Evaluation of the Medicare Local Implementation Adviser Role: An Interim Report. September 2014

Ms Laurann Yen
Dr Anne Parkinson
Dr Karen Gardner

Contact
Dr Anne Parkinson
E: anne.parkinson@anu.edu.au
Ph: 02 6125 1908
ACKNOWLEDGEMENTS

This evaluation report was prepared by Australian Primary Health Care Research Institute (APHCRI) researchers. APHCRI is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Australian Government Department of Health and Ageing.

CITATION


Australian Primary Health Care Research Institute
The Australian National University
Acton ACT 0200 Australia
T 61 2 6125 1908
F 61 2 6125 2254
E anne.parkinson@anu.edu.au
W www.anu.edu.au/aphcri
CONTENTS

Acknowledgements.................................................................................................................. 4
Executive Summary ................................................................................................................... 5
1. Introduction.......................................................................................................................... 7
2. Background.......................................................................................................................... 8
   Clinical leadership and quality improvement ..................................................................... 9
   Meso level PHCOs and the implementation of a quality agenda ...................................... 11
   Summary.............................................................................................................................. 13
3. Intended purpose of the role ............................................................................................... 13
   Facilitating access to clinical expertise, research evidence and advice ........................... 14
   Translating research evidence into practice ....................................................................... 15
   Strengthening engagement of General Practice with the ACT Medicare Local ............... 16
   Summary.............................................................................................................................. 16
4. The role in practice .............................................................................................................. 17
   Key achievements and reach .............................................................................................. 17
   Perceived barriers to implementing the role ....................................................................... 19
   Summary.............................................................................................................................. 22
5. Perceived value of the GP Adviser role in a Primary Health Network future ................ 22
6. Conclusions ......................................................................................................................... 26
References ............................................................................................................................... 28
Appendices ............................................................................................................................... 31
   1. Interview Questions......................................................................................................... 31
   2. List of interviewees.......................................................................................................... 32
ACKNOWLEDGEMENTS

In addition to those named as authors on the report, others who have made a particular contribution include Associate Professor Terry Findlay and Dr Paresh Dawda.

Thanks also to the staff and Board of the Medicare Local for their willingness to participate in interviews and without whom this report would not be possible.
EXECUTIVE SUMMARY

This interim evaluation report of the ACT Medicare Local (ACTML) Implementation Adviser role was commissioned by the Australian Primary Health Care Research Institute (APHCRI) Head of Programs at The Australian National University (ANU) as a preliminary investigation of the achievements of the role and future needs and developments. Data for this report were obtained from interviews with the person currently in the role, with APHCRI Programs and ACTML staff and ACTML Board members.

The Implementation Adviser role was developed under an agreement between the Australian Primary Health Care Research Institute and the ACT Medicare Local. It was designed to support the uptake of evidence into practice and enhance capacity at the meso level to use research effectively to improve quality and outcomes. Clinical leadership is recognised as fundamental to driving service redesign in the health care sector and for improving patient outcomes. Clinical advisory roles that incorporate a clinical leadership function with a focus on translation of knowledge for improving practice are consistent with international developments for meso level organisations.

The purpose of the role is as a key connection point between the ACTML and the research and General Practice communities. The core focus of the role was envisaged as bringing clinical and research knowledge into local ACTML programs and the ACTML’s vision for the future, and especially into local General Practice through working with practices to identify variations in practice and improve quality. A role statement was developed that described key duties and responsibilities in relation to the work-streams of the ACTML. Stakeholders’ perceptions of the role were consistent with key aims and functions articulated by the position description. Not surprisingly the emphasis that individuals placed on different functions varied according to their individual role and position within the stakeholder organisations.

As intended, the role has been shaped by the ACTML to meet their needs. To this early point, the work of the Implementation Adviser has been directed principally to two areas: contributing at the program level and at the strategic planning level. Staff working in both areas, from the CEO to the program managers, saw a great value in having access to such advice and expertise, and particularly valued the availability of the Implementation Adviser, who, working two days a week in the office is significantly more accessible than other program Advisers.

Other aspects of the role that relate to connecting stakeholders and building research and implementation capacity within practice settings are yet to be further developed. Given the time needed to build relationships and trust and the challenges associated with engaging
stakeholders across multiple organisational and professional boundaries careful consideration of strategies required to support implementation of these aspects of the role will be needed to ensure its acceptability into the future.

Stakeholders interviewed for this evaluation saw many benefits to having the Implementation Adviser role continue into the future, including the contribution they felt it could make in engaging GPs, as well as other primary health care (PHC) clinicians, consumers, and academics in the PHC networks; commissioning; and supporting the development of data use at the practice level for quality improvement.

To this end, continuation of the role may help to build the evidence base for knowledge translation activity, particularly in relation to testing the role of clinical leadership at the regional PHC organisation level as part of the improvement mechanism. Experience from other countries suggests that connecting stakeholders and building capacity and linkages is an essential first step and that such activity takes time. Future formal evaluation of the role as it matures may also help to ensure that lessons learned can inform developments.
1. INTRODUCTION

This interim evaluation report of the ACT Medicare Local (ACTML) Implementation Adviser (IA) role was commissioned by the Australian Primary Health Care Research Institute (APHCRI) Head of Programs at The Australian National University (ANU) as a preliminary investigation of the achievements of the role and future needs and developments.

The role was developed under an agreement between the Australian Primary Health Care Research Institute and the ACT Medicare Local. It was designed to support the uptake of evidence into practice and enhance capacity at the meso level to use research effectively to improve quality and outcomes.

The key areas the evaluation addresses are shown in Figure 1 below. These are the rationale and supports put into place to operationalise the role, its key achievements and reach, as well as the perceived benefits at the client, service and system levels. Consideration is also given to the future viability of the role under transition to a network environment and potential support and adaptations required.

Figure 1: Key areas the evaluation addresses
Data for this interim report were obtained from interviews with the person currently in the role, with APHCRI Programs and Medicare Local staff and Board members. It should be noted these do not extend to include other external stakeholders, such as local GPs not directly involved with the program. Documents and relevant literature in the public domain were also reviewed. A list of questions are contained at Appendix 1.

The report is set out in six parts. Part 1 describes the background to the evaluation and its scope. Part 2 provides a brief overview of the national and international context for clinical leadership and quality and describes the Adviser role as it was originally designed. Part 3 describes the intended purpose and the key elements and scope of the role. Part 4 discusses the role as it is operating in practice, its key achievements to date and perceived barriers to implementation. Data from interviews are used to illustrate key points. Part 5 discusses the perceived value of the role into the future as Medicare Locals transition to Primary Health Networks (PHNs). The report conclusions are outlined in Part 6.

2. BACKGROUND

A recent Strategic Review of Health and Medical Research in Australia found that a disconnect exists between research and the delivery of health care services (DOHA, 2013). The report recommended this is best addressed by embedding research within health care delivery. It also identified facilitating translation of research into evidence-based health care and policy as a priority.

There is a substantial literature that identifies the importance of leadership in the implementation of change both at the systems level (Greenhalgh et al., 2004, Best et al., 2012) and at the practice level (Grol 2000, Grol and Grimshaw 2003, Grol et al., 2013), but the difficulties of creating and sustaining change in practice continue to challenge health services. One factor in achieving sustainable and embedded change identified by Gardner et al. (2010, 2013), among others, is the way change at the practice, or micro, level can be best supported by actions at the meso level.

In Australia, there is a considerable history with the development of meso level organisations since the establishment in the mid 1990’s of Australia’s first primary health care organisations (PHCO), the Divisions of General Practice. Through these and their later iterations, Medicare Locals, general practice had begun to engage in planning and coordinating local primary care services and improving the quality of care through supporting practice participation in initiatives such as accreditation, the primary care collaboratives (Knight et al., 2012), practice based networks (Armstrong et al., 2010), and engagement in practice based research (Smith and Sibthorpe 2007, Nicholson et al., 2012).
The IA role with the ACTML builds on this history by exploring how clinical leadership acting at the meso level can best support the implementation of evidence into practice; and enhance the capacity of the meso level to use research effectively to improve practice and outcomes. The role acts as a bridge between these activities and creates a leadership role with the capacity to look strategically at improving quality across both PHC service delivery and service design. As the original holder of the role says, the GP Adviser, Implementation Adviser, provides ‘support to the practice support people’ to foster their development and enhance their capacity.

With the transition from Medicare Locals to Primary Health Networks (PHNs) in future, it is important to identify how clinical leadership, and in particular the GP Adviser role at the meso level, will assist the new organisation to fulfil its roles and responsibilities.

Clinical leadership and quality improvement

Quality improvement

Embedding quality improvement in primary health care is complex and demanding. It requires ‘leaders to manage uncertainty, foster cultural and behavioural change, and manage implementation’ (Hardacre et al., 2011). A recent King’s Fund report examining the culture of continuous quality improvement in general practice in the UK argues that it is best understood as a ‘paradigm for systems change’ that comprises a set of values and tools for setting goals and planning, implementing and measuring change (Dawda et al., 2010). Drawing on the literature the authors identified a number of key principles applicable to health care:

**Culture** A culture of quality should exist throughout the organisation. Quality should be prioritised over other issues and every member of staff should be involved in delivering and improving quality.

**Aims** The needs of the patient are paramount, with the key aim being delivery of quality as perceived by the patient.

**Collaboration** Teamwork, evidenced by joint learning, planning and service delivery, is critical to the organisation’s work.

**Training** Specific tools and techniques are employed to improve quality, rather than intuition and consensus alone. As with any science there is a need to train staff to apply these.

**Anti-perfectionsim** It is never assumed that ideas for service improvement will be perfect. Even seemingly excellent ideas are tested and refined through practical implementation before being fully adopted. Similarly, care is never judged to have become perfect. Quality is
presented as a journey, requiring one to be always asking new questions and finding new solutions.

**Measurement** When assessing processes and outcomes, extensive use is made of data, to identify areas needing improvement and evaluate the impacts of change.

**Small steps** The use of small pilots or ‘test of change’ is used to implement innovations as a means to refine plans through identifying and removing problems before a wide-scale roll out.

**Standardisation** Ad hoc customised solutions are sometimes necessary, but standardised approaches to similar problems are preferred, in order to benefit from measurement, refinement, teamwork and economies of scale.

Embedding a culture of continuous quality improvement is a process that takes time and requires committed leadership.

**Clinical leadership roles and skills**
Discussing the broad ranging literature on leadership, Swanwick and McKimm (2011) make the point that leadership is distinct from management (although they are complementary to each other), with leadership more focused on ‘setting direction, influencing others and managing change’.

In a review of the literature on clinical leadership, Garrubba et al., (2011) identified a number of common themes including the ability of clinical leaders to influence peers to act and enable clinical performance; provide peers with support and motivation; play a role in enacting organisational strategic direction; and to challenge existing processes.

In a study of English health care networks, Zachariadis et al., (2013) view clinical leaders as ‘relational catalysts’ and identify three key processes for establishing leadership practices to facilitate health care innovation across their networks: (1) managing knowledge mobility (e.g. identify and engage knowledge brokers/develop digital networks/knowledge circulation), (2) healthcare network coherence (e.g. incorporate patient experience/use evidence based research to benchmark and improve quality), and (3) network stability (e.g. establish a vision and values that promote trust and collaboration/accountability mechanisms).

Clinical leadership is recognised as fundamental to driving service redesign in the health care sector and for improving patient outcomes (Garrubba et al., 2011, NHS Leadership Academy 2011). In Australia, the importance of fostering clinical leadership has been acknowledged nationally with the National Health and Hospitals Reform Commission (NHHRC) stating:
At a national level we have called for a systematic approach to encouraging, supporting and harnessing clinical leadership across all health settings and across different professional disciplines. This includes promoting a continuous improvement culture by providing opportunities for clinicians to participate in teaching, research and quality improvement processes across all health service settings (NHHRC, 2009: 125).

Leadership theories have emerged over time, moving from a focus on individuals to current models of more collaborative, shared and engaging leadership, which in the case of clinical leadership:

emphasise working across boundaries and the short-range relationships between leaders and followers, highly relevant to integrated health services, which may be led by different health professionals (Swanwick and McKimm 2011: 25).

To aid clinicians involved in the planning, delivery and transformation of health care services the UK National Health Service (NHS) have developed a clinical leadership competency framework. They emphasise a conceptualisation of leadership as one that is shared and the importance of developing and empowering the leadership capacity of colleagues (NHS Leadership Academy 2011). Drawing on a range of theories, the framework comprises five domains covering (1) the development of personal traits; (2) working with others through developing networks and building relationships; (3) managing people and resources; (4) encouraging improvement and innovation; and (5) setting future directions.

Clinical engagement is now viewed as vital to the implementation of change in any health care system and has emerged most recently from the revamp of the world’s largest health care organisation - UK’s National Health Service - driven by Lord Ara Darzi (UK Health Minister in 2007), who placed quality and clinical leadership at the centre of health service provision (Swanwick and McKimm 2011). This model has also been adopted by other successful health care providers elsewhere (for example, Kaiser Permanente in the USA) (Swanwick and McKimm 2011). The UK health care system also encompasses meso level bodies that are positioned between government at the macro level and local primary health care providers at the micro level as a vehicle to aid change.

**Meso level PHCOs and the implementation of a quality agenda**

Experience from the UK, the Netherlands, Canada and New Zealand demonstrates a decentralised regional approach can drive improvements in the quality of care and facilitate a more efficient and integrated health care system (Horvath 2014, Willcox et al., 2011). The experience of the Netherlands suggests that the implementation of a quality agenda
requires a long term commitment and effort at multiple levels including engagement of PHC professionals in a leadership role to drive innovation and quality improvement (Van Weel et al., 2012).

Ongoing ‘experimentation’ by countries reflects the dynamic nature and expanding role of regional primary health care organisations (PHCOs) as governments seek to address the ever increasing demands placed on their health care systems (Donato and Segal 2010).

Australia rates well in health system comparisons of OECD countries (OECD 2013); however, it also faces a number of challenges including unwarranted variations in clinical practice between clinicians, services and geographic locations that is leading to variable patient outcomes and quality of care (ACSQHC 2013, ACSQHC and AIHW 2014, Horvath, 2014).

Models of meso level PHCOs vary between countries and differ greatly in terms of whether they are public or private organisations; require voluntary or compulsory membership; possess any level of purchasing power; and governance arrangements. In a more general sense, there are a number of features they share, which include a responsibility to create greater cooperation between primary health care providers and enhanced collaboration between primary and secondary health care providers to improve patient outcomes (Cabana and Jee 2004, McDonald et al., 2007).

This is reflected in the purpose of both Australia's current Medicare Locals and new Primary Health Networks (PHNs) planned to operate from 2015. HealthPathways and a Chronic Care Coordination Service Redesign project are two initiatives undertaken by the ACTML that provide examples of common goals (ACTML 2013). HealthPathways is an online health information portal for GPs and primary health care clinicians to be used within patient consultation to streamline the referral pathway of patients to local specialists and services. The Chronic Care Coordination Service Redesign is a cross sector collaboration between the ACTML and The Canberra Hospital's Chronic Disease Management Unit to improve transitions of care for patients with complex multi-morbid chronic disease by providing a more integrated approach between acute settings and the patient’s general practice based health care home.

As with Australia’s Medicare Locals and future Primary Health Networks, England’s newest PHCOs known as clinical commissioning groups (CCGs) have been directed to promote innovation and the use of research evidence (Zachariadis et al., 2013). They have also been tasked with supporting quality improvement in general practice with the aim of delivering more integrated forms of care. Lessons for Australia’s meso level bodies might be learned
from their approach. For example, Naylor et al., (2013: 44) argue these meso level bodies can facilitate much needed changes that:

allow general practitioners (GPs) and other practice staff to take greater responsibility for the co-ordination of care, to adopt more proactive approaches based on a population health perspective, and to support an expansion in the range of services available in the community.

In England the move towards a ‘more dynamic network-centric approach’ to the health care system that encourages collaboration (Zachariadis et al., 2013), in conjunction with the development of peer-to-peer relationships has fostered change (Naylor et al., 2013).

**Summary**

Clinical leadership is recognised as fundamental to driving service redesign in the health care sector and for improving patient outcomes. Clinical advisory roles that incorporate a clinical leadership function with a focus on translation of knowledge for improving practice are consistent with international developments for meso level organisations.

3. **INTENDED PURPOSE OF THE ROLE**

The Implementation Adviser role was designed by the partners, the Australian Primary Health Care Research Institute and the ACT Medicare Local, to provide a demonstration of how such a role could contribute to improved quality in primary health care. While designed specifically to fit local circumstances in the ACT, the role was intended to test how such innovations could become a key feature of the future primary health care landscape more broadly.

The role in the ACT was intended to assist the ACTML and local General Practice to improve quality and outcomes by better application of research evidence to clinical practice, and to decision making about service redesign and planning by the ML organisation.

In addition, the role was to act as a bridge between general practice, the Medicare Local and academic researchers. It would build relationships between the entities, creating opportunities for research activity in a local ‘research laboratory’ and to test system and service changes. An essential aspect of this was seen as ‘hands-on’ engagement across multiple levels: with the practice level in projects directed at performance and implementation; with the ML (or future PHN) in strategy development for practice reform and implementation; and, with academia in securing the theoretical basis of implementation strategies.
Specifically, the role was described in a series of themes, broadly correlating with the work-streams of the ACTML, with the key duties and responsibilities to:

- Facilitate translation of primary health care research findings to service re-design,
- Provide clinical leadership to identify opportunities to conduct and test system/service changes that have the potential to be generalised or scaled up,
- Facilitate partnerships and collaborations between ACTML programs, primary health care service providers and research teams (including the APHCRI network),
- Establish partnerships with local health, social care and consumer interests to facilitate research and service redesign in areas involving transitions in care and requiring integration,
- Identify research and service development opportunities that recognise and address social determinants of health and health inequities,
- Facilitate access by ACTML and primary health care providers to information, research evidence and advice and assist to build ACTML research literacy and skills,
- Identify and support primary health care professionals wishing to develop careers or explore part-time roles in primary health care (PHC) research to build research and implementation capacity.

There was general consensus among staff interviewed that the purpose of the Implementation Adviser role was clear and distinct from other ACTML positions and service support. Not surprisingly, interviewees placed different emphases on what they understood the purpose to be and these covered functions in three main areas as set out below: facilitating access to clinical expertise, research evidence and advice; translating research evidence into practice; and strengthening engagement of General Practice with the ACTML.

Facilitating access to clinical expertise, research evidence and advice

Staff at the ACTML saw the Implementation Adviser role as bringing expert clinical and research knowledge that could assist them with program design and planning, and position the activities of the ACTML at the cutting edge of practice and research into the future. Those with responsibility for individual programs were focussed on enhancing program development and its acceptability among the general practice population, others with more strategic responsibilities saw the role as having higher order value in the design of the organisation into the future.

The CEO of the ACTML, articulated this purpose as follows,

... the gap was really (for) someone who was a clinician... who could bridge our primary health care program delivery, services systems, development roles and
mandate, and help us provide specialist advice into how we can best identify service development opportunities, (and) system reform opportunities in a way that is mindful of the evidence, mindful of where the leading thinking is, mindful of the people and what to avoid, but mixed with a clinician perspective.

The clinical knowledge, experience and the connections to general practice that an Implementation Adviser could bring were seen as key to the successful development of the work of the organisation.

**Translating research evidence into practice**

There was a clear vision on the part of many that the role should be focussed on practice based research activity and implementation of research into the practice setting. Others took a wider view, seeing the role as necessarily and desirably flexible, using evidence from research to inform a range of decisions to be made by the ACTML and responding to the particular needs of the individual Medicare Local.

Commenting on the IA role, a senior program manager with the ACTML said:

*The most important thing for him to do… was all of the ‘wicked problem’ stuff... how do you actually get some of the better and more relevant evidence based interventions or concepts into a practical implementation mode or framework because everyone’s throwing up their hands and saying, ‘Oh well - there’s just so much around, it’s impossible’.*

A senior APHCRI academic stressed the importance of the role in engaging with practices around the idea of variation in care and addressing variation that led to poorer outcomes:

*(Their) idea was to invite practices to look at variations, try to understand the variation and to see which priorities there would be to address the variation in care… and from that start what you might call a quality circle, we can put practices looking at these data, planning priorities from it to see what actions they would take, see what the outcome of the action was in terms of the diminished variation, and then evaluate what was their perception of this exercise, was this really helpful for them to prescribe better care?*

In this respect, the role was strongly linked to translation of evidence with a practice orientation and a quality improvement focus. From APHCRI’s point of view, the clinical leadership elements of the role and its location within the ACTML were crucial to its success in supporting evidence based practice and translation of research findings for improving quality. It was envisaged from the initial design stage:
… that it be a Medicare Local position, not an APHCRI position, not a University position, it must be theirs. And it must meet their needs first and foremost. And their needs for clinical leadership are around mobilising practice; essentially practice and professional engagement in quality improvement type initiatives that use evidence in order to effect practice in a voluntary capacity without levers… and it would need a position of a practitioner in order to do that.

**Strengthening engagement of General Practice with the ACT Medicare Local**

The importance of building up engagement of practices with the ACTML was identified as a key issue by senior staff and Board members. There was a sense that GP involvement and interest had fallen off with the broadening of the membership of the ACTML to include nursing and allied health staff working in primary health care, when MLs were formed in 2012. It was felt that the role of Implementation Adviser could be a means of rebuilding trust between GPs on the ground and the Medicare Local organisation.

A senior academic, and ACTML Board member, said:

*There was a sense from some of the Board members that the active engagement of the GPs had decreased, so it was keen to see them being re-engaged… There was quite a lot of concern from GPs about becoming a much wider primary care organisation, and about whether the Medicare Local would lose the focus on them (GPs) and their needs… The talk around that position was having a focal point within the Medicare Local, who could actively engage with general practices around taking what we know from APHCRI and other primary health care research work in the policy and the practice setting, and helping people to be able to apply it in their day to day work.*

**Summary**

The purpose of the role was as a key connection point between the ACT Medicare Local and the research and General Practice communities, with a core focus on bringing clinical and research knowledge into Medicare local programs and its vision for the future, and especially into local General Practice through working with practices to identify variations in practice and improve quality. A role statement was developed that described the key duties and responsibilities in relation to the work-streams of the ACTML. Stakeholders’ perceptions of the role were consistent with the key aims and functions articulated by the position description. Not surprisingly the emphasis that individuals placed on different functions varied according to their individual role and position within the stakeholder organisations.
4. The role in practice

Key achievements and reach

As envisaged by both partners (APHCRI and the ACTML) in the initial design stage, the role has been shaped by the ACTML to ‘meet their needs first and foremost’. Reflecting this, the first activities of the IA have involved detailing the work plan in the light of the transition to primary health networks. Stakeholders perceive that many of the elements included in the role description are being actively implemented but that the focus in this early phase has shifted to support development of a new model to evolve and transition the ACTML to its next stage as a primary health care organisation. In this respect, some of the work that had originally been identified as key to the role has had to be reprioritised:

… quite frankly, the demands on his time have been…assisting us with that next transition phase.

Notwithstanding this, three key areas of work as set out in the work plan have been progressed. These include work related to building research literacy skills among ACTML staff; facilitation of the translation of research evidence for implementation and program redesign; and partnership development.

With respect to enhancing research literacy within the Medicare Local officers, the IA has surveyed staff of the ACTML and put together a series of seminars on introductory research topics, to be presented by staff from the ANU. At this stage, the connection to academic practice and the utility of creating and building relationships into the academic world is not a feature of the thinking of the program staff but is an area which this work aims to enhance.

Initial efforts to create a link between the IA and General Practice for implementation of research through the existing PracNet network have commenced. Creating longer term links and relationships that would enable the ACTML, the General Practice community and the local Universities to establish an effective learning community for research, evaluation and implementation of research findings into primary health care will be an area of work that will need significant time and commitment into the future. As yet these activities have not been progressed as input into the development of an ACT primary health network have taken precedence. Interviewees involved in PracNet commented on the need for a planned and directed approach that clearly outlines the activities with which the IA will engage PracNet, going forward.

In general, this reorientation of the role to provide significant input into the ACTML’s transition to its next stage as a PHCO was not perceived as a problem. One of the key points made by the Director, APHCRI, is that the role must be suited to, and directed to, the
needs of the organisation. Having a current focus that is operating at a design and strategic level, is clearly consistent with the areas for which the role was intended.

In addition, the flexibility attached to the role is appreciated by many at the ACTML, particularly the CEO who referred to the IA as a ‘flexible resource that we have deployed across the organisation’.

She also commented on the value to the transition process of having input from an incumbent with such extensive experience and knowledge.

_**Having the IA here assisting us with that next phase transition role and the change management we need to do around that in terms of framing a model evolving this primary care organisation into its next stage… (It) has meant that we’ve been able to strategically look at areas where we would have been looking to take action and introduce service developments and system improvements… ranging from an innovative and interdisciplinary practice base… around GP and Pharmacy integration, right up to what could we do given these organisations have to be, and should be, clinically led? What can we do to workforce development in the context of a workforce development strategy that includes clinical leaders? How do you nurture and support them to be involved in the systems via the business?… We have been using his expertise and time more strategically to conceptualise those, marrying the evidence to our local context, and our local arrangements so that we can contemplate translating into real life the re-design of programs and services.**_

The CEO made clear that the role was initially envisaged as possessing flexibility to allow it to be tailored to the needs of the ACTML, leaving the incumbent free to be deployed across the organisation as an ‘agile’ resource. A strategic decision was made to use the IA’s skills to work on the development of the ACTML’s efforts to support GP improvement in the areas of data quality and the HealthPathways initiative, and a plan to evolve the current model of practice support in place. Therefore, the focus on implementation and evidence translation aspects of the role has been lessened.

This has also extended to opportunities for developing links between the ACTML and Academia, and exploring the benefits these can bring all parties. At present, these are not well developed nor understood due to the limited time available to pursue this. Specifically, how the relationship between the incumbent IA, academics and GPs (and health care professionals more broadly) might aid practice based research, collection of practice data, and ongoing translation of findings into practice is yet to be explored. A senior Board member commented on this:
I think we were keen to be working with, you know APHCRI as a research organisation, because certainly I think we had realised that… (it was) something that we hadn’t really capitalised on, as an organisation sitting surrounded by, you know, tertiary institutions and research institutions…(but) I think there was a little bit of trepidation at Board level as to actually what this role (is) going to achieve, and I think also what messages would we be sending out to our members?

Perceived barriers to implementing the role

Implementation of a new role within an organisation is dependent on a number of factors, including how well prepared the organisation and its stakeholders are for the change, the extent to which it fits and is acceptable within its existing environment and how valuable the change is perceived to be.

Those interviewed at the ACTML perceived the role as highly valuable and reported having drawn on the expertise of the incumbent to a great extent. They pointed to a perceived lack of clarity about the role among program staff at the ACTML as a potential barrier to implementation in its early months, primarily because of the multitude of demands placed on the incumbent for support. They were unclear whether their requests for support were consistent with the role as it was designed and questioned whether this was creating too great a workload.

Reflecting these views, one ACTML staff member commented,

When [he] came on board, … there was not a lot of definition around what he would do… But because I was already quite familiar (with him), having worked with him in a couple of different other places, … so I perhaps asked him things that may not have been within his role… So rather than define his scope of what he’s supposed to be doing, I probably just adapted it to what I… (wanted)

Another commented on the need for clarity due to the sheer volume of the work,

In terms of the volume of work that’s expected of him, I think that’s significant and in some respects probably too much. So I think there’s probably a priority… probably to make the role clarification and prioritisation in terms of what he does and how he does it.

ACTML staff identified two days per week as insufficient when they have found him to be a useful source of advice and information on issues ranging from clinical guidance and evidence synthesis to how best to engage GPs in education and other programs delivered. For example, an ACTML program manager commented:
If we could clone the IA and have him here all the time we’d steam ahead fast. Look, I think obviously time is the only (barrier)... and more time in the context that we’re working in at the moment.

Appreciating the IA’s contribution, the CEO speculated, 'The question is (whether) two days a week is enough?’ And, reflecting on the IA’s advisory skills and accessibility another ACTML staff member commented:

Every now and then I have a few questions where I feel like I’m harassing (the) IA, not that he ever says that, but because he’s only here those two half days and then a full day, do you know what I mean? It can be a Friday morning or something and I think, I really need someone to ask and I have nobody employed here that’s a GP that I can actually go directly to.

In contrast, some Board members questioned the cost and value of the allocation of two days per week, noting that the time was substantially greater than other Medical Adviser roles currently undertaken by practicing GPs at the ACTML:

That's quite considerable… two days a week is (a) quite substantial time and I'm not actually sure... apart from that (working on the transition process)... I can't recall seeing anything that's been implemented or pursued.

There were also suggestions that externally the GP community do not have an awareness of the role, what it encompasses, why it exists, and what it can offer. Some respondents hinted at a perceived potential sense of conflict among GPs that may impact on their willingness to engage with the Implementation Adviser role. An ACTML program manager explained:

I don’t know if it is a barrier, but I think part of it is the GP community understanding what his role is. And I don’t think there’s been conflict but… do you know what I mean… GPs looking, they might say… What’s that position about? So I think it’s also in terms of the need to communicate that role to the GP community. … not all GPs, we’ve got lots of GP leaders who get it.

At least two respondents described the Canberra GP community as ‘conservative and parochial’, suggesting that the creation of a role which is intended to provide leadership for translation and implementation of research into practice both directly through practice initiatives, and indirectly through ACTML program design, is likely to face some challenges in gaining acceptance and credibility. He said:

I think that there is an inherent threat when a kind of… a GP, with a much broader view of the world…comes to town, which does start to question, I guess, some of the
more comfortable assumptions and modes of modus operandi that’s sort of built up over many years. Not that (he) is in any way… (confrontational). . There is absolutely no problem from that perspective.

The extent to which such difficulties may be perceived as a barrier or simply as part of the realities of the existing landscape was summed up by one participant as:

I think the relationship with the practitioners is not a barrier; it is just what it is… and it'll either in some cases work well, (in) some cases (practitioners will want) nothing to do with them… it's simply the… it is the situation that some people will and some people won’t.

Such realities point perhaps to the need for strategies that focus specifically on engaging GPs. This was reflected in the comments of one participant as a need to get GPs to appreciate the value of such a role and the lessons that can be learned from overseas experience,

Probably one of the greatest barriers is really getting clinicians, in particular, to kind of appreciate that there are significant lessons that we actually can learn from what’s gone on before this in other places.

A key consideration related to this is the need to take into account the specific attributes brought by different incumbents to the role. While it was generally noted that the combination of skills required for such a position are highly specialised and not widely available, the particular combination of skills and practical experience will shape the different trajectories that can be taken and the different supports required to facilitate these. In this respect the newness to the ACT of the current incumbent was seen as both a strength and a weakness with respect to the relationship and capacity building objectives that are important for engaging General Practice and the research community with the ACTML.

Pointing to the quantum of effort required for building those one respondent commented,

as a relatively newcomer in Canberra... he had less of those sort of long term relationships to build on,

On the other hand, others including the incumbent himself, felt that the international connections and contacts brought to the role were extremely valuable from a strategic perspective.

As a senior APHCRI academic stressed, the most effective strategy to engage PHC professionals in change processes,
is to connect first to the practices most likely to change and use the success with them to add further practices to the work. This step-by-step approach is more successful than trying to get everyone on board from the word go.

Developing supportive structures for engaging GPs to ensure acceptability of the role into the future is likely to be beneficial.

Summary
A number of the key elements included in the role description have been actively implemented to date but the focus has shifted to support the ACTML in the transition process to its next stage as a primary health care organisation. The flexibility that enables the position to meet different imperatives as they arise is highly valued by the CEO and ACTML staff as is the specific clinical and research expertise brought to the role by the incumbent. Strategies supporting implementation of other aspects of the role as planned are yet to be implemented and, given the nature of engagement of the different sectors will require careful consideration to ensure acceptability of the role.

5. Perceived value of the GP Adviser role in a Primary Health Network future

Reflecting on the IA role, respondents were generally supportive of its continuation and inclusion within future Primary Health Networks. However, the difficulties of demonstrating the potential benefits are limited by the short time in which the role has been in place. A senior academic and Board member explained:

I don’t really think that we’ve had long enough to really assess… Any of those sort of leadership positions and change management positions take years to really have impact anyhow, and that’s assuming that there’s relative stability. And I think we’ve had in the last six months, you know, one of the most unstable periods in primary health care for a very long time… I don’t know that there’s many conclusions that you would draw, except that I don’t think it’s had (a chance to have) a huge impact yet

Notwithstanding these considerations, three key areas of activity for the IA role were seen as central to the future of Primary Health Networks. These include providing specialist advice to support the development of commissioning processes, clinical leadership for engaging the GP and other PHC stakeholders; and the promotion of and support for data collection and use at the practice level for quality improvement.
Commissioning processes

The Australian government, in supporting a progression towards larger PHCOs and meso level bodies have signalled a move towards devolved purchasing arrangements. The CEO commented that Primary Health Networks, due to begin operation in mid-2015, are the next evolution in a move towards commissioning and that a role such as the IA will be critical to the transition process and into future commissioning functions:

The government… are talking about primary health (care) organisations with a common use of scale… replacing it (MLs) with regional meso level, you know primary health (care) organisations… with an end in mind… devolved Commonwealth funding, localised commissioning (and) needs assessment, you know the full gamut of commissioning functions. In that context I just think it’s a really fundamentally important role to assist with that transition; to assist with the change management; to assist strategically then reach (for) the opportunities there are to be had being a commissioning organisation.

I think it is a strategic and viable position thinking about its (the IA role) function around supporting translation of knowledge and evidence into practice. Again, back to the core function of a PHN as a commissioning organisation. You know it’s one thing to be identifying need at that point of the commissioning cycle and then going out and testing the market and procuring services, but critical (is) it’s specification for a new service or a new program and having some good, tight conceptualisation around those; that means that they are… needs driven and takes account of evidence, (and) knowledge; models that can be translated into other contexts based on that advice and the input from that (IA) role.

Central to supporting this transition to Primary Health Networks and any commissioning functions is clinical leadership to aid with the change process and support the general practice community. The CEO was of the view that:

…as PHN’s make their transition into the commissioning world… there’s the expectation that they are a clinically led community and consumer driven. I would see a need for a role like that to be operating at the very strategic level. I think there’s another level of clinical participation in the organisation. Again, that’s more focussed or (to) fit the purpose for various project or program streams. You know, like HealthPathways for example (where) we have a team of clinical leaders and GP leads.
Instructive here is the English experience which has moved through a number of models for commissioning primary health care, most recently from clinicians holding advisory functions to having more involved roles. Clinical leadership and the broader engagement of GPs is recognised as ‘key to affecting behaviour of individual GPs’ and to support more successful commissioning activity (Miller et al., 2012).

In the Australian context, clinicians are at the advisory end of the spectrum; however, the transition to PHN’s is a potential catalyst for the role of clinicians to develop into a more involved clinical leadership role.

**Clinical leadership for engaging primary health care**

Respondents were in agreement that as the ACTML has a GP-led focus any IA role in the future would need to encompass a clinical lens and focus on how to engage GPs:

> A role like the IA, would be a very great value add to a Primary Health Network… in bringing a GP perspective to our day to day work, bringing a clinical lens to what we do.

The CEO also noted that central to future success of PHNs is workforce and practice development, particularly in relation to supporting a network of lead GPs keen to take on continuous quality improvement.

> The scope for primary health (care) organisations to have a very active comprehensive workforce development and practice development… is really declining and that’s where all of those things we were talking about earlier like clinical leadership and working with practice around data and quality improvement are just going to be critical for success. And then critical to the success of all that is how that’s clinically led and the conceptualisation put into that in order to be able to sell it to practices… I would imagine an IA type role…supporting a network of those lead GPs that want to sort of go that next step in terms of QI and developing their practices in response to that.

It was also pointed out by a senior APHCR interviewee that the international experience supports the value of such a role thereby justifying, from a policy perspective, the inclusion of this role in future PHNs:

> We know from other places that these roles are important. We even know from the… review of Medicare Locals (Horvath) that… this is important… and this is the modest way of saying look people, these are important roles, it would be worth you thinking about in policy terms making this… if not mandatory at least heavily suggesting it
and… to invest in some development of the tool kit around this and make it easier for them to pick it up.

He further argued the importance of recognising and supporting clinical leadership, particularly in the context of a predominantly fee-for-service general practice sector, in which there are limited levers for ensuring quality.

*I cannot believe that you wouldn't make clinical leadership and engagement mandatory for these (PHN) organisations… You have no contractual relationship, you have no money levers, and you have got nothing at all in the current system. So... clinical leadership is absolutely critical… This engagement thing... is absolutely (key)... and I just don't know how any organisation does it without, at least as a minimum, a post like this… it's the (one) thing that specifically indicates to GP's who ultimately would be looking to that post for leadership, not in the managerial sense, but leadership in the sense of making connections, building their own internal networks, communication, what's going on... and that post fits into (that), as it would in any different ML (and any) different structures that they have.*

**Data collection at the practice level**

The collection of data from the practice level is central to developments in monitoring the quality and impact of programs and their contribution to health outcomes. Data collection at the practice level was viewed as a key priority into the future and the role of the IA in continuing to facilitate this was perceived as very important. This requires two levels of activity as articulated by the respondents below:

*Working intensively with practices to understand the value of data and understand the importance of managing data; understanding the importance of knowing and managing the population; your practice population profile; and managing that proactively. We are starting from a very low base with that stuff. Obviously a shock to (the current IA), but having said that, starting from a low base - at least it's a common place and you know what to do… You start with a good framework, a good business case of why… that it’s in the interests of quality patient care and the interests of good business in general practice. (Then), get your clinical champions on board, get some co-designing minimum data sets and… that’s where having the current IA’s experience has been invaluable.*

ACTML respondents also spoke of the need for greater access to and collection of data at the practice level. They thought it may be easier to action when PHNs are in place and their framework created, which will likely have a greater focus on this area:
The PHN… will have an outcome focussed health framework… so data will actually come to the fore in that respect. But I think that will start the conversation in terms of how we collect data, what we use it for and so forth. But, also that evidence base. Yeah, so having that informed knowledge (from the IA) to establish the rationale for doing things differently.

6. Conclusions

The changing policy environment has shaped the development and operation of the ACTML Implementation Adviser role during its first year. While it is not possible to provide hard evidence of benefit in the context of such a short timeframe, what is clear is the high level of acceptability of the role among ACT Medicare Local staff and the contribution they feel it has made to both program and strategic development. Significant progress has been made in developing the role and while its focus has shifted from what was initially anticipated the role has provided important expert input into the development of the ACTML as an evolving PHCO. There is general consensus that having the mix of clinical and research expertise within the role is very beneficial. Also evident is the consistency of this role with international developments at the meso level.

To this point, the work of the Implementation Adviser has been directed principally to contributing at program level and at the strategic planning level. Staff working in both areas, from the CEO to the program managers, saw a great value in having access to such advice and expertise, and particularly valued the availability of the IA, who, working two days a week in the office is significantly more accessible than other program Advisers.

However, a focus at these levels in the organisation may prevent the IA from supporting actual implementation activity within practice settings, and may lessen the capacity of the Implementation Adviser to act as a ‘bridge’ between the ACTML, General Practice and Academic research into the future. Strategies supporting implementation of these aspects of the role as planned are yet to be implemented and, given the nature of engagement of the different sectors will require careful consideration to ensure acceptability of the role. It must be recognised that connecting stakeholders and building research and implementation capacity is a long term undertaking that involves negotiation of relationships and trust building across existing professional and organisational boundaries. Given the associated challenges in any locality, support for the role is critical and future development may consider the scope of work and the appropriate support structures required to ensure its acceptance and maximum impact.

Stakeholders interviewed for this evaluation saw many benefits to having the IA role continue into the future, including the contribution they felt it could make in engaging GPs,
as well as other PHC clinicians, consumers, and academics in the PHC networks; commissioning; and supporting the development of data use at the practice level for quality improvement.

To this end continuation of the role may help to build the evidence base for knowledge translation activity, particularly in relation to testing the role of clinical leadership at the regional PHCO level to connect stakeholders and build research and implementation capacity as part of the improvement mechanism. Future formal evaluation of the role as it matures may also help to ensure that lessons learned can inform developments.
REFERENCES

ACSQHC 2013. Medical practice variation: Background paper, Sydney, ACSQHC.


cancepts, roles and relationships related to clinical leadership. Melbourne: Centre for
Clinical Effectiveness, Southern Health. Available from:
http://www.monashhealth.org/icms_docs/6079_Clinical_Leadership_A_literature_revi
ew_to_investigate_concepts_roles_and_relationships_related_to_clinical_leadership

innovations in service organizations: Systematic review and recommendations.
Milbank Quarterly, 82, 581-629.

Grol R. 2000. Between evidence-based practice and total quality management: The
implementation of cost-effective care. International Journal for Quality in Health
Care, 12, 297-304.

Grol R, Grimshaw J. 2003. From best evidence to best practice: Effective implementation of


do with it? London: Health Foundation. Available from:
http://www.health.org.uk/public/cms/75/76/313/2119/What%27s%20leadership%20g
ot%20to%20do%20with%20it.pdf?realName=JTGpo2.pdf. Accessed 14 August
2014.

August 2014.

Knight AW, Caesar C, Ford D, Coughlin A, Frick C. 2012. Improving primary care in
Australia through the Australian Primary Care Collaboratives Program: A quality

Mcdonald J, Powell Davies G, Cumming J, Fort Harris M. 2007. What can the experiences
of primary care organisations in England, Scotland and New Zealand suggest about
the potential role of Divisions of General Practice and primary care
networks/partnerships in addressing Australian challenges? Australian Journal of
Primary Health, 13, 46-55.


Swanwick, T. and Mckimm, J. 2011. What is clinical leadership…and why is it important? The Clinical Teacher, 8, 22-6.


APPENDICES

1. Interview Questions

2. What is your understanding of the GP Adviser (implementation) role and what it has been designed to achieve?
3. How does it work as a leadership role in your area of work?
4. What do you think the benefit/s of such a role are for
   - MLs
   - PHC services
   - interface with the broader health system?
5. What are your expectations of the role and what it could achieve?
   - eg. culture change for quality
   - support for implementation of research
   - improved service
   - reduced variation
6. In your view, is there a shared sense among staff in the ML about what the role is?
7. How is the role distinct from others at the ML?
8. What kinds of support are there for the role within the ML and beyond?
   a. Technical – policy, financial, other structures eg. consumer engagement; research dissemination
   b. Social norms for quality/research culture, eg. effective teams, consumer engagement
9. What activities have been undertaken to date?
10. What have been the barriers for the Adviser in implementing the role?
    a. How are these being addressed?
11. Has the role helped you in doing your job this far? If so, how?
12. Is it feasible to continue this role into the future, beyond June next year?
    a. If so, how would such a role be structured/designated in the future?
2. List of interviewees

ACTML Staff
Ms Leanne Wells
- Chief Executive Officer, ACTML
Mr Vlad Aleksandric
- Director, Policy, Population Health and Planning, ACTML
Ms Angelene True
- Manager and Special Adviser, Service Development, ACTML
Ms Paula Sharp
- Senior Manager, Practice Support and Services, ACTML
Ms Marie Bennett
- Director, Corporate Affairs and Organisational Development, ACTML
Ms Leah Peut
- HealthPathways Coordinator, ACTML
Ms Jenny Permezel
- Director, Primary Care Integration, Programs and Services, ACTML

ACTML BOARD
Dr Rashmi Sharma
- Chair ACTML Board, the General Practice Advisory Committee and the Board’s Clinical Governance Committee;
- Principal GP, Isabella Plains Medical Centre;
- FRACGP Quality Assurance Examiner;
- Member of the Commonwealth Pharmaceutical Benefits Advisory Committee and Drug Utilisation Sub Committee;
- Board Member of Coast City Country GP Training Ltd;
- Member of the ACT Local Hospital Network Council;
- Adjunct Associate Professor, ANU Medical School.

Professor Kirsty Douglas
- Board Member ACTML
- Professor of General Practice, ANU Medical School;
- Director, Academic Unit of General Practice, ACT Health

APHCRI
Associate Professor Terry Findlay
- Head of Programs, APHCRI Network

Professor Chris van Weel
- Professor of Primary Health Care Research, ANU
POSTHOLDER

Dr Paresh Dawda

• GP Adviser Primary Care Implementation, ACTML;
• Medical Director and practicing GP, Ochre Health (ACT);
• RACGP Faculty Board (NSW and ACT) Member;
• Visiting Fellow, ANU;
• Visiting Fellow, Keele University (UK);
• Editorial Board Member, Australasian Medical Journal;
• Strategic Advisory Board, BMJ Quality Improvement