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# POLICY OPTIONS

## The enablers and barriers for the uptake, use and spread of Primary Care Collaboratives in Australia

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# Policy context

### Introduction

There is a limited understanding of the organisational development for quality and safety taking place in Australian general practice, and the contribution of quality improvement Collaboratives to these developments. To improve system performance more knowledge is required on the ways in which Australian general practice innovates and the individual, organisational and systemic characteristics associated with quality and safety.

This report uses the clinical microsystems framework and diffusion of innovations theory to examine the uptake, use and spread of the Australian Primary Care Collaboratives (APCC) program as the Australian Government's quality improvement program for general practice.

### The Australian Primary Care Collaboratives (APCC) program

The APCC program uses the Institute for Healthcare Improvement's Collaboratives methodology and is managed by the Improvement Foundation Australia (IFA). APCC participants are recruited and supported through improvement "waves" by Collaborative Program Managers (CPMs) from Divisions/Medicare Locals/Primary Health Networks. APCC participants use the PDSA method to make small and manageable changes within their practices.

Since its inception in 2004 the APCC program has reported impressive quality improvements in participating practices. However, only 20% of Australian general practices have participated in the APCC program.

### Study Methods

This qualitative study involved face-to-face interviews with 40 informants with first-hand knowledge of the APCC program. Between June and December 2013 interviews were conducted with:

- 10 GPs, 11 Practice Managers and 5 Practice Nurses from 18 general practices across Australia who had taken part in previous waves of the APCC program;
- 12 Collaborative Program Managers (CPMs) from seven Medicare Locals who had recruited and supported practices in the program; and
- 2 key informants from IFA, purposefully sampled due to their clinical and administrative knowledge of the program.

Interviews were semi-structured, with an interview guide categorised into the key themes of uptake, use and spread. Thematic analysis was conducted using both an *a priori* and emergent coding

framework. At the clinical microsystem level, we analysed the data against Berwick's three spheres of influence: (1) the perception of the innovation; (2) the characteristics of the practices; and (3) the contextual and managerial factors.

# Key findings

The individual and practice level enablers and barriers to the uptake, use and spread of the APCC are tabulated below:

*Table 1- The enablers and barriers at the individual & clinical microsystem levels*

| **INDIVIDUAL STAFF** | **Uptake** | **Use** | **Spread** |
|---|---|---|---|
| Belief & understanding of QI | enabler | enabler | enabler |
| Motivation to improve health outcomes | enabler | enabler | enabler |
| Lack time and have personal commitments | barrier | barrier | barrier |
| **CLINICAL MICROSYSTEM** | | | |
| **Perception of the innovation** | | | |
| Perceived benefits | | | |
| *Networking* | enabler | | enabler |
| *Critical comparison of clinical performance* | enabler | | enabler |
| *Improvement in systems* | | enabler | |
| *Continuing Professional Development* | | | enabler |
| Understanding of & inflexibility in the PDSA | barrier | barrier | |
| Concern over external oversight ( "big brother") | barrier | | |
| **Characteristics of the practices** | | | |
| Practice culture (team based) | enabler | enabler | |
| Presence of a champion | enabler | enabler | |
| Lack technological capacity | barrier | barrier | |
| Staff turnover | | barrier | enabler |
| **Contextual and managerial factors** | | | |
| Synergies with internal & external environments | enabler | enabler | enabler |
| Financial incentives | enabler | enabler | enabler |
| Time pressure | barrier | barrier | barrier |

The findings on the individual and practice characteristics suggest that the 20% of general practices that have participated in the APCC have been the innovator and early adopters. These comprised staff who believe in quality, who want to be high achievers and who see the value in system improvement. These practices have been able to overcome barriers in using the PDSA method with the assistance of CPMs. Further spread of the APCC to the later adopter practices is likely to need strategies that have a greater emphasis on local influence. Hence, we recommend the continued use of CPMs at a more localised level in order to facilitate the social influence of the innovator and early adopter practices. These practices can be used to show the later adopters the benefits of participating in the APCC and how it can be done. The role of the macro and meso levels to support this spread is shown in figure 1.

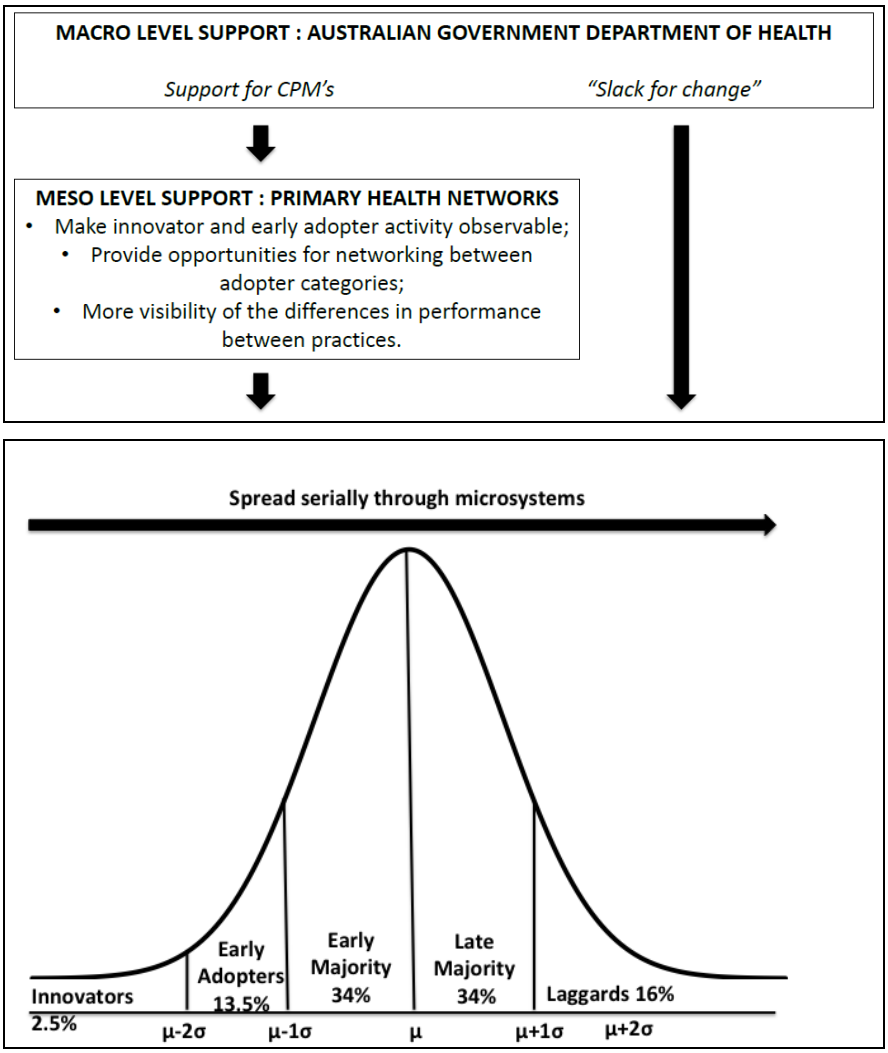


*Figure 1 – The roles of the macro and meso levels in the spread of QI through the innovation adopter categories.*

# Key recommendations to encourage the spread of the APCC

1. The IFA develop *strong working relationship with meso-level organisations (Medicare Locals or Primary Health Networks).*
   A working partnership between IFA and meso-level organisations is required to ensure that practices are provided with external support to participate in the APCC program.
2. *The IFA further promotion of APCC successes at the local level.*
   The use of local "show and tell" events could bring the innovator and early adopters together with the later adopter general practices to make the benefits of the APCC program more observable.
3. *The Australian Government Department of Health continue to provide dedicated funding for CPMs.*
4. *The Australian Government Department of Health examine models for funding of general practice so that there is capacity(slack for change) for participation in QI such as the APCC.*

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