

Quality and general practice accreditation: The approach of Australian General Practice Accreditation Limited

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Abstract

The purpose of this article is to outline the underlying assumptions, principles and processes of a continuous quality improvement approach which underpins the accreditation of general practice offered by Australian General Practice Accreditation Limited.

Background

The impetus for the development of an accreditation system for general practices came with the 1992 General Practice Strategy agenda. In simple terms, the argument was that quality assurance initiatives based on vocational registration would be directed at practitioners whilst an accreditation system would be directed at practices. Since then a long and complex process has culminated in the formation of Australian General Practice Accreditation Limited (AGPAL). AGPAL offers practice accreditation based on the standards and processes developed and validated over the last five years. This process has been summarised in the recent General Practice Strategy Review Group report (Department of Health and Family Services 1998).

The National Expert Advisory Group report on safety and quality in Australian health care relies heavily on a paradigm of continuous quality improvement which involves all stakeholders, including users of services, funders, managers and providers

(Department of Health and Aged Care 1998). Following are two recommendations from the report of direct relevance to general practice accreditation and AGPAL:

- Recommendation 15

That accreditation or certification of health care organisations be strongly encouraged with incentives, or indeed made mandatory, but choice of accreditation/certification/award approaches be allowed. The requirement for accreditation could be achieved through the Health Care Agreements or other Commonwealth and State mechanisms. Whatever the mechanisms adopted, accreditation of health care organisations should require both mechanisms/processes for continuous improvement and demonstrated achievement of quality enhancement outcomes.

- Recommendation 16

That the Australian Council of Health Care Standards and other accreditation bodies ensure that expertise in consumer issues be included in all levels of accreditation processes.

While the report is mainly concerned with hospital care there is no obvious reason why such an approach should not apply to community-based care, including general practice, provided that the approach is contextualised.

Quality is a difficult concept to define unambiguously as its dimensions will vary for different stakeholders (Rees Lewis 1994; Williams et al. 1995; Jung, Wensing & Grol 1997). The Government has agreed with the General Practice Strategy Review Group report's recommendation that the Institute of Medicine's definition of quality be adopted. This definition states that:

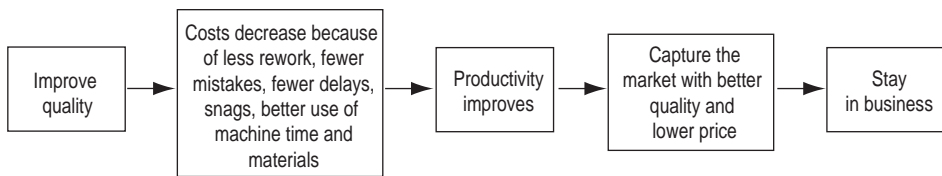
...quality is the degree to which health services for individuals and the population increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Department of Health and Family Services 1998)

The dimensions of quality for general practice comprise nine main elements. They are:

- patient satisfaction
- professional training
- review and audit
- practice efficiency
- staff improvement and organisational development
- good established practices and introduction of new procedures
- effective time utilisation
- information management (including technology), and
- adequate facilities.

The issues underpinning training and ongoing learning that concern practitioners are dealt with through vocational registration and training schemes. Donabedian (1996) describes three components of quality in health care – good technical care, good relationships and good amenities. Accreditation concerns the last two areas of quality. It can be seen that this must be an ongoing process, not a single intermittent event, to be an effective strategy. Such an approach neatly fits the continuous quality improvement paradigm.

Deming was the first proponent of a quality approach to processes in this manner – initially concerning production processes (cited in Donabedian 1996). The Deming Chain was basically as follows:



Each component in the process was subjected to a circular process to minimise failures and errors; that is, to plan, do, check, act, plan, and so on. This approach is used in everyday practice activities, but not in a very systematic or even conscious way.

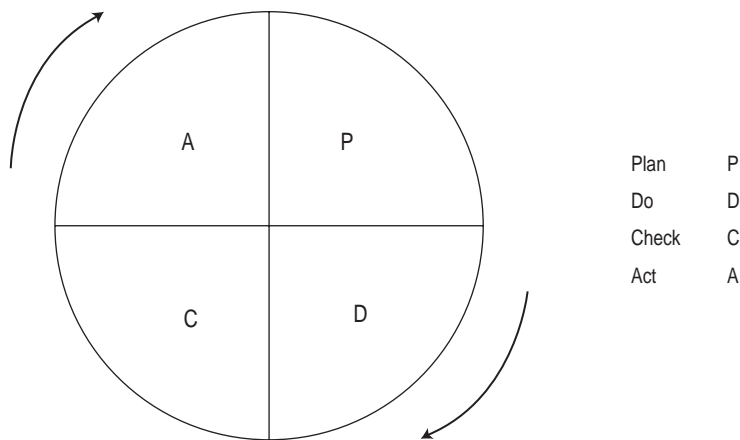


Figure 1: The action/planning cycle.

Errors or failures in the delivery of quality health care can be expensive for the practice, not only in terms of time and resources wasted but also in terms of the potential for being subject to litigation. Mistakes can often be overlooked unless one takes the opportunity of looking at the way business is being transacted or the way the service is provided. Entering into a continuous quality improvement process therefore has positive advantages, irrespective of other third party rewards, such as preferential standing and direct incentive payments.

Costs of quality and poor quality

Seven categories of quality costs may be identified, as shown in Figure 2.

Prevention costs	Control costs	Total cost of quality
Appraisal costs		
Internal failure costs	Failure costs	
External failure costs		

Figure 2: Structural relationships of costs

Prevention costs are an investment in minimising measurable costs (appraisal, internal failure and external failure) and unmeasurable costs (for example, the investment of time a practice makes working to improve quality). Some of the early feedback from practices that have undertaken the accreditation process has highlighted a feeling that the time taken to think about the way the practice operates has been time well spent.

Appraisal costs are those costs incurred by a practice when monitoring whether they are conforming to a standard. They may include such things as:

- the time taken to put in control systems and to verify that those systems are working as intended
- error tracking in paperwork
- installing computerised systems to minimise variances and human errors
- keeping a log of fridge temperature
- sterilisation procedures, and
- stocktaking medicines and consumables in the practice.

Internal failure costs are required to fix errors before patient care is compromised, such as replacing faulty equipment.

External failure costs involve third-party activities such as failure to collect bad debts, inappropriate use of resources, re-ordering consumables (for example, too many of some and running out of others) and practice expenses.

Implementation of a continuous quality improvement approach should minimise failure costs through investing in prevention and appraisal costs – that is, control costs. However, it is unavoidable that some cost will be incurred in ensuring quality issues are addressed.

Culture change

The concept and implementation of general practice accreditation has received a mixed response ranging from open hostility to almost evangelical support. If accreditation and the continuous quality improvement process are based on sound principles and evidence, then why would opposition be so vociferous? In order to understand this one must consider the dynamics behind culture change as illustrated in Figure 3.

Organisations are dynamic systems that are held in balance or equilibrium by equal and opposing forces. For the equilibrium position to be altered – that is, for organisational change to occur – there must be either a strengthening of the driving forces (legislation, economic imperatives and competitive pressures) or a weakening of the restraining forces (traditional practices, organisational culture, job insecurity) or a degree of both. Lewin (1947) argued some time ago that the better strategies for implementing change rest on reducing the restraining forces, although an incremental approach balancing the forces in a dynamic way may be a better change process.

In the case of general practice this argument requires the profession to believe it is undertaking accreditation for the right purpose rather than linking the process to any financial or other incentive. This understanding will have a far greater and more lasting effect on quality improvement across general practice. The fact that the practice may receive a payment for being accredited should be thought of as a bonus rather than a required driving force.

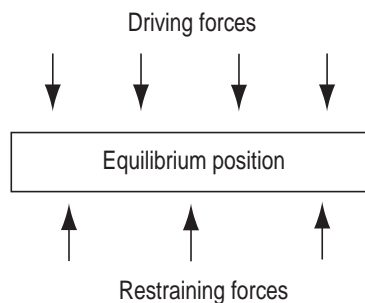


Figure 3: Forces of organisational culture change

Unfortunately this is an ideal. In the real world, in many cases, this will not be true. There is no information as to what proportion of practices that adopted accreditation early were motivated by the prospect of a financial gain. This balance will be seen more positively by the profession if financial incentives are themselves based on a quality framework and reward activities which make clinical sense in terms of improving patient and/or business outcomes.

Structure, process, outcomes

Early work by Donabedian (cited in Donabedian 1996) described quality assessment as dependent on measuring structure, process and outcome variables and comparing results to norms or standards. In the health context these ideas become structures (such as settings and arrangements), care processes (service content) and outcomes of care. Each of these has a number of variables. Structural variables describe the inputs to care processes. They include fixed resources, such as buildings and equipment, but also the training and qualification of providers. Process variables describe what care is provided or the characteristics of its provision (for example, whether a particular test or procedure is carried out for a presenting problem). Outcome variables describe the results of the provision of care. This may be in terms of disease management outcome or patient satisfaction with the process. Each of these variables is an important part of the care process and any quality assurance process must cover all three.

It is important to see accreditation as a process, not an event. The requirement that a feedback loop be part of the process creates opportunities for incremental improvement. Defining areas for improvement is of little use unless the continuous quality improvement process revisits and re-measures care processes to ensure those improvements have occurred. In addition there may be new technologies or new knowledge changing the standards or introducing new ones. In this sense, the continuous quality improvement process must be dynamic as well as continuous.

The continuous quality improvement process may therefore proceed either by incremental change or by innovation. AGPAL is focused mainly on assisting practices to achieve incremental change. It does so by taking on board suggestions for small improvements in the way practices operate. Many of these small improvements become obvious to practitioners and managers as they undergo the self-assessment process. There may be occasions when major change is required to achieve a standard. Equally, there may be major changes to the standards created by technological breakthroughs, which would require innovative approaches within the continuous quality improvement process. Table 1 outlines and contrasts these two approaches.

Innovation will be more important in a reaccreditation context. It seems pointless to revisit, in more than a checking sense, issues which practices have already addressed. Checking simply measures the practice's performance in maintaining the status quo. A continuous quality improvement approach demands that reaccreditation involve advancing the standards – either in total or through targeting specific issues. For

example, if, on analysing accreditation reports, AGPAL found that practices were having difficulty with certain standards or areas of practice, those standards or areas of practice may become the focus of a reaccreditation process. Alternatively, the profession may reach consensus on a new standard (for example, for medical records or report handling) and this would be the chief focus of the reaccreditation process. Hence the accreditation process itself is progressive in nature.

Table 1: Innovation versus incremental improvement

Characteristics	Improvements	Innovations
Impact	Visible over the long term, permanent, not dramatic	Immediately visible but may be dramatic
Rhythm	Small steps	Very noticeable steps
Frequency	Continuous	Discontinuous, unique
Changes	Gradual	Abrupt and challenging
Participation	Everyone	Usually selectively driven
Approach	Joint group efforts, systematic approach	Individual ideas and efforts to make it happen
Operating method	Improvements to the existing system	Replacement with something new
Knowledge required	Simple and conventional	New theories and technologies
Level of effort	Minor initial investment, but sustained effort	Very significant initial investment in time/effort
Assessment criteria	The functioning of the process the efforts made	Earnings and profits

The AGPAL framework

There are six elements to the AGPAL accreditation framework. Each will be briefly described below.

Pre-survey visit

Once a practice registers and starts on the process of continuous quality improvement, it is making a commitment to be assessed against professionally developed standards. The self-assessment workbook has been developed by AGPAL based on entry standards and is an ideal focus for the practice to undertake an internal assessment of itself. However, an accreditation system based entirely on self-assessment, without benchmarks, would not be satisfactory. A practice, for example, might assess itself as soundly meeting a criterion that the surveyors subsequently find has not been met. Alternatively, a practice might assess itself as being in low compliance with a criterion.

The surveyor, however, might give feedback that the practice was in high compliance compared to other practices of a similar category. The system of self-assessment prior to a visit has been highly regarded by participating practices and should be continued and developed.

Survey visit

The survey visit is an ideal opportunity to generate some ideas on areas that can be improved in an incremental manner. At a recent presentation, one of the AGPAL surveyors highlighted the fact that he had gleaned some ideas during a survey visit that he had taken back to his own practice. These included ideas about managing and displaying brochures, having a perspex-enclosed children's play area and a developing a method of recall for patients. It became a learning experience for the surveyor as well as the practice.

Report

After visiting a practice, the surveyors generate a report which is likely to contain a series of recommendations on those standards and criteria that have been identified as needing possible improvement. Even though the practice may have complied with a standard, it is envisaged that, where appropriate, some recommendations can still be made. It is possible for a practice to be recommended for full accreditation even if areas for improvement have been identified (for example, for non-essential criteria). This is consistent with the continuous quality improvement approach.

Action plan

This is placed at the end of the report and is intended to encourage the practice to put in place an internal continuous quality improvement process (plan, act, check, do). Practices that are not recommended for full accreditation are initially given up to six months to address identified problem areas. AGPAL can offer support during this time, if requested. The aim of the process is to assist all practices to get over the line – not to pass some and fail others. With this approach it is anticipated that well over 90% of practices will achieve accreditation.

Newsletter

The newsletter is the key communication channel to the accredited practices. It will also provide the main medium by which AGPAL promotes products and services, together with ideas and innovations gleaned from surveyors and practices across the country and from contemporary research. Thus AGPAL itself is subject to a continuous quality improvement process which includes incorporating gained experience.

Endorsement of products and services

It is important that endorsement be treated as a partnership arrangement with companies who wish to promote AGPAL's stamp of approval. AGPAL is particularly interested in endorsing quality products that will assist practices to either:

- achieve accreditation or
- build a continuous quality improvement process into practice management strategies.

Patient feedback instruments and sterilisation protocol manuals are two examples.

Discussion

There are two further issues of considerable importance – accrediting the accreditors and evaluating the accreditation/continuous quality improvement process.

It is critical that the basis on which any continuous quality improvement program is founded has been independently validated. In the case of general practice, the only currently validated standards are the Royal Australian College of General Practitioners Entry Standards (Royal Australian College of General Practitioners 1996). Field trials of these standards indicated that they are robust, provided that surveyor training is properly conducted to minimise inter-observer variation. The process by which standards are used is equally important.

Both the process and the standards need to be evolutionary so that, as experience accumulates, refinements can occur. This has limits, however, and if either become significantly different from the original, the issue of validity may have to be revisited. In this context, accrediting the accreditor becomes important. There are a number of overarching accreditation systems, such as ISO 9000 and JASANZ. Adoption a system such as these ensures that the continuous quality improvement process itself is subject to a continuous quality improvement process.

Evaluation is an important part of the continuous quality improvement cycle. Each component can be made subject to an evaluation cycle, which is summarised generically in Figure 4.

The World Organisation of Family Doctors captured this concept in their 1992 publication *Quality Assurance for Family Doctors* (Marwick et al. 1992). In their framework they propose that:

...quality assurance is defined as a process of planned activities which includes performance review and enhancement with the aim of continually improving standards of patient care. The definition includes the important concept of continual improvement rather than inspection. (p 2)

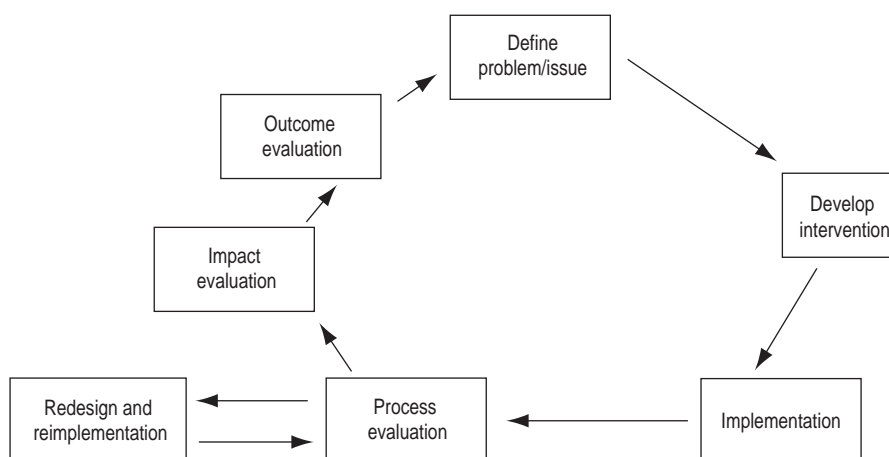


Figure 4: The evaluation cycle

To accomplish this continual improvement approach, the collection of information and the use of that information for informing both the end-user (in this case the practice) and the accreditor (in this case AGPAL) is required. A consequence of this is the need for a reaccreditation system. This allows the continuous cycle to have a defined time limit before it is reassessed at the macro level – the opportunity for innovation and extension of the overall process.

Conclusion

This article has described AGPAL's approach to general practice accreditation from both a practical and theoretical perspective. The approach stresses the need to have a system which makes sense in terms of the way practices run and in terms of improving clinical outcomes. It also stresses the need for a continuous process which builds through a mix of incremental and innovative change. There is also an implicit assumption that, as with any change process, there will be early adopters, gradual adopters and resisters of the process. It remains to be seen what proportion of practices fall into each category.

References

- Donabedian A 1996, 'Evaluating the quality of medical care', *Millbank Quarterly*, vol 44, pp 166–206.
- Department of Health and Family Services 1998, *General Practice: Changing the Future Through Partnerships – The Report of the General Practice Strategy Review Group*, Department of Health and Family Services, Canberra.

Department of Health and Aged Care 1998, *National Expert Advisory Group on Safety and Quality in Australian Health Care – Report*, Department of Health and Aged Care, Canberra.

Jung HP, Wensing M & Grol R 1997, 'What makes a good general practitioner: Do patients and doctors have different views?', *Br J Gen Prac*, vol 47, no 425, pp 805–9.

Lewin K 1947, 'Frontiers in group dynamics: Concept, method and reality in social science, social equilibria and social change', *Human Relations*, vol 1, pp 5–41.

Marwick J, Grol R & Borgiel A 1992, *Quality Assurance for Family Doctors*, World Organisation of Family Doctors, Australia.

Royal Australian College of General Practitioners 1996, *Entry Standards for General Practice*, Royal Australian College of General Practitioners, Sydney.

Rees Lewis J 1994, 'Patient views on quality care in general practice: Literature review', *Soc Sci Med*, vol 39, pp 655–70.

Williams S, Weinman J, Dale J & Newman S 1995, 'Patient expectations: What do primary care patients want from the GP and how far does meeting expectations affect patient satisfaction?', *Fam Prac*, vol 12, pp 193–201.