TOWARDS QUALITY IN FAMILY PRACTICE

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ABSTRACT

Quality in healthcare is an important concept. It is important to recognise its multidimensional nature. There is a need for quality improvement in healthcare because poor quality care generates unnecessary costs and unsatisfactory outcomes through misuse, overuse, and underuse of healthcare products and services. The trend towards quality in healthcare involves family practice as well. There is a need to bear in mind special features of family practice when discussing quality. A multi-level approach is needed when addressing problems in quality – at the individual practioner level and at the system level. In addition, patients and consumers should be engaged where feasible. Continuous quality improvement is becoming increasingly popular in healthcare as a model for improving quality. A model for quality improvement in family practice includes these elements: management, data collection, systematic approach and collaboration (teamwork). There are barriers to quality in family practice and these pose practical challenges.

INTRODUCTION

The term "quality" probably has differing definitions in different disciplines. To many people, quality is often an abstract term – difficult to define but one can know it when they see or experience it. Quality also operates at different levels. One can have different perceptions of quality depending on one's position in a system, for example, as a consumer, service provider and funder. When we talk about quality, we are in essence debating about what processes should be used and what outcomes should be achieved. In business terms, this is akin to maximising returns on investments.

DEFINITIONS OF QUALITY IN HEALTHCARE

The World Organisation of Family Doctors (WONCA) has the following definition:
"Quality means the best health outcomes that are possible, given available resources, and that are consistent with patient values and preferences."[1]

The WONCA Working Party on Quality in Family Medicine has stated the following principles:

- To improve the quality of care, family doctors strive for the best structure, process and outcomes of health care which is:
  - consistent with patient values and preferences, consistent with professional knowledge of appropriate and effective care, and is possible, given available resources.
- Quality efforts should:
  - promote accountability, and;
  - consistent with patient values and preferences, consistent with professional knowledge of appropriate and effective care, and is possible, given available resources.
- Quality efforts should be:
  - explicit.
  - systematic.
  - a routine of daily practice.
  - an integral aspect of routine and continuing medical education.
  - consistent with the special role and setting of the family doctor, and applied in a positive, not punitive, manner.

The Institute of Medicine (IOM) defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[2] The IOM has identified six Aims for Improvement, which are essentially six dimensions (or domains) of quality in healthcare (Table 1).

Table 1. Aims for Improvement

Safe: avoiding injuries to patients from the care that is intended to help them.
Effective: providing services based on scientific knowledge.
Patient-centered: providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions.
Timely: reducing waits and sometimes harmful delays for both those who receive care and those who give care.
Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.
Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

In an American consumer website provided by Federal agencies, it is stated that quality health care means "doing the right thing, at the right time, in the right way, for the right person – and having the best possible results."[3]

Quality is both a relative and an empirically based term. When assessing quality, judgement calls have to be made in the background of uncertainties in its knowledge and practice. Quality improvement will therefore need to be a continuous and evolving process.

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IS THERE A NEED FOR QUALITY IMPROVEMENT IN HEALTHCARE?

Do a Google search today on quality healthcare related topics and one realises that there is a mountain of information, links and websites on these topics. There is a big consumer movement towards demanding quality in healthcare services provided to patients. Many government agencies and healthcare institutions are paying attention to this area. The need for quality improvement in healthcare is reflected in this global trend. Family physicians (FPs) cannot practise in isolation without due regard to this trend.

Poor quality care generates unnecessary costs and unsatisfactory outcomes through misuse, overuse, and underuse of healthcare products and services. McLoughlin and Leatherman, in their article, gave a good summary of the scope and scale of problems with quality[4]. Firstly, from the stakeholder perceptions of quality point of view, they cited surveys that reflect concerns on widespread eroding performance through the eyes of physicians, patients and purchasers/payers. Secondly, the USA, UK and Australia have experienced growing concerns about medical errors with consequent emphasis on safety and quality in recent times. As an example, the IOM report "To Err is Human" was mentioned where the incidence of mortality relating to medical error was quoted to be 44,000 – 98,000 per year. (Note: A report brief of this comprehensive IOM publication is available on the web[5]). Thirdly, the authors highlighted that significant variations in the use of specific healthcare interventions have been observed (for example underuse of beta blockers to prevent recurrent heart attacks) and the effectiveness of care for common conditions were questioned (for example, use of antibiotics in upper respiratory tract infections). These reflect the issues of effectiveness and appropriateness of healthcare provision and hence the problem with quality. In addition, widespread variation in the quality of general practice care has been shown in recent UK observational studies[6,7].

SPECIAL FEATURES OF FAMILY PRACTICE

Family practice differs from institutional and hospital care in several aspects.

- Family physicians see a broad range of medical problems. These problems are often undifferentiated and non specific in nature. While many problems are self-limiting, the scope can include serious ailments and longstanding chronic conditions as well.
- Family practice is characterised by frontline care to the community. Patients have easy access to their family physicians. In fact, in the local setting, most family practices do not require them to make a prior appointment before consultation. This means many patients consult family physicians for a first diagnosis which is often preliminary because of the undifferentiated and non specific nature of ailments in the early stage.
- Family physicians often have long term doctor-patient relationships. They can play a crucial role in health promotion and disease prevention in their community. In particular, they are suited for managing and monitoring chronic conditions like diabetes mellitus, hypertension and asthma.
- In the local setting, most family practices are small entities with a small staff (one or two doctors with a few clinic assistants). These entities are often owned by the doctors themselves, that is, the doctor is both the owner and manager of the practice. Most clinic assistants are not registered nurses although an increasing number are attending the one year accredited course for clinic assistants offered by the Institute of Technical Education.

The features mentioned above are important in the considerations of an approach to quality improvement in family practice. In recent years, the terms "total quality management" or "continuous quality improvement" have been used to describe the quality improvement models in the healthcare industry. At the same time, it is important to bear in mind that it is probably not feasible to translate quality improvement strategies in large healthcare organisation to family practices because of differences in institutional and family practice.

PRINCIPLES FOR QUALITY IMPROVEMENT

Established tools that can be used to improve care – these include vocational training, continuous medical education, peer review, clinical audit and development of clinical practice guidelines, play an important role in improving professional expertise. However, quality improvement requires more than good training of healthcare professionals. It is also related to how processes for quality improvement are built into systems design.

In other words, problems in quality may occur at two levels – firstly, at the individual practitioner level and secondly, at the system level. Addressing either level alone is unlikely to be successful. McLoughlin and Leatherman stated the principles of three strategies to be employed[4]:

- **Knowledge and performance enhancement at the individual practitioner level**

  There is concern over knowledge deficiencies of clinicians who have to grapple with the volume of evidence that is constantly becoming available. There is a time lapse between identification of more efficacious treatments and their incorporation into routine practice. In addition, for procedures and surgical interventions, poor individual performance or skills may lead to a poorer outcome even when they are considered best practices. There is a need for strategies to enhance knowledge and performance of the individual practitioner.

  Performance indicators embedded in guidelines and protocols at a level understandable by clinicians are widely used to facilitate translation of evidence into routine practice. Identification of performance indicators is important for evaluating quality of healthcare. However, it is a dynamic process that is shaped by information from ongoing scientific

research. It is impossible to identify a static set of indicators as scientific evidence changes. A recent Canadian article identified a range of performance indicators representing various categories of family practice[8]: prevention, promotion, acute care, chronic care, patient interaction and practice organisation. For example, in the chronic care category, a list of performance indicators include:

- Record of follow up for borderline or elevated blood pressure measurements with repeated measures.
- Record of blood pressure measurement in hypertensive patients at least once every six months.
- Record of degree of asthma control at every visit where asthma is the presenting complaint.
- Record of fundoscopic eye examination for diabetic patients at least once every year.
- Record of diabetes management education information for patients with diabetes.

- **Improving processes and organisation at the system level**

  Many of the failures relate to the organisation features of care rather than the acts of individual carers failing in their duties. These flaws can be "designed out" of the system of care – moving the focus of attention away from the individual carer's behaviour towards environmental issues, equipment deficiencies, team functioning etc.

  Focusing on organisations and systems of care is more practical compared to the challenges of dealing with every individual practitioner directly.

- **Engaging patients and consumers**

  This principle is based on an understanding that quality from a patient's point of view relates not only to outcomes but also to humane and respectful treatment, convenience and timely access. Doctors often believe that quality should be based more on "what is done" to patients than "what happened to them" and "how it happened". This mindset needs to be changed as improving patients' experience of healthcare is attached more importance.

CONCEPT OF CONTINUOUS QUALITY IMPROVEMENT

Continuous quality improvement is becoming increasingly popular in healthcare as a model for improving quality. It has advantages over profession oriented models for quality assurance because it combines managerial and collaboration aspects with a systematic approach. This concept stresses the need to learn about current practice to generate ideas which will lead to improvements in future. It is essential to create conducive conditions for continuous learning in practice and for effective teamwork to produce higher practice standards through incremental improvement. Practices need to incorporate a practice culture in which improving the care process is a continuous aim. The use of continuous quality improvement will evolve gradually, bringing about many cultural changes.

A MODEL FOR QUALITY IMPROVEMENT IN FAMILY PRACTICE

Geboers et al[9,10] have classified four core elements of continuous quality improvement:

- **Management**

  Leadership is needed to get quality improvement started and sustained. Priorities are set because not all goals can be achieved at once. People motivation and management of resources and knowledge of change are important too. Annual plans and regular reports on improvement can help practices to set their targets.

- **Data collection**

  Reliable up-to-date facts about the practice and its performance are the starting point for effective decision making and improvement. Data can convince people that the changes made are really an improvement, and importantly, allows monitoring performance regularly.

- **Systematic approach**

  Improvement is a planned activity in which the quality cycle based on the plan-do-study-act model (PDSA cycle) is used as a process of decision making. Examples of tools that can be used to go through the quality cycle include flowcharts, control charts, Pareto diagrams, cause-and-effect diagrams and run charts. Improvement is made step by step. For difficult goals and complex processes, more steps will be needed to achieve quality standards. Essentially, the practice initiates improvement projects using the PDSA cycle and quality improvement tools and strives to learn from experience with subsequent improvement in quality. Regular reports on performance and outcomes of care will help to evaluate progress.

- **Collaboration**

  Teamwork is important. If anyone is not involved or there are negative attitudes, then improvement will fail. Everyone should be aware of the targets of quality improvement and the collective responsibility for it. At the same time, patients need to be involved and informed too.

For small family practices, it is better to run simple improvement projects in view of the limitations in resources. Data collection methodology and the tools employed should be simple to use and not time consuming. Note that quality of care is a multidimensional concept and different aspects of quality need different methods of measurement. Quality of care should not be assessed from a single perspective or for a single condition. It should be assessed with a range of measures, as each approach illustrates different aspects of quality of care.

BARRIERS THAT AFFECT QUALITY IN FAMILY PRACTICE

There are several factors that continue to pose a challenge to FPs in their quest to provide quality care. These factors may be more apparent in smaller practices due to resource constraints.

Lack of financing for quality care

The current family practice model tends to promote remuneration based on volume of cases seen. When FP remuneration or financing of practices are not tied to provision of quality care, it is not difficult to expect that quality will be sacrificed for quantity. Unrealistic benchmarks of general practice charges in managed care schemes and healthcare institutions that provide subsidised care serve to compound the difficulty further in providing quality care. For example, there are managed care schemes that do not pay family physicians for performing minor surgery. Such cases are expected to be referred to surgeons instead. Most schemes do not compensate the extra time and effort spent in managing chronic conditions like diabetes.

Pay for performance (paying for results or rewarding high quality of care) is a concept of growing interest in both publicly financed and private payment healthcare systems in some countries. For example, it has been applied in UK and Australia to promote preventive services such as immunisation. It is prudent that financing incentives be used only when there is strong evidence of effectiveness and specific outcomes can be demonstrated. Marshall and Smith in an editorial article (11) highlighted that financial incentives have been shown to be an effective way of influencing professional and organisational behaviour in a wide range of countries and health systems, in particular, when incentives are aligned to professional values, targeted on areas that are deemed to be important and represent a sufficiently high proportion of total income.

In the UK, a new National Health Service (NHS) General Medical Services (GMS) contract was implemented in April 2004 (12). One of the key changes in the new GMS contract was that for the first time, practices are financially incentivised for delivering quality patient care, via the evidence-based Quality and Outcomes Framework. A significant proportion of the new money tied to the contract will be available to reward practices for providing higher quality services. Practices will have the opportunity to receive additional funding to support achievement of a range of quality standards. This is a major milestone and it will be interesting to monitor the progress as a result of this new policy.

Information management and technology issues

Local healthcare information technology (IT) systems are fragmented with duplication in certain areas. This has resulted in an inability to manage medical information across sectors of healthcare. Locally, there is no common healthcare IT platform between public and private sector healthcare entities. Shared care between private family physicians and public sector institutions would be more efficient and effective if this gap is bridged. Likewise, there is a similar deficiency between family physicians and private specialists. This makes timely tracking of patient data and clinical parameters difficult when there is transfer of care.

There are small family practices that do not use computers and information technology in their daily patient encounters. This will impede the ability to register, track and audit medical data efficiently and effectively. It will thus be an obstacle to implementing quality improvement strategies.

Rapid advances in medical science and knowledge

Such advances may not be readily accessed by FPs in a timely fashion. Thus there will be a gap between current practice and best practice care. The reality is that it is far more difficult to keep in touch with advances in medical developments than what is perceived by many FPs. In addition, the acceptance of protocols and guidelines by doctors is likely to differ resulting in different standards of care.

Current state of practice size and infrastructure

The majority of private family practices in Singapore are small with limited capacity. Although several practices may coexist in a district, the competitive culture of family practice is likely to prevent multi-practitioner cooperation in patient care delivery. A small family practice on its own often has limited resources. The range of primary care services will understandably be limited. For example, diabetic retinal photography, specialised nutritional counselling, simple radiological investigations, endoscopy and physiotherapy services are suitable to be part of a comprehensive primary care delivery system. It is feasible only if there is a multi-practitioner arrangement. This provides the economy of scale to organise resources and deliver more services to the community. The need for specialist and hospital referral can be reduced. A solo practitioner is unlikely to achieve that.

In a small practice, the family physician is often the owner and manager. If he does not take on the role of the quality coordinator and provide leadership, it is unlikely quality improvement can be initiated and sustained. In addition, the constraint in staff, infrastructure and other resources may discourage family practices from participating in activities that may cause further drain on their resources.

However, small family practices do not necessarily score poorly for quality of care. The UK observational study by Campbell et al emphasised that no single type of practice has a monopoly on high quality care (6). In fact different types of practice may have different strengths. In this study, it was shown that smaller practices scored better than larger ones for access to care but for diabetes care larger practices had higher scores.

Medicolegal considerations

Defensive medicine practices may result in FPs being unwilling to manage complicated cases, or their threshold for specialist referral is low to avoid malpractice suits.

This is particularly obvious locally as patients have tremendous freedom in obtaining second opinions from other practitioners. Access to specialist care is easy as the waiting time to get a specialist appointment is often short. FPs may feel pressured to refer early if patients demand early specialist consult.

CONCLUSION

There is a need for quality improvement in healthcare, including family practice. As we move towards providing quality care in family practice, we need to be mindful of the special features of family practice care and the multidimensional nature of quality. There are barriers that affect quality in family practice and these deserve serious considerations because they pose challenges to any family physician who wants to improve the quality of his practice. For small family practices, it is better to run simple improvement projects in view of the limitations in resources. To implement quality improvement projects, the following elements are needed: management and leadership, data collection, systematic approach (quality cycle), and collaboration with staff (and patients if feasible).

REFERENCES

1. Global Family Doctor – Wonca online. Mission and Principles for Quality in Family Medicine. http://www.globalfamilydoctor.com/aboutWonca/working_groups/quality_ass/wonca_qualityassurance.asp?refurl=wg (Accessed on 1 November 2005).
2. Institute of Medicine. Crossing the Quality Chasm – The IOM Health Care Quality Initiative. http://www.iom.edu/focuson.asp?id=8089 (Accessed on 1 November 2005).
3. The Quality Interagency Coordination Task Force. What is Quality? http://www.consumer.gov/qualityhealth/quality.htm (Accessed on 2 November 2005).
4. McLoughlin V, Leatherman S. Quality or financing: what drives design of the health care system? Qual. Saf. Health Care 2003; 12; 136-42.
5. Insitute of Medicine Report Brief November 1999. To Err is Human: Building a Safer Health System. http://www.iom.edu/Object.File/Master/4/117/0.pdf (Accessed on 4 November 2005).
6. Campbell S, Hann M, Hacker J, et al. Identifying predictors of high quality care in English general practice: observational study. BMJ 2001; 323; 1-6.
7. Campbell S, Roland M, Middleton E, et al. Improvements in quality of clinical care in English general practice 1998-2003: longitudinal observational study. BMJ 2005; 331; 1-5.
8. Barnsley J, Berta W, Cockerill R, et al. Identifying performance indicators for family practice: Assessing levels of consensus. Can Fam Physician 2005; 51: 701-8.
9. Geboers H, Grol R, van den Bosch W, et al. A model for continuous quality improvement in small scale practices. Qual. Health Care 1999; 8; 43-8.
10. Geboers H, van der Horst M, Mokkink H, et al. Setting up improvement projects in small scale primary care practices: feasibility of a model for continuous quality improvement. Qual. Health Care 1999; 8; 36-42.
11. Marshall M, Smith P. Rewarding results: using financial incentives to improve quality. Qual. Saf. Health Care 2003; 12; 397-8.
12. RCGP Information Sheet No 6. New GMS Contract (Overview and Resources Guide). August 2004.

RECOMMENDED READING

1. Royal Australian College of General Practitioners. A Quality Framework for Australian General Practice. Background Paper Draft Version 7 (October 2004).
2. The Singapore Family Physician Vol 31(3) July – September 2005. Distance Learning Course on Clinical Quality.