



# Acute Rheumatic Fever and Rheumatic Heart Disease Care for Aboriginal and Torres Strait Islander People: Findings from the ESP Project

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rates of RHD and ARF among Indigenous people are amongst the highest recorded globally

recommended best-practice care not consistently provided

how to achieve improvement?

**identify and minimise evidence-practice gaps**

# aim

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engage stakeholders across the primary health care system in using aggregate continuous quality improvement data to identify:

- priority evidence-practice gaps
- barriers and enablers
- strategies for improvement

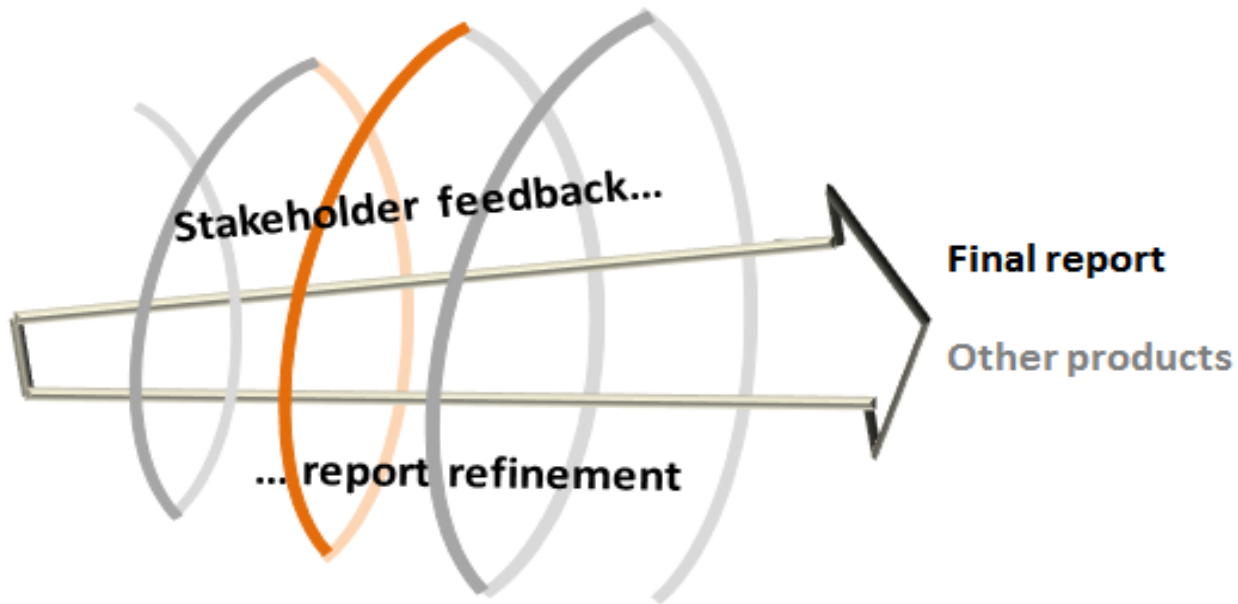
continuous quality improvement (CQI) data, 2008 - 2014:

- 60 Indigenous PHC centres
- 2,581 audited patient records
- 80 systems assessments



ARF/RHD clinical audit - based on evidence-based guidelines

# Engaging Stakeholders in identifying Priority evidence-practice gaps and strategies for improvement (**ESP Project**)



**Phase 1**  
Priority evidence-practice gaps

**Phase 2**  
Barriers & strategies for improvement

**Review**  
Final report

**Phase 1** - 21 responses: 17 individuals, 4 groups (n= 50)

**Phase 2** - 9 responses: 5 individuals, 4 groups (n= 69)

**Review of report** - <5 individuals

# recruitment and responses

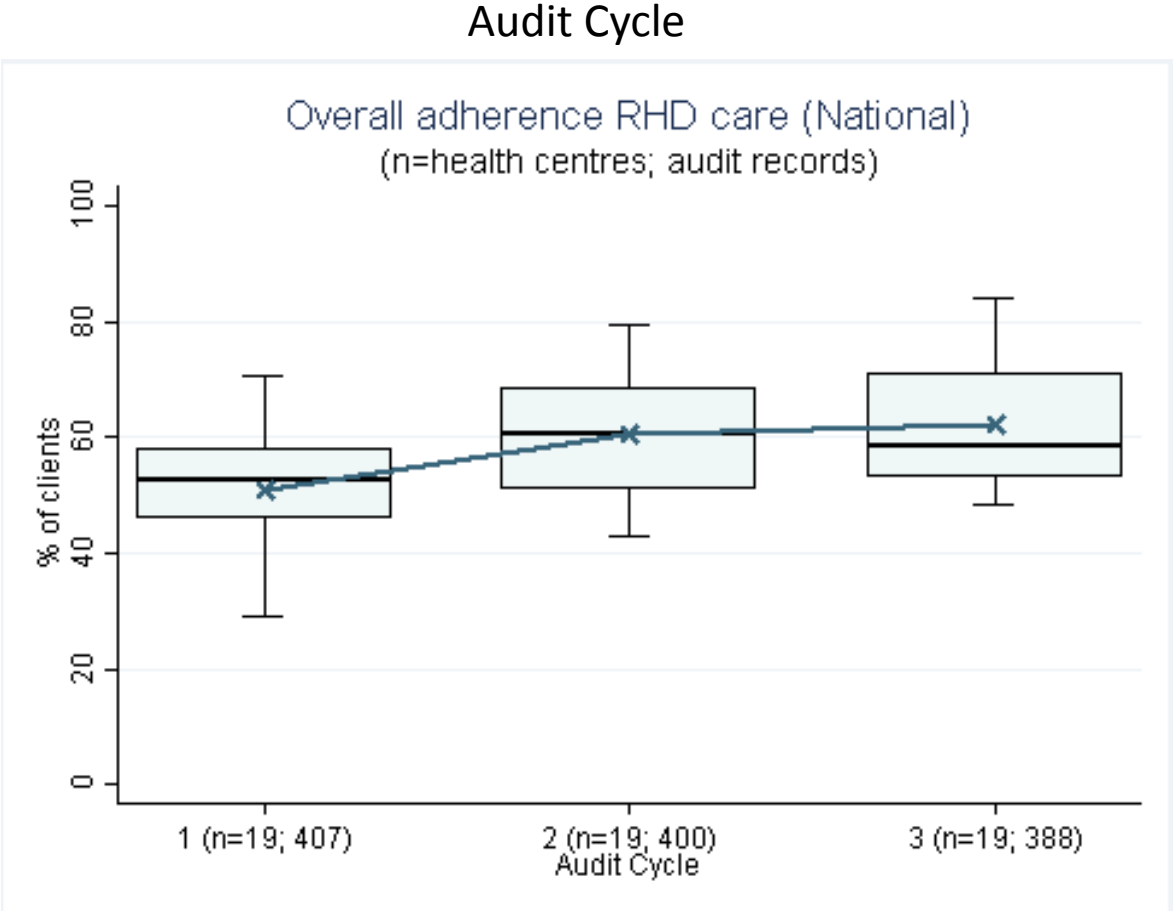
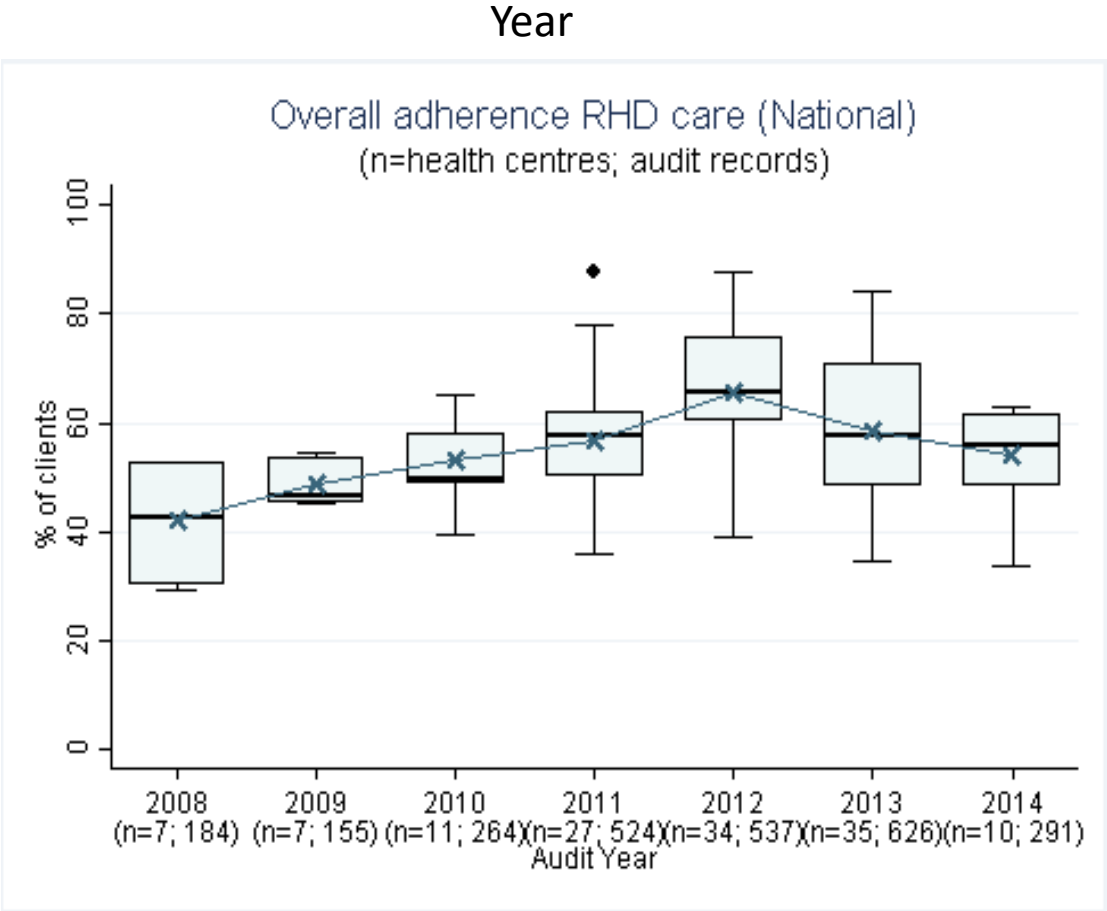
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**roles** - nurse, CQI facilitator, policy staff, Aboriginal and Torres Strait Islander health practitioner, academic, doctor, manager, other

**jurisdictions** - NSW, SA, QLD, WA, NT, Victoria

**organisations** - community-controlled health centre, peak body; government health centre, department; primary health care network; academic institution

Mean health centre overall service delivery to ARF/ RHD clients, by audit year for all health centres and by audit cycle for health centres that have at least 3 years of audit data (n=number of health centres; number of client records audited).



# Identified priority evidence-practice gaps

Improving:

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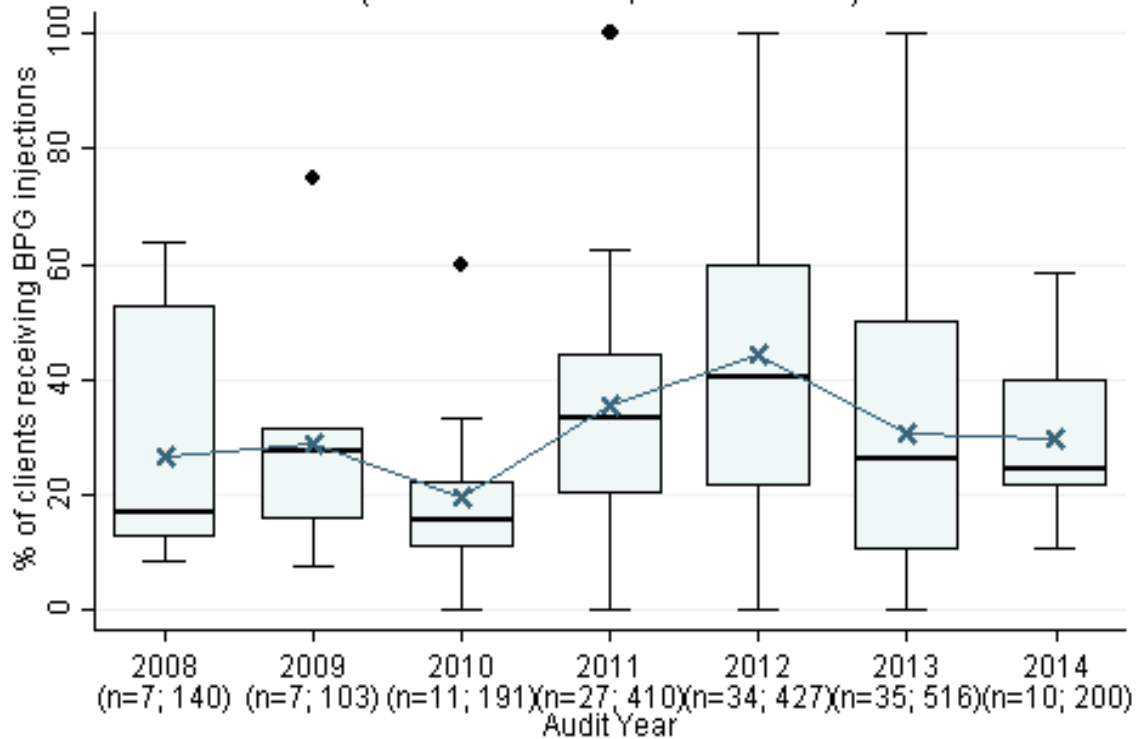
1. coverage of injections to at least 80% for all clients who are prescribed BPG
2. client follow-up
3. recording of key information in client files and master sheets (such as planned frequency of BPG injections, current prescriptions)
4. disease management planning
5. recording ARF diagnoses
6. interventions for clients who have ARF despite adequate injection delivery
7. practice and recording of rheumatic fever education for all clients



Mean health centre percentage of clients with BPG injections > 80% of planned frequency, by audit year for all health centres and by audit cycle for health centres that have at least 3 years of audit data (n=number of health centres; number of clients)

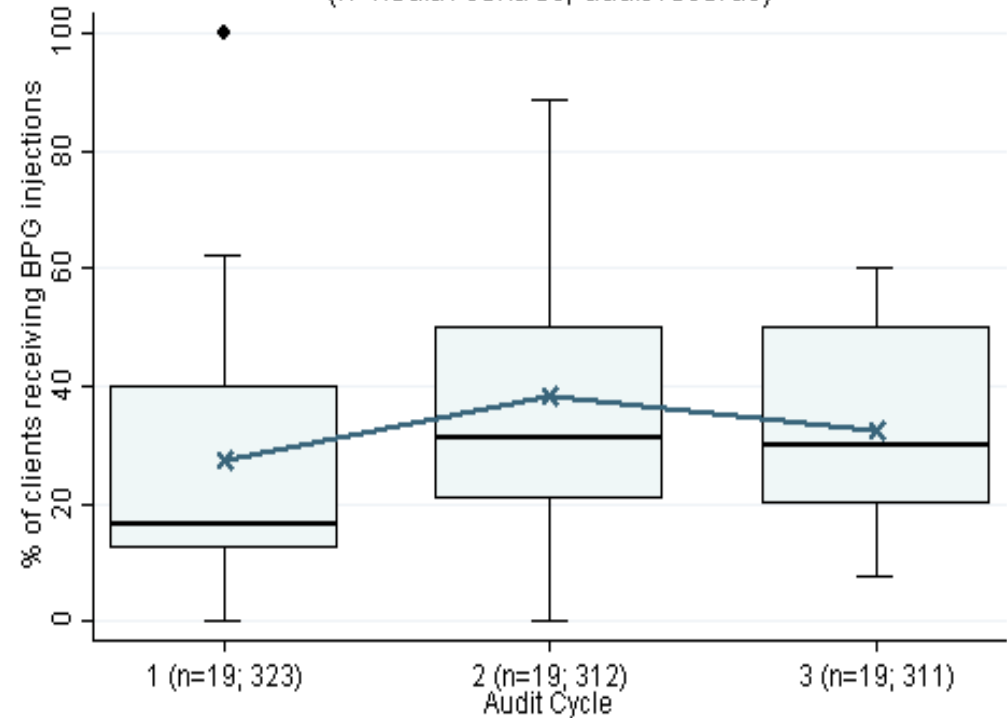
Year

Good delivery of BPG injections (National)  
(n=health centres; audit records)

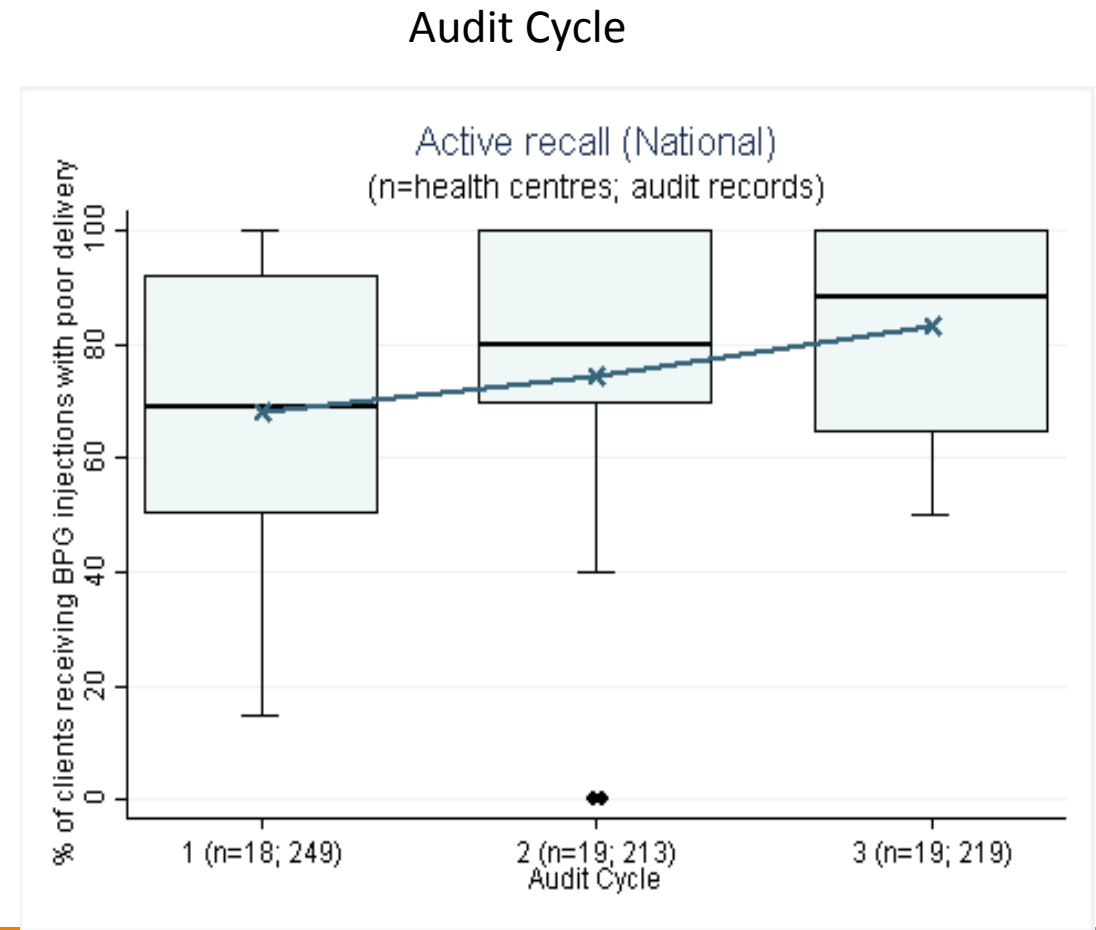
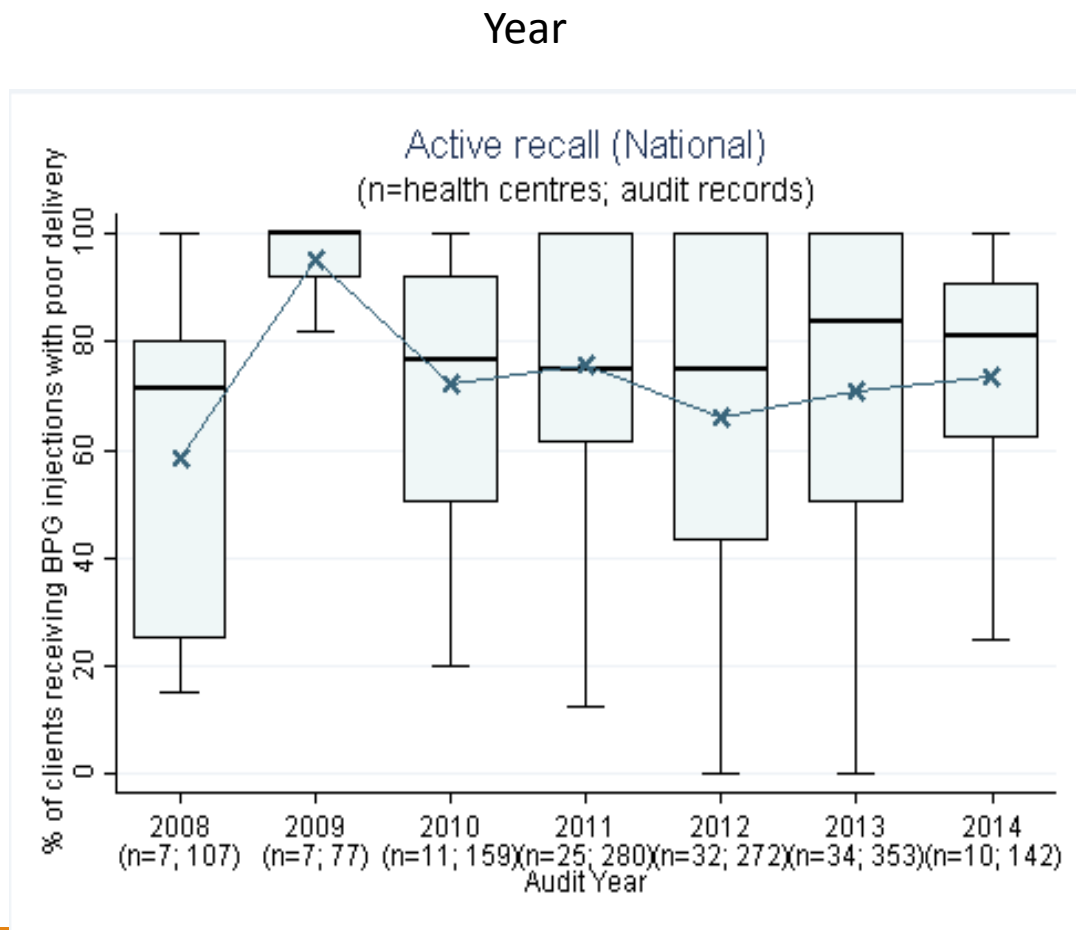


Audit Cycle

Good delivery of BPG injections (National)  
(n=health centres; audit records)



Mean health centre percentage of clients with record of follow-up action if BPG injections <80% of planned frequency, by audit year for all health centres and by audit cycle for health centres that have at least 3 years of audit data (n=number of health centres; number of clients with poor BPG delivery)



# barriers to addressing identified gaps:

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- financing and resourcing
- recruitment and retention of staff
- community capacity, engagement and mobilisation
- primary health care team structure and function
- training and development
- effective use of clinical information systems
- management support for quality improvement

# strategies to addressing identified gaps in care

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## *workforce:*

educate staff on the importance of injection schedule and best practice guidelines

train staff in social determinants of health and patient centred care

establish a dedicated staff role with responsibility for RHD care

## *community development:*

provide community, patient and family education on the importance of receiving injections – for example, one on one education, family focus groups, broader community education such as films in local language

# strategies to addressing identified gaps in care (cont)

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## *health systems:*

establish a national data base of ARF/RHD patients to support BPG injection & management

strengthen regional programs and partnerships to enable care for patients who move across jurisdictional boundaries

improve resources and follow-up of patients who require BPG injections, provide flexible options for BPG delivery including outreach & use of interpreters, use CQI approaches & data to inform planning & service delivery

## strengths

use of a comprehensive and large-scale data set  
reflects knowledge held by a range of stakeholders

## limitations

not possible to accurately measure reach or response rates  
audit data based on recorded delivery of services

# conclusion

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priority evidence-practice gaps in ARF/RHD care were identified

barriers to addressing these gaps and strategies for improvement were shared

findings identify areas of focus for development of barrier-driven, tailored interventions to improve health outcomes

- One page summary RHD findings
- Key messages
- Final report
- Data supplement



[https://www.menzies.edu.au/page/Research/Indigenous Health/Primary health care and health systems research/The ESP Project/](https://www.menzies.edu.au/page/Research/Indigenous_Health/Primary_health_care_and_health_systems_research/The_ESP_Project/)





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