Moyez Jiwa
Wendy Chan She Ping-Delfos
Jackie Ross
Tim Shaw
Parker Magin

Communities of practice

Quality improvement or research in general practice

Background

A 'communities of practice' (CoP) approach has the potential to address quality improvement issues and facilitate research in general practice by engaging those most intimately involved in delivering services – the health professionals.

Objective

This article outlines the CoP approach and discusses some of the challenges involved in using this approach to raise standards in general practice and how these challenges might be addressed.

Discussion

General practitioner insight needs to be harnessed in order to develop solutions that are conceived in, and informed by, clinical practice. A CoP approach provides control to the practitioners over selection of the most relevant research question and outcome measure. However, the method is challenging as it requires a focus that is suitable, that motivates the participants, and effective management strategies and resources to support the CoP.

Keywords: research; general practice; research support as a topic; quality assurance, healthcare

Etienne Wenger[1] is credited with coining the term 'community of practice' (CoP) which he defines as, 'groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise by interacting on an ongoing basis'.[1] Wenger believes that learning is a social activity and that people learn best in groups. Communities can form around a specific purpose and disband or choose to continue once that purpose has been achieved. Members may share a professional discipline or they may be multidisciplinary. Some communities may be small and localised while others may be geographically dispersed 'virtual communities' that communicate primarily by telephone, email, online discussion groups and or videoconferencing. This concept has been successfully adopted internationally and may have particular relevance to primary care in Australia where practitioners who share an interest may be working closely in one location or dispersed across a wide geographical area.[2]

With the imperative to encourage more research in general practice and raise clinical and organisational standards, the motivation for taking a CoP approach is increasing.[3,4] The success of recruitment of practitioners to participate in traditional investigator driven research has been limited.[5] A key challenge in taking a CoP approach is to ensure that practitioners feel a sense of ownership of the research question or quality improvement issue and see themselves as an integral part of the change management team rather than as a 'research substrate'. This article summarises the results of workshops (at two national conferences) on an inclusive approach to raising standards in general practice.[6,7]

Guiding principles

In the context of general practice, a CoP may be a group practice or it may define itself more broadly to include people who usually work in different locations and in different disciplines. It may include practice nurses, pharmacists, physiotherapists, occupational therapists, podiatrists, dieticians and other allied health professionals who are focused on the needs of a specific patient group or a particular clinical, administrative or process challenge. A CoP has a voluntary membership and its success is a function of the commitment and interest of members in addressing an agreed set of goals.

Identifying common needs and interests

The CoP needs to be given clear information about the extent of co-operation of members and there needs to be open and honest disclosure of the factors that have motivated the team to select what has been identified as a common problem or compelling research question. Detailing this information requires detailed discussion and may take several meetings. It cannot be overemphasised that the chosen topic is a key factor to the success of the CoP. If the topic is proposed by parties other than members of the CoP there may be a failure in maintaining the members' interest in the project.[8] In addition, some topics are better suited to this approach than others, as illustrated by discussion among workshop participants who identified 'implementation of clinical guidelines or protocols for chronic and complex conditions', 'modifications in practice protocols' and 'test follow up procedures' as suitable topics for a CoP. The CoP approach works best where outcomes can be clearly defined by SMART – specific, measureable, attainable, realistic and timely goals.[9]

Recruiting members

A CoP may be established by professionals who wish to participate in research or quality improvement or it may be suggested by an outside organisation such as a university department with an interest in research, or a division of general practice keen to promote group effort in tackling local health issues. Lack of time is probably the greatest barrier to CoP participation by busy health professionals. This could be addressed by enlisting support from practice managers or receptionists in data collection and other group activities. One workshop group pointed out that assumptions cannot be made about who might be interested in participating, eg. although part time practitioners have less time at work, they may have more time for reflection and might be ideal participants or even project champions.

Recruitment of members to a CoP can be particularly challenging in rural areas where there can be large distances between practices and limited opportunities for any face-to-face meetings. Ideally, a CoP is launched with a meeting or workshop so that members can network, and spend some time together exploring and agreeing to their purpose, terms of reference and methods of participation.[10] General practitioners were recruited from both rural and metropolitan practices in a recent Western Australia study and it was never practical to hold any face-to-face meetings. This may have contributed to the waning interest in the project over time.[8] Distance need not be a barrier if the team is well motivated to address the topic in question; distance between practices can be overcome by use of teleconferencing or videoconferencing to substitute for face-to-face meetings. Many practitioners are now experienced in such communication.

A significant aspect of the CoP approach, discussed below, is the need to share information. A key factor in recruiting to a CoP is dealing with rivalries and different styles of practice. Willingness to participate may therefore vary depending on goodwill between participants. On one hand, overt rivalry and refusal to share information could be moderated by recruiting from different locations, outside of each practice's 'catchment'. On the other hand, in some circumstances it may be an advantage to recruit members who already work together under a broad umbrella and share similar standards or practice protocols, as was the case in another successful project in the United Kingdom that used this approach.[11] There is a need to maintain an acute sensitivity to any perceived increased workload or any potential for financial disadvantage in a fee for service model, especially where participating practices are in the same locality.

Sustaining and maintaining the CoP

How do you sustain the CoP and maintain practitioners' involvement? First, the CoP needs to choose a topic and set the standards as a group. Where benchmarks are set from outside the group, as in the Western Australian study, some participants may not be engaged and may leave the group.[8] If a CoP approach is suggested by parties other than the participants, it is vital that the facilitating organisation does not actively promote the specific topics to be addressed or express an opinion about the standards to be achieved. The facilitator of CoP meetings should also be aware of the risk that while it may be tempting to offer 'solutions', these may lead the group in a direction which they later regret or find uninspiring.

The activity of the group needs careful monitoring to ensure ongoing commitment to achieving the group's aims. Sensitive handling of feedback to group members about their performance in CoP quality improvement projects is particularly important to prevent members becoming disillusioned or disheartened. Close scrutiny of personal performance can be threatening and doctors are not immune to feeling aggrieved or upset when presented with stark comparisons in performance.[11]

In the Western Australia study, standards for referral letters were set by the group and there was a before and after audit with feedback. The process for providing feedback about the 'quality' of their performance was negotiated up front with the group. Sensitive handling of feedback was emphasised and the project coordinator responded to every comment, explaining how the member's participation benefited the group.[8] It is important to make support available to help the group deal with their reactions and to implement systems change.

Suggestions from workshop participants regarding this stage of the CoP included much more reflection by participants in analysing their performance. Very careful consideration must be given to the choice of topic to ensure consensus among the group that there is room for improvement and that improvement will benefit the practice. It may be helpful if the group chooses a topic where there is clear motivation, eg. accreditation standards or some other driver for change. If there is a project champion it is important that this individual also submits their own identifiable results in the individual feedback to group members – this would be particularly powerful if these results are not the 'best' in the group.

Regular contact between group members is also essential in maintaining a CoP. A project newsletter, regular reminders or even a desktop screensaver may help to keep the project fresh in the minds of participants. In the Western Australia study a project officer was employed to recruit members, maintain regular contact, collect and score referral letters and coordinate feedback.[8]

Workshop participants have expressed that without support there are barriers to ongoing

participation that may not be overcome even where group members are genuinely interested in the topic. They pointed out that a GP in a well resourced practice may find it much easier to participate than a solo practitioner. Administrative staff are an important support resource but workshop participants also identified divisions of general practice as a potential source of support. Partnering with a university that might be able to leverage further resources was also acknowledged.

Adding value and closure

Communities thrive when members can see the value in participation. Publicising and celebrating successes, as well as demonstrating the value of the activity are important. The benefits of participation in feedback to group members was emphasised in the Western Australia study. The activity of the group was celebrated at the end of the project by making a toolkit available online to enable others to replicate the project.[12] Another significant advantage of the CoP approach in practice is that it facilitates professional development activity – 'learning on the run' for the busy practitioner. An example of a CoP is shown in *Table 1*. Similar approaches have been described in the literature.

One such approach is the 'quality circle' – this approach has been used to address issues where a gap exists between care delivery and best known practices in the management of a condition. The Canadian Quality Circle project, a multifaceted integrated disease management process strategy that utilised reflective learning approaches, was developed and implemented to reduce specific care gaps.[13,14] The difference with the CoP approach is that the focus in the CoP is much more on the participants' interests and not necessarily on a predetermined regional agenda. The Practice Health Atlas is another Australian initiative which aims to 'inspire general practice teams to reflect on their activities and to develop business models for more effective health care services/outcomes (innovation)'.[15] This approach is based on the synthesis of practice health data and the use of such data to predict future healthcare needs and trends (intelligence). The CoP in contrast does not necessarily need to be formed only as a response to data. Does the CoP approach work? Previous evidence suggests that it does.[16] The difference between the CoP approach and other quality improvement initiatives is that the innovations tested in such projects are generated by, or tailored for, those directly involved in delivering care within a specific local context.

Table 1. Development of a community of practice

- A group of GPs was interested in improving the care of people attending their practices. They enlisted the support of the diabetic educator, practice nurse, an optician, a pharmacist and a podiatrist who worked in their local area. They approached a local university department for support with the necessary resources
- The team decided to meet monthly over 6 months to identify issues that were of particular interest and that it was feasible to address within a 6 month timeframe
- The team appointed a facilitator – a local academic on the agreement that she was able to write up a short report for publication, and to interview the participants about the experience in the project
- The first two meetings focused on exploring issues that the team considered especially relevant to their patients or clients. Three themes emerged: the need for high quality information for patients with diabetes; to ensure that all diabetics have an annual eye examination; and to implement a system for annual review of the medications of all diabetics
- In subsequent meetings the team considered six parameters that determined how the solutions generated to these problems would be addressed: 'Who? What? How much? Where? When? How? Why?' Each of these questions was considered for suggested solutions in the three themes
- The team agreed to implement specific changes to their practice, emphasising SMART goals
- After 3 months they were able to demonstrate improvements in all three areas identified as a priority by the CoP

Conclusion

Communities of practice have great potential for facilitating clinician led practice change. The involvement of those who can effectively implement change is a key element in quality improvement and research in general practice. This approach may be particularly relevant to rural and remote Australia where practitioners are geographically dispersed and often isolated in terms of professional development and opportunities to engage in research, quality improvement and other practice changing activities.

Authors

Moyez Jiwa MA, MD, MRCGP, FRACGP, is Professor of Health Innovation, Curtin Health Innovation Research Institute, Curtin University of Technology, Perth, Western Australia. m.jiwa@curtin.edu.au

Wendy Chan She Ping-Delfos PhD, BSc(Hons), is a Postdoctoral Research Fellow, Curtin Health Innovation Research Institute, Perth, Western Australia

Jackie Ross BA, GradDipContEd, GradDipHumNut, is Director Operations, Workforce Education and Development Group, Sydney Medical School, The University of Sydney, New South Wales

Tim Shaw BSc(Hons), PhD, is Director Workforce Education and Development Group, Sydney Medical School, The University of Sydney, New South Wales

Parker J Magin PhD, FRACGP, is Senior Lecturer, Discipline of General Practice, University of Newcastle, New South Wales.

Conflict of interest: none declared.

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correspondence **afp@racgp.org.au**

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