

Primary Care Quality Digest

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> The probability that a disseminated document will arrive on someone's desk the moment it is needed is infinitesimally small. Secondly, the probability that the same document will be found three months later, when it is needed, is even smaller.[1]

The aim of the Primary Care Quality Digest is to bring to your attention to a selection of recently published papers related to issues of quality in primary care.

Acceptability and impact of performance feedback for primary care teams

This study explored how acceptable primary care interdisciplinary teams found the feedback of data on their performance, and how this impacted upon the seven teams studied. Data on performance, covering chronic disease management, access, patient satisfaction and team function was fed back to each team through a one-hour facilitated session. The sessions were followed up with surveys and interviews and the authors found that the measurement and feedback of performance were welcomed by the teams, irrespective of the discipline of team members. They reported, however, that while a culture and capacity for quality improvement could be developed by team feedback, there was a lack of understanding within the teams regarding how they should use the data to improve quality.

Johnston S, Green M, Thille P *et al.* Performance feedback: an exploratory study to examine the acceptability and impact for interdisciplinary primary care teams. *BMC Family Practice* 2011;12(14).

Adverse events in primary care as an educational tool to improve patient safety

This study, set in Galicia, Spain, aimed to assess whether an adverse events registry could be used as an educational tool to improve patient safety in primary care and also to assess whether the Spanish version of the Hospital Survey on Patient Safety Culture, which measures culture change, could be applied to the primary care setting. Residents in their final year of Family and Community Medicine participated with their tutors with an intervention group randomised to receive training and feedback on recording adverse events in their patients. The control group received no intervention. The authors discuss the limitations on their study, notably in selecting an appropriate tool, working within the training calendar of the residents and reducing bias in the surveys used to measure change.

Gonzalez-Formoso C, Martin-Miguel MV, Fernandez-Dominguez MJ *et al.* Adverse events analysis as an educational tool to improve patient safety culture in primary care: a randomized trial. *BMC Family Practice* 2011;12(50).

Archetypes of success and failure in quality improvement interventions

This paper, a dissertation by a graduate fellow of the Pardee RAND Graduate School, has been supervised, reviewed and approved. The RAND Corporation is a non-profit institution aiming to improve policy and decision making through research and analysis. The author compared 38 quality improvement interventions, half of them more successful, half less so. The comparisons were made systematically with a common framework across a range of clinical and organisational settings enabling the design features of each intervention to be catergorised into 'levers for

change' and 'implementation challenges'. Nine archetypes (five for failure, four for success) resulted from the comparison, revealing patterns in the success or failure of quality improvement interventions set against a range of influences, intentions, design and implementation.
O'Neill SM. *How Do Quality Improvement Interventions Succeed? Archetypes of Success and Failure*. Santa Monica, CA: RAND Corporation, 2011.

Benefits to general practitioners from patient evaluations

This study aimed to assess the impact on general practitioners (GPs) of the feeding back of patient evaluations. Nearly 600 GPs volunteered to be evaluated using the EUROPEP patient questionnaire. The results were fed back to the GPs through reports and a meeting. The GPs were then requested to complete a questionnaire between 3 and 17 months after the feedback to assess whether they perceived any benefits from the evaluation information. Of the 79.4% of GPs who completed the questionnaire, 33% reported having had their attention to the patient perspective on quality raised while 26% reported improved job satisfaction. Seventy-seven per cent learnt from the evaluation feedback and over half made changes to their own practice in response. The authors note the potential importance as a facilitator of the 'significant willingness' among the GPs taking part to discuss their results with others
Heje HN, Vedsted P and Olesen F. General practitioners' experience and benefits from patient evaluations. *BMC Family Practice* 2011;12:116.

Challenges and solutions for multi-country primary care research

Research in primary care conducted across several countries enables the recruitment of large numbers of patients in a short period, but these studies present particular challenges and the practice is unusual. The authors here reflect on their involvement in a multi-country study of acute cough, sharing challenges and solutions and examining the original setting up of the study which was implemented by 14 primary care networks in 13 European countries. The authors categorise the challenges into; the set up and maintenance of the research network, the design of local data collection tools and maintaining the commitment and enthusiasm of all involved. They describe their solutions for each particular area and note that they hope their experiences will assist others undertaking multi-country studies in primary care.
Nuttall J, Hood K, Verheij TJ *et al.* Building an international network for a primary care research program: reflections on challenges and solutions in the set-up and delivery of a prospective observational study of acute cough in 13 European countries. *BMC Family Practice* 2011;12(78).

Collaborative care for depression in primary care

This US study evaluated how sustainable collaborative care models for improving the treatment of depression within Veterans Affairs in primary care could be developed and implemented. Using antidepressant use as the primary study outcome, the authors applied evidence-based quality improvement methods to a locally adapted model for collaborative care and randomised patients to intervention or non-intervention across ten practices in five states. The authors measured how far the primary care clinicians were disposed to adopt the model finding this element had 'substantial effects' on patient participation. Overall, the authors found that the design and implementation of the collaborative care model improved the initiation of antidepressant use. The authors discuss the challenges they faced in using these quality improvement methods within a randomised evaluation study.
Chaney EF, Rubenstein LV, Liu C *et al.* Implementing collaborative care for depression treatment in primary care: a cluster randomized evaluation of a quality improvement practice redesign. *Implementation Science* 2011;6:121.

Compliance with urgent suspected cancer referral guidelines

This study, set in Scottish general practice aimed to audit compliance with referral guidelines for urgent, suspected cancer over a six-month period. Nearly 18,800 referrals from 516 practices were analysed, revealing referral rates ranging from 3.7 to 24.0 per 1000 per year, with a higher than expected proportion of referrals (30.8%) for people aged under 50. Compliance with the guidelines was calculated to be nearly 91% and the authors note that for many patient referrals deemed to be outside the requirements of the guidelines, cancer was diagnosed.

Baughan P, Keatings J and O'Neill B. Urgent suspected cancer referrals from general practice: audit of compliance with guidelines and referral outcomes. *British Journal of General Practice* 2011;61(592):e700–6(7).

Effectiveness of a primary care quality improvement programme

This paper assessed the effectiveness of the European Practice Assessment (EPA) programme in two groups comprised of 102 German primary care practices. The EPA aims to facilitate quality improvement across the five domains through outreach work and feedback. Focusing upon the quality and safety domain, this study involved one group of 102 practices completing a baseline assessment with the EPA instrument which was followed up with an assessment three years later while for comparison, the second group of 102 practices completed their baseline assessment to coincide with the follow-up assessment of the first group. Significant improvements across all five domains were found between the baseline and second assessments of the intervention group. The authors discuss their findings and note they show the value of quality improvement cycles.

Szecsenyi J, Campbell S, Broge B *et al.* Effectiveness of a quality improvement program in improving management of primary care practices. *Canadian Medical Association Journal* October 31, 2011; doi: 10.1503/cmaj.110412.

Good stewardship in primary care clinical practice

This paper describes a project, 'Promoting Good Stewardship in Clinical Practice', initiated by the American National Physicians Alliance (NPA), which saw the development of a list of the top five activities where the quality of care in primary care could be improved. Working groups representing three areas of primary care – family medicine, internal medicine and paediatrics – looked to identify activities common to each which were supported by strong evidence and would result in significant health benefits while reducing risk, harm and cost. Selected activities were put through two rounds of field testing by panels of health professionals resulting in a final list of 12 common clinical activities which met the criteria. The authors recommend that the top five be implemented across US primary care.

Good Stewardship Working Group. The 'top 5' lists in primary care: meeting the responsibility of professionalism. *Archives of Internal Medicine* 2011;171(15):1385–90.

Pay for performance in disease management

This systematic review examined pay-for-performance (P4P) schemes devised to improve the quality of care for chronic diseases in America, Germany and Australia in order to provide an overview of their mechanisms and an insight into their impact on the costs and quality of health care. Eight P4P schemes for chronic disease management were identified through a literature search, five of these being part of larger quality improvement programmes. Only five studies were retrieved which addressed the effects of the schemes on quality and no studies could be found which looked at effects on costs. The authors discuss the limited number of schemes for chronic disease and the lack of evaluative information.

de Bruin SR, Baan CA and Struijs JN. Pay-for-performance in disease management: a systematic review of the literature. *BMC Health Services Research* 2011; 11: 272–14.

Perceived quality of care in general practice

This Swiss study examined the differences in the quality of interpersonal care as perceived by patients under two primary care models; independent general practitioners (GPs), or practitioners operating within an organised GP network (around a third of the Swiss population opts for the latter). The European Project on Patient Evaluation of General Practice Care (EUROPEP) questionnaire was used to measure patient–physician interaction with the results showing that overall, patients consulting independent GPs were more satisfied. When the results were stratified by disease, the differences were less significant for patients with chronic diseases.

Berchtold P, Kunzi B and Busato A. Differences of the quality of care experience: the perception of patients with either network or conventional health plans. *Family Practice* 2011;28(4):406–13.

Reforms to strengthen primary care in Australia, England and the Netherlands

This briefing published by the Commonwealth Fund summarises a study examining the quality improvement strategies utilised in countries which have sought to improve access and quality of primary care through healthcare reforms, including England, Australia and the Netherlands. The study discusses the use of postgraduate training, national targets, greater involvement of nursing staff and out-of-hours services. The coordination and purchasing of primary care services is assessed along with pay-for-performance schemes introduced in England and Australia.
Willcox S, Lewis G and Burgers J. *Strengthening Primary Care: recent reforms and achievements in Australia, England, and the Netherlands*. The Commonwealth Fund, November 2011.

Safety and harm in primary care

The Health Foundation is an independent UK charity. Its occasional Research Scans provide rapid collations of empirical research. All of the evidence is sourced and compiled systematically, but the Research Scans are not systematic reviews and have not been formally peer reviewed.

The following Research Scans focus upon primary care:
Research Scan: Improving safety in primary care. The Health Foundation, November 2011.

Published research about improving patient safety in primary care is sparse and of inconsistent quality, rarely looking beyond the implementation of strategies in a single organisation. This Research Scan collates the evidence addressing three questions:

- What initiatives have been implemented to improve safety in primary care and what are the impacts of these initiatives?
- How have patients, professionals, researchers and funders been involved?
- Are there ongoing studies or media stories about this topic?

www.health.org.uk/publications/improving-safety-in-primary-care-research-scan/
Research Scan: Levels of harm in primary care. The Health Foundation, November 2011.

Errors resulting in patient harm in primary care are less well documented and researched than those in hospitals. This Research Scan collates evidence to address the following questions:

- How is harm measured in primary care?
- What are the levels of harm in primary care?
- What are the main causes or sources of harm in primary care?
- Is there unpublished or ongoing work or media stories about this topic?

www.health.org.uk/publications/levels-of-harm-in-primary-care-research-scan/

REFERENCE

1 Muir Gray JA. Where's the chief knowledge officer? *BMJ* 1998;317:832–40.

PEER REVIEW

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