Improving the quality of Aboriginal and Torres Strait Islander primary health care

What the research shows

This draft evidence brief has been prepared for the 'Engaging Stakeholders in Identifying Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP)' project. You are invited to provide feedback to refine the brief, using the online project questionnaire**.**

The Aboriginal and Torres Strait Islander primary health care (PHC) sector has embraced continuous quality improvement (CQI) as a way of improving the overall quality of care delivered to Aboriginal and Torres Strait Islander Australians, in order to **improve health outcomes**. This evidence brief presents an overview of findings from local and international research about **barriers, enablers and strategies** for using CQI to make improvements in PHC quality.

Local research has reflected the diversity and complexity of Aboriginal and Torres Strait Islander PHC delivery – geographic diversity, remote-rural-urban health care settings and community-controlled, government, non-government or private providers. Data have been gathered in settings in which political, cultural, social, educational, technological, emotional and ideological factors interact in complex ways. Despite this diversity and complexity, there are some common messages from the research findings, which are supported by international literature about CQI.

Who is this evidence brief for?

Primary health care policy makers, managers, clinical governance groups. The information will also interest providers and practitioners.

Key messages

- Don't wait for perfect data before commencing CQI. Even where good quality data on care processes are not consistently available at the start, the use of data in CQI cycles can act as a catalyst for improved data quality. Meanwhile, invest in developing good health centre systems and staff skills in using data.
- Emphasise use of CQI data for improving care for patients and populations. Practical use of CQI data helps to motivate clinicians and managers to participate in CQI.
- Design improvement strategies to suit local conditions – or adapt strategies that are working successfully in similar settings.
- Build on staff skills and strengths to implement improvement strategies. Share success stories and information about CQI between health centres to enable learning between peers.
- Work on developing a common vision and culture for CQI. Address any underlying organisational leadership and management issues that may detract from implementing CQI.
- Empower Aboriginal and Torres Strait Islander staff and managers to lead, participate in and promote CQI, to ensure improvement strategies match local population and community needs.
- Invest in developing leadership for CQI at each level of the system.
- Use system-wide approaches to integrate CQI across the whole system. Use CQI processes to achieve large-scale change.

Don't wait for perfect data before commencing CQI. Even where good quality data on care processes are not consistently available at the start, the use of data in CQI cycles can act as a catalyst for improved data quality. Meanwhile, invest in developing good health centre systems and staff skills in using data.

In PHC generally, clinical information systems are often poor and fragmented. Policy makers may therefore find it difficult to access consistent and broad scale data on relative need, priorities, performance and quality of care. In addition, there is limited focus and capability at various levels of the system to manage, interpret and use data for the purpose of improving system performance[1], and skills in the use of data to inform improvements in service delivery appear highly variable across all levels of the health system[2,3].

The quality of data is important. Technical advancements (electronic patient information and recall systems, tools, guides, practice standards) can make CQI processes easier and quicker, but if CQI data are perceived to be inaccurate it will not be credible[4,5]. At the health centre level, there is evidence that the quality of health system data can be improved by staff carrying out audits of client records[4].

Competing pressures and perceptions about unreasonable workloads, poor resources and support are often seen as barriers to CQI in Aboriginal and Torres Strait Islander health centres. Staffing constraints influence capacity to deliver guideline-scheduled care – or to make improvements in care. Health centres able to sustain performance in the face of high staff turnover tend to have strong regional support systems together with commitment to good health centre systems[6].

Emphasise use of CQI data for improving care for patients and populations. Practical use of CQI data helps to motivate clinicians and managers to participate in CQI.

For CQI to work successfully, staff need to value the use of data for improvement purposes and believe they can influence change[6]. Local staff increase their support for CQI when they see demonstrated improvements in care and clinical outcomes for clients. Hands-on auditing and participation in feedback and planning sessions by nurses and Aboriginal and Torres Strait Islander practitioners also increases staff support[2,4].

Many staff in Aboriginal and Torres Strait Islander PHC have enthusiasm and a sense of urgency to improve health outcomes[4]. In remote areas in particular, staff may also have a sense of burden and hopelessness (due to long work hours and lack of apparent improvement in health and social determinants) that can lead to clinical inertia. Quality improvement initiatives have been demonstrated to boost morale in these contexts, because they can demonstrate that the hard work is producing results[4,6].

Design improvement strategies to suit local conditions – or adapt strategies that are working successfully in similar settings.

There is strong evidence that improving the quality of care requires a good match between the conditions or context for care delivery, and the strategies used to achieve improvement[7]. Decision makers need to consider **what works, for whom, under what conditions** when planning for improvement. A one-size-fits-all approach is unlikely to be successful. However, successful strategies for improvement may require taking on the core elements of a proven product or strategy and adapting the way it is presented or used locally[8].

Adaptability is important in large-scale application of strategies for improvement; however the underpinning logic of a new product or strategy should be made explicit, so implementers

understand the core that should not be compromised. In addition, problem-solving suggestions may help implementers make adaptations for the local context[9]. This approach may help policy makers and program managers to meet the dual challenges of supporting large-scale implementation of best practice, while also enabling local decision making and tailoring to specific needs.

Build on staff skills and strengths to implement improvement strategies. Share success stories and information about CQI between health centres to enable learning between peers.

Strategies for improvement need to build on the skills and attributes of the existing Aboriginal and Torres Strait Islander PHC workforce. Staff need to be involved in completing the latter steps of CQI cycles in order to strengthen the interpretation of data, but also to go beyond focusing only on data or specific indicators to define and act on systemic problems, including through group interpretation and community consultation[3]. The ability to work and communicate effectively in cross- and inter-cultural settings is a critical component of the skills and attributes needed to achieve improvements[10,11].

CQI networks and training events are important opportunities to build relationships, share CQI knowledge and learn practical information about 'what works' from others[2,3]. The remote location and geographic dispersion of many health centres serving Aboriginal and Torres Strait Islander populations mean that staff tend to value opportunities to connect through CQI and to form CQI networks[6].

How evidence was identified

We drew evidence from the ABCD program of work and other publications on CQI in Aboriginal and Torres Strait Islander PHC, then extended our search to include relevant national and international literature about implementation of CQI and innovations in PHC.

Work on developing a common vision and culture for CQI. Address any underlying organisational leadership and management issues that may detract from implementing CQI.

Effective and sustained quality improvement needs a shared understanding of the purpose of CQI and a common vision shared by multiple stakeholders. CQI needs to be embedded into the day to day work of front-line health workers, clinical leaders and managers through routines and relationships that function across and between organisations[4].

What helps to develop a culture of quality improvement?

- Top and middle managers aligned in their CQI vision and goals.
- Commitment to workforce development, with management and staff participation in CQI training at all levels of an organisation.
- Strong team orientation and 'no blame' culture.
- Active management of CQI (e.g., dedicated CQI facilitators, regular progress reviews)
- Use and promotion of small scale projects that demonstrate change is possible and which, if successful and appropriate, may be scaled up across the health system.
- Willingness to embrace change and initiative[4,5,12,13].

Organisations with a strong CQI culture treat barriers such as funding or staff shortages as motivators for CQI. Instead of being viewed as 'extra work', CQI is seen as 'a way of working smarter and making jobs easier'. Disruptions such as restructuring or disease outbreaks can slow CQI work, but can also be used as a platform to apply CQI approaches in responding to the issue[13].

Where there is a culture of CQI, staff values are more likely to align with best practice in Aboriginal and Torres Strait Islander PHC[1].

Where there is poor management, uncertainty and confusion over roles, staff are discouraged and place less value on their data. Interventions to tackle unfavourable service delivery conditions need to be developed alongside CQI implementation[6].

Poor support for collaboration for CQI can lead to competitiveness, fatigue, staff who feel disillusioned with CQI and lack of cooperation. Identifying health centres with similar conditions and working to build adequate trust for networking might help staff believe they can influence change[6].

Empower Aboriginal and Torres Strait Islander staff and managers to lead, participate in and promote CQI, to ensure improvement strategies match local population and community needs.

Aboriginal and Torres Strait Islander leadership in CQI is most important[4,5,14], for example, through active involvement of community health boards or Aboriginal and Torres Strait Islander staff and managers committed to CQI. This leadership for CQI can help ensure the 'cultural, linguistic and practical relevance of health care and population health services'[14].

When planning or implementing strategies for change, the risk of overlooking cultural and historical influences on Aboriginal and Torres Strait Islander health care contexts is reduced where Aboriginal and Torres Strait Islander health practitioners actively lead or are engaged in CQI initiatives. Aboriginal and Torres Strait Islander health practitioners' involvement in clinical care and CQI processes is important in influencing the extent to which CQI processes result in improvements in delivery of guideline-scheduled services[15].

In Aboriginal and Torres Strait Islander settings the credibility of a strategy for improvement is likely to be influenced by who makes the decision to adopt a particular strategy, and how that decision is made[10,16].

Invest in developing leadership for CQI at each level of the system.

Leadership for improving the quality of care is needed at all levels of the health system to guide, support and facilitate CQI efforts[4,5,7,13]. Leaders for CQI are not necessarily in management roles; 'distributed' leadership with leadership functions vested in 'a set of people who can collectively perform them' is effective[12]. Shared responsibility and control of CQI by local staff as well as area/regional and jurisdiction managers is important for successful and sustainable CQI in health systems[5,17].

The attitudes of leaders and managers within the health system towards CQI can influence how clinic staff respond[4,13]. If management or reporting requirements are focused more on using data for accountability than to drive improvements in care, other managers and staff are likely to be suspicious of CQI and perceive it as 'checking up'[3-5].

Use system-wide approaches to integrate CQI across the whole system. Use CQI processes to achieve large-scale change.

The Australian health system operates at three levels; the service and health centre level (individual organisations), the regional level (regional and state/territory health bodies, community-controlled peak bodies, general practice networks), and the national level (nationwide policies and programs, accreditation and regulatory regimes)[18]. At each level, multiple factors influence the context in which improvement might take place. What happens at each level is partly dependent on, and influences, what happens at other levels. So achieving large-scale improvement in the quality of care is likely to require specific attention at each level of the health system[7].

Mechanisms needed to support improvement at the upper levels of the system are often overlooked. Large-scale change may require a package of interventions and long term

'institution-building' for regional and national level organisations to adapt to new ways of functioning[19].

Building a system wide and sustainable approach to CQI across Aboriginal and Torres Strait Islander PHC centres requires certain and sustained funding[3,5]**.** Dedicated funding has resulted in measurable improvement outcomes in service delivery, often achieved by allocating responsibility for CQI processes to a particular staff member and/or establishing regional quality systems[5,6,15]. Resources invested in CQI facilitator roles enable health centres to move to a higher level of capability and capacity in CQI[3].

Applied system-wide, integrated CQI uses multi-site, multi-faceted approaches that reflect the enablers described by the evidence and aim to achieve change at various levels of the system. In successfully integrated CQI models, CQI programs are: part of core business (rather than an add-on or one-off project); engage front-line workers, clinical leaders, and managers in CQI processes; distribute leadership for CQI across the whole health system; use CQI processes and tools to address multiple enablers of good quality care, and; use data from different stakeholders at different levels of relevant organisations to understand and inform broader system level performance[17,20,21].

A **Partnership Learning Model**[20] illustrates how large-scale change can lead to improved Aboriginal and Torres Strait Islander population health outcomes, through the interaction of comprehensive PHC, integrated CQI, system-based research networks, and system-based participatory action research. In its development and application through the ABCD National Research Partnership (2010-2014), the model showed potential for achieving wide-scale engagement of researchers, practitioners, managers, and policy makers in efforts to scale-up and spread effective quality improvement programs. It provides mechanisms to build or strengthen the capacity of a health system to continually work towards improving its performance.

For more information

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