

**Priority Evidence-Practice Gaps in Aboriginal
and Torres Strait Islander Mental Health and
Wellbeing Care**

(with supporting data: 2011 – 2013)

Phase 2 ESP Project Report

**Engaging stakeholders in identifying priority evidence-practice gaps
and strategies for improvement in primary health care (ESP Project)**

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Abbreviations

ABCD	Audit and Best Practice in Chronic Disease
ABCD NRP	Audit and Best Practice in Chronic Disease National Research Partnership (the Partnership)
ATSIHW	Aboriginal or Torres Strait Islander Health Workers
CQI	Continuous Quality Improvement
EPGs	Evidence-practice gaps
ESP	Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement
GP	General Practitioner
PHC	Primary Health Care
SAT	Systems Assessment Tool

Authorship

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JB played a lead role in data interpretation, writing of this report and project design and management. VM played a lead role in the development of the ESP project process, and in management, analysis and presentation of data. TN provided clinical expertise in development of the mental health audit tool and contributed to the data analysis and interpretation of this report. AL contributed to development of the ESP Project process and report writing. RB provided overall leadership of ABCD National Research Partnership (including the ESP Project), and had a major role in data analysis and interpretation, and drafting and reviewing of this report.

Acknowledgements

We sincerely thank the range of employees of stakeholder organisations and individuals who have provided generous contributions to the ESP Project. The success of this project is built on feedback, engagement and participation by a range of individuals and groups within and beyond the ABCD National Research Partnership.

The ABCD National Research Partnership is led by Menzies School of Health Research and funded by the National Health and Medical Research Council (ID No.545267) and the Lowitja Institute. The Partnership includes Aboriginal Community Controlled Health Organisation peak bodies and member services, government health departments, academic institutions, and primary health care services in five states and territories: the Northern Territory, Queensland, South Australia, Western Australia and New South Wales. Ethical approval has been granted by the Human Research Ethics Committees in all jurisdictions where there are participating health services.

Suggested citation:

Bailie J, Matthews V, Nagel T, Laycock A, Bailie R. Aboriginal and Torres Strait Islander Mental Health and Wellbeing Care (with supporting data: 2011- 2013), Menzies School of Health Research, October 2015.

1 Section 1: Executive summary

1.1 Purpose

The purpose of this project is to engage key stakeholders in the use of aggregate continuous quality improvement (CQI) data to identify and address system-wide evidence-practice gaps in Aboriginal and Torres Strait Islander mental health and wellbeing care. System-wide gaps are likely to be due to deficiencies in the broader primary health care (PHC) system, indicating that system-level action is required to improve performance. Such system-level action should be developed with a deep understanding of the holistic nature of Aboriginal and Torres Strait Islander wellbeing beyond just physical health (including healthy connections to culture, community and country), of the impact of Australian colonist history on Aboriginal and Torres Strait Islander people, and of how social systems – including the health system - should be shaped to meet the needs of Aboriginal and Torres Strait Islander people.

This project builds on the collective strengths within PHC services in order to continue improving the quality of care for Aboriginal and Torres Strait Islander communities.

1.2 Approach

Through two cyclical phases of reporting and feedback, we aim to engage stakeholders in a theory-based process using aggregate CQI data to identify:

1. priority evidence-practice gaps;
2. barriers and enablers to high quality care and system-wide strategies for achieving improvement.

Implementation research suggests that by using evidence to identify and link priority gaps to theoretical domains that are known to be system enablers or barriers, strategies can be developed that will most likely produce the desired change.

This report forms part of the second phase of the Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (ESP) project for mental health and wellbeing care and uses de-identified trend data from 21 health centres participating in the ABCD National Research Partnership that conducted audits of care for clients with a diagnosed mental illness over the period Jan 2009 – December 2014 (975 client records; 29 system assessments). We present trends over time from 2011 to 2013 where there is sufficient data for indicators relevant to the priority evidence-practice gaps identified from Phase 1 to assist stakeholder reflection on the barriers and enablers to addressing these gaps and system-wide strategies for achieving improvement.

1.3 Summary of findings

Although a proportion of health centres are doing well in many aspects of mental health and wellbeing care, the majority of health centres are not doing well in key areas. There is wide variation between health centres in almost all aspects of mental health and wellbeing care.

The preliminary identified priorities for improvement in the Phase 1 report were:

1. client records and health summaries, including completeness and consistency of recording of mental health diagnoses and comorbidities, development and documentation of shared care arrangements and referral, mental health care plans, and regular review of care plan goals;
2. risk factors and brief interventions, particularly enquiry about and recording of drug misuse, brief intervention, counselling or advice on tobacco use, nutrition and physical activity;
3. scheduled services, including consistent recording across all aspects of recommended care for clients with mental illness;

4. complete and consistent recording of relevant investigations for clients on psychotropic medication;
5. follow-up of abnormal results for clients with a deterioration or exacerbation of symptoms; and
6. health centre systems, particularly links with the community to inform service and regional planning; organisational commitment for support structures and processes that promote safe, high quality care, and team structure and function.

All respondents stated that the evidence-practice gaps highlighted in Phase 1 were consistent with their views prior to reading the report. When asked to rate the importance of the evidence-practice gaps on a scale of 1 – 10, those most commonly rated in the range of 7 – 10 were:

(1) = Development and documentation of shared care arrangements and referral. [100% (13/13)]

(1) = Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms. [100% (13/13)]

(1) = Enquiry and recording of drug misuse. [100% (13/13)]

(1) = 'Organisational commitment' within the organisational influence and integration component - referring to organisational culture, support structures and processes that promote safe, high quality healthcare. [100%(13/13)]

(1) = 'Team structure and function' - within the component 'Delivery system design' - referring to the extent to which the health service staffing profile, allocation of roles and responsibilities, client flow and care processes maximise effectiveness. [100% 13/13]]

(6) = 'Links with the community' component to inform service and regional planning (in particular 'communication and cooperation on regional health planning and development of health resources') [90% 9/10]]

These findings are based on 13 survey responses – 12 individual responses and 1 group response on behalf of 2 people. Not all respondents answered all questions.

Phase 2 of the ESP Project for mental health and wellbeing care

In this second phase, we encourage stakeholders to review the trend data presented in this report for the purpose of considering both the barriers and enablers to improvement and strategies for improvement. It is helpful to reflect on the trends in general over time and variation between health centres.

Summary of trends

There is little evidence of improvement over time for the identified priority evidence-practice gaps. There is little or no evidence of a reduction in variation in service delivery between health centres for these priority areas.

1.4 Next steps

In order to enhance understanding of the barriers and enablers and strategies for improvement, please complete the online survey that has been developed from international and Australian research regarding attributes of PHC staff, health centres, and the broader system environment that support best practice and/or present barriers to closing evidence-practice gaps.

Your involvement in this project is greatly appreciated, and will make an important contribution to understanding how the key barriers to improvement in priority areas of care can be overcome.

The results of the survey will be fed back to all survey respondents and other stakeholders through a review of the final report.

To access the accompanying survey to this report, click on this link:

<https://www.surveymonkey.com/r/Mentalhealthphase2>

Feedback is due by Friday 6th November, 2015

2 Section 2: Mental health and wellbeing care for Aboriginal and Torres Strait Islander people

Mental health conditions account for 10% of the health gap between Aboriginal and Torres Strait Islander people and other Australians – another 4% of the gap is attributable to suicide. Aboriginal and Torres Strait Islander adults experience psychological distress (anxiety and depression symptoms) at a rate three times that of non-Indigenous adults.¹

2.1 ABCD National Research Partnership/One21seventy

The ABCD National Research Partnership (the Partnership) and One21seventy, the National Centre for Quality Improvement on Indigenous Primary Health Care*, are founded on the premise that a holistic or comprehensive approach to primary health care (PHC) is fundamental to an effective health system. The One21seventy clinical audit and systems assessment tools are developed by expert reference groups and are based on widely accepted evidence-based guidelines that reflect best practice across the scope of primary health care. These tools have to date been used by more than 270 Aboriginal and Torres Strait Islander primary health care centres across the country. Automated reports are provided routinely to health centres and managers comprising their service level audit data as well as relevant regional or state comparison data to support local and regional level CQI efforts. Appendix A and B provides more information about the One21seventy data collection process and sources used to develop the audit tools.

One hundred and seventy five of these PHC centres have agreed to allow their data to be used to address the aims of the Partnership, including improving understanding of barriers and enablers to high quality care, and informing development of strategies for improvement. The ESP Project contributes to this process, increasing understanding and use of national aggregate CQI data for achieving wider system change. The establishment of this dataset has been made possible by the active contributions of health centre staff, CQI facilitators, managers, policy makers, community-controlled organisations and government health authorities, researchers and clinical leaders. Their ongoing contributions are vital to making the most effective use of data for improving the quality of care for Aboriginal and Torres Strait Islander people across Australia.

2.2 Large-scale health system strengthening

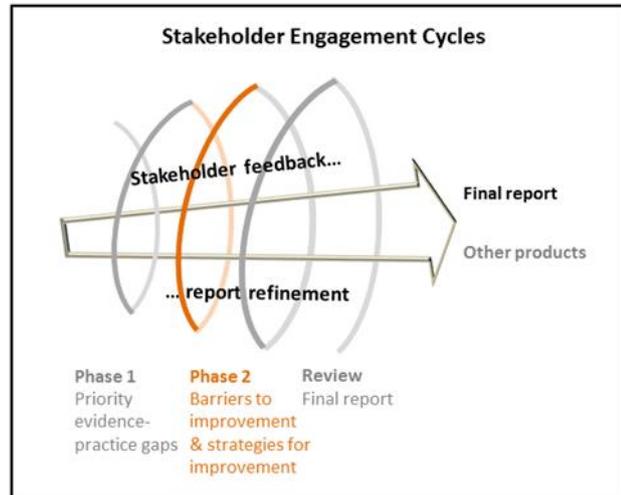
Large-scale improvement in the delivery of PHC requires change at multiple levels of the health system, not only at the local health centre level. Where aspects of care are not being done well across a range of health centres, this is likely to be due to inadequacies in the broader PHC delivery system. These broader systems therefore directly impact health care and health outcomes for Aboriginal and Torres Strait Islander people. Improvements to systems should be based on evidence about what is working well and what service gaps need to be addressed. Aggregated CQI data can contribute to this evidence.

* For more information on the ABCD Partnership Project: <<http://www.menzies.edu.au/abcd>>. For more information about One21seventy: <<http://www.one21seventy.org.au/>>.

2.3 Engaging stakeholders in identifying priority evidence-practice gaps and strategies for improvement

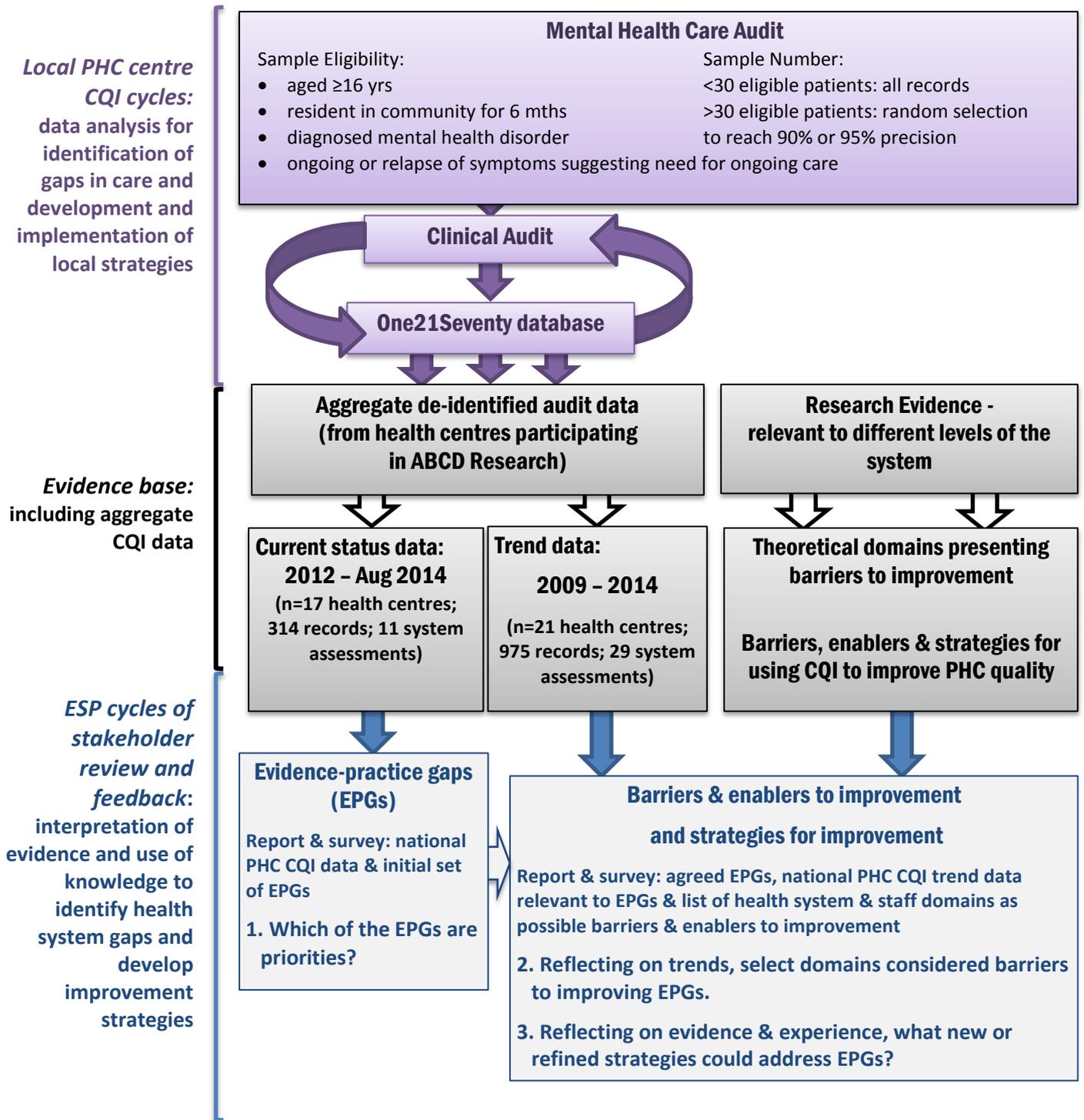
The ESP Project is a major initiative of the Partnership, and is consistent with the purpose of supporting development of the health system to provide high quality comprehensive primary healthcare on a wide-scale. It explores how aggregated CQI data can be used across the broader health system in a series of action-research cycles to: 1) identify evidence-practice gaps; 2) identify barriers, enablers and system-wide strategies to addressing these evidence-practice gaps (Figure 1).

Figure 1. *ESP Project phases*



This phased approach has been adapted from systematic methods designed to link interventions to modifiable barriers to address evidence-practice gaps.^{2,3} As part of their approach, French and colleagues utilised previously tested theoretical domains relevant to behaviour change of healthcare professionals to identify barriers to be addressed as part of intervention strategies^{2,4,5}. In recognition that there are multiple barriers at different levels of the health system, the ESP Project has drawn on other research to extend the theoretical domains related to include broader system factors relevant to the Aboriginal and Torres Strait Islander PHC sector^{3,6,7} (Figure 2). For more information about the ESP process, see Appendix C.

Figure 2. Use of aggregated CQI data for stakeholder identification of system wide evidence-practice gaps and strategies for improvement.*



* The mental health audit tool was only used by sufficient numbers of services to report aggregate data for the years 2011-2013.

The ESP Project aims to encourage national and State/Territory level conversations about systemic barriers or enablers that could affect improvement in the delivery of PHC, and help inform system changes to direct resources and efforts where they can most improve the health of Aboriginal and Torres Strait Islander communities.

3 Phase 1: Identifying priority evidence-practice gaps

During Phase 1 we presented national clinical audit and systems assessment data on adherence to best practice across the broad scope of care for the purpose of consulting with stakeholders to identify priority evidence-practice gaps (see [Data Supplement](#) or available on request). To start the discussion, the ABCD Project team and a clinical expert identified a preliminary set of priorities using the following criteria:

- a) important aspects of comprehensive PHC that were generally recorded at low levels;
- b) aspects of care where there was more general wide variation in recorded delivery of care;
- c) basic aspects of clinical care that were being delivered and recorded at a high level of performance by the majority of services, but that were being delivered at a much lower level by a proportion of services; and
- d) components of PHC centre systems that were relatively poorly developed.

Although a proportion of health centres are doing well in many aspects of mental health and wellbeing care, the majority of health centres are not doing well in a number of key aspects of care. The evidence-practice gaps identified as priorities for improvement in Phase 1 are listed below.

Client records & health summaries

- Completeness and consistency of recording of mental health diagnoses and of comorbidities
- Development and documentation of shared care arrangements and referral (median 50%, range 0-100%)
- Development and documentation of mental health care plans and regular review of care plan goals

Risk factors and brief interventions

- Enquiry about and recording of drug misuse (median 61%, range 0-100%)
- Brief intervention, counselling or advice on tobacco use (median 50%, range 0-100%) nutrition (median 50%, range 19-81%) and physical activity (median 43%, range 19-81%)

Scheduled services

- Consistent recording across all aspects of recommended care for clients with mental illness

Investigations

- Complete and consistent recording across all relevant investigations for clients on psychotropic medications

Follow-up of abnormal findings

- Appropriate follow-up for clients with a deterioration or exacerbation of symptoms

Health centre systems

The system components and items within these components that have relatively low scores are clear priority areas for attention. These include:

- *Links with the community* component to inform service and regional planning (in particular ‘Communication and cooperation on regional health planning and development of health resources’) (median Systems Assessment Tool (SAT) score 5.3, range 1.5-10)
- ‘Organisational commitment’ within the *Organisational Influence and Integration* component referring to organisational culture and support structures and processes that promote safe, high quality health care (median SAT score 4.9, range 4-11)
- ‘Team structure and function’ within the *Delivery system design* component referring to the extent to which the health centre’s staffing profile, allocation of roles and responsibilities, client flow and care processes maximise the potential effectiveness of the centre (median SAT score 6, range 1-11).

3.1 Feedback from stakeholders on the identified priority evidence-practice gaps

There were 13 survey responses in total. One of these responses was on behalf of a group of 2 people. Respondent roles included nurses, doctors, medical specialists, managers and researchers. Appendix D contains further information about the respondents.

Regarding discussion on prioritising action for health centres performing at relatively lower levels, a majority of respondents, considered improvement across all health centres as a priority (regardless of performance) in order to assist improvement at the lower end and to ensure sustainability of performance at the higher end.

All respondents stated that the evidence-practice gaps highlighted in Phase 1 were consistent with their views prior to reading the report. Respondents also highlighted other priorities such as more access to psychological services that were not identified in the Phase 1 data. While not every respondent answered every survey question, most reflected that the priority evidence-practice gaps for their State/Territory would be the same as those arising from the national data. One respondent suggested that the NT may be different due to the younger age structure and high burden of disease.

The evidence-practice gaps most commonly rated as 7 - 10 on a scale of importance of 1 – 10 are presented in Table 1 below.

Table 1. High priorities for improvement as reflected by frequency of ratings of 7- 10 on a scale of 1 - 10.

	Number & % who identified the evidence-practice gap as important i.e. rated between 7 – 10
Development and documentation of shared care arrangements and referral.	100% (13/13)
Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms.	100% (11/11)
Enquiry and recording of drug misuse.	100% (13/13)
'Organisational commitment' within the organisational influence and integration component - referring to organisational culture, support structures and processes that promote safe, high quality healthcare.	100% (10/10)
'Team structure and function' - within the component 'Delivery system design' - referring to the extent to which the health service staffing profile, allocation of roles and responsibilities, client flow and care processes maximise effectiveness.	100% (10/10)
'Links with the community' component to inform service and regional planning (in particular 'communication and cooperation on regional health planning and development of health resources').	90% (9/10)

Note: There were 13 responses in total – one of these were on behalf of a group of 2 people. Not all respondents answered all questions.

Appendix E presents trend data for the other eight priority evidence-practice gaps as identified in the Phase 1 report.

4 Phase 2: Identifying barriers and enablers to addressing the priority evidence–practice gaps and system-wide strategies for improvement

The national priorities are the basis of this Phase 2 report, which presents data on trends for the first three key indicators identified above. Trend data could not be published for the final three components due to insufficient number of health centres completing system assessments. Appendix F contains trend data on all the preliminary priorities identified in Phase 1. It is helpful to reflect on the trends in general over time and examine variation between health centres, in particular, whether the variation is getting less, and importantly, whether there is an improvement for centres at the lower end of the range.

We encourage stakeholders to reflect on the influences underlying these trends and on their experience in PHC to:

- a) Identify the main barriers and enablers to addressing the priority evidence–practice gaps and
- b) To propose possible improvement strategies.

To assist with this, a survey has been developed from international and Australian research regarding attributes of PHC staff, health centres, and the broader system environment that support and/or present barriers to best practice care. Table 2 details the domains that may present barriers to improvement. We ask you to rate their importance relative to the extent to which they are barriers/enablers to improvement.

Table 2. Health system and staff attributes that may act as barriers or enablers to addressing gaps in care

Health system attributes	Staff attributes
Financing and resources	Knowledge
Facilities and equipment	Skills
Staffing/workforce	Social/professional identity
Staff/workforce support, recruitment and retention	Beliefs and capabilities
Teamwork	Optimism
In service training and development	Beliefs about consequences
Self-management	Memory, attention and decision processes
Patient centred care	
Population health	
Decision support	
Clinical information systems and communication technology	
Quality Improvement	
Community capacity, engagement, mobilisation	
Leadership and Management	

We also provide an evidence brief on the barriers, enablers and strategies for using CQI to make improvements in PHC quality (Appendix G). We encourage you to reflect on the evidence provided in this brief.

The focus of this report is on priority areas for improvement. There are other aspects of care that are being done relatively well, or that have shown marked improvement over time, and these will be covered in other reports.

4.1 Presentation of data

Audit data on indicators relevant to the identified evidence-practice gaps in mental health and wellbeing care are presented over years for the period 2011 to 2013. Data for other years are not publishable due to a small number of health centres completing audits in those years. There are no publishable data available by audit cycle due to a small number of health centres completing 3 audit cycles.

The trend data provides an indication of influences on clinical performance that may be occurring at different times in the general health system environment. These influences might include changes in CQI processes, changes in the number and types of participating health centres and various other influences on the CQI data that are generated through the use of One21seventy tools.

Interpretation of box plots – variation between health centres

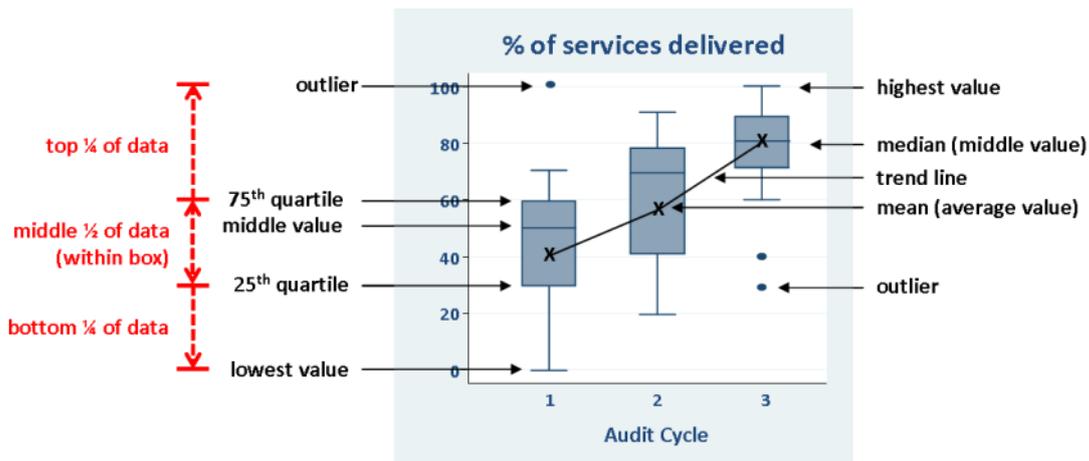
An important focus of the Partnership is understanding variation between health centres and over time in delivery of care in accordance with best practice guidelines. 'Box and whisker plots' (or box plots) are a useful way of presenting data on variation in a graphical form that should assist with interpretation.

In the analysis of the audit data, the mean (average) percent delivery of items of clinical care relevant to each indicator is calculated for each health centre. These mean percentages are displayed in a box plot for a given year or audit cycle to show the distribution or range in recorded delivery of care between health centres.

Box and whisker plots show (Figure 3):

- health centres with the minimum and maximum mean percentage in recorded delivery of care in accordance with best practice guidelines (ends of whiskers show highest value if no outliers);
- outliers – health centres that are far away from most others in the data set (or a distance that is greater than 1.5 times the length of the box); and
- the level of variation between health centres in recorded delivery of care by dividing scores into quarters:
 - the box represents the middle 50% of health centres, and the line within the box represents the median (or middle health centre);
 - the 'whisker' at the top of the box (and outliers if present) represents the top 25% of health centres
 - the 'whisker' at the bottom of the box (and outliers if present) represents the bottom 25% of health centres;
 - the longer the box plot, the greater the range of care delivery (or variation) between health centres.

Figure 3. Interpretation of boxplots



In assessing data trends for indicators relevant to the priority evidence practice gaps, it is helpful to focus on:

- the trend for the mean (average) and median (middle) values for health centres** – in particular whether the mean and median are increasing, staying steady or decreasing; and
- the trend in the variation between health centres** – in particular whether the variation is getting less (shorter boxes, shorter whiskers), and importantly, whether there is an improvement in the values for the health centres at the lower end of the range (higher level for the bottom end of whiskers under boxes).

4.2 Characteristics of participating health centres and patients whose records were audited

Health centre characteristics

Twenty-one health centres conducted mental health audits between 2009 and 2014 auditing a total of 975 patient records.

The mental health audit tool became available in 2009, however take up of the tool was relatively slow with a peak in use in 2011 (10 health centres) and 2013 (15 health centres) (Table 3).

There were two health centres that conducted at least three audit cycles, hence not enough data is available to show trends by cycles of audit (Table 4).

Overall, 12/21 health centres were in remote locations and 13/21 were government managed (Table 5).

National data show that initial assessment at the health centre was most commonly conducted by a nurse (33%), with general practitioners (GPs; 28%) and Aboriginal or Torres Strait Islander Health Workers (ATSIHWs; 19%) being the next most common professionals to do the initial assessment (Table 5).

Patient characteristics

The data presented relate to aspects of care for patients over 16 years with a diagnosed mental health disorder which is likely to recur and who have been unwell in the past twelve months.

Almost all audited records showed a record of attendance at the health centre within the previous 12 months and the majority of these attendances were for mental health and wellbeing care or a mental health crisis (54%) (Table 5).

Table 3. Mental health and wellbeing care audit and systems assessment completed between 2009-2014 (number of patient records audited, number of health centres and number of SATs)

		Audit Year						Total
		2009	2010	2011	2012	2013	2014	
QLD	#Records	0	0	177	131	145	30	483
	#Centres	0	0	7	3	5	1	10
	#SATs	0	0	6	1	3	0	8
SA	#Records	0	0	0	27	65	0	92
	#Centres	0	0	0	1	2	0	2
	#SATs	0	0	1	1	1	2	3
WA	#Records	30	30	30	0	78	30	198
	#Centres	1	1	1	0	2	1	2
	#SATs	1	1	1	1	1	0	1
NT	#Records	0	0	70	32	70	30	202
	#Centres	0	0	2	1	6	1	7
	#SATs	1	0	3	1	4	0	6
Total	#Records	30	30	277	190	358	90	975
	#Centres	1	1	10	5	15	3	21
	#SATs	2	1	11	4	9	2	18

Table 4. Mental health and wellbeing care audit completed between 2009 and 2014 by audit cycle (number of patient records audited and number of health centres)

		Audit Cycle						Total
		1	2	3	4	5	6	
QLD	#Records	232	121	100	30	0	0	483
	#Centres	10	4	1	1	0	0	10
SA	#Records	57	35	0	0	0	0	92
	#Centres	2	1	0	0	0	0	2
WA	#Records	48	30	30	30	30	30	198
	#Centres	2	1	1	1	1	1	2
NT	#Records	130	72	0	0	0	0	202
	#Centres	7	3	0	0	0	0	7
Total	#Records	467	258	130	60	30	30	975
	#Centres	21	9	2	2	1	1	21

Table 5. Characteristics of participating health centres and patients whose records were audited between 2009 & 2014 (number & %)

		2009	2010	2011	2012	2013	2014	Total
Primary Health Care Centres		1	1	10	5	15	3	21
Location	Urban			2 20%	1 20%	2 13.3%	1 33.3%	3 14.3%
	Regional	1 100%	1 100%	4 40%	2 40%	5 33.3%	1 33.3%	6 28.6%
	Remote			4 40%	2 40%	8 53.3%	1 33.3%	12 57.1%
Governance	Government			8 80%	4 80%	7 47%	2 67.7%	13 62%
	Community Controlled	1 100%	1 100%	2 20%	1 20%	8 53%	1 33.3%	8 38%
Size of population served	≤500			3 30%		2 13.3%		3 14%
	501-999			1 10%		5 33.3%		6 29%
	≥1000	1 100%	1 100%	6 60%	5 100%	8 53.3%	3 100%	12 57%
Completed mental health audit cycles	Baseline	1 100%		9 90%	4 80%	7 46.7%		12 57%
	2 cycles		1 100%		1 20%	6 40%	1 33.3%	7 33%
	≥3 cycles			1 10%		2 13.3%	2 67.7%	2 10%
Number of audited records		30	30	277	190	358	90	975
Age: mean (& range)		38(17-66)	38(17-62)	38(16-86)	39(17-69)	39(16-83)	36(17-65)	39(16-86)
Gender	Male	11 37%	10 33%	139 50%	79 42%	159 44%	42 47%	440 45%
	Female	19 63%	20 67%	138 50%	111 58%	199 56%	48 53%	535 55%
Indigenous status	Indigenous	26 87%	30 100%	224 81%	181 95%	341 95.2%	84 93%	886 90.9%
	Non-indigenous	4 13%		51 18%	9 5%	16 4.5%	6 7%	86 8.8%
	Not stated			2 1%		1 0.3%		3 0.3%
Reason for last attendance	Mental health care	16 53.3%	15 50%	159 57%	116 61%	160 45%	45 50%	511 52.4%
	Mental health crisis					15 4%		15 1.5%
	Acute care	7 23.3%	8 26.7%	96 35%	47 25%	108 30%	28 31%	294 30.2%
	Other	7 23.3%	7 23.3%	22 8%	27 14%	75 21%	17 19%	155 15.9%
Profession patient first seen by	ATSIHW	9 30%	10 33.3%	53 19%	28 15%	71 20%	17 19%	188 19.3%
	Nurse	3 10%	4 13.3%	91 33%	80 42%	119 33%	27 30%	324 33.3%
	GP	8 26.7%	4 13.3%	81 29.2%	58 30.5%	91 25.4%	35 39%	277 28.4%
	Psychiatrist		1 3.3%	15 5.4%	3 1.5%	15 4.2%	1 1%	35 3.6%
	Psychologist	10 33.3%	9 30%	7 2.5%	1 0.5%	12 3.4%	5 5.5%	44 4.5%
	Mental Health Worker			20 7.2%	16 8.4%	20 5.6%		56 5.7%
	Counselor			1 0.4%		5 1.4%		6 0.6%
	Other		2 6.7%	9 3.2%	4 2.1%	25 7%	5 5.5%	45 4.6%
	Attended within past 6 months		27 90%	29 97%	256 92%	177 93%	332 93%	80 89%
Attended within past 12 months		30 100%	30 100%	275 99%	188 99%	353 99%	89 99%	965 99%

5 Section 3: Trends over time for key indicators of priority evidence-practice gaps in preventive health care

In this section we present trends over time in overall delivery of mental health and wellbeing care and indicators that reflect priority evidence-practice gaps identified by stakeholders from the Phase 1 report. The time period includes 2011 to 2013 when there were sufficient numbers of health centres (≥ 5) that completed mental health audits. Trends by cycle of audit are not presented due to low numbers of centres completing three or more cycles.

The indicator trends presented here are for priority evidence-practice gaps that were most commonly rated 7 - 10 on scale of 1 – 10 as described above. The trend data for the other identified preliminary priorities detailed in the Phase 1 report are presented in Appendix F.

While certain aspects of health centre systems were identified as priority gaps (such as links with the community; organisational commitment to promote safe and high quality health care; and team structures and function to maximise potential effectiveness of the service), no trend data for the systems assessment are provided due to insufficient numbers of health centres completing system assessments over the years.

There is little evidence of improvement over time for the identified priority evidence-practice gaps. There is little or no evidence of a reduction in variation in service delivery between health centres for these priority areas. Table 6 presents a summary of trends in areas relevant to identified priority evidence-practice gaps (where there were sufficient data).

Table 6. Summary of trends in areas relevant to identified priority evidence-practice gaps

	Overall - service delivery	Development & documentation of shared care arrangements and referral	Recording and delivery of follow-up of abnormal findings	Enquiry & recording of drug misuse
Trends (ideal to see an increase in delivery)				
Variation (ideal to see improvement for services at lower end of range)	\approx	\approx	\approx	\approx

 Decreasing trend;  Increasing trend;  No clear increasing or decreasing trend;

 Some change - but inconsistent  Improvement for services across the range - no clear trend in variation;  Improvement for services at the upper end of the range - Increase in variation;

\approx No clear trend in variation

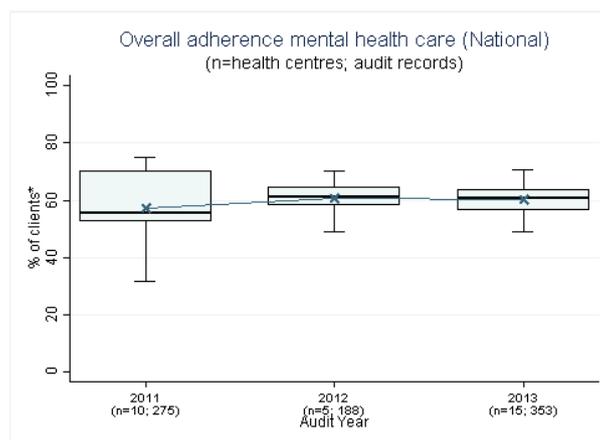
Overall mental health and wellbeing care service delivery

Stakeholder feedback on the priority evidence-practice gaps highlighted the importance of continuing attention to holistic care, and of ensuring that focus on specific indicators does not detract from the importance of providing high quality care across the scope of best practice. Figure 4 shows trends in a composite indicator* of overall service delivery to mental health and wellbeing clients in accordance with best practice guidelines. The composite indicator includes services such as recording of risk factors, physical checks, laboratory investigations, brief interventions and follow-up if there is a record of exacerbation or deterioration of symptoms.

Summary of trends (Figure 4)

- There is no clear improvement in the overall service delivery of mental health care. The mean and median level of care delivery is around 60% over the three years.
- There was a reduction in variation in service delivery between health centres from 2011. Performance of health centres at the lower end of the range was around 30% in 2011 and was around 50% in 2012 and 2013.

Figure 4. **Mean health centre overall service delivery* to mental health & wellbeing clients, by audit year for all health centres (n=number of health centres; number of clients records audited).**



* Services included in composite indicator include: recording of alcohol, tobacco and drug use; brief interventions for alcohol and drug misuse; health check within the last 12 months; blood pressure check in last 6 months; mental health assessment (if client attended in last 3 months); provision of social issues and family or individual counselling (if client attended in last 3 months); joint discussion regarding culturally appropriate interventions (if client attended in last 3 months); liver function test; serum creatinine; thyroid function test; full blood count; and follow up action if deterioration in symptoms including medication review and adjustment, referral or psychosocial/culturally appropriate intervention.

Development and documentation of shared care arrangements and referral

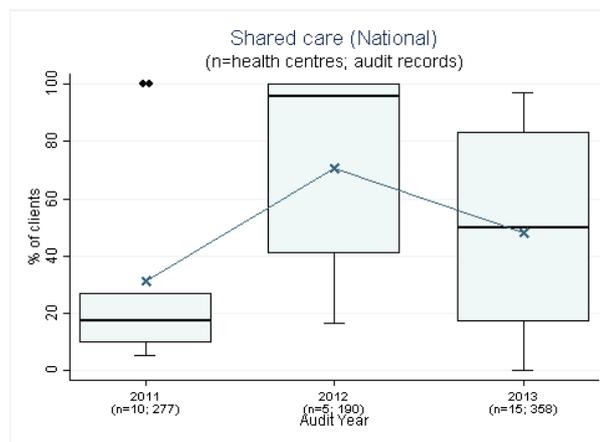
All respondents (13/13) identified 'Development and documentation of shared care arrangements and referral' as a high priority for improvement.

Figure 5 shows the mean health centre record of shared care planning, by audit year for all health centres.

Summary of trends (Figure 5)

- There was no clear evidence of improvement from 2011 - 2013.
- There was wide variation amongst health centres for 2011 and 2012.

Figure 5. *Mean health centre record of clients being in shared care in the last 12 months, by year for all health centres (n=number of health centres; number of clients records audited).*



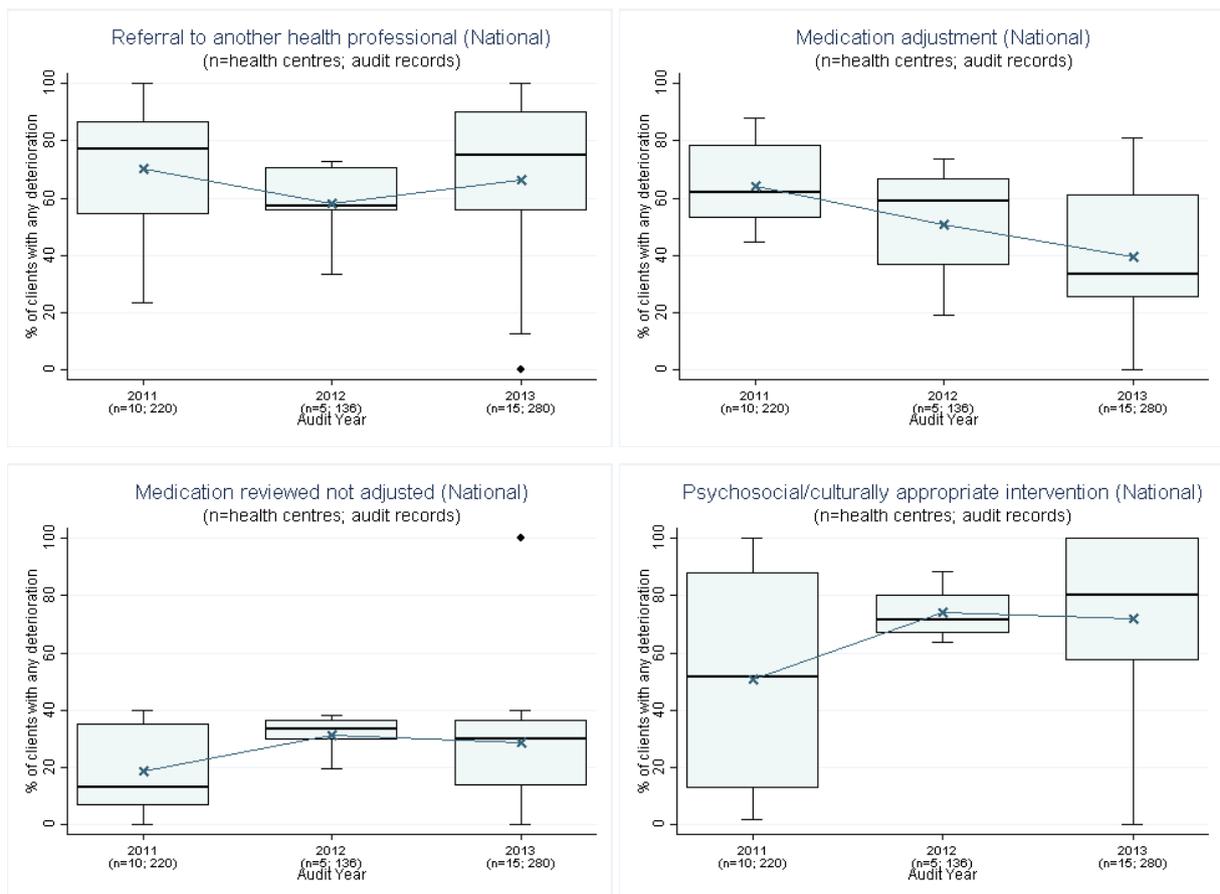
Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms.

All respondents (13/13) identified 'Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms' as a high priority for improvement. Figure 6 shows the mean health centre recording of various follow-up actions if there is evidence of exacerbation or deterioration of symptoms, by audit year for all health centres.

Summary of trends (Figure 6)

- For follow-up actions if a client shows signs of exacerbation or deterioration of symptoms, there was some improvement in the median level of delivery for culturally appropriate interventions;
- a decrease in the mean level of medication adjustment; and
- widening variation between health centres in delivery of all follow-up actions.

Figure 6. **Mean health centre record of follow-up action if evidence of exacerbation or deterioration of symptoms/behaviours (n=number of health centres; number of clients records audited).**



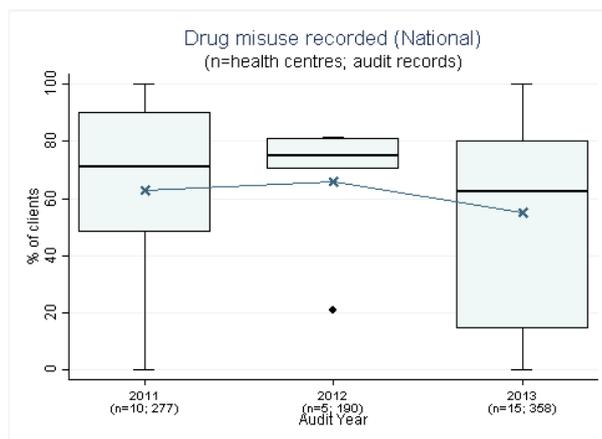
Enquiry and recording of drug misuse.

All respondents (13/13) identified 'Enquiry and recording of drug misuse' as a high priority for improvement. Figure 7 shows the mean health centre record of drug misuse, by audit year for all health centres.

Summary of trends (Figure 7)

There was no clear evidence of improvement in the mean level of delivery or reduction in the level of variation between health centres.

Figure 7. *Mean health centre record of enquiry regarding drug misuse (n=number of health centres; number of clients records audited).*



'Organisational commitment' within the organisational influence and integration component - referring to organisational culture, support structures and processes that promote safe, high quality healthcare.

Due to small numbers of health centres completing the SAT we have insufficient data available to display trends over time and audit cycle

'Team structure and function' - within the component 'Delivery system design' - referring to the extent to which the health service staffing profile, allocation of roles and responsibilities, client flow and care processes maximise effectiveness.

Due to small numbers of health centres completing the SAT we have insufficient data available to display trends over time and audit cycle

'Links with the community' component to inform service and regional planning (in particular 'communication and cooperation on regional health planning and development of health resources').

Due to small numbers of health centres completing the SAT we have insufficient data available to display trends over time and audit cycle

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Appendix A – Data collection and reporting

Where do the data in this report come from? The report is based on analysis of audits of clinical records of well adults who attend services that use One21seventy CQI tools AND participate in the ABCD National Research Partnership. The mental health audit tool was developed by an expert working group, with participation of experts and health service staff. The tool is designed to enable services to assess their actual practice against best practice standards, and is accompanied by a protocol that includes reference to the guidelines and standards that form the basis of the tool. The audit data are supported by a summary of system performance as assessed by staff in health centres that completed a systems assessment tool (SAT) related to mental health care delivery. Copies of the One21seventy mental health audit tool and how the audits are conducted are available on request.

Who collects the audit and systems assessment data? The clinical audits are generally done by health centre staff, trained in the use of One21seventy tools and supported by quality improvement facilitators and One21seventy staff. In some centres where staff are not available or lack skills or confidence the audits are done by CQI facilitators. The systems assessment is completed by health centre staff in a process that is facilitated by a CQI facilitator.

How do health centres use the data? The data collected through One21seventy CQI tools and entered into the One21seventy web-based information system are analysed and made available to health centres in real time for use in quality improvement processes. Reports of aggregated data for clusters of health centres, by region or by state are also available through the One21seventy web-based information system in order to support regional or State/Territory level CQI efforts. The ESP Project is intended to contribute to enhancing the quality of reporting and use of aggregated CQI data for the purpose of service improvement.

Restrictions and limitations on the data presented. The data in this report are not expected to be representative of all health centres nationally or for specific jurisdictions because participation of health centres is either through self-selection or through regional decision making processes. In jurisdictions where a high proportion of health centres are participating, the data may be more generalisable; for jurisdictions where there are relatively few health centres participating the data are less generalisable.

The data reflect what has been documented in electronic and paper based client records, depending on what record systems are used in each health centre. There has been a trend in recent years to increasing use of electronic records. Many health centres are still using paper-based systems, and some are using a mix of paper and electronic systems. The quality of recording of clinical care is variable in both paper and electronic systems, and the audit data may not provide a true reflection of actual care. We have no way of collecting data or reporting on services that are not recorded. Accurate and clear recording of care is an important aspect of quality of care and has important implications for continuity and coordination of care, for medico-legal purposes and for efficient use of resources.

Criteria for inclusion of records in the audit: To be eligible for inclusion in a mental health clinical audit, a client must: be 16 years or older; have a diagnosed mental illness or a mental health disorder; have experienced symptoms for more than six months in the past or at least one relapse/recurrence of symptoms suggesting a need for ongoing care; be currently unwell or have been identified as unwell in the last 12 months; and have been resident in the community for 6 months or more in the last 12 months. Where the eligible population is 30 clients or less, the audit protocol recommends including all records. Where the eligible population is greater than 30, the protocol provides guidance on the random selection of a number of records, with the number depending on the precision of estimates required by health service staff.

Appendix B – Sources for the mental health audit

The Mental Health clinical audit protocol draws heavily on the following:

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Appendix C – ESP Project processes

Phase 1 – Evidence-practice gaps

This phase focuses on the identification of priority areas for improvement (priority evidence-practice gaps) in the delivery of mental health care in Aboriginal and Torres Strait Islander PHC.

Information provided to participants

1. aggregated CQI data (2012-2014) about the delivery of care presented in national and State/Territory reports
2. preliminary priority areas for improvement, based on national data

Feedback/data collection

Online survey, workshop sessions and email responses.

Outputs

Draft report on preliminary priority evidence-practice gaps in best practice care. Refinements based on stakeholder feedback and survey data will be incorporated into Phase 2 report.

Phase 2 – Barriers and enablers to addressing gaps and strategies for improvement

This phase focuses on trends in indicators relevant to the identified priority evidence-practice gaps, and on influences that may enable or hinder improvement at different points in the health system. In particular, it seeks to:

1. identify those factors that may be most important in addressing the identified priority evidence-practice gaps in best practice care identified in Phase 1.
2. identify new or existing strategies that could be introduced or strengthened to enable improvement in priority evidence-practice gaps.

Information provided to participants

- Report on trends over time for key indicators relevant to priority evidence-practice gaps in best practice care.
- An evidence brief synthesising findings from research about barriers, enablers and strategies for improvement in the delivery of PHC, with particular attention to research in the Australian Aboriginal and Torres Strait Islander health context.

Feedback/data collection

Online survey, including questions about barriers and enablers to improvement based on international, national and Aboriginal and Torres Strait Islander-specific evidence and frameworks.

Participants will be encouraged to draw on their own experience, the evidence brief and the data presented throughout the project to identify strategies to address priority evidence-practice gaps.

Outputs

Draft report on barriers and enablers to improvement in care relevant to identified priority evidence-practice gaps and identified strategies for improvement, based on responses to the online questionnaire. The draft report will be returned to participants for review in Phase 3.

Review and final report

A draft report on strategies for improvement will be returned to participants for review. Comments from the review will be used to inform a final report on strategies for improvement in identified priority-evidence practice gaps. This final report will be provided to key stakeholders in all participating jurisdictions. Project findings will be reported in academic journals and in conference presentations and workshops.

Appendix D: Survey respondents

	Phase 1	
	Individual responses	Group responses
Number of responses	12	1
Number of attendees per group (recorded attendees in group)		
Less than 5		1
5 to 10		-
11 to 20		-
More than 20		-
Jurisdictions of interest for respondents*		
National		1
ACT		-
NSW		-
Queensland		3
NT		6
SA		2
WA		-
Victoria		1
Tasmania		-
Rurality of population group to which responses relate*		
Urban		4
Regional		3
Remote		9
Number of group responses to question about Indigenous status		
All		-
Majority (more than half)		-
Minority (less than half)		-
None		1
Number of individual responses identified as Indigenous		
Indigenous	3	
Non Indigenous	9	
Position types		
Nurse	3	-
Middle Manager	1	-
Doctor	2	1

Public Health Physician	1	-
Other Medical Specialist	1	-
Senior Management/executive	-	1
CQI facilitator	-	-
Board member	-	-
Policy officer	-	-
Aboriginal and/or Torres Strait Islander practitioner	-	-
Research/Academic	2	-
Other	2	-
Organisation types		
Community controlled health centre	5	1
Community controlled peak body	-	-
Government health centre	2	-
Government health department	2	-
Medicare Local	-	-
General Practice	-	-
University/Research organisation	1	-
Other	2	-

*Numbers may not tally with total number of respondents as respondents were able to select multiple answers

Appendix E: Responses to phase 1 survey on relative importance of gaps

Respondents were asked to rank the relative importance of the identified evidence-practice gaps on a scale of 1-10, where 10 is the most important and 1 is least important.

Table E1: Respondents ranking of relative importance of the identified evidence-practice gaps

	1 Least Important		2	4	5	6	7	8	9	10 Most Important	Total Responses
Client records/health summaries											
Completeness and consistency of recording of mental health diagnoses and of comorbidities.	0%	0%	0%	0%	0%	15%(2)	8%(1)	0%	46%(6)	31%(4)	13
Development and documentation of shared care arrangements and referral.	0%	0%	0%	0%	0%	0%	23%(3)	15%(2)	31%(4)	31%(4)	13
Development and documentation of mental health care plans and regular review of care plan goals.	0%	0%	0%	0%	8%(1)	8%(1)	8%(1)	23%(3)	31%(4)	23%(3)	13
Risk factors and brief interventions											
Enquiry and recording of drug misuse.	0%	0%	0%	0%	0%	0%	23%(3)	23%(3)	23%(3)	31%(4)	13
Brief intervention, counselling or advice on tobacco use, nutrition and physical activity.	0%	0%	8%(1)	0%	8%(1)	0%	15%(2)	46%(6)	8%(1)	15%(2)	13
Scheduled services											
Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on consistent recording across all aspects of recommended care for clients with mental illness.	0%	0%	9%(1)	0%	9%(1)	9%(1)	18%(2)	9%(1)	18%(2)	27%(3)	11
Investigations											
Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on complete and consistent recording across all relevant investigations for clients on psychotropic medications.	0%	0%	0%	0%	9%(1)	18%(2)	9%(1)	27%(3)	27%(3)	9%(1)	11

	1 Least Important		2	4	5	6	7	8	9	10 Most Important	Total Responses
Follow-up of abnormal findings											
Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms.	0%	0%	0%	0%	0%	0%	9%(1)	18%(2)	45%(5)	27%(3)	11
Health centre systems											
'Links with the community' component to inform service and regional planning (in particular 'communication and cooperation on regional health planning and development of health resources').	0%	0%	0%	0%	0%	10%(1)	10%(1)	10%(1)	20%(2)	50%(5)	10
'Organisational commitment' within the organisational influence and integration component - referring to organisational culture, support structures and processes that promote safe, high quality healthcare.	0%	0%	0%	0%	0%	0%	10%(1)	30%(3)	10%(1)	50%(5)	10
'Team structure and function' - within the component 'Delivery system design' - referring to the extent to which the health service staffing profile, allocation of roles and responsibilities, client flow and care processes maximise effectiveness.	0%	0%	0%	0%	0%	0%	10%(1)	20%(2)	20%(2)	50%(5)	10

Note: Total responses represent the number of responses entered; it includes 1 group of 2 people.

Table E2: Ranking by respondents of the most important gaps to address, scored 7 – 10.

Priority evidence-practice gaps	% and n
Development and documentation of shared care arrangements and referral.	100%(13/13)
Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms.	100%(11/11)
Enquiry and recording of drug misuse.	100%(13/13)
'Organisational commitment' within the organisational influence and integration component - referring to organisational culture, support structures and processes that promote safe, high quality healthcare.	100% (10/10)
'Team structure and function' - within the component 'Delivery system design' - referring to the extent to which the health service staffing profile, allocation of roles and responsibilities, client flow and care processes maximise effectiveness.	100%(10/10)
'Links with the community' component to inform service and regional planning (in particular 'communication and cooperation on regional health planning and development of health resources').	90%(9/10)
Completeness and consistency of recording of mental health diagnoses and of comorbidities.	85%(11/13)
Development and documentation of mental health care plans and regular review of care plan goals.	85%(11/13)
Brief intervention, counselling or advice on tobacco use, nutrition and physical activity.	85%(11/13)
Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on consistent recording across all aspects of recommended care for clients with mental illness.	72%(8/11)
Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on complete and consistent recording across all relevant investigations for clients on psychotropic medications.	72%(8/11)

Note 1: Total responses represent the number of responses entered; it includes 1 group of 2 people.

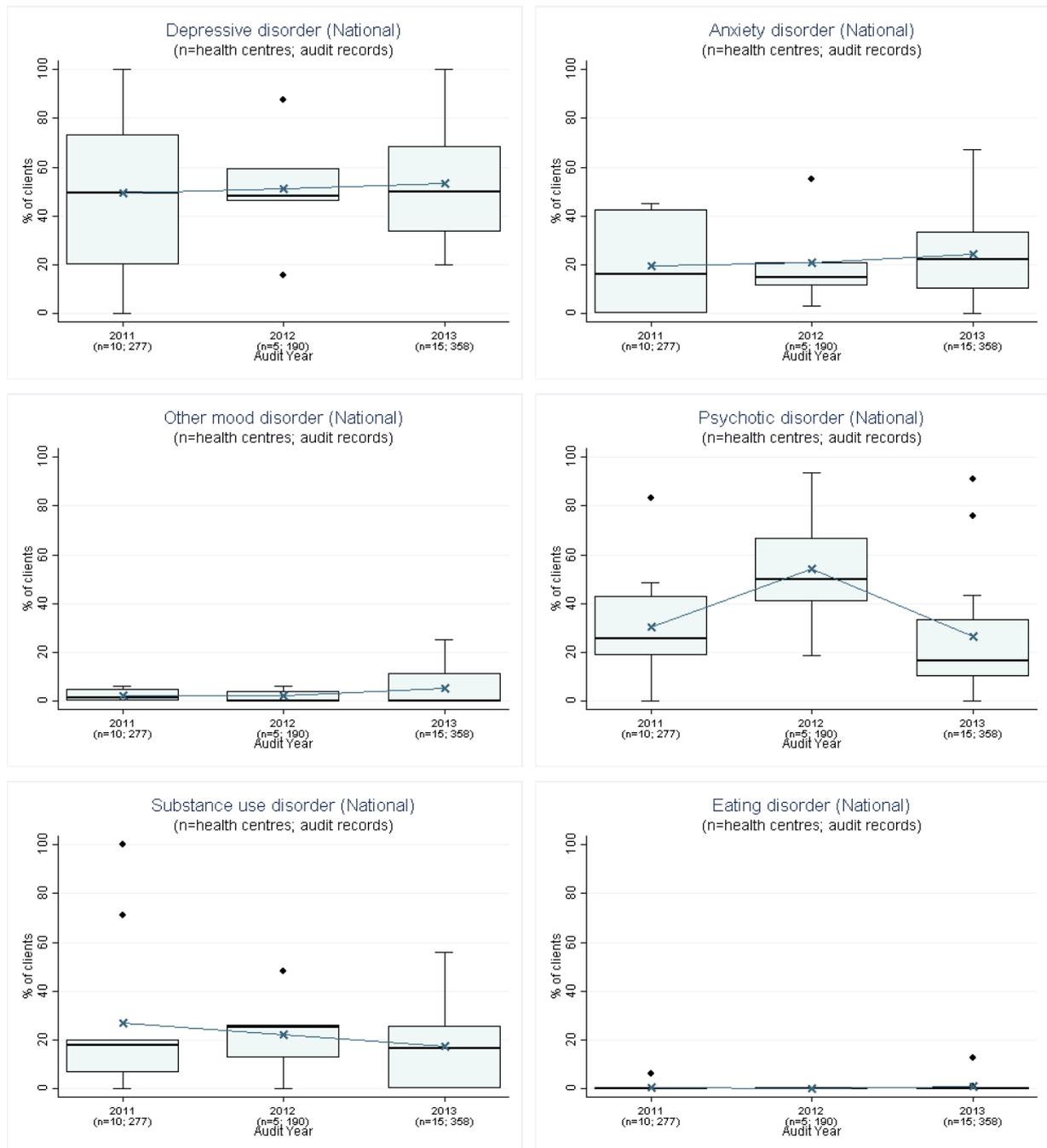
Appendix F: Trend data on preliminary priorities identified in phase 1

This appendix contains the trend data for the indicators that were identified as preliminary priorities in the phase 1 report but not ranked as being as of high importance compared to other priorities.

Completeness and consistency of recording of mental health diagnoses and of comorbidities (Figures F1 & F2)

Completeness and consistency of recording of mental health diagnoses and of comorbidities was ranked as important to address by 85% (11/13) of respondents to the phase 1 survey.

Figure F1: Mean health centre recording of mental health diagnoses (n=number of health centres; number of clients records audited).



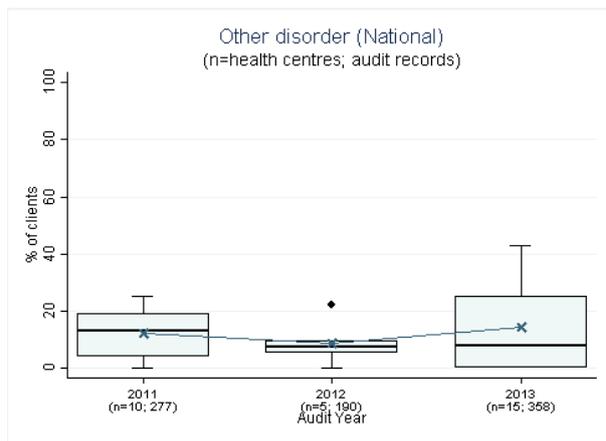
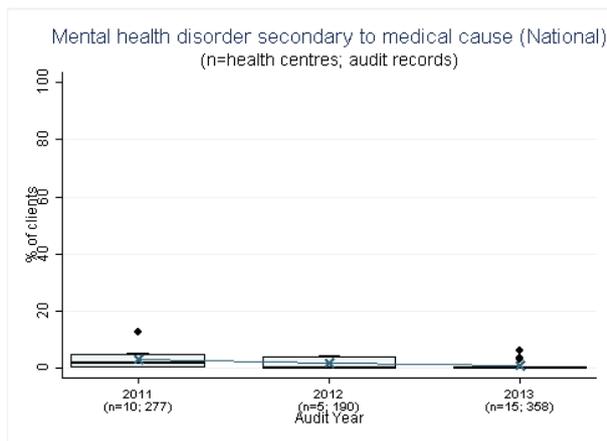
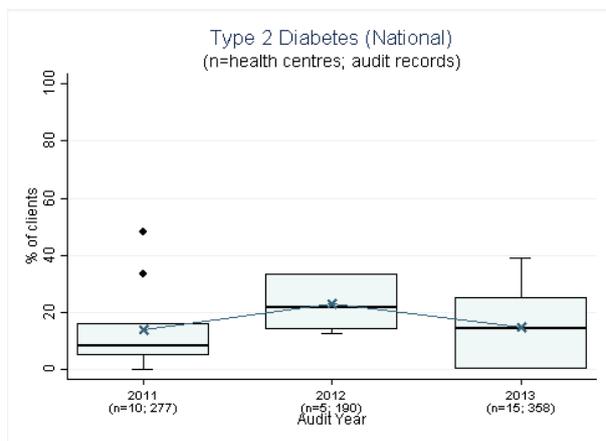
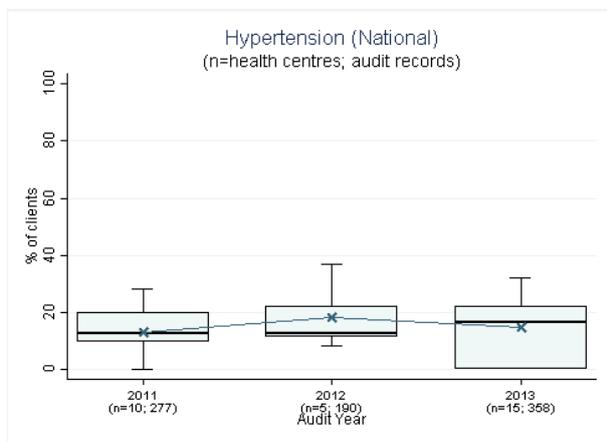
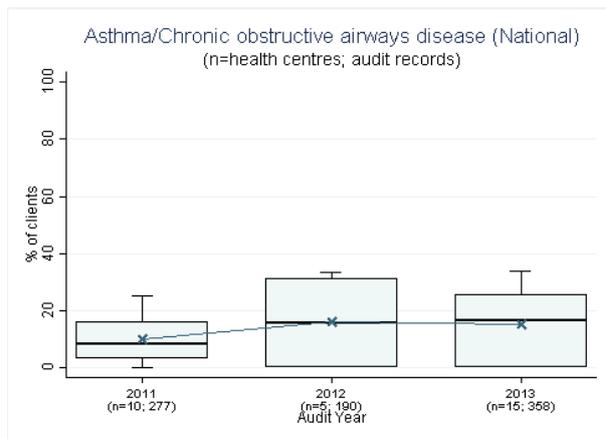
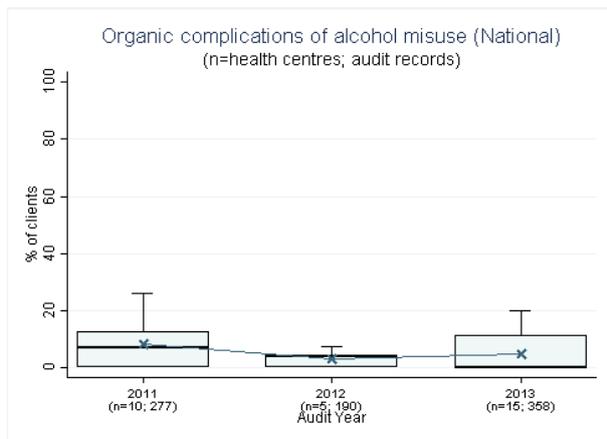
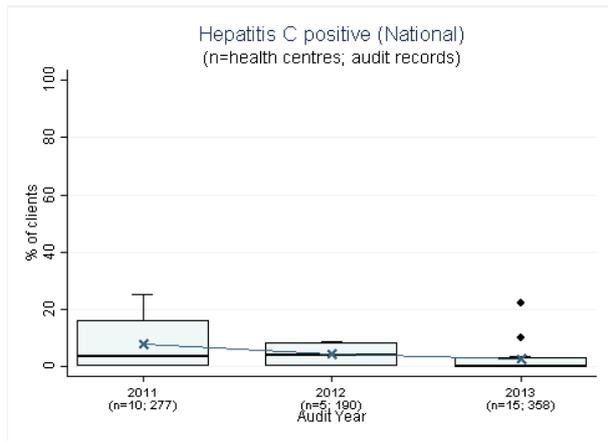
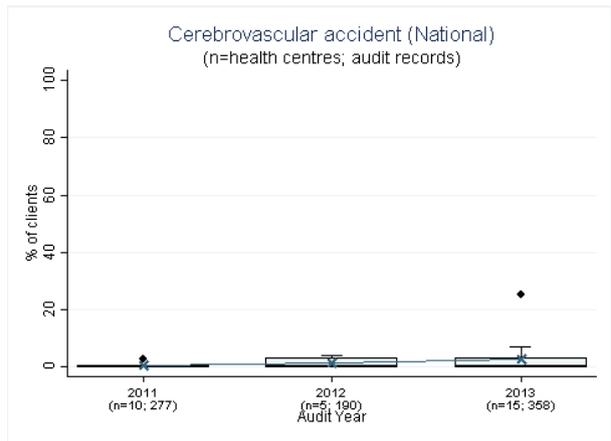
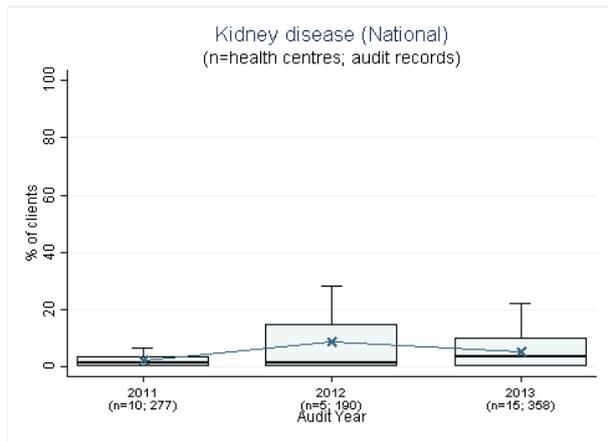
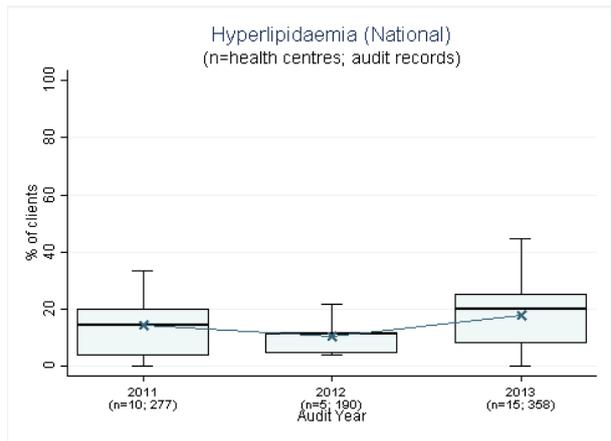
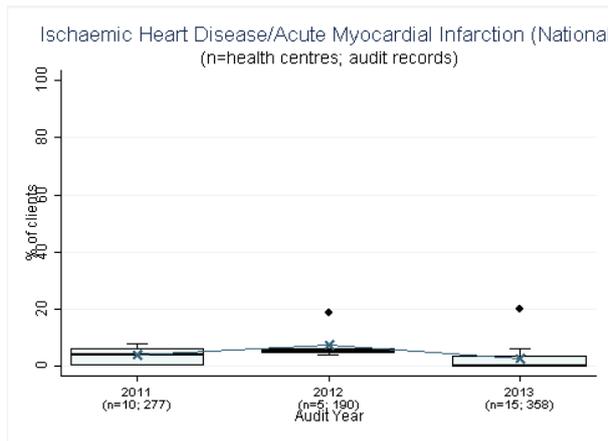


Figure F2: Mean health centre recording of comorbidities (n=number of health centres; number of clients records audited).

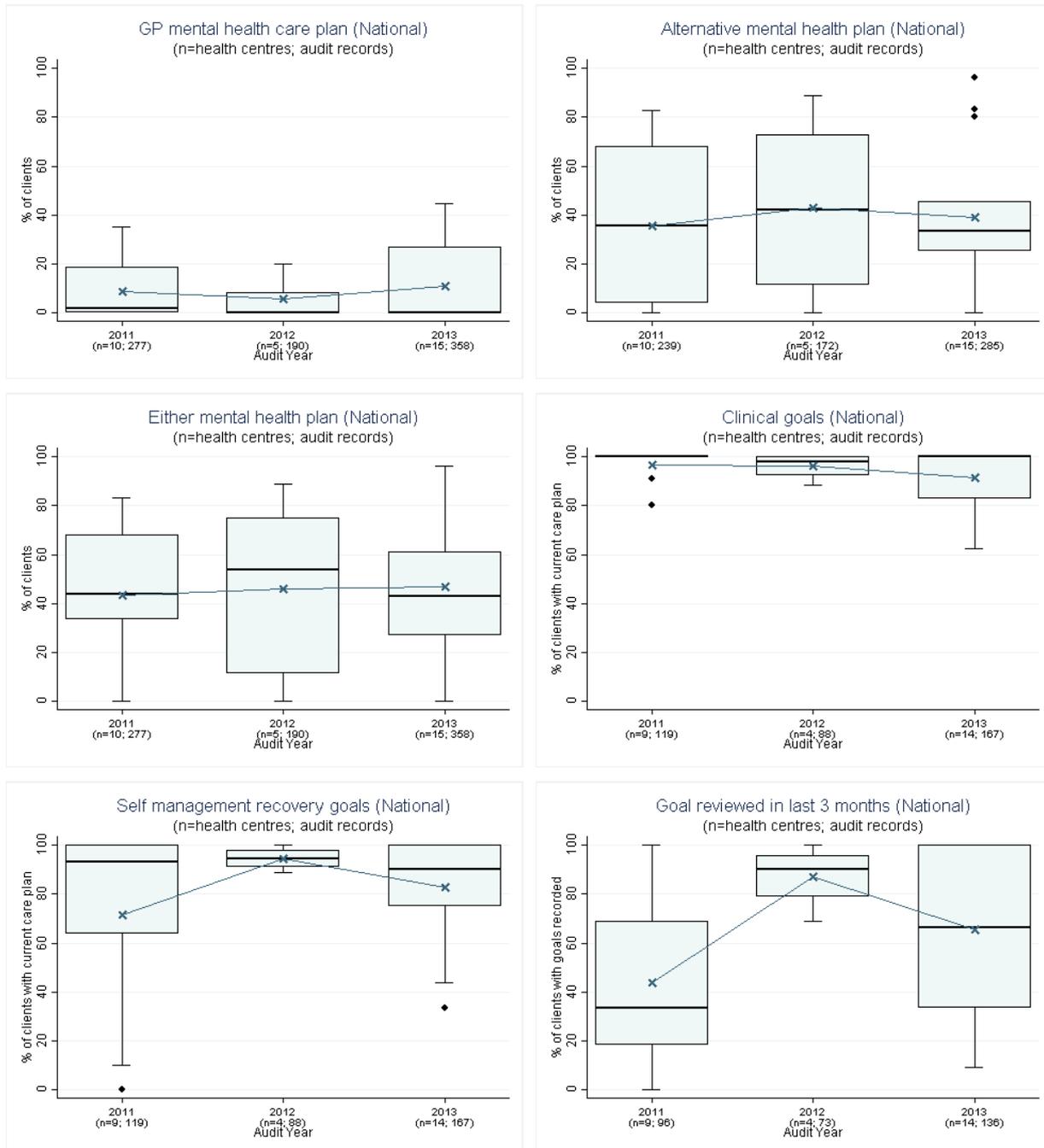




Development and documentation of mental health care plans and regular review of care plan goals (Figure F3)

Development and documentation of mental health care plans and regular review of care plan goals was ranked as important to address by 83% (15/18) of respondents to the phase 1 survey.

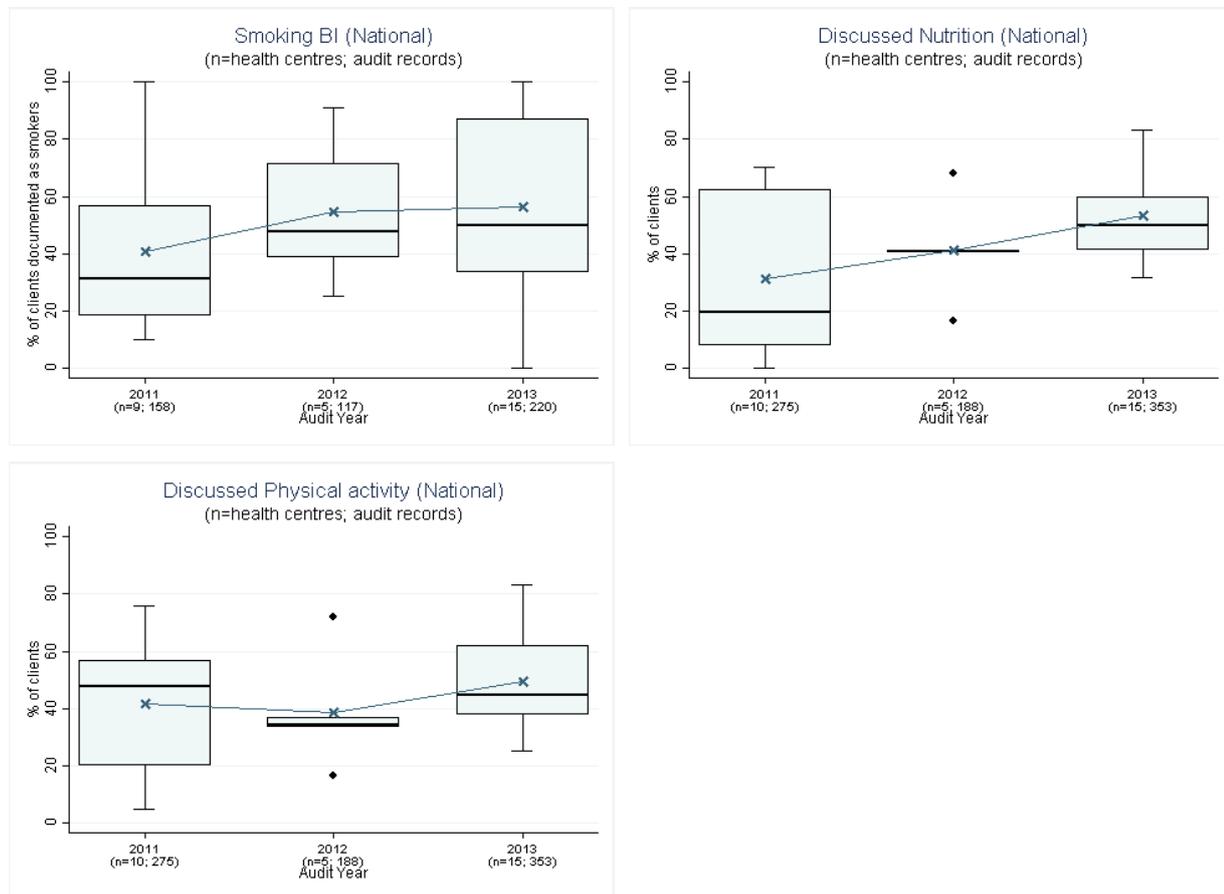
Figure F3: Mean health centre record of mental health care plans and associated goals (n=number of health centres; number of clients records audited).



Brief intervention, counselling or advice on tobacco use, nutrition and physical activity (Figure F4)

Brief intervention, counselling or advice on tobacco use, nutrition and physical activity was ranked as important to address by 83% (15/18) of respondents to the phase 1 survey.

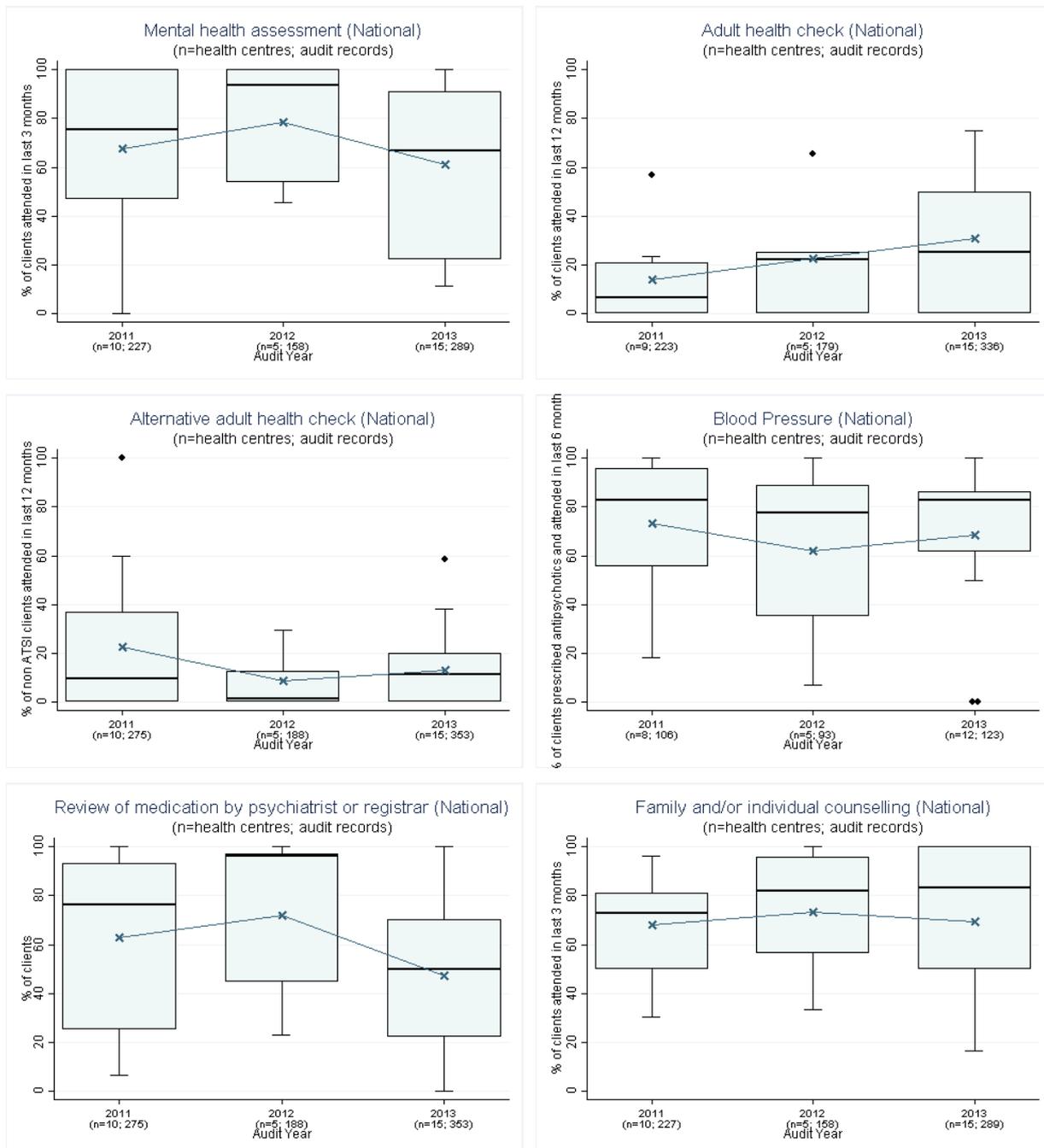
Figure F4: Mean health centre record of discussion on tobacco use, nutrition & physical activity (n=number of health centres; number of clients records audited).

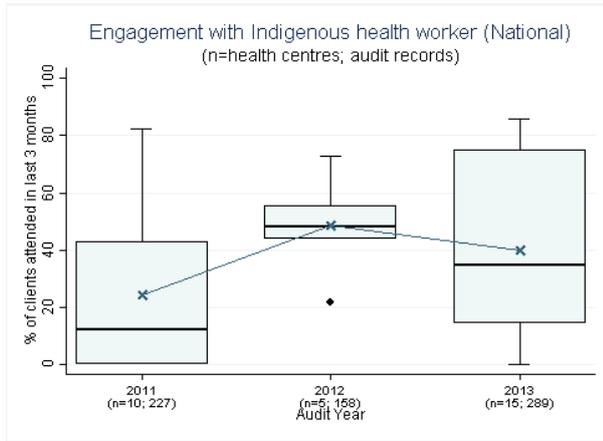
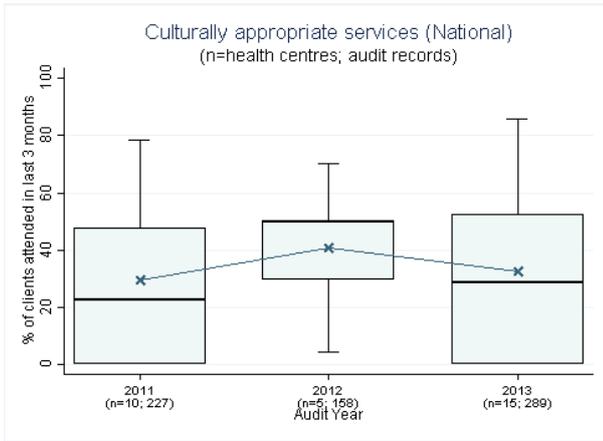
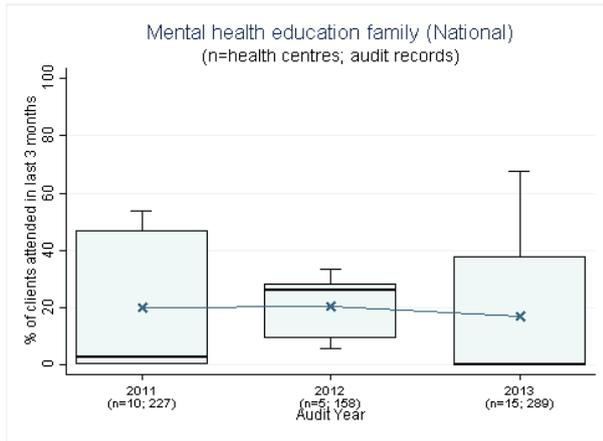
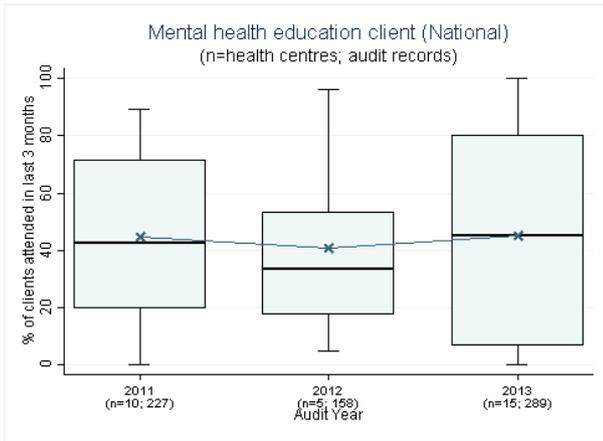
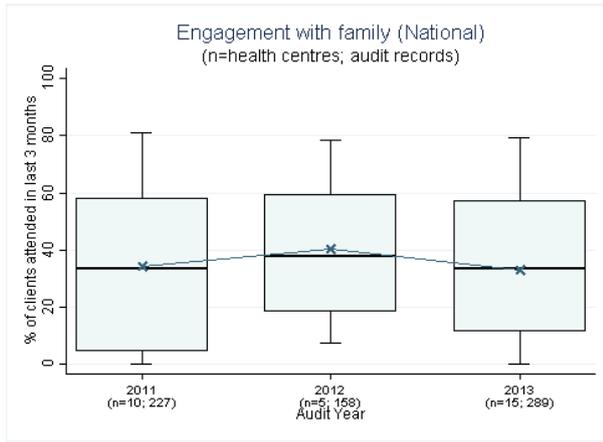
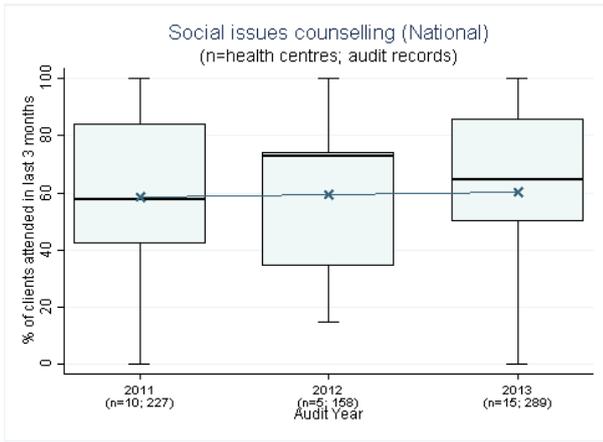


Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on consistent recording across all aspects of recommended care for clients with mental illness (Figure F5)

Improving recording and delivery of scheduled services across the scope of best practice, with a specific focus on consistent recording across all aspects of recommended care for clients with mental illness was ranked as important to address by 72% (8/11) of respondents to the phase 1 survey.

Figure F5: Mean health centre record of scheduled services delivered by general health team or mental health team (n=number of health centres; number of clients records audited).

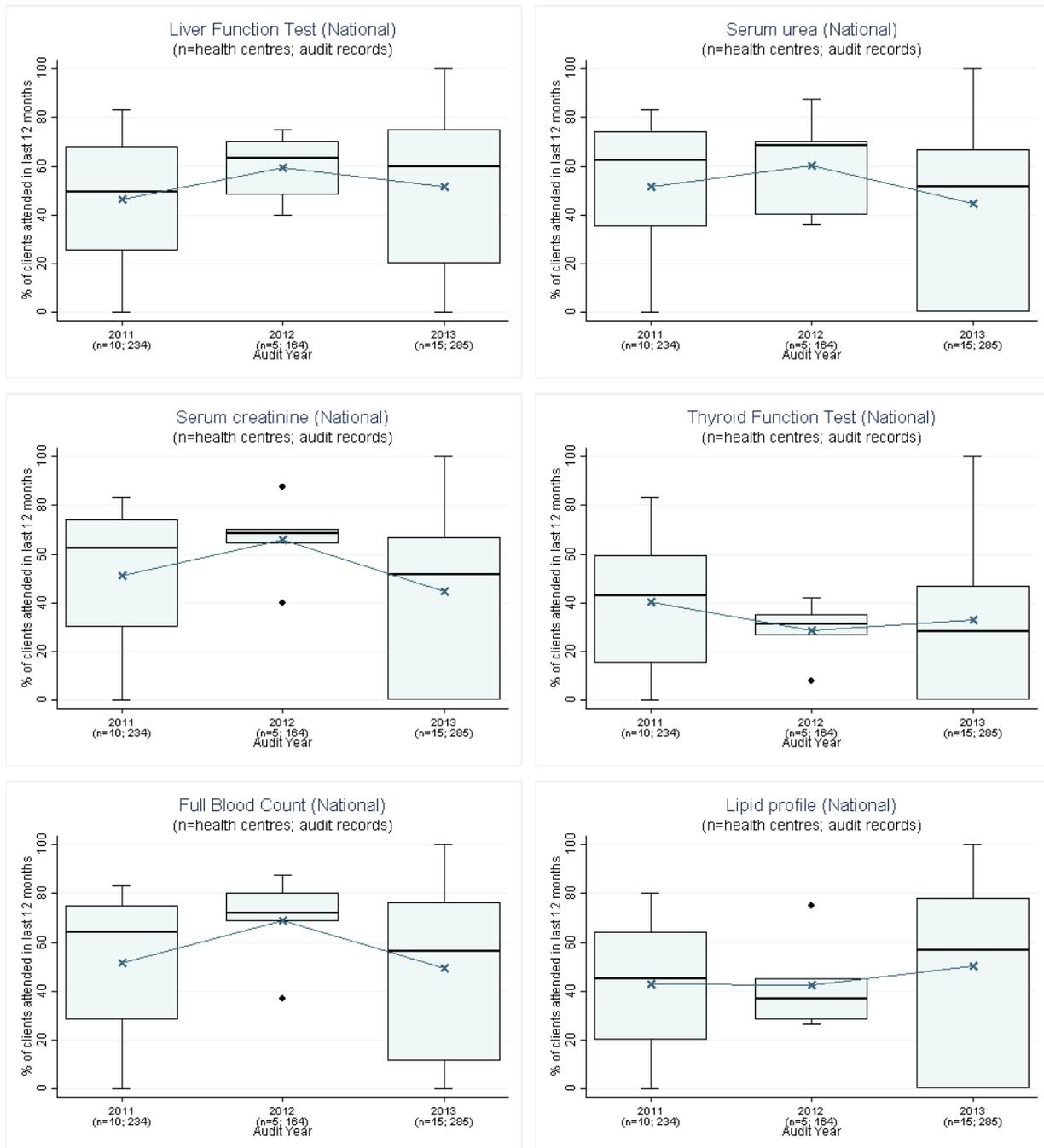


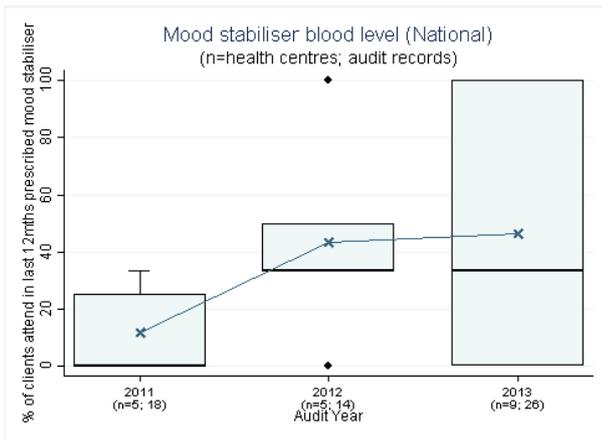


Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on complete and consistent recording across all relevant investigations for clients on psychotropic medications (Figure F6)

Improve recording and delivery of scheduled services across the scope of best practice, with a specific focus on complete and consistent recording across all relevant investigations for clients on psychotropic medications was ranked as important to address by 72% (8/11) of respondents to the phase 1 survey.

Figure F6: Mean health centre record of laboratory investigations for clients on psychotropic medications (n=number of health centres; number of clients records audited).





Appendix G: Evidence Brief - barriers, enablers and strategies for using CQI to make improvements in PHC quality

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 performance¹, 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 records⁴.

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 systems⁶.

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 change⁶. 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 outcomes⁴. 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 improvement⁷. 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 locally⁸.

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 context⁹. 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 consultation³. 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 networks⁶.

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 organisations⁴.

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 issue¹³.

Where there is a culture of CQI, staff values are more likely to align with best practice in Aboriginal and Torres Strait Islander PHC¹.

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 implementation⁶.

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 change⁶.

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 services¹⁵.

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 effective¹². 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 system⁷.

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 functioning¹⁹.

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 CQI³.

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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Acknowledgements: ESP team input from Ross Bailie, Gill Schierhout, Jodie Bailie, Anna Sheahan, Veronica Matthews and Cynthia Croft.

Date: March 2014

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