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68 – Do Practice Visits Have a Future?

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Assessment in visits in the various countries

Many countries have initiated some sort of visit programme depending on the level of commitment from the profession and on external pressure. In an individualistic culture of general practice more resistance to the introduction of practice visits can be expected. Practice visits require a culture of valuing feedback and reflection. Donabedian puts it succinctly with: “every defect is a treasure”.

The UK had a first with the “What sort of Doctor” programme assessing GP performance, which included an extensive visit by three GPs as a requirement to become a “fellow” of the RCGP. It developed into a portfolio system requesting data to be entered in order to qualify for “revalidation” and re-registration.

The Netherlands’ Practice Accreditation program was set up in 2001 by the Dutch College based on the validated VIP (Visit Instrument Practice management) to improve the quality of care in general practices. Each practice can voluntarily participate in the programme by meeting conditions regarding hygiene, telephone accessibility in emergency situations, use of electronic medical records and safety report incidents. The programme tests the practice on three aspects: practice organization, medical care and patient experiences.

European Practice Assessment (EPA)

The successful development with the help of EQUIP (European Quality Improvement Party, WONCA) of a European patient questionnaire (EUROPEP) led to much insight into the variation between countries. The next step was an attempt by Germany, Holland, The UK, Switzerland, France and Belgium to develop the Dutch VIP-method into a European approach. Practice organization/management was defined as: ‘systems, structures and processes aimed to enable the delivery of good quality patient care’, excluding clinical processes and clinical outcomes. 171 indicators within five domains of practice organization were identified, organized into 202 questions and allocated to specific questionnaires for the principal GP or practice manager, all GPs and all staff respectively. In addition, 30 patients completed the EUROPEP patient questionnaire. During a practice visit, an external visitor used an observer check-list and interview schedule for the principal GP or PM, and all data were entered into the computer. Thus the EPA-system was able to generate real-time practice feedback (provided by the AQUA-institute, Göttingen, Germany) to be discussed with the practice team. Developed in English the EPA visit-instrument was translated into relevant languages and adapted by each country.

Development worldwide

Many other countries started in the nineties to develop their own standards of care and practices were assessed against these standards. For example in Australia, Canada and New Zealand, practices could increasingly provide their own data (internal auditing) to make independent, external visits more feasible. Meanwhile, Scandinavian countries have continued to value personal, formative mutual practice visits including observation of consultations using straightforward check-lists. The different countries and their respective colleges all appear happy with their approach to practice visits and agree it deserves a place in their CME-system and/or (re)registration. Almost no research, however, compares the methods on their effectiveness or uses the data for benchmarking. Also problematic is that the more selective the instrument becomes, the more local its use for research. Most methods appear to result in an improvement process using the quality or the Deming circle, but few of the methods provide benchmarking data.

Effectiveness of practice visits and accreditation or certification in Family practice

Practice visits mostly form part of accreditation programmes for healthcare providers (3). Accreditation affects the institution or practice and is more or less voluntary, while certification focuses on a specific norm that individuals or particular services should reach. In hospitals, accreditation and certification have proven more effective than 'no intervention', with accreditation scoring slightly better; but the results have to be interpreted cautiously (4).

A Cochrane review suggested that an audit and feedback system has a small positive effect on quality of care overall (5), but the added value of accreditation was not considered. In another systematic review Greenfield and Braithwaite found that accreditation can promote change, for example through the opportunity to reflect on organizational performance, and influence professional development. However, they reported inconsistent findings regarding quantifiable effects of accreditation on measures of clinical processes and outcomes.

Few rigorous evaluations of effectiveness of accreditation are available, particularly in primary care. This conclusion emerges from the review by O'Beirne et al. (6) on accreditation in primary care. Nevertheless, Szecsenyi et al. examined an accreditation programme (The EPA-program, adapted to Germany and Switzerland called Topaz) that focuses on practice management; they found improvements on several quality and safety measures regarding complaint management, analysis of critical incidents and quality development (7). A study with two cohorts including 138 Dutch family practices showed improvement of the quality of primary care for patients with chronic diseases, but few could be attributed to the accreditation programme (8). We conclude that there is growing evidence that accreditation has an effect, but we do not know at what costs and how much patients benefit.

Personal view on the coming of age of practice visits

Collins, an American anthropologist who visited 60 British practices in 1950, published a blistering report in the JAMA which was a turnaround for General practice. But visits can be a major, cumbersome enterprise. The profession has an obligation to make the procedure as "lean and mean" as necessary.

Practice visits were the first step towards accountability and transparency and ICT has increased the possibilities to make the visit more virtual and lean. Dutch practice visits shifted from internal audit and feedback to meeting standards. Consequently accreditation shifted more to certification and has become quite bureaucratic. Often GPs delegate required activities to their staff, which make you wonder whether visits may become more of a ritual to get protocols in place and to be able to tick them off rather than making an effort to change the culture of the practice. After 15 years, Dutch GPs are proud to have been assessed, feel safe to do so and take time to reflect in assessment/peer groups or quality circles. Ultimately visits could become obsolete, with mere data and patient feedback followed by reflection becoming sufficient to produce quality improvement and innovation. The future may be that practices have their own dashboard with data serving an ongoing improvement process.

Figure 1 Practice visit with auditors and FP

Take home messages

- Feedback and taking action on feedback have become an ethical imperative for a practice
- Practice visits with a validated tool can provide the necessary feedback on quality of care and patient safety and are complementary to self-assessments
- Consensus on framework and indicators for quality of care assist in benchmarking and comparison between practices, population/ regions and countries
- Practice visits / generating feedback should be lean and mean
- All GPs and staff always have to be engaged in the feedback and improvement

Original abstract

http://www.woncaeurope.org/content/175-practice-visits-controlling-doctors-or-improving-practice

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