

## AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

GREATER GREEN TRIANGLE UNIVERSITY DEPARTMENT OF RURAL HEALTH,  
FLINDERS AND DEAKIN UNIVERSITIES

# ORGANISATIONAL DEVELOPMENTAL APPROACHES IN PRIMARY CARE

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In our Stream Six report, we investigated the contribution of approaches to organisational change in optimising the primary healthcare workforce. We defined Organisational Development (OD) as the application of behavioural science action research and systems theory to human systems to increase the internal and external effectiveness of the organisation, especially managing change, using participative processes that involve all those affected. We concentrated on the challenges of having a workforce fit for the purpose of chronic disease prevention and management.

OD could be thought of as facilitating change for human beings. This report is a story about change and therefore improvement in healthcare. The lessons for Australia are many and outlined in the final section of this report.

## FROM RANDOMISED TRIALS TO IMPLEMENTATION

A number of people stressed the limitations of randomised controlled trials in trying to improve chronic disease management, safety and quality. General scientific knowledge, usually gained through randomised trials to demonstrate efficacy has all context removed to create it, and is therefore inert. Generalisable scientific evidence is built by design of the research, but this knowledge just sits there. In order to move from there, you have to build knowledge of the particular context because we know the context is all important when implementing scientific knowledge in health services. Context knowledge is a very different knowledge. It requires active work to build this knowledge; sometimes from less formal sources like anecdotes and stories. Batalden argues that we need a very different way to find that knowledge. In Batalden's equation, the + sign indicates the plans and options, and the  $\rightarrow$  indicates "making it happen". (See Figure 2 in main report.)

There is a third system – time. Time is included as a variable like measurement of a river over time. You want to change the system over time.

Batalden emphasises experiential learning. He points out that champagne was discovered by a monk who noticed that adding sugar resulted in a second fermentation. There never was a randomised controlled trial to demonstrate or test the phenomenon.

A remarkable feature of implementation projects in the US is a widespread understanding of the methodology for improvement with highly skilled teams managing projects. We give two examples here

The Diabetes Initiative used a toolkit and set up a Collaborative Learning Network. There were multiple activities including face-to-face meetings, workgroup meetings related to specific topics and challenges, teleconferences, learning intensives, site visits, website, e-mail and phone contacts. Ten face-to-face meetings each lasting a day and a half over the 45 months of the funding were crucial. Meetings included sessions on special themes like working with the media, facilitated discussion sessions about what works well and what doesn't, work group sessions addressing key issues like depression or organisational capacity, and quality improvement sessions.

## IMPACT COLLABORATIVE CARE

The Department of Psychiatry at the University of Washington in Seattle has conducted a number of landmark clinical trials pioneering coordinated care of depression under the banner of the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) model. When Professors Wayne Katon and Jurgen Unutzer finished their randomised trial of coordinated care in 2002, Unutzer went back to the funders and asked for distribution money to develop the training, tools and support for rolling out collaborative care to 150 clinics. Now 3,000 people have been trained to provide collaborative care. People who showed special aptitude in applying collaborative care were drawn in as trainers by Unutzer including Dr Virna Little, manager and former clinical psychologist from the Institute of Family Health which has 26 practices in New York.

We visited Parkchester Family Practice in south Bronx to see collaborative care in action they had built it into their daily workflow and were committed to it. The CEO provided top-level commitment. Dr Little was given the time and resource for implementation. She started with one early adopter practice gaining commitment from family physicians, nurses, case manager and psychiatrist. A key feature is that the organisation has electronic medical records so that it is easy to track performance. The clinical staff of the first practice became the champions who presented their results to other practices. Using the electronic record, the performance of each practice was tracked and clinicians called to account for poor performance. She describes the success as "being all over them like a cheap suit" reinforcing the key features of IMPACT with its pre-defined professional roles, supporting guidelines and protocols for recall supported by IT and especially the monitoring of PHQ-9 scores.

Implementation of collaborative care at the Institute of Family Health is organisational development in action.

## LINKAGE AND EXCHANGE

The 1:3:25 report format has proved useful. Although linkage and exchange did work well between the nine research teams of Stream Six, in our view, it is naïve for policy change. Linkage and Exchange did not work for us in the way it was intended mainly because the policymakers were either too junior or did not attend. We have reviewed other viewpoints on the links between research and policy: *Agendas, Alternatives, and Public Policies* by John W Kingdon, an article entitled *Why 'knowledge transfer' is misconceived for applied social research* written by Huw Davies, and RAND CORP whose motto is: *'Improved policy and decision making through research and analysis'*

## OPTIONS FOR IMPROVING LINKAGE AND EXCHANGE

- Recognise that policymakers are too busy to participate in the research process. The best way to present the results is by visiting them at the end of the study. Make a personal

presentation to the appropriate level of policymaker part of the funded work and develop a short training program on research and policy.

- Consider bringing leading researchers together for a forum that synthesises what is known from the work of previous streams.
- Health Forum: arrange for researchers and policy makers to meet at the relevant time, for instance, shortly after the publication of the primary care strategy.

## POLICY OPTIONS

In the Stream Six report we listed three options. They were:

- Continuation of the Collaboratives
- Practice accreditation extended to clinical standards and systems
- Initiatives in clinical leadership and team development

The information we gathered in Stream Ten supports these options and adds further refinement to how they would work.

## COLLABORATIVES

The quality improvement methodologies used in the United States are now more sophisticated than simply Collaboratives.

**Aim:** To enlarge substantially the understanding and practice of quality improvement methodology in Australian research and healthcare. Some of the ways this aim can be realised are:

- The Australian Commission for Safety and Quality in Healthcare benchmarks itself against the US National Quality Forum.
- The National Institute for Clinical Studies, the Improvement Foundation or both be funded to run training programs in quality improvement methodology for health professionals.
- Research into quality improvement of Australian healthcare be strongly supported by ensuring that the NHMRC has Grant Review Panel chairs for primary care, public health and health services research trained in quality improvement methodology.
- The NHMRC Partnership round could set a priority for collaborations that seek to implement the results of randomised trials in the real world. The techniques used in Collaborative Learning Networks could be embedded in Divisions of General Practice.
- The Australian Healthcare Agreement could be used to embed quality improvement methodology for translation of evidence into practice in the same way that it has been used to promote patient safety.

## ACCREDITATION

The Government could require accreditation of doctors to be based on an Australian version of the six competencies. These are:

- **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- **Medical Knowledge** about established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioural) sciences and the application of this knowledge to patient care.
- **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and the assimilation of scientific evidence, and improvements in patient care.
- **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.

- **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to access effectively: system resources to provide care that is of optimal value.

## CLINICAL LEADERSHIP

In the Stream Six report we drew attention to various clinical leadership programs and to the UK Royal College of General Practitioners Quality Team Development program. We continue to recommend these approaches. In addition we recommend that selected medical leaders in Divisions be funded to complete programs such as the Harvard Business School course with an integrated course at the Institute for Healthcare Improvement, both in Boston.

For more details, please go to the [full report](#)

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