribute to the necessary resources, including finance, involved in the process. Within this package the contribution of the practices to the self-assessment time and the costs of improvement processes subsequent to this should be acknowledged.

Cornerstone is an opportunity for practices and Primary Health Organisations to lever off the College's extensive experience and knowledge in quality improvement and quality assurance as it applies to primary health care and to share the cost with external funding agencies who have a responsibility and accountability for purchasing safe services of high-quality. There are already a significant number of practices that have been through the process, and nearly all have found the gain far outweighs the pain.

Now is a great time to be part of this integrated process!

References

1. Lawrence M, Packwood T. Adapting total quality management for general practice: evaluation of a programme. Qual Health Care 1996; 5:151-158.
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3. Buetow S, Wellingham J. Accreditation of general practices: challenges and lessons. Qual Saf Health Care 2003; 12:129-135.
4. Grol R. Improving the quality of medical care building bridges among professional pride, payer profit, and patient satisfaction. JAMA. 2001; 286:2578-2585.

Depression in medical students

It is unclear whether there has been a recent increase in depression among medical students or whether greater awareness of mental health issues has simply led to increased recognition of the phenomenon. Nanette Gartrell is an associate clinical professor of psychiatry at UCSF who has treated many medical students and physicians for depression during 25 years of private practice. She said that in recent years, "[we] are seeing more students, because we have some more efficient pharmaceutical treatments." Students know that selective serotonin-reuptake inhibitors (SSRIs) can make them feel better much more quickly than psychotherapy or older classes of antidepressants could. Gartrell added that virtually all the depressed physicians she sees have self-medicated with an SSRI before consulting her.

Rosenthal JM, Okie S. White coat, mood indigo - depression in medical school. NEJM 2005;353:1085-88.