



Australia's National Institute for Aboriginal and
Torres Strait Islander Health Research

FINAL REPORT

Recommendations for a National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care

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Project partners

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The project team would like to thank all those who participated in the project, including Affiliates who hosted the regional consultations in Cairns, Perth, Adelaide, and Canberra, and the individuals who shared their insights and experience.

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The project was overseen by a Steering Committee with major stakeholder group representation

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Abbreviations and Acronyms

Acronym	Definition
ABCDE	Audit and Best Practice for Chronic Disease Extension
ACCHO	Aboriginal Community Controlled Health Organisation
ACE	Achieving Clinical Excellence program
ACSQHC	Australian Commission for Safety and Quality in Health Care
ACT	Australian Capital Territory
AH&MRC	Aboriginal Health and Medical Research Council of New South Wales
AHCSA	Aboriginal Health Council of South Australia
AHCWA	Aboriginal Health Council of Western Australia
AHPACC	Aboriginal Health Promotion and Chronic Care
AIHW	Australian Institute for Health and Welfare
AMSANT	Aboriginal Medical Services Alliance Northern Territory
APCC	Australian Primary Care Collaboratives
CCI	Continuous Care Improvement
CCMM	Chronic Conditions Management Model
CQI	Continuous Quality Improvement
CtG	Closing the Gap
GP	General Practitioner (may be based in Private General Practice and/or ACCHOs)
HHS	Hospital and Health Service
ICDP	Indigenous Chronic Disease Package
NACCHO	National Aboriginal and Torres Strait Islander Community Controlled Health Organisation
NGO	Non-Governmental Organisation
nKPIs	National Key Performance Indicators
NSW	New South Wales
NT	Northern Territory
NT DOH	NT Department of Health
NTAHKPIs	Northern Territory Aboriginal Health Key Performance Indicators
PDSA	Plan-Do-Study-Act
PENCAT	PEN Systems Clinical Audit Tool
PHC	Primary Health Care
PHMO	Public Health Medical Officer
PIRS	Patient Information Recall System
QAIHC	Queensland Aboriginal and Torres Strait Islander Health Council
QI	Quality Improvement
Qld	Queensland
RFDS	Royal Flying Doctor Service
SA	South Australia
SQID	SA Quality Improvement Data
TAC	Tasmanian Aboriginal Centre
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Executive Summary

This report provides advice to the Commonwealth Department of Health (the Department) about the relevance and potential shape of a national framework for Continuous Quality Improvement (CQI) in Aboriginal and Torres Strait Islander primary health care (PHC).

Consultations carried out in this project showed that the timely development of a national CQI framework for improved PHC for Aboriginal and Torres Strait Islander peoples was widely supported by all stakeholder groups. They also showed that, based on Australian and international evidence, such a framework could be useful in supporting efficiency and continued development of CQI efforts in Aboriginal and Torres Strait Islander PHC.

The report identifies key principles that should underpin the development of a national CQI framework in this area, components that might be included, and recommendations about timeframes, resourcing and stakeholder engagement likely to lead to improved quality of care and health outcomes for Aboriginal and Torres Strait Islander people.

Project objectives

The Department commissioned this project through open tender to '*identify barriers and enablers in improvement and assess, develop and refine systems and capacity to support improved Primary Health Care for Aboriginal and Torres Strait Islander peoples*'.¹ The tender specified that the project include CQI across the PHC system, including Aboriginal and Torres Strait Islander Health Organisations (ACCHOs), state- and territory-run PHC services, and privately run General Practices with significant numbers of Aboriginal or Torres Strait Islander patients.

The tender outlined two potential stages of work. Stage 1, the current project, required a series of consultations and a synthesis and analysis of CQI activity and evidence '*to explore system wide national, regional and local enablers, barriers and linkages relevant to the development of a national CQI framework*'.¹ Depending on the findings and recommendations of Stage 1, the Department would decide whether to proceed with Stage 2, the development of a national CQI framework for Aboriginal and Torres Strait Islander PHC.

Approach

The project was conducted by the Lowitja Institute with a team that included members from its research and community organisation partners, including the National Aboriginal Community Controlled Health Organisation (NACCHO) and Affiliates in each jurisdiction.

This report brings together information from a range of sources:

- national and international evidence about what works in CQI
- CQI activity in Aboriginal and Torres Strait Islander PHC
- perspectives of key stakeholders gathered through a series of four regional workshops, targeted consultations, stakeholder interviews and a national workshop.

More than 150 people were involved in the stakeholder consultations, including many practitioners and other frontline staff, policy makers and leaders who have helped build the Aboriginal and Torres Strait Islander PHC CQI effort over the past 10–15 years.

What is Continuous Quality Improvement?

CQI is a way of working that supports frontline health care staff to get on with the business of providing good quality care. It helps staff identify and remove barriers to good care such as poor systems or red tape. CQI is not a one-off stage of improvement, but continuous cycles that can eventually build into a service-level or system-wide culture of improvement.

The core of CQI is a simple, practical process of using information and analysis at the health service or practice level to understand the quality of care that clients are receiving, working to improve those elements that are not working as well as they might, and measuring change.

Why is it important?

International and Australian evidence shows there is often great variation between health services in the quality of care they provide.^{2,3,4} That means many clients do not receive the quality of care recommended in evidence-based guidelines. CQI helps health services improve the quality of care they provide with the specific purpose of improving the health of the population.

PHC services that deliver care primarily to Aboriginal and Torres Strait Islander Australians are at the forefront of applying CQI in Australian PHC. These efforts show promising results: those health services in jurisdictions that have had long-term and large-scale CQI programs demonstrate better performance on key indicators of quality PHC.⁵ This is consistent with evidence of improved delivery of PHC services in association with sustained commitment to CQI in Aboriginal and Torres Strait Islander PHC.^{6–8}

It is difficult to quantify the costs and benefits associated with CQI,⁹ as with most complex interventions where there may be multiple influences on any change. CQI covers a diverse range of activities, and local context and implementation are critical to its impact.¹⁰ However, this close relationship with the local context makes CQI an appropriate tool for addressing the wide variation in capability and practice that exists in PHC services.¹¹

Why a national framework?

The Aboriginal and Torres Strait Islander PHC CQI effort has been driven from frontline services up, with increasingly mature leadership by the ACCHO sector and often in partnership with research institutions. Government investment (at national and state/territory levels) has been unevenly spread over time and place. As a result, the uptake of CQI in Aboriginal and Torres Strait Islander PHC is at various levels of development across Australia and across individual services. It is timely to consider a national framework that could improve coordination, build efficiencies into the Aboriginal and Torres Strait Islander PHC CQI efforts being conducted across Australia, and provide guidance about where effort and investment is likely to achieve the best results.

What a national framework might look like

Frameworks can take different forms, depending on their purpose. In health care, frameworks can help to guide the support and enhancement of clinical services by mapping out key areas of interest around an issue, and the relationships between them; clarify key terms to increase shared understanding; identify key partners and their roles; and guide policy development.

A national framework for CQI in Aboriginal and Torres Strait Islander PHC might include:

- the intended outcomes of the CQI effort (improved Aboriginal and Torres Strait Islander health outcomes) expressed as a clear and compelling vision
- a logic model indicating how the CQI effort will contribute to that outcome (by ensuring ongoing improvement in the overall quality of PHC for Aboriginal and Torres Strait Islander people across the PHC system)
- system-wide building blocks or components that are integral to effective CQI at health service level (for example, information systems that support the use of data for CQI; leadership for CQI; networks, resources and enablers of CQI)
- articulation of roles, functions and intended outcomes of CQI at various levels of the health system (national, jurisdictional, regional, health service level)
- timeframes that recognise the long-term, incremental change and ongoing nature of CQI, and
- an implementation plan.

Recommendations

Based on the national and international evidence and consultations with key stakeholders the project team makes the following recommendations.

Recommendation 1: The Department should proceed with supporting the development of a national CQI framework for Aboriginal and Torres Strait Islander PHC.

Development and implementation of the framework should take into account the guiding principles and specific recommendations identified through this project. These reflect the concerns of key stakeholder groups, and are informed by international evidence about ‘what works’ in supporting improvements at scale.

Recommendation 2: An implementation plan for the framework should be developed. To ensure that the framework takes effect, it needs to be supported by an implementation plan including the identification of resources across the PHC system (not only within Aboriginal and Torres Strait Islander-designated funding).

Recommendation 3: All key stakeholders should be engaged in the development of the framework and implementation plan. A useful early step could be the development of a ‘model of change’ or program theory and/or logic that will help to surface assumptions from different stakeholder groups about the medium and longer term outcomes expected, and how these outcomes might be achieved. The consultations and evidence review informing this report have begun this process.

Recommendation 4: The implementation of the framework should also include a rigorous and useful monitoring and evaluation process. A formative or developmental evaluation could run alongside the framework development and implementation and assist with real-time refinement and improvement.

Recommendation 5: Successful implementation of a national framework will require support systems and activities to grow the ‘building blocks’ of effective CQI. (**Recommendations 7-9 cover specific components of support that may be required**). A co-ordinated and multi-level CQI approach, including support systems and activities at regional/jurisdictional and national levels will help to address identified barriers to CQI. A multi-level CQI approach is also a key mechanism through which services with lower capacity can be supported to improve quality of care and address variation.

Recommendation 6: Development and implementation of a national CQI framework should take a ‘systems approach’ to thinking about the ways in which the building blocks of support for CQI link up and interact with one another – in order to optimise synergies and minimise potential negative effects.

Recommendation 7: Foster leadership and support networks for CQI at all levels of the system. Support networks should be evidence-based, linked up with one another, accountable, and coordinated, and their functioning regularly reviewed.

Recommendation 8: Build the capacity of front line services to undertake CQI including through training in CQI, use of data systems for improvement, and managing and leading change. Ensure workforce engagement in CQI is supported by the broader system.

Recommendation 9: Enhance coordination and governance mechanisms of clinical information systems to support CQI.

- Recognise that quality use of clinical information systems is an essential component of a CQI framework, not separate from it.
- Enhance coordination and governance of investment in clinical information systems to support CQI. This will achieve:
 - efficiency in expenditure
 - better data quality
 - improved linkage of indicators and CQI tools to clinical guidelines and best practice
 - better dissemination of local innovations to harness technology.
- Acknowledge that data for CQI is data for action and not for accountability. This will drive:
 - best practice care
 - improved planning at local and regional levels
 - closer relationships with research teams.
- Any use of data must value CQI models and change management tools.

Recommendation 10: Develop longer-term strategies for aligning CQI with other quality initiatives including accreditation, service governance, and existing and emerging national policies and plans in Aboriginal and Torres Strait Islander health and the PHC system as a whole.

Recommendation 11: Ensure there is a focus on tailoring strategies and approaches to meet the needs of health services at differing levels of development in relation to CQI recognising that health services are at different points in their quality journey.

Principles:

The key principles identified in this report (refer Recommendation 1) are:

1. Build on momentum already established in CQI and learn from past experience.
2. Focus on strengthening enablers to CQI, not imposing specific models or standard approaches.
3. Identify what cultural capability means for CQI: embed cultural safety and Aboriginal and Torres Strait Islander perspectives on health and health care into all levels of the framework. This has implications for the scope of PHC covered by a framework.

4. A collaborative approach led by the ACCHO sector, for best practice PHC for Aboriginal and Torres Strait Islander people across the PHC system.
5. Support the principle of flexibility of use of CQI tools and approaches (and indicators) with health services supported to use tools that are a good fit for their needs and context.
6. CQI in Aboriginal and Torres Strait Islander PHC requires sustained commitment and a national CQI framework needs a 10-15 year timeframe.

Conclusion

The key recommendation of this report is that the Department should develop a national framework for CQI in Aboriginal and Torres Strait Islander PHC. With a clear focus on supporting front-line services to improve the quality of PHC for Aboriginal and Torres Strait Islander people wherever they receive care, a national system-wide CQI framework for Aboriginal and Torres Strait Islander PHC could contribute to closing the health gap between Aboriginal and Torres Strait Islander people and the general Australian population. Implementation of a framework as outlined in this report will also support a better national understanding of the quality of PHC delivered to Aboriginal and Torres Strait Islander people, and the factors that enhance quality of care. A framework would also enable more opportunities for using data for improvement at different levels of the system. This is a process that requires adequate time to build a culture of improvement at all levels of the system, and requires clear agreements with data providers about the way in which data are used, and the purpose of use.

1. Introduction

Project objectives

The Commonwealth Department of Health (the Department) commissioned this project through open tender to '**identify barriers and enablers in improvement and assess, develop and refine systems and capacity to support improved Primary Health Care for Aboriginal and Torres Strait Islander peoples**'.¹ The tender focused on CQI in ACCHOs and in other organisations with significant numbers of Aboriginal or Torres Strait Islander patients.

The tender outlined two potential stages of work. Stage 1, the current project, required a synthesis and analysis of CQI activity and evidence '**to explore system wide national, regional and local enablers, barriers and linkages relevant to the development of a national CQI framework**'.¹ Depending on the findings and recommendations of Stage 1, the Department would decide whether to proceed with Stage 2, the development of a national CQI framework.

Frameworks can take different forms, depending on their purpose. Frameworks have different uses in health care; for example, frameworks can represent and define key factors of interest and their interplay and interdependence, identify key partners, guide policy development, and guide the support and enhancement of clinical services (Annex 1 provides a brief discussion of the use of frameworks in health care). This report provides advice to the Department about potential advantages (and disadvantages) of developing a national CQI framework in Aboriginal and Torres Strait Islander PHC. The report identifies general principles for a framework and suggests recommended components for development, should the Department decide to proceed to the development of a framework.

Approach

The project was conducted by the Lowitja Institute with a team that included members from its research and community organisation partners, including the National Aboriginal Community Controlled Health Organisation (NACCHO) and Affiliates in each jurisdiction.

This report brings together information from a range of sources:

- national and international evidence about what works in CQI
- CQI activity in Aboriginal and Torres Strait Islander PHC CQI
- perspectives of key stakeholders gathered through a series of four regional workshops, targeted consultations, stakeholder interviews and a national workshop.

More than 150 people were involved in the stakeholder consultations, including many practitioners and other frontline staff, policy makers and leaders who have helped build the Aboriginal and Torres Strait Islander PHC CQI effort over the past 10–15 years.

The project was managed by the Lowitja Institute and was overseen by a Steering Committee with broad representation across major stakeholder groups (membership list in acknowledgment pages of this report).

The project was conducted between 15 May 2014 and 31 July 2014. Two streams of work were undertaken concurrently:

- a review of available Australian and international evidence about CQI models of support, and of current CQI activity in Aboriginal and Torres Strait Islander PHC. The evidence review focused on understanding the scope of CQI underway across the PHC system and barriers and enablers to supporting CQI at scale.
- a consultation and communication stream involving a series of four regional workshops, targeted consultations (NACCHO Summit and NT CQI Steering Committee), stakeholder interviews and a national workshop.

Four full-day regional workshops were held, involving a total of 117 representatives across different stakeholder groups (Figure 1). A further 35–40 people participated in two supplementary workshops of 1.5–2 hours' duration, held at the NACCHO Summit and as part of a Northern Territory CQI Steering Committee meeting. Six people who had been unable to attend the workshops were interviewed by phone. Workshops were facilitated by independent Aboriginal facilitator, Kate Kelleher.

The workshop invitations, sample agenda and pre-reading supplied for the regional consultations are included in Appendices 2 and 3. A full list of participants in the workshops is provided in Appendix 7.

Several broad areas of recommendation in relation to a CQI framework for Aboriginal and Torres Strait Islander PHC were developed based on key themes identified in regional workshops. A project team sub-group ('small writing team') further identified possible implications of the outcomes of regional consultations, and the project as a whole, in a face-to-face workshop held in the NACCHO offices on 22 July 2014.

A final national workshop was held on 23 July 2014 in Canberra to present outcomes of the regional consultations and to discuss and refine the emerging recommendations (participant representation shown in Figure 2).

International and Australian evidence relevant to wide scale CQI and the key themes were synthesised together with the workshop outcomes. These formed the basis of the recommendations of the project.

Figure 1: Representation at regional workshops (n = 117)

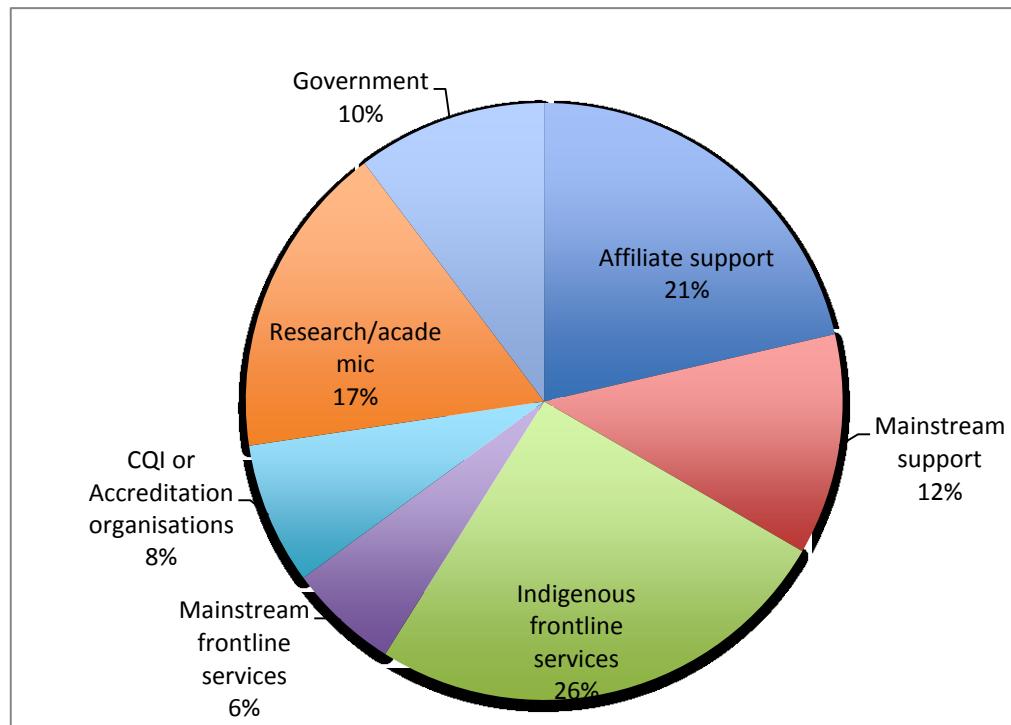
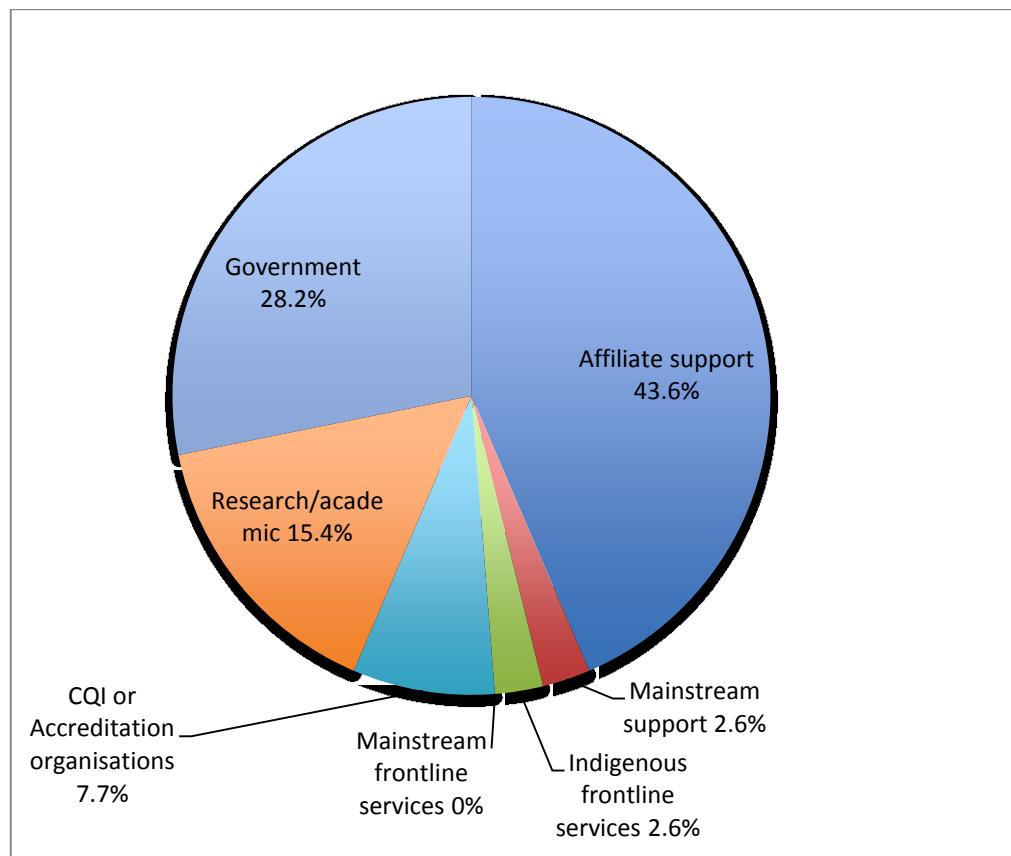


Figure 2: Representation at national workshop (n=40)



Caveats

In the timeframe for this project, it has not been possible to fully scope the extent of CQI related activity (including Affiliate activity) and CQI support provided by other major initiatives. The evidence review should be regarded as indicative only, noting that some important aspects of activity may have been missed. This limitation is countered to some extent by the participation of all major stakeholders either as part of the project team, or on the Steering Committee.

Also owing to project timeframes, the regional consultations and national workshop were scheduled with relatively short notice. This may have meant that some key stakeholders were unable to attend, and their views may have been missed. This risk was mitigated by inviting stakeholders to provide feedback through individual interviews, written responses, and if unable to attend a workshop closest to them, to elect to attend one of the other regional workshops.

Definitions of CQI

The Department provided a working definition of CQI in the Tender documentation¹ for this project, which was used as a starting point to stimulate discussions during the consultations.

CQI is an important component in identifying gaps and generating improvement to support best clinical practice in PHC. It is an ongoing internal process at the service level that includes the collation and analysis of accurate, timely, de-identified patient data, to identify needs/gaps by measuring activity against an agreed set of regional or national benchmarks.

CQI programs are part of a broader set of activities and initiatives that operate under the banner of ‘quality’ and aim to improve the overall delivery of health care. In the Australian PHC sector these include CQI, accreditation, and national reporting against key performance indicators.

Internationally it has been suggested that three characteristics distinguish CQI from other quality activities:

- systematic data guided activities
- designing with local conditions in mind
- iterative development and testing.¹²

Structure of this report

The remainder of this report is structured in the following main sections:

- Section 2 provides a brief overview of CQI efforts to improve PHC for Aboriginal and Torres Strait Islander people, including a description of models and approaches, and a broad brush stroke of activity in the different jurisdictions.
- Section 3 presents a synthesis of the evidence from the project consultations and from the review of the literature in relation to a national CQI framework for Aboriginal and Torres Strait Islander PHC. This includes evidence (and recommendations flowing from the evidence) related to:
 - what a framework could offer and why a framework might be considered useful

- guiding principles that reflect stakeholder concerns about the conditions under which a national framework would be most beneficial to front-line service delivery
- core components of what is needed to support CQI to improve services.
- Section 4 presents an overall summary of recommendations and conclusions.

2. Overview of CQI to Support Improved Primary Health Care for Aboriginal and Torres Strait Islander People

This section provides an overview of the policy context relating to CQI in Aboriginal and Torres Strait Islander PHC, and an overview of CQI activities and large-scale CQI initiatives in the Australian PHC system.

Policy context

There has been substantial experience with quality improvement in PHC in Australia. In the Aboriginal and Torres Strait Islander PHC sector, funding for quality improvement was first provided to ACCHOs in 2002 through the introduction of the Continuous Improvement Projects.¹³ This funding supported 13 services to identify, implement and monitor changes in service systems and processes using a continuous improvement approach to service development. Developmental and open-ended rather than prescriptive in their approach to CQI, these projects pioneered the development and use of quality improvement initiatives at the service level. Experimentation with quality improvement programs expanded rapidly and has become part of a much broader focus on quality with the introduction of a variety of policy initiatives and programs aimed at improving the quality and performance of PHC services. These initiatives include:

- accreditation
- financial incentive payments to general practices and ACCHOs and other services to improve adherence to best practice for certain services
- improving complaints mechanisms
- establishing the Australian Commission on Safety and Quality in Health Care (ACSQHC)
- strengthening accountability of health care providers through the introduction of a National Health Performance Framework, and national targets for Aboriginal and Torres Strait Islander health and the Closing the Gap (CtG) Strategy.

At the regional level, efforts to improve quality of services for particular populations have also progressed through the development of regional bodies in mainstream and Aboriginal and Torres Strait Islander health, and through integrated purchasing and provision arrangements in the Primary Health Care Access Program to expand delivery and improve regional planning for services to Aboriginal populations. Efforts to strengthen capacity of PHC through support for systems development and workforce capacity building are also evident.

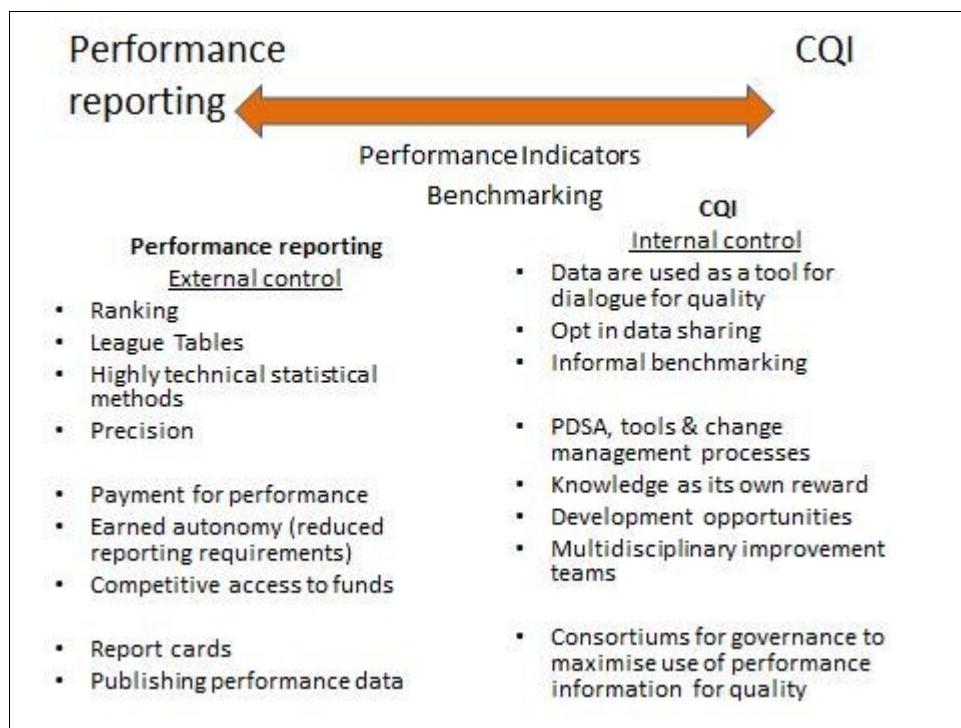
At the service level, these initiatives have been accompanied by developments in the use of electronic records for quality improvement and service reporting purposes, automated data extraction tools, and rapid changes in the way that data reporting and collection arrangements for Commonwealth funded programs are supported and linked to national key performance indicators (nKPIs) under the national Aboriginal and Torres Strait Islander Health Performance Framework. There has long been concern about the reporting burden on PHC services in the ACCHO sector – the reporting burden being seen to stem from multiple funding sources with different reporting and accountability requirements.¹⁴ Recent developments in automated data extraction were in part intended to help ameliorate this burden.

Despite increasing interest in CQI, access to funding and other resources to support CQI at local levels has been uneven across the PHC system with some services investing significant effort and energy while others dropped behind with limited capacity to engage in these activities. The uneven development of CQI across the PHC system, and the variation in quality of PHC services for Aboriginal and Torres Strait Islander people is a central issue for a potential national CQI framework and will be returned to at various points in this report.

Performance reporting versus CQI

At the policy level, these quality initiatives have different origins and purposes and use a variety of mechanisms to achieve improvement but there is a lack of clarity about the differences and what might be required to operationalise and link them. As shown in Figure 3, performance reporting and quality improvement initiatives can be seen as operating along a continuum. While each use performance indicators, measurement and benchmarking techniques to identify variation in performance, they have different philosophical bases and use data in different ways to promote service provider behaviour change and improvement.¹⁵

Figure 3: Key differences between performance reporting and CQI



Source: Gardner and Sibthorpe 2014 (adapted from Freeman 2002)

On the left of the spectrum, performance reporting systems are externally driven systems that use league tables to rank and report on levels of service performance, linking these to rewards and sanctions, and culminating in public reporting and report cards. CQI systems on the other hand are internally driven systems that use more informal benchmarking and other metrics (including qualitative reporting by consumers) to make comparisons descriptively. Data are used as a starting point for engaging stakeholders in dialogue about quality and to generate insights into practice. CQI systems focus on building infrastructure and providing tools to support CQI activity and service improvement, and in many circumstances involve consortia of stakeholders working together to improve care.¹⁵

Although there can be some overlap, these different purposes have implications for the types of data required, the choice of methods used for analysis and the types of infrastructure needed to support and promote behaviour change.

International evidence suggests that different approaches can be effective under certain conditions but experience demonstrates that when linked to ‘pay-for-performance’, performance reporting systems may be associated with unintended consequences that may undermine the very conditions required for improving quality.¹⁶⁻¹⁸

In ACCOs, development of a national data platform together with electronic records, automated data extraction software and national (and a number of state/territory based) performance indicators have put into place the basic infrastructure required for reporting individual service performance on these indicators – and could in theory also contribute to an enabling infrastructure for some elements of CQI activity in the ACCO sector.

Development of data platforms and availability and use of automated data extraction software in state/territory-run PHC services, and in General Practice more broadly, is more uneven.

The ACCO sector provides services to large numbers of Aboriginal and Torres Strait Islander people and is proactive in the development and implementation of CQI models in the Australian PHC environment. Emerging evidence suggests that these developments are leading to improvements in the quality of care that exceed those provided by mainstream General Practice.¹⁹

Large scale, long-term initiatives

This section describes a number of large scale and long term initiatives that function nationally and are in use in Aboriginal and Torres Strait Islander PHC across several jurisdictions. In the following section, CQI activity is described for each jurisdiction. To avoid repetition, the initiatives used across multiple jurisdictions are briefly described here.

The three national initiatives used across several jurisdictions in Aboriginal and Torres Strait Islander PHC are:

- the Australian Primary Care Collaboratives (APCC)
- Healthy for Life
- One21seventy and its earlier iterations, Audit and Best Practice for Chronic Disease and its Extension program (ABCD/E).

There are some similarities across these initiatives. Each program has a set of core components that include indicator sets; some form of training (face-to-face or online); ‘Plan-Do-Study-Act’ (PDSA) cycles (rapid or annual); facilitation (external or internal); and a data information platform that enables services to share de-identified data. They use quality indicators, audit and feedback of information, action planning and other change management processes within PDSA cycles to evaluate performance and make improvements in service delivery. Table 1 summarises key elements of these three large-scale initiatives.

Many services consulted for this project reported using a combination of the strategies outlined in these major initiatives. Health services and support agencies also adapt tools and resources from these and other CQI models, to be locally or regionally relevant and useful. This is illustrated in the overview of CQI activity by jurisdictions below.

Table 1: Large scale and long term CQI initiatives in use across multiple jurisdictions

Australian Primary Care Collaboratives (APCC): Mainstream practices and Aboriginal health services across Australia 2005 – current
Aims To use the Breakthrough series collaborative methodology, creating a structure in which teams can learn from each other and recognised experts in selected topic areas.
Strategies <ul style="list-style-type: none">• The identification and development of Collaborative topics which focus on key health priorities and closing the gap between evidence and practice• System change on national scale by encouraging teams to innovate and devise local solutions to a common aim using rapid PDSA cycles and other improvement methods• Capacity building and training to support sustainable CQI amongst teams; learning workshops; expert reference panels• Measurement system to monitor improvements (uniform national data set)• Compensated protected time for participants• Audit tools and indicators• Data collected through the Pen Clinical Audit Tool.
Scope Reported in the literature are 13 ‘waves’ between 2005–2011 for 1,185 (numbers now higher – approx. 1,800 in total) health services across Australia of which 53 were ACCHOs (4.5%). ‘Waves’ focused on prevention, appointment waiting times, self-management, diabetes, heart disease and COPD. The ‘waves’ tend to be time-limited, with each health service participating for a limited period of time.
Current Funding Commonwealth Department of Health; fee-for-service for additional services considered out of scope.
Evaluation External evaluations conducted in 2009 and 2011; not publically available.
Healthy for Life, announced in 2005–2006 budget, commenced reporting in 2007
Aims To improve the quality of life for people with a chronic condition and, over time, reduce the incidences of adult chronic disease. Focus on availability of maternal and child health care; prevention, early detection and management of chronic disease; improve men’s health; improve long term health outcomes and increase workforce capacity through a scholarship scheme.
Strategies <ul style="list-style-type: none">• Support infrastructure included encouraging sites to appoint a quality improvement facilitator who is then supported by the program with networking, orientation and training, and written resources; support was also provided by (then) OATSIH state and territory officers. Prior to 2011, support to services through SCARF project (a collaboration between AIHW and Menzies School of Health Research)• QI support infrastructure developed including regional meetings, national conferences, service-level support for data quality, individualised reports and national comparison data• Data reporting through nKPIs and other online service reporting (e.g. OSCAR)• Funding was provided for both CQI activities and service delivery through a ‘2-phased’ approach.
Audit tools/Indicators Healthy for Life indicators (which informed the development of the nKPIs).
Scope In 2013, 100 services in 57 sites (See Table 2 for 2014 breakdown by jurisdiction). Since funding for the program has been rolled into base funding from 2013–2014 onwards, the extent to which

Australian Primary Care Collaboratives (APCC): Mainstream practices and Aboriginal health services across Australia 2005 – current

regular CQI activities are being carried out at the service level is unknown.

Current Funding

Commonwealth Department of Health.

Evaluation

Independent evaluation 2009.

One21seventy, 2010–current (previously ABCD 2002–2009)**Aims**

To foster high-quality primary health care and better health outcomes for Aboriginal and Torres Strait Islander people throughout Australia through support for CQI in everyday PHC practice.

Practically, provides tools, training and service support to health services in using One21seventy tools (developed through ABCD projects research projects ABCD 2002–2005; ABCDE 2005–2009; ABCD National Research Partnership 2009–2014 and other tools) at a national scale.

Strategies

- Annual PDSA cycles with data obtained from clinical file audits
- Systems assessment (organisational systems to support quality of care)
- Web-based data entry and reporting enables services to review data and compare to other de-identified participating services
- Service support to assist staff to interpret audit information, identify priority areas, set goals and develop action plans (training, national help desk and other support on request)
- Workforce training programs in CQI and in use of One21seventy tools, e-learning, and a web-based information portal
- Subscribers invited to join ABCD National Research Partnership (2010–2014) to contribute data to a national database and identify local research priorities related to improvement.

Audit tools/Indicators

Tools and indicators to audit against best practice clinical guidelines across the scope of clinical care for: chronic disease (diabetes, CHD, hypertension, renal disease); maternal health care; child health care, preventive services; mental health; rheumatic heart disease; health promotion; youth health; sexual health. Tool for assessing consumer perceptions of the quality of chronic care provided is being tested for release. All tools regularly reviewed by expert panels including practitioners in the field.

Scope

- ABCD (2002–2005): 12 health centres in NT involved in action research
- ABCDE (2005–2009): 69 health centres took part in a research project to trial large scale implementation, plus 60 additional services used ABCD tools outside of the research project. Participating services mainly from NT, Far West NSW, WA and North Qld
- One21seventy: Subscriber numbers vary over time (total 280+ sites since 2009, 128 sites in mid-2014). (See Table 2 for 2014 breakdown by jurisdiction.)

Current Funding

Operational funding through direct fee-for-service contracts with health centres or management structures (e.g. state departments of health). Original program and ongoing tool development predominantly funded through research grants.

Evaluation

No independent external evaluation of One21seventy, though included in NT CQI evaluation (as major CQI tool in use in the NT). Annual customer satisfaction surveys.

Other national initiatives or infrastructure that may support CQI

The nKPIs and the OCHREStreams data platform are also important elements that might underpin CQI effort. While the stated aims of these initiatives include support for local CQI effort, they have not been included in the Table.

The nKPIs are reported through the Australian Institute of Health and Welfare (AIHW), which has responsibility to manage, analyse, and report information collected as part of the nKPIs. From June 2012, nKPI data have been collected six-monthly and participation is mandatory for Aboriginal and Torres Strait Islander organisations funded by the Australian Government (~200). Reports for individual health services are provided and the first national report was released in May 2014. The AIHW undertakes extensive data improvement processes with individual services to ensure the accuracy of data being submitted. This is an iterative process that can take some time but results in improvements in the overall quality of the data. The AIHW provides analysed, individualised reports back to services. Services can also immediately access the unanalysed data they have recorded in OCHREStreams, which have the potential to be used for CQI activities at the service level.

Finally, with an overarching role at a system level, is the ACSQHC, a government agency that leads and coordinates national improvements in safety and quality in health care across Australia. The Commission's work in coordinating national improvements in quality of care for Aboriginal patients specifically, has to date been fairly limited. However, following the introduction of the National Safety and Quality Health Service Standards, and assessment against these Standards in the acute sector, some work has commenced to improve quality of care for Aboriginal people within mainstream services. This initiative intends to determine 'the areas of greatest safety risk' and on this basis, develop resources to support mainstream health services to implement culturally appropriate safety systems and quality services.

Overview of CQI activity by jurisdiction

This section provides an overview of CQI support models in each jurisdiction; an outline of the CQI programs currently in use; and suggested next steps for each jurisdiction. The information may not be complete, as the project scope did not include a survey of PHC services. However the overview illustrates the extent to which different jurisdictions have taken up CQI, and particularly the different ways in which Affiliates have provided and continue to provide support to member services in improving the quality of PHC for Aboriginal and Torres Strait Islander people.

A summary overview illustrating the wide variation in the extent of participation in CQI between the different jurisdictions, and the types of CQI initiatives used, is provided in Table 2.

Table 2: Summary of reported use of various CQI initiatives in each state/territory, July 2014

	ACT	NT	NSW	Qld	SA	Vic	Tas	WA
Healthy for Life	1 ACCHO	11 services (9 sites)	16 services (8 sites)	13 services (6 sites)	14 services (9 sites)	17 services (7 sites)	1 service (3 sites)	11 services (8 sites)
One21seventy		7 ACCHOs (26 sites) 50 NT DOH sites	5 ACCHOs	5 ACCHOs (8 sites) 5 Qld Hlth HHSDs (27 sites)	2 ACCHOs	1 ACCHO (4 sites)		2 ACCHOs (3 sites) and 1 WA Gov
APCC (ACCHOs - over the life of the program)		11	17	17	4	7		7
Achieving Diabetes Action & Collaborative Change	2 ACCHOs	5 ACCHOs	1 PHC service	2 PHC services	2 ACCHOs	3 ACCHOs		
NT CQI Collaboratives		70–80 participants each workshop						
QAIHC ACE Program				All 22 ACCHOs 1 RFDS & 8 GPs				
Rapid PDSA cycles/ own models/ Multifaceted CQI approach	1 ACCHO	varies	Multi-faceted tailored CQI support to members	varies	varies	27 ACCHOs		varies
Aboriginal workforce training in CQI		7 workshops						
Chronic condition management (traffic light system)		All NT Gov						
Torpedo Project			12 ACCHOs	10 ACCHOs				
SQUID CQI program					8 ACCHOs			
Various PH and research programs	varies	varies	6 + ACCHOs	varies	All ACCHOs	varies		varies
AHPACC CQI Initiative						11 sites (ACCHOs and other)		
Practice Health Atlas						9 ACCHOs		
WA CCI project								6 ACCHOs
WA AOD Sector Quality Framework								Unknown

Australian Capital Territory

The Australian Capital Territory (ACT) is home to an estimated 6,167 Aboriginal and Torres Strait Islander peoples.^{20,21} The NACCHO Affiliate in the ACT, Winnunga Nimmityjah Aboriginal Health Service (Winnunga), is also the major service provider to Aboriginal and Torres Strait Islander people. In addition, there are a number of General Practices where Aboriginal and Torres Strait Islander people access PHC in the ACT.

CQI support models, programs and related initiatives in ACT

Winnunga has implemented CQI activities integrated with clinical governance. This is led by the Executive Director of Clinical Services. The service has a data officer, and support and leadership for quality improvement is also provided by the Public Health Medical Officer (PHMO). CQI is frequently ‘problem-driven’ rather than ‘data-driven’ – the staff, board and management identify where improvement is needed, and data are then requested and used in CQI cycles working towards improvement. CQI has been used to improve care delivery in immunisation, diabetes management, Medicare income, patient flow, health checks, chronic disease management, mental health, prison health, keeping up to date with guidelines, use of practice health atlases, and ensuring quality Continuing Professional Development and teaching for health professionals. Internal research (by trainees and students) is also used as a form of CQI to inform change. Winnunga participates in the Achieving Diabetes Action and Collaborative Change Study (a large randomised controlled trial testing a collaborative style CQI model), and the Talking about the Smokes Project (which provides client and staff feedback to the service which is used for reflection and improvement).

Future directions

Winnunga will continue to use multiple methods of CQI, and is planning a more formalised framework for ongoing internal program evaluation.

New South Wales

There are an estimated 208,364 Aboriginal and Torres Strait Islander people living in New South Wales (NSW), comprising 31 per cent of the total Aboriginal population in Australia.^{20,21} NSW has the largest Aboriginal population of any state or territory.

The NACCHO Affiliate in NSW, the Aboriginal Health and Medical Research Council (AH&MRC) provides support to approximately 50 member organisations across the state, including around 40 ACCHOs that deliver a comprehensive range of PHC services, and 10 Aboriginal Community Controlled Health Related Services that deliver specialist PHC services to Aboriginal communities, such as drug and alcohol rehabilitation and aged care. AH&MRC member services are located in urban, inner and outer regional and remote areas of NSW. Aboriginal people in NSW also access PHC through the private General Practice sector, as well as through a range of other service arrangements including via Divisions and Medicare Locals.

CQI support models, programs and related initiatives in NSW

The AH&MRC has developed and refined a model of tailored support to member ACCHOs aiming to build capacity and improve the quality of care and services. CQI-related approaches have been used by the AH&MRC since 2006, to support ACCHOs in building their systems to enhance chronic disease prevention and management. Activities such as regional workshops, targeted upskilling, developing and supporting the use of tools and

resources, supporting peer learning opportunities, and providing tailor support, were associated with a doubling in the uptake of adult health checks at the NSW population level between 2007 and 2008.

In 2009, the AH&MRC provided tailored support to five NSW member ACCHOs participating in a mainstream APCC wave in 2009, and evaluated the appropriateness of the APCC model for NSW ACCHOs. Key findings of this evaluation were that while ACCHOs found elements of the APCC model useful, there were limitations relating to it having been developed as a mainstream General Practice model. Participating ACCHOs required more and different support with implementation, and expressed strong preferences for a more flexible and ACCHO tailored approach.

From 2011 until June 2014, the AH&MRC built on earlier experience to develop and implement a multifaceted program of CQI support and capacity building in the NSW ACCHO sector supported by NSW Government funding. AH&MRC CQI Program activities included training and tailored, targeted support for ACCHOs on patient information management systems and data extraction tools, as well as CQI approaches, tools and models of good practice. These were delivered through visits to health services, local and regional workshops, and several state-wide events. Other program elements included a small scholarship scheme for ACCHO staff, and the development and piloting of an accredited training package. Member ACCHOs were supported to develop and use a Practice Health Atlas report, a tool used in mainstream General Practice and Divisions that provides collated data on specific aspects of chronic disease management and Medicare billing.

The AH&MRC CQI Program also developed a website to enhance access to CQI tools and resources, and collected ten ACCHO CQI success stories and published them as a booklet and DVD, available on the website. Other AH&MRC CQI Program activities and outputs included a literature review about indicators and their uses, and a report of a state-wide meeting about data governance. The AH&MRC CQI Program also worked to encourage the integration of CQI approaches into other AH&MRC programs of support, through upskilling within AH&MRC about CQI approaches, and contributing CQI expertise and input, for example in the development of a toolkit to support ACCHOs with their tobacco resistance and control efforts. The AH&MRC also hosted a CQI Conference ‘Data driving change: What works for us?’ in 2013,²² and a national meeting in 2014 to facilitate discussions about CQI concepts within the ACCHO sector.

The AH&MRC is involved in several research collaborations focused on CQI support for ACCHOs including:

- eye health: Brien Holden Vision Institute and Vision CRC partners
- cardiovascular disease: George Institute and others involved in Health Tracker/TORPEDO, and
- sexual health: Kirby Institute and others.

The AH&MRC PHMO has provided clinical leadership for AH&MRC CQI activities, and ACCHO clinicians, including General Practitioners (GPs), nurses and Aboriginal Health Workers have been involved in all of AH&MRC CQI program activities.

Maari Ma Health Aboriginal Corporation provides PHC services to Aboriginal people across a large area of far west NSW including a number of remote towns and communities. Maari Ma has had a long involvement in various formal and less formal CQI initiatives. Maari Ma

used the ABCD CQI program for nine years, and the Kanyini vascular risk assessment tool (as part of a CQI cycle) for approximately five years. The organisation currently does not have involvement with a formal CQI program, but drawing on the organisation's experience in CQI, is using CQI approaches to address problems that arise in the service/s. It is also exploring use of the nKPIs and the Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC) core indicators as part of CQI (see below).

At Maari Ma, it was felt that engagement of clinicians in CQI was facilitated by use of the Kanyini audit tool because of the value-add that it provided to GPs in relation to the ability to drill down to individual patients and offer decision support (in comparison to sample-based auditing). The aggregate data generated through the use of the tool could still be used (by the service) as part of a CQI process – for example, to suggest and test improvements in broader systems and organisation of care.

Table 3: CQI activity in Aboriginal and Torres Strait Islander PHC in NSW

CQI model/approach used	Number of NSW services	Duration; comment
AH&MRC CQI Program	All ACCHOs	Multifaceted program of support and capacity building delivered by the AH&MRC from 2011 to June 2014
APCC (tailored to ACCHO context)*	5 ACCHOs	2009; other ACCHOs participate in mainstream APCC data collection
ABCD/E CQI program ^{&}	6	2005–2012; coordinated and supported by Maari Ma in Far West NSW
One21seventy ⁺	5 ACCHOs	Varying time periods – 5 are current paying subscribers as of January 2014
Healthy for Life	16 services in 8 sites in NSW	
Other related programs using QI approaches		
Healthtracker/TORPEDO*	12 ACCHOs	Varying time periods; NSW ACCHOs supported by AH&MRC and the George Institute
Vision CRC CQI research projects	6 ACCHOs	Brien Holden Vision Institute is working with AH&MRC and other partners, including 6 ACCHOs to develop and pilot indicators and a CQI toolkit to improve vision care
Various sexual health CQI research projects	Multiple ACCHOs	Kirby Institute, AH&MRC working on various research projects using a CQI approach around STIs and sexual health
Achieving Diabetes Action and Collaborative Change*	1 ACCHO	Randomised controlled trial – national, includes one service in NSW

* supported by the affiliate

& supported by regional hub coordinator funded through research grants

+ supported by national infrastructure (fee for service)

In NSW, participation in Healthy for Life has in some cases been through consortium arrangements which have helped to formalise the linkages between health services. For example, the Bila Muuji Upper Sector consortium in northern NSW included four services who were already part of a regional network of ACCHOs (known as Bila Muuji) that met bi-monthly to identify and address shared issues impacting on Aboriginal communities in rural and remote NSW.²³ Data from 2009 suggested that a notable gap in reach of the Healthy for Life program is in Sydney – showing that with one exception (a new Round 3 site) there were no Healthy for Life sites funded in Sydney, the Illawarra, Newcastle or the Central Coast of NSW – a region that is home to over 15 per cent of Australia's Aboriginal and Torres Strait Islander population.

Data systems and management

Primary health care services in NSW use a range of different Patient Information Recall Systems (PIRS). The majority use Medical Director with PracSoft or Communicare, with a trend towards more services using Communicare over recent years. Specialist ACCHOs have different information systems and indicators that reflect their different areas of focus.

The AH&MRC has provided and continued to provide significant levels of support to member ACCHOs around PIRS, including around building Information Technology (IT) infrastructure, support for changing PIRS systems, as well as training on PEN Systems Clinical Audit Tool (PENCAT) and supporting the collection of nKPI data. The AH&MRC literature review about indicators and their uses, and the report of the statewide meeting about data governance, were each prepared to provide an evidence base to inform the development of indicator sets for NSW ACCHOs to use for CQI.

Maari Ma recently started three-monthly extraction of QAIHC indicators, and is planning to find ways to use them in CQI. This is through a region-wide database maintained by the Royal Flying Doctor Service (RFDS) with their base in Broken Hill. The sub-set of data relevant to the Maari Ma services is approximated by client post-code. The QAIHC indicators were chosen because the data extraction tool is already accessible within PENCAT, and these indicators have been designed as relevant to Aboriginal and Torres Strait Islander health.

Future directions

- Identify resources to continue the multifaceted program of work that was being undertaken through the AH&MRC CQI program; NSW government funding for this program ceased in June 2014.
- Should resources be able to be identified, current thinking about possible future directions for AH&MRC CQI activities are to:
 - Continue to develop and deliver a tailored and flexible multifaceted program of CQI support to NSW ACCHOs that is designed and responsive to their needs and preferences and integrated with other support activities
 - Build capacity within the AH&MRC and develop systems more broadly, to enhance the collation, sharing and use of available and new sources of health information and data by and for ACCHOs for quality improvement purposes
 - Continue to collaborate within NSW and nationally within the sector and with other stakeholders to: develop and document ACCHO models of CQI; develop and use indicator sets for CQI purposes around topics that are priorities for ACCHOs and Aboriginal communities; and to develop and share tools and resources for effective CQI within the sector and more broadly.

Northern Territory

The NT is home to an estimated 68,901 Aboriginal and Torres Strait Islander people, comprising 30 per cent of the total population of the NT, and 10 per cent of all Aboriginal and Torres Strait Islander people in Australia.^{20,21}

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) provides support to approximately 25 member organisations. The majority of these services are in very remote

or remote areas. The NT Department of Health (NT DOH) is also a large provider of PHC services to Aboriginal and Torres Strait Islander people. Most PHC accessed by Aboriginal and Torres Strait Islander people in the NT is through the ACCHO sector and PHC services run by the NT DOH.

Unlike some other jurisdictions, the private General Practice sector in the NT does not play a significant role in providing PHC to Aboriginal and Torres Strait Islander people.

CQI support model in the NT

The NT has an established support model for CQI in Aboriginal and Torres Strait Islander PHC. This CQI support model (the ‘NT CQI Strategy’) is led by AMSANT, which employs two program coordinators to oversee implementation. These coordinators work with a team of CQI facilitators who are employed by health services to drive CQI activity across the NT.

The overall goal of the CQI Strategy is to build a consistent approach (albeit with considerable flexibility about how CQI is implemented on the ground) to CQI across the NT Aboriginal PHC sector (both ACCHOs and NT Government), and to support sustainable, long term service improvement and improved health outcomes in the Aboriginal population. Governance of the NT CQI Strategy is through a steering committee that reports to the NT Aboriginal Health Forum. A key component of the strategy is the use of clinical data to inform and drive quality improvement activity. There is a focus on shared learning, working with the whole team and systems thinking.

Components of the NT CQI Strategy include:

- Consistent approach
 - Based on PDSA cycle, completion of cycle; clinical guidelines & best practice standards using CQI tools (One21seventy; SECA; NT AHKPI; nKPI)
- Team approach
 - Effective and functional teams; trained in and using CQI approach; CQI part of everyone’s role and clarified in job descriptions
- Support
 - Training, coaching, develop and maintain CQI skills; building a learning culture; encouragement/reinforcement; dedicated CQI roles; tailored support – capability of PHC; flexible – support and implementation
- Systematic use of data
 - Collection and use of reliable data; identify problems and/or opportunities; set priorities; evaluate outcome; data sharing throughout the NT
- Governance
 - Clinical, corporate (monitoring, evaluating performance); CQI model; accreditation; risk management; quality and safety
- Leadership and accountability
 - Organisational priority and commitment; embedded CQI; understanding roles and responsibilities at all levels; leadership to reinforce CQI approach; embed at all levels of PHC; NT Aboriginal Health Forum
- Aboriginal engagement
 - Patient centred; consumer input – two-way communication; building CQI skills and competence in Aboriginal workforce; Boards/advisory committees; CQI steering committee membership

- Structured information sharing
Regular feedback; share information/learnings on improvements; research translation and knowledge sharing; national linkages
- Resources
Human resources; finance; tools; protected time for CQI activity; information technology; clinical information systems.

CQI programs and related initiatives in the NT

The NT CQI Strategy Evaluation³² described a range of different CQI activities used in the case study sites participating in the evaluation. The key finding was that different sites used different CQI tools and approaches. For example, some sites used One21seventy tools in conjunction with interpretation of the Northern Territory Aboriginal Health Key Performance Indicators (NTAHKPIs) or nKPI reports, some used manager-led ‘mini cycles’ which comprised managers interrogating their own electronic PIRS to gather data on a specific issue, rather than a comprehensive audit process. Another case study site had adapted elements of ABCD CQI tools, and developed their own audit tools using a similar process. These findings demonstrate that the ability to tailor approaches to local context is a factor in successful CQI.^{10,25} CQI programs and resources used in the Aboriginal and Torres Strait Islander PHC system in the NT are shown in Table 4 – noting that this may not be a complete list.

NT participation in Healthy for Life has tended to have less emphasis on consortium arrangements than some other jurisdictions – with only one Healthy for Life consortium in the NT. Healthy for Life sites have also tended to be engaged in other CQI activities over the years, including the ABCD CQI program.²⁶ Individual services have also been involved in APCC waves at various times.

The NT DOH, AMSANT and individual ACCHOs have had a long involvement with, and commitment to, CQI. This has included active partnership in CQI research, through for example ABCD/E participatory action research projects (2002–2009), and in the ABCD CQI National Research Partnership Project (2010–2014).

Table 4: CQI activity in Aboriginal and Torres Strait Islander PHC in the NT

CQI model/approach used	Number of NT services	Duration; comment
Rapid PDSA cycles, and health service own models	Varies	Varies
One21seventy ⁺	7 ACCHOs covering 26 sites and 50 NT Government sites	Varying time periods – these numbers current paying subscribers as of August 2014
Healthy for Life	11 services in 9 sites [^]	Varying time periods depending on Rounds
CQI collaborative sessions* (AMSA NT hosted)	All Services in the NT are invited to participate in CQI Collaboratives with around 70–80 participants at each workshop	Seven NT Wide CQI Collaborative workshops over the past 4 years. Three Regional CQI Collaboratives.
Building CQI knowledge, skills and confidence in Aboriginal workforce*	All	7 CQI Skills training workshops have been delivered for Aboriginal workforce
Other related programs using QI approaches		
Chronic conditions management model/ traffic light system	All NT Government PHC services	2012–present; draws automated extraction of data from PCIS (the electronic clinical information system used by NT government services) to report quarterly on a suite of clinical performance indicators, including NTAHKPIs and provide support for conducting PDSA cycles
Achieving Diabetes Action and Collaborative Change	5 ACCHOs	Randomised controlled trial – national includes 5 PHC services in the NT
Other PHC intervention research projects using a CQI approach	Most services	Examples include sexual health, rheumatic heart disease, decision support and diabetes.

* supported by the NT CQI Strategy;

+ supported by national infrastructure (fee for service);

[^] reported in 2009 evaluation

Data systems and management

There is some consistency with PIRS across the NT – most government sites use PCIS (with two government sites in East Arnhem using Communicare), and most ACCHOs use Communicare.

The NT has developed a common data platform in the NTAHKPIs, a set of 15 clinical indicators currently in use, and seven Qualitative Indicators not reported on formally. Reporting against NTAHKPIs commenced in 2009. This reporting is valued by regional managers, as they provide a broad, system-wide view, including state-based services and ACCHOs. They are also used in a ‘traffic light system’ by regional management in NT DOH (see Table above). At health service level they tend to be used along with other CQI tools as they are generally considered too narrow on their own to guide improvement.

Future directions for the NT CQI strategy

- Ongoing identification and implementation of effective strategies to further embed CQI at all levels of the PHC system.
- Continue to support the CQI activity of NT PHC services, building their expertise and capacity to identify local improvement priorities and implement improvement strategies.

- Ensure all PHC services have access to appropriate training, CQI tools and support to enable them to achieve their CQI goals.
- Support the development of effective processes to effectively engage communities and clients in two-way feedback.
- Clearly articulated program logic that defines short, medium and long term outcomes of the CQI strategy.

Whilst there is no ‘one size fits all’ approach, the past experience of the NT CQI Strategy implementation could inform other jurisdictions embarking on support initiatives for wide-scale CQI. Mechanisms to enable cross-jurisdictional learning should be supported.

Queensland

Queensland has the second largest number of Aboriginal and Torres Strait Islander people of any jurisdiction in Australia. It is home to an estimated 188,892 Aboriginal and Torres Strait Islander people, comprising 28 per cent of the Aboriginal population in Australia, and 4.2 per cent of people in Queensland.^{20,21}

The QAIHC provides support to its approximately 28 member organisations, including 22 organisations providing PHC medical services. Queensland Department of Health is also a large provider of PHC services to Aboriginal and Torres Strait Islander people, with approximately 100 PHC services having significant proportions of Aboriginal and Torres Strait Islander people in their client populations. The private General Practice sector also plays some role in PHC provision to Aboriginal people in Queensland.

CQI support models in Queensland

There are a number of different CQI support models that have been developed and adapted for different purposes in Queensland.

QAIHC’s Achieving Clinical Excellence (ACE) program is an extension of the Queensland Close the Gap Collaborative, which began as an APCC Collaborative wave in 2010–2011 and then continued with QAIHC leadership, support and continued use of the Improvement Foundation QiConnect portal. This Affiliate-led support model has enabled ACCHOs in Queensland, together with 4 mainstream general practices, 1 RFDS site and an independent NGO clinic, to systematically collect performance data relevant to patient access and delivery on key clinical care.⁷

The ACE program assists clinical teams to improve clinical outcomes and enhance their clinical care delivery. Data provide an overview of:

- access to the service
- service performance on best practice care
- health status of user patients
- gaps and areas that require changes in strategic planning.

The infrastructure developed allows services to connect to the QAIHC pages or module in the QiConnect portal, in order to monitor the effectiveness of the changes they implement in care delivery through CQI cycles. This information platform allows monthly electronic extraction, transmission, analysis and graphic display of clinical data with the ability to compare de-identified data with other services and practices as both time trends and benchmarked. The program is governed by the QAIHC Lead Clinician Group.

The ACE program includes:

- a model for improvement and change management principles
- leadership, set standards and targets
- workshops, site visits, networking via teleconference, webinars
- partnerships (Improvement Foundation, other PHC providers)
- supported by a small support team (CQI coordinators; EMR/systems support officer; Data Management Officer).

Other support strategies include:

- data repository, with the following indicator sets stored at QAIHC for all participating services:
 - QAIHC Core Indicators
 - APCC measures
 - nKPIs
 - TORPEDO CVS indicators
 - Online Services Reports
 - Public Health Atlases
- secondary use of data (overview of performance, Geographic Information System work)
- integrating and harnessing technology (e.g. electronic medical records, electronic decision support systems, CQI tools and portals)
- research programs.

QAIHC has led a focus on several themes over its five year clinical CQI journey. These have included challenging participant clinics to improve service/clinic access, health check coverage, cardiac care, renal care, and maternal and child health.

The ACE program's success is reflected in the data trends for the 22 participant clinics. In 2010 the first six services began sending data through to QAIHC. By 2014 this had increased to 22 participating clinics, regularly sending data covering just under 52,000 Aboriginal and Torres Strait Islander patients, about 30 per cent of the Queensland Aboriginal and Islander population. This coverage will increase further in late 2014 as MMEx becomes linked to the PENCAT. Examples of the sustained improvements made by ACE participants are shown below in Figures 4–6.²⁷

Figure 4: Proportion of regular Indigenous adult patients' completeness of recording risk factors over time

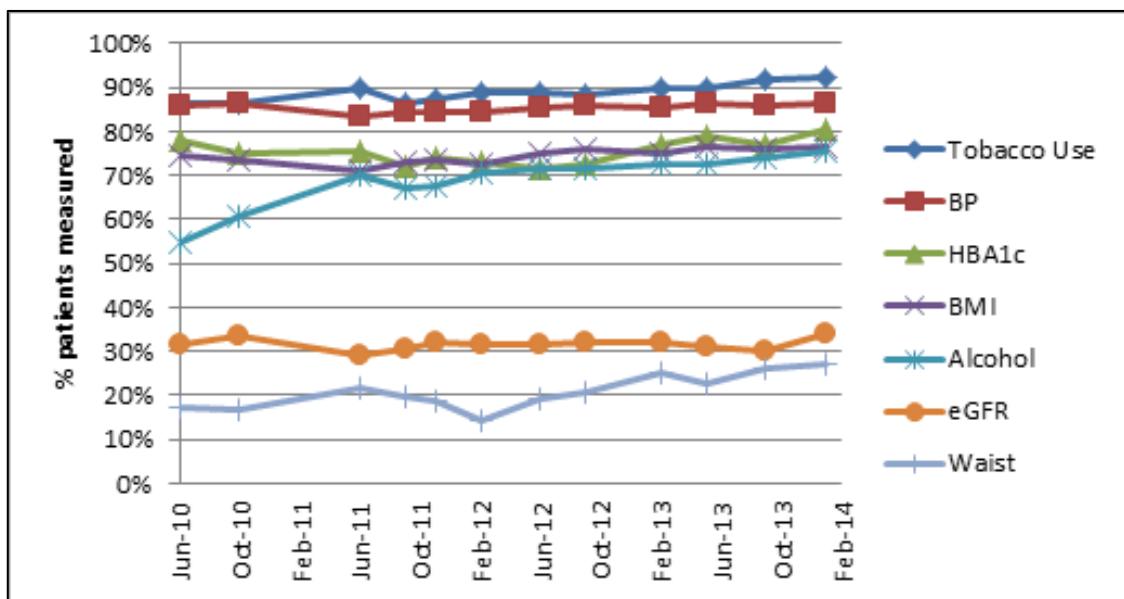


Figure 5: Proportion of regular Indigenous adult patients with current health assessments (performed in 2 years prior to data extraction) over time

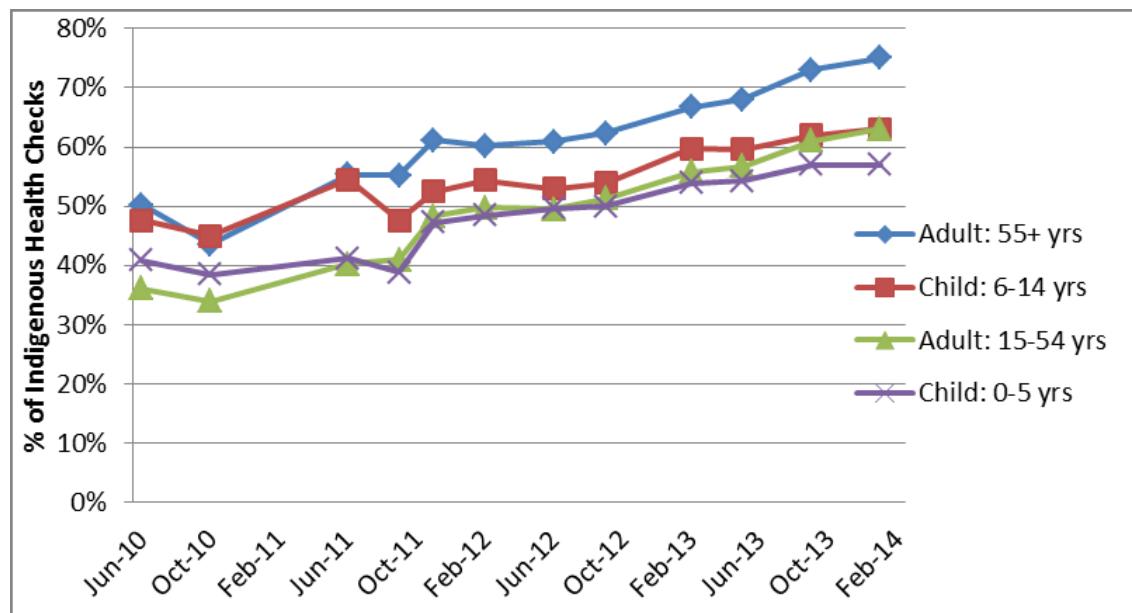
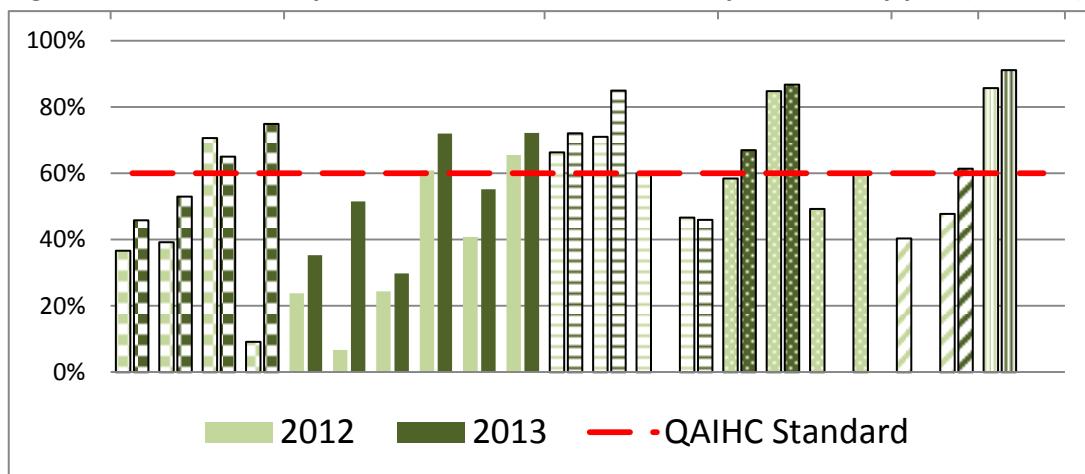


Figure 6: Adults 15 to 54 years with a health check billed, by clinic and by year (2012–13)



In the government health sector, the Queensland Government Chronic Disease Strategy provided a program of support for state-run PHC services with large Aboriginal and Torres Strait Islander populations. This included a state CQI coordinator and regional facilitators, and funding for approximately 100 state-run PHC sites (and ACCHOs if they chose) to use One21seventy. The state-wide CQI initiative was largely redistributed to the new Hospital and Health Service (HHS) areas from June 2013, and state-wide funding for One21seventy ended. Five Queensland HHS areas, covering 27 sites, and five ACCHOs, have continued as subscribers to One21seventy (as at August 2014).

Various regional organisations provide support to ACCHOs for CQI (in addition to, or alongside support provided by QAIHC) as part of their general support role to member services. Examples include:

- The Institute for Urban Aboriginal and Torres Strait Islander Health (IUIH). CQI work with seven services in South East Queensland. IUIH employs PDSA cycles with health service staff.
- Apunipima Cape York Health Council also has a CQI culture embedded in their work. Most ACCHOs use local CQI frameworks; for example, those developed by the Apunipima Cape York Health Council, and Goondir Health Services (Appendix 5).
- In addition most services have participated in many research programs over the years that have a CQI component.

CQI programs and related initiatives

CQI programs and resources used in the Aboriginal and Torres Strait Islander PHC system in Queensland are shown in Table 5 – noting that this may not be a complete list.

Table 5: CQI activity in Aboriginal and Torres Strait Islander PHC in Queensland

CQI model/approach used	Number of QLD services	Duration; comment
QAIHC's ACE program	22 – all ACCHOs in Queensland, plus 1 RFDS and 8 GPs	QAIHC staff; supports services to use a range of models and strategies to enhance best practice care and comprehensive PHC
One21seventy ⁺	5 state-run services covering 27 sites and 5 ACCHOs covering 8 sites	Varying time periods – these numbers represent current paying subscribers as of August 2014
Healthy for Life	13 services in 6 sites [^]	
Other related programs using QI approaches		
TORPEDO Project – Absolute Cardiovascular risk assessment tool (and electronic decision support)*	10 ACCHOs	QAIHC and the George Institute, supported implementation of a clinical decision-support system and QI intervention (TORPEDO), to improve guideline-recommended screening for cardiovascular risk management – part of a RCT with NSW
Achieving Diabetes Action and Collaborative Change*	2 PHC services	WHO-Baker IDI randomised controlled trial – national includes 2 PHC services in Queensland

*supported by Affiliate and research

+supported by national infrastructure (fee for service)

[^]reported in 2009 evaluation

Data systems and management

QAIHC has developed a core indicator set, the ‘QAIHC core indicators’, which provide a common data platform across ACCHOs in Queensland. These are accessible using PENCAT, with a matching module to monitor performance and trends in the QiConnect web portal. The ease of access and suitability to the Aboriginal health context has meant that other agencies have started to use these indicators (AHCSA, AHCWA and Maari Ma in Far West NSW). There are 26 QAIHC core indicators developed with a focus on access, maternal and child health and chronic disease.²⁸ New immunisation, STI and antenatal indicators with corresponding CAT CQI modules are planned for release in late 2014.

A range of PIRS are used in Queensland in the ACCHOs, state PHC clinics and mainstream General Practices. Any PHC service or provider using a PIRS can be linked into PENCAT tool and allowed access to QAIHC core indicators, APCC measures and nKPIs for CQI work. QAIHC has led significant enhancements to the PENCAT tool in 2013–2014, to broaden its focus from chronic disease to prevention. New CAT modules will be available for sexual health, immunisation and antenatal care in late 2014. Similarly QAIHC has heavily influenced change at the Improvement Foundation where QAIHC’s customised QiConnect portal is no longer time limited for services or practices wanting to engage in or embed CQI work in their clinic culture.

QAIHC and the George Institute have successfully completed a randomised controlled trial on Health Tracker, an electronic decision support system for assessing absolute cardiovascular risk. This trial demonstrated improved risk factor screening and medication prescribing in the intervention clinics.

Future directions

- Mentoring: The experience of QAIHC in developing indicator sets, facilitating their access, and promoting their use through a support model to ACCHOs could help inform other jurisdictions embarking on support initiatives for wide-scale CQI. Several other jurisdictions have started to use the QAIHC core indicators. Mechanisms to enable cross-jurisdictional learning should be supported.
- Sustained funding: Within Queensland, several elements of the ACE program are largely unfunded, limiting the activities which can be undertaken e.g. collaborative workshops with GP providers who have expressed interest in participating in the CQI program. Sustainable and secure resourcing needs to be identified for the continuation of these and other activities.
- Expansion to other sectors: QAIHC will continue to expand the ACE program. Preliminary discussions are underway with Queensland Health about including some of their state clinics within the ACE program. General Practices with large Aboriginal and Islander user populations will also be targeted.
- Harnessing technology: QAIHC will continue to lead and coordinate work on
 - Continued development and embedding of electronic decision support tool
 - Participatory health and patient feedback (with ACE participants and the support of the Lead Clinicians Group).

South Australia

There are an estimated 37,392 Aboriginal and Torres Strait Islander people living in South Australia, comprising 2.3 per cent of the total population, and including 6 per cent of the total Aboriginal and Torres Strait Islander population in Australia.^{20,21} The Aboriginal Health Council of South Australia (AHCSA) provides support to their approximately 15 member organisations. These organisations are located in very remote, remote, regional and city locations. There are also a number of state-run services and General Practices where Aboriginal and Torres Strait Islander people access PHC.

CQI support models in SA

In SA, AHCSA has provided support to CQI in the ACCHO sector over a number of years through a range of mechanisms. The SA Quality Improvement Data (SQID) program based at AHCSA supports data analysis and feedback to SA ACCHOs using the OCHREStreams data platform. In this program, nKPIs and QAIHC core indicators (supported through the APCC web portal) are the common data sets.

From 2010–2014 AHCSA was a partner on the ABCD National Research Partnership project, and through this project trialled the use of One21seventy tools and processes in 15 PHC services in SA, including 10 ACCHOs and five SA health state services. In this project, the research officer located at AHCSA provided a dual service support and research role exploring barriers and enablers to CQI in the SA context, with a focus on supporting CQI implementation in the ACCHO service sector. In the research conducted alongside this project,²⁹ health service staff regularly cited the dedicated support from the research officer/CQI coordinator as a key enabler to both initial and sustained CQI activity.

The research found that a key success factor for CQI support role was that it was embedded within the broad AHCSA service delivery team offering integrated support. For example, AHCSA's Public Health Medical Officer and the Public Health team (particularly

Accreditation and Governance; Patient Information Systems and E-Health project officers) worked closely with ACCHO staff to identify linkages between these activities and often promoted a coherent and systems-based approach to broad organisational level planning.²⁹ The research also confirmed the central role of leadership for CQI in effective implementation, highlighting that this needs to go beyond support for undertaking CQI activities, and extend to leadership and support for making changes within the organisation.²⁹

CQI programs and approaches in SA

CQI programs and resources used in the Aboriginal and Torres Strait Islander PHC system in South Australia are shown in Table 6 – noting that this may not be a complete list.

Table 6: CQI activity in Aboriginal and Torres Strait Islander PHC in South Australia

CQI model/approach used	Number of services	Duration; comment
Various public health programs with embedded CQI (e.g AHCSA Sexual Health program)*	All	Ongoing
One21seventy+	2 ACCHOs	Support by AHCSA for a number of ACCHOs to use One21seventy through a national research partnership ended in June 2014, and only two ACCHO had the resources to continue using this program
Healthy for Life	14 services in 9 sites^	
SQUID program*	8 member services	Commenced 2014
Other related programs using QI approaches		
Achieving Diabetes Action and Collaborative Change	2 ACCHOs	Randomised controlled trial – national, includes 2 services in SA

*supported by the Affiliate

+supported by national infrastructure

^reported in 2009 evaluation

Affiliates provide support to ACCHOs within their jurisdictions in many ways, including through supporting the development of specific public health and PHC programs. While funding for CQI within these programs is not usually included in the budget, it is important to appreciate that it is often through these programs that some of the most effective support for CQI occurs. An example is the AHCSA Sexual Health program (see below), which is just one example of a public health program run by an Affiliate to support activities at the health service level, which has embedded CQI as part of the program. The ability to do this effectively required time, resources and expertise, and deserves more recognition by funding bodies.

Healthy for Life, while not specifically a CQI program, has a CQI component. In SA, participation in Healthy for Life has included single service arrangements, with one consortium.²⁶ The single consortium is a partnership between Nunkuwarrin Yunti (lead agency), the Aboriginal Sobriety Group (co-located with Nunkuwarrin Yunti), and the Government health regions of Central Northern Adelaide Health Service, Southern Adelaide Health Service and the Children, Youth and Women's Health Service. Together, these consortium members provide health care to half of SA's Aboriginal Peoples.²⁶

Nunkuwarrin Yunti, which is one of the largest AHCSA member services, has developed a sophisticated and comprehensive local CQI framework (Nunkuwarrin Yunti's Continuous Improvement Framework, 2012). Extracts from this framework are shown with permission

in Appendix 5. This framework is independent of any particular CQI model or resource, and embeds CQI as part of a quality organisation, showing where CQI initiatives fit in the broader system.

Data systems and management

Health service data available for CQI in SA is being developed, and includes the nKPIs, QAIHC Core Indicators used in the SQID program, and the health service data obtained through service participation in One21seventy. As part of the SQID program, the ACCHOs of SA send monthly data to the Improvement Foundation web portal. AHCSA uses this data submission pathway in order to compile health service reports. AHCSA identified a number of strengths and limitations of these data. Core concerns were that both the nKPI and QAIHC Core Indicators use denominators that are not consistent with health service current patient lists in SA, that little evidence exists as to the accuracy of the data submission pathway to the web portal, and that at present the data able to be extracted have limited value for CQI as they are very narrowly focused (in time, it was hoped that a greater range of indicators could be included). Concerns related to One21seventy data and the time taken by manual audit, with a lot of attention paid to the auditing, but less than optimal focus on identifying, implementing and testing improvements. The SQID program has the advantage that all ACCHOs in SA use the same PIRS, Communicare.

The AHCSA Sexual Health Program commenced in early 2010 with funding from the SA Health Department, with the aim of building capacity within SA ACCHOs for the improvement of sexual health services for Aboriginal community members across SA. The AHCSA sexual health action plan incorporates quality improvement as an integral part of the program which focuses on community engagement with young people and developing clinical capacity in ACCHOs to address the issues of sexually transmitted infections & blood borne viruses within the SA Aboriginal community. Over the past few years, SA ACCHOs have undertaken a six-week period of intensive screening for Sexually Transmitted Infections (STIs), with the aim of reducing transmission of STIs within their communities. AHCSA has supported these activities, and for CQI purposes has analysed the data from each health service each year to provide feedback to each service on the rates of screening and STI prevalence. Extracting and analysing these data is time-consuming, and there are challenges in extending the data collection and analysis over the whole year to provide ongoing information to ACCHOs to assist with CQI for their sexual health programs.

However, over the past year AHCSA has developed an arrangement with the pathology provider that is used by all SA ACCHOs for STI testing. A monthly report is now provided by the pathology provider to AHCSA. AHCSA staff are then able to analyse the data and present in a reader-friendly form so all ACCHOs are receiving regular reports on screening rates and rates of STIs. Health service staff are able to compare their local data with aggregated data across the state.

Future directions

- There would seem to be several opportunities to build on the CQI support models within AHCSA. This will need some funding support and a clear articulation of how change can be achieved and through what mechanisms.
- There may be value in leveraging the experience of more ‘CQI mature’ organisations, particularly Nunkuwarrin Yunti and Port Lincoln Aboriginal Health Service to other

organisations to spread CQI capacity, recognising that there is no ‘one size fits all’ approach.

- A national framework could draw on the work that has gone into making the various indicators more useful and meaningful at a local level, in SA, specifically the SQID CQI program.

Tasmania

Tasmania is home to an estimated 24,155 Aboriginal and Torres Strait Islander people respectively, 4 per cent of the total Aboriginal and Torres Strait Islander population in Australia.^{20,21} Currently there is one Healthy for Life site in Tasmania, delivering services in three different cities. In the timeframe of the project, we were unable to obtain any further information about CQI in Aboriginal and Torres Strait Islander PHC in Tasmania.

Victoria

There are an estimated 47,327 Aboriginal and Torres Strait Islander people living in Victoria, comprising 7 per cent of all Aboriginal and Torres Strait Islander people, and 2.9 per cent of Victoria’s total population.^{20,21} The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) supports 27 member services. Several of these are specialised services, for example, aged care, drug rehabilitation, and community care. The majority of member services are located in inner and outer regional areas. Aboriginal and Torres Strait Islander people also receive PHC from the privately run General Practice sector, although as for other jurisdictions, reliable data on the patterns of PHC service use by Aboriginal people by sector are not available.

CQI support models in Victoria

VACCHO support to member services includes support for quality across a range of areas. This includes support to member services in meeting accreditation requirements and in supplying indicators required for reporting including the nKPIs. VACCHO also provides support to boards around governance and to senior management regarding organisational planning and review. VACCHO has a strong focus on promoting cultural safety and cultural respect as an integral component of a quality service. VACCHO provides support to services in PIRS and in using PENCAT. In some cases VACCHO has been able to link services to Medicare Locals to assist services with their PIRS and use of PENCAT.

CQI programs and related initiatives in Victoria

CQI programs and resources used in the Aboriginal and Torres Strait Islander PHC system in Victoria are shown in Table 7 – noting that this may not be a complete list due to time constraints making consultation with each ACCHO unfeasible. External support has tended to be specific to each of these initiatives (with the exception of Affiliate support which covers a broader range of issues and approaches).

Table 7: CQI activity in Aboriginal and Torres Strait Islander PHC in Victoria

CQI model/approach used	number of VIC services	Duration; comment
VACCHO member support-no formal model*	27 ACCHOs	See text for details of clinical and governance CQI support
APCC	7 ACCHOs	Participated in various ‘waves’ including Diabetes and Close the Gap; some services have continued submitting data through the Improvement Foundation web portal for their own CQI initiatives
One21seventy ⁺	1 ACCHO covering 4 sites	As of August 2014
Healthy for Life	17 services in 7 sites [^]	
Other related programs using QI approaches		
Achieving Diabetes Action and Collaborative Change*	3 ACCHOs	Randomised controlled trial – national includes three ACCHOs in Victoria
AHPACC CQI initiative	11 sites, including ACCHOs and mainstream services	CQI tool was developed in 2011/2012–present; mandatory use of CQI tool for AHPACC funded organisations
Practice Health Atlas	9 ACCHOs	Funding was provided by Victoria’s Department of Health and ceased in 2013.

*supported by the Affiliate

⁺supported by national infrastructure (fee for service)

[^]number of services reported in Urbis 2009 – unable to ascertain if these are all ACCHOs, or include state services.

Some services use several CQI approaches or related initiatives. For example, many Healthy for Life funded services in Victoria were funded through the Victorian Government’s Aboriginal Health Promotion and Chronic Care (AHPACC) initiative, which began at a similar time. The AHPACC initiative intends to support Aboriginal community-controlled and mainstream primary health services to work in partnership to improve health outcomes for Aboriginal people who are living with, or at risk of, chronic disease. A CQI tool developed for these initiatives, based on a Health Promotion CQI tool, is not clinically focused. Use of the tool twice in the first year, and annually thereafter is mandatory for services receiving partnership funding. Initially support in use of the tool was provided by a contracted Industry Advisor. An evaluation reported that those organisations that accessed the Industry Advisor felt that the implementation was more meaningful than those who had not accessed the Advisor.³⁰

The state-funded Strengthening Primary Health Care project uses a range of VACCHO-developed tools to identify gaps and areas for development across a range of business ‘systems’, including governance, clinical governance, quality, risk and compliance, finance, IT and Human Resources. It also looks at cultural safety. These tools are used as ‘pre and post’ quality improvement measures.

Data

ACCHOs in Victoria have experienced significant issues with data quality and IT to support extraction of clinical indicators for use in CQI. In consultations conducted for this project VACCHO reported that the development of a portal (by an external agency) to support extraction of indicators for CQI use (the ‘Counting on Your Community’ pilot project), had experienced significant delays and it was unclear if or when it would provide the promised support. It had been intended that ‘Counting on Your Community’ would use the OCHREStreams web portal and enable extraction, sharing and use of health service data.

It does not appear that the nKPIs have been used to any significant extent for CQI in the VACCHO member services. Key barriers in Victoria have included software systems that are sufficiently developed to support CQI, issues with data quality, lack of staff time available for CQI activities, limited usefulness of some nKPIs as CQI indicators, and the limited applicability of nKPIs and available indicators to ACCHOs that offer specialised services.

ACCHOs in Victoria use various PIRS including Communicare, Best Practice and Medical Director.

Future directions

- VACCHO appears to be well placed to provide support to member ACCHOs across a number of CQI programs/approaches, but most activity to date has been unfunded and therefore limited in scope. Identification of further funding opportunities and resources would allow expansion of the current programs and development of new programs to support member ACCHOs in CQI activities related to both corporate and clinical governance aiming for improved health outcomes.
- Any funding for CQI activities should not be prescriptive in the approach taken to achieve a result, but should be complementary to existing activities and responsive to state, regional and service priorities.
- The significant delays in the ‘Counting on Your Community’ clinical quality improvement project have resulted in some changes in the initial scope of the project. VACCHO member services have recently reiterated their willingness to share data with VACCHO for the purpose of supporting quality improvement, service planning and advocacy activities. VACCHO is currently designing a program to support member ACCHOs in the use of these data, the scope of which will depend on current and future funding opportunities.
- Models of support for CQI in the ACCHO sector in Victoria need to be appropriate to the types of services delivered by different organisations, and there may be value in linking with and sharing CQI approaches that address broader social determinants of health within a comprehensive PHC model – for example health promotion, and drug and alcohol.
- Support provided through the Strengthening Primary Health Care project is limited through lack of personnel to engage meaningfully with member services and to provide guidance and ‘mentoring’ through broad organisational change processes.

Western Australia

Western Australia (WA) has the second largest share of the Aboriginal and Torres Strait Islander population, with 13 per cent of all Aboriginal and Torres Strait Islanders living in WA – or 88,277 people. This is around 3.8 per cent of WA’s total population.^{20,21}

The Aboriginal Health Council of Western Australia (AHCWA) provides support to their approximately 30 member organisations. Around one half of these services are located in remote or very remote areas.

CQI support model

AHCWA is currently trialling Affiliate based CQI support to six ACCHOs using a set of integrated CQI strategies involving Affiliate based clinical governance support, rapid PDSA cycles, online training and the use of web based technologies to support uptake of evidence. This Continuous Care Improvement (CCI) project is focused on four topics:

uptake of health assessments, smoking, sexual health and otitis media. This is a two-year funded support program. The model intends to embed CQI in daily routines of health services, and build capacity.

CQI programs and approaches

CQI programs and approaches used in the Aboriginal and Torres Strait Islander PHC system in WA are shown in Table 8 – noting that this may not be a complete list.

Table 8: CQI activity in Aboriginal and Torres Strait Islander PHC in Western Australia

CQI model/approach used	number of WA services	Duration; comment
Continuous Care Improvement Project*	6 ACCHOs	2013–2016 pilot funded; trialling Affiliate support, rapid PDSA, clinical governance support, quality leads; online training and e-technologies.
APCC	None currently	
One21seventy ⁺	5 ACCHOs and 1 state service	As of January 2014; varying time periods
Healthy for Life	11 services in 8 sites [^]	
Other related programs using QI approaches		
WA Alcohol and Other Drug Sector Quality Framework	Unknown	2004–present; is used by some ACCHOs, and other services

*supported by the affiliate, research funding and Commonwealth

⁺supported by national infrastructure (fee for service)

Health services in WA have had prior experience with CQI, and/or use more than one CQI approach. Twelve services participated in the ABCD/E for varying periods of time. Eight participated in Wave 3 of the APCC but none are currently participating.

At least four of the services currently participating in the CCI project had previously had involvement in CQI. Unlike some of the other jurisdictions, health services participating in the Healthy for Life initiative in WA are mostly participating as single services, apart from two small consortia of two and three services each.

Although overall the numbers of health services engaged in CQI in WA are smaller than in some other jurisdictions, several WA health services have a long history and experience in CQI. Derby Aboriginal Health Service, located in remote Western Australia is an example of a service that has conducted clinical audits over an extended time period, with demonstrated service improvement and health outcomes. (Derby is part of a regional collective of Aboriginal health services). Published data show improvements in diabetes monitoring and outcomes, and the maintenance of these improvements over a 10 year time period (1999–2009).³¹ Key characteristics of CQI in this service include a whole-of-service involvement in internal CQI processes, use of electronic patient information and recall systems, and regional support and standardisation of care. Formal CQI activities included short periods of involvement with the APCC and the ABCD programs, ongoing internal and external (Kimberley Aboriginal Medical Services Council) audit of service data; and formalisation of a regular audit process during the 2006–2007 audit year. Derby experiences a number of challenges common to remote services, including recruitment and retention of skilled professionals, and nonetheless has been able to demonstrate and sustain improvements in care over an extended period of time.

Data systems and management

Most of the ACCHOs involved in the CCI project use Communicare, making data extraction for the program relatively straightforward. One service is using MMEX.

Future directions

- Development of an Affiliate-led support model of CQI through AHCWA is a positive step. There are likely to be opportunities to bring to bear learnings from other jurisdictions which are further along in a CQI journey, and to share the learnings from the CCI Project out to other Affiliates.
- An assessment of health service needs in relation to CQI support and capacity for CQI in WA will be an important step in developing a scaled-up support model. This type of assessment has been a useful approach in the NT. In this process linkages and synergies between the different CQI models shown in the Table should be explored further.
- A national framework could foster and make more visible the leadership for CQI that already exists in WA, for example, in AHCWA, other services like Derby Aboriginal Health Service, and from other organisations with CQI experience.

3. Key Findings and Principles

This section brings together the evidence gathered throughout this project into findings relevant to the development of a national framework for Aboriginal and Torres Strait Islander PHC. It synthesises knowledge from international and Australian evidence, consultations with stakeholders, and information about current CQI activity in Aboriginal and Torres Strait Islander PHC.

This section also describes a number of parameters or guiding principles that need to be taken into account in developing and implementing a national framework. The consultations undertaken for this project identified widespread support for a national framework, but also elicited wise advice about factors that will contribute to making sure a framework is ‘not just a piece of paper’ and will make a real difference for the health of Aboriginal and Torres Strait Islander people. This advice was highly consistent with the international and Australian evidence, as demonstrated at various points in the text below.

The following sections present the findings of this project organised into 12 key themes. For ease of reference, the principles or recommendations related to each theme are shown in a box below the relevant section. The key themes are:

- potential contribution of a national CQI framework to ‘Closing the Gap’
- ensure clear linkages between ‘inputs’ to a national CQI framework, intended outcomes and implementation
- strengthen enablers for CQI
- articulate what effective CQI means in the context of providing quality PHC for Aboriginal and Torres Strait Islander people, particularly the importance of cultural capability
- a collaborative approach, led by the ACCHO sector but for the PHC system
- system-wide support for CQI and linkages between different components of support
- leadership and support networks
- strengthening workforce capacity
- flexibility in CQI tools and approaches
- data platforms and clinical information systems to support CQI
- a whole-of-quality system
- support to services with limited capacity for CQI.

These 12 key themes are highly interdependent, so several issues (such as leadership for example) appear across a number of themes.

3.1 A national CQI framework could contribute to Closing the Gap

CQI in health care contributes to improved health outcomes by systematically focusing attention on the quality of care provided to clients, across the spectrum of care provided. A strong and effective PHC system that ensures high quality care for Aboriginal and Torres Strait Islander people is vital to Closing the Gap. CQI implemented at scale and across the system will help to improve the effectiveness of the PHC system in delivering quality care to Aboriginal and Torres Strait Islander people, and improve the performance and effectiveness of clinical teams in front-line services.

Improving quality of care across the PHC system and at scale is a long-term change effort that requires engagement from a wide range of stakeholder groups. There are several characteristics of PHC that make it a particularly challenging context within which to bring about large scale change of the kind required to Close the Gap. These characteristics include the diversity, autonomy and dispersion of PHC providers, the wide scope of care, and the limited common support infrastructure for improvement. A well-structured national framework could help to build and strengthen an overarching vision for high quality care, articulate a ‘line of sight’ program logic between activity and intended outcomes, and identify and support infrastructure to embed and sustain improvement efforts. It could also help to systematically address the variation in quality of care provided across health services across Australia, so that Aboriginal and Torres Islander people receive good quality PHC whatever PHC services they use. Sections 3.1.1–6 discuss ways in which the potential benefits of a national CQI framework for Aboriginal and Torres Strait Islander PHC might be realised.

3.1.1. Build on the expertise and leadership of the ACCHO sector in order to improve care for Aboriginal and Torres Strait Islander people across the PHC system

Three main service sectors are engaged in the delivery of PHC to Aboriginal and Torres Strait Islander people: the ACCHO sector, government sector and the private General Practice sector. Each sector has its own distinctive characteristics and systems. Approaches to care provision, and to quality improvement, differs between these sectors and also between services and jurisdictions. A national CQI framework could provide a means to articulate and share what it means to deliver quality PHC for Aboriginal and Torres Strait Islander people, and provide an evidence-based and context-sensitive ‘road map’ to help PHC services across the system to improve the quality of their care. The expertise and leadership of the ACCHO sector is critical to this task, and ways in which this might occur are discussed in section 3.5.

3.1.2. Reduce fragmentation and duplication in efforts to support CQI at service level, and build a culture of use of data for improvement at all levels of the system

There are many CQI activities occurring in the PHC system that are relevant to improving care for Aboriginal and Torres Strait Islander people (described in Section 2). However there are currently few linkages and synergies between the various initiatives at regional and higher levels, and still some reluctance to share data at different levels. This means that it can be difficult for services to find resources on CQI and to share lessons and learn from one another. A national framework could enable more opportunities for using data for improvement at different levels of the health system, a process that requires adequate time to build a culture of improvement at all levels of the system, and clear agreements about the purposes and ways data may be used. Over time, this will help to provide a clearer picture of the quality of PHC delivered to Aboriginal and Torres Strait Islander people, and the factors that enhance that quality of care.

3.1.3 Connect existing CQI programs more effectively with front-line services and with a broader quality agenda

Despite considerable progress made in recent years to establish and strengthen elements of a broader quality system, including accreditation, there is no clear articulation of how CQI fits in the broader quality agenda. A national CQI framework could help to build support for greater uptake of CQI programs by articulating what CQI has to offer organisations, and how it fits into the broader quality agenda. Health service staff often

move between services, and across service sectors, and a shared understanding could help to embed CQI across the system and make it easier for CQI programs to be well connected with front-line services.

3.1.4 Provide a mechanism to help raise the overall quality of PHC for Aboriginal and Torres Strait Islander people, including for those services with less capacity

Capacity for delivering high quality care to Aboriginal and Torres Strait Islander people, and for CQI, is spread unevenly across the PHC system. There is wide variation in how care is delivered, and in how services understand and engage in quality improvement.^{4,32} This is not a problem unique to Aboriginal and Torres Strait Islander or even Australian PHC contexts; health systems internationally struggle with the same issue.^{2,3} Whilst CQI infrastructure and other support at the system level could be a tool to address this variation and strengthen the system overall,³³ there is evidence that those services with limited capacity can struggle to realise the benefits of such initiatives.³⁴ There is currently little shared understanding about how to spread the benefits of CQI to all services, particularly those with lower capacity. There is potential for a national framework to engage systematically with this challenge.

3.1.5 Provide national leadership and give a collective voice to what is already happening on the ground

Leadership for improvement is important at all levels of the health system. The actions of leaders at higher levels create many of the conditions that constrain and enable lower-level leaders to act.³⁵ From consultations, health services considered that a national framework could provide legitimacy to their efforts in CQI. A potential advocacy role of a national framework was discussed during project. For example it was suggested that as Primary Health Networks (PHNs) are being established, it would be important to have a document that sets out the collective vision and importance of CQI in order to help sustain commitment to CQI during times of change. This was also raised in relation to commitment at a national level, where it was hoped that a framework could potentially help to shore up recognition of the value of CQI that would endure through changes in government. In relation to this, participants in the consultations reflected on CQI as a change process, and that change takes time, requiring a long-term commitment. Clinicians also pointed out that improving systems to support chronic disease prevention and management is a long-term change effort. Potential roles of a framework in relation to PHC leadership for CQI are outlined in Section 3.7.

3.1.6 Build on momentum already established in CQI and learn from past experience

A rapid scoping study of the evidence related to frameworks identified a range of benefits of frameworks, and that frameworks in health care take many different forms depending on their purpose (Annex 1). National frameworks can be viewed as a ‘tool’ for bringing evidence and sensitivity to context to bear on a problem of national importance – their effectiveness in supporting improvements in health outcomes will depend on how well that task is completed, and the extent to which the main stakeholder groups support and implement the framework. This means that it is critical that a national framework in this area builds on what is already underway, learns from past successes and failures, draws on relevant international experience, and takes into account the values and concerns of key stakeholders at different levels of the system (including front-line health services) in its development.

Recommendation 1: The Department should proceed with supporting the development of a national CQI framework for Aboriginal and Torres Strait Islander PHC. Development and implementation of the framework should take into account the guiding principles and specific recommendations identified through this project. These reflect the concerns of key stakeholder groups, and are informed by international evidence about ‘what works’ in supporting improvements at scale.

Principle: Build on momentum already established in CQI and learn from past experience.

3.2 Ensure clear linkages between ‘inputs’ to a national CQI framework, intended outcomes, and implementation

3.2.1. A national CQI framework needs to lead to action

From the consultations, the urgent need to improve health outcomes for Aboriginal and Torres Strait Islander people was referenced repeatedly, with the strong view expressed that any framework developed should not just be ‘a piece of paper’ but have a clear plan of implementation. There was some uncertainty apparent about the difference in frameworks, models of care, strategies and strategic planning and methods to promote implementation – there is in any case significant overlap in these concepts. The wide diversity of stakeholders who participated in the consultations in some cases held differing views about what a national framework in this area might include – highlighting the importance of early identification of the key purpose, intended outcomes, and the means through which these would be expected to be achieved. Considerations included:

- Accountability to community, including sufficient time allocated to consultation in any next phase of development of a national CQI framework for Aboriginal and Torres Strait Islander PHC
- Flexibility and adaptability - the experience of the NT in implementing the NT CQI Strategy over the past five years was that it was not possible to anticipate everything in advance, and some flexibility in the framework itself was important, including room for improvement over time
- Development of a shared understanding between key stakeholders about how outcomes will be achieved (‘program logic’).

3.2.2 Use a national framework to identify existing (or new) resources that could be leveraged to improve the quality of PHC provided to Aboriginal and Torres Strait Islander people.

There was a strong hope expressed in the consultations that a national framework would help to sharpen and focus use of existing resources (not only financial resources, and not only Aboriginal and Torres Strait Islander-designated resources), and lead to longer-term support for CQI infrastructure. Participants made concrete suggestions about where there could be a sharpening of use of resources to support implementation of a national CQI framework for Aboriginal and Torres Strait Islander PHC. For example, some recommended tying Healthy for Life funding more specifically into a national CQI framework, perhaps as a means of supporting those services that have lower core resourcing than other services.

Another suggestion was to expect CQI participation from services receiving a certain level of core funding per person (appropriately adjusted for remoteness/service delivery context). There was also consideration given to the extent to which other funds allocated to chronic disease for Aboriginal people could tie into a CQI framework. Some stakeholders expressed concerns that if there were central resources made available for implementation of a CQI framework, it would be important to focus their use; if resources were spread too thin, their impact would be lost.

Whilst the development and implementation of a national CQI framework was broadly supported by key stakeholder groups, there were varied understandings about what form a national framework might take, what it might accomplish and through what means. Participatory development of a program theory and/or logic and ‘model of change’ can help to surface stakeholder expectations, and develop a shared understanding of how change is to be achieved.

Recommendation 2: An implementation plan for the framework should be developed.

To ensure that the framework takes effect, it needs to be supported by an implementation plan including the identification of resources across the PHC system (not only within Aboriginal and Torres Strait Islander-designated funding).

Recommendation 3: All key stakeholders should be engaged in the development of the framework and implementation plan. A useful early step could be the development of a ‘model of change’ or program theory and/or logic that will help to surface assumptions from different stakeholder groups about the medium and longer term outcomes expected, and how these outcomes might be achieved. The consultations and evidence review informing this report have begun this process.

Recommendation 4: The implementation of the framework should also include a rigorous and useful monitoring and evaluation process. A formative or developmental evaluation could run alongside the framework development and implementation and assist with real-time refinement and improvement.

3.3 Strengthen enablers for CQI

In a complex system like a health system, cultivating the conditions that encourage health services to improve the quality of care – strengthening enablers to CQI – is likely to have more impact than requiring mandatory participation in CQI.

3.3.1. Achieving large scale change in complex systems

In 2001, the Institute of Medicine released a landmark report ‘Crossing the Quality Chasm’.³⁶ This report recognised that a health system is a ‘Complex Adaptive System’: dynamic, chaotic and made up of many individual agents who act in ways that may not be predictable, and whose actions flow on to change the context for others. While innovations in complex environments may not be ‘manageable’, it is however possible to cultivate organisational conditions that ‘enhance the possibility of innovation occurring and spreading’.³⁷

Quality improvement initiatives are increasingly recognised as complex interventions introduced into complex environments.³⁸ Complexity is also reflected in the high degree to which local context and history affect the ways that CQI interventions unfold in a given setting or site. No one model of CQI works for all settings all of the time.¹⁰ Health services

vary widely in their contexts, capability and history – and have differing levels of capacity to apply complex interventions such as CQI.³⁴ In considering ‘what works’ in complex health system change, it is therefore necessary to also consider the question of ‘what works well for whom, and in what circumstances?’.³⁹

A recent international review of what works for large scale transformation in health care identified five simple ‘rules’ for large scale change:

- Blend designated leadership with distributed leadership – that is, someone must be formally in charge of the change effort ('designated') and professionals and partner organisations must share responsibility for mobilising effort and delivery ('distributed')
- Establish feedback loops – that is, careful identification of measures and tracking of these over time
- Attend to history
- Engage clinicians, specifically doctors
- Include patients and families.⁴⁰

These ‘rules’ are largely consistent with factors at different levels of the system that influence CQI effectiveness. For example, leadership for CQI is a key element driving large scale change, and is also widely recognised as a favourable context (or ‘enabler’) for QI, with leadership at organisational and higher levels influencing the success of QI at health service level.⁴¹ Feedback loops are a key foundational principle of CQI, infrastructure to support feedback at different levels is a possible role of the support networks for CQI suggested in Section 3.7. Improvement networks are in turn supported by data platforms (Section 3.10). Table 9 provides a high level summary of enablers and barriers that have been identified in CQI work in Aboriginal and Torres Strait Islander PHC. Strategies to address barriers are summarised in Table 10.

The consultations conducted in this project affirmed the importance of using a national CQI framework to strengthen enablers of CQI, rather than imposing a specific nationally endorsed model or approach. Participants in the consultations were strongly opposed to any form of mandatory top-down approaches. Some PHC services have already developed extensive strategies for CQI and would not want the framework to be overly prescriptive. For example, some participants spoke about a 10-15 year journey of building a culture of quality within their organisations, and were concerned that a 'top-down' initiative could squash achievements and risk disengagement, if not seen to be working from the base already established. Other health services appeared to be in the early stages, or had not yet commenced their quality journey – suggesting the need for flexible approaches that are tailored to capacity needs and gaps.

Specific issues in relation to supporting services with lower capacity are discussed in more detail in Section 3.12.

Principle: Focus on strengthening enablers to CQI, not imposing specific models or standard approaches.

Table 9: Lessons from implementation of CQI in Aboriginal and Torres Strait Islander PHC – enablers and barriers

<p>Enablers:</p> <ul style="list-style-type: none"> • High level organisational support, including leadership and support from senior staff • A no-blame, systems-oriented and experienced based learning approach • Staff expertise and interest • Clinical, Aboriginal and Torres Strait Islander, and management and policy champions • Well-established infrastructure in information systems • Support for implementing steps in CQI cycle • Clear framework and structure for implementation • Appointment of someone at the health centre to negotiate implementation of action plans • Support for clinic managers to use CQI for business planning • Teams have achievable targets • Integration of CQI data collection with other reporting requirements • Institutional commitment to a systematic rather than ad hoc approach to CQI • Support for staff training and development of information systems and practice-based networks • Quality network for developing and sharing expertise and resources for CQI • Clearly defined objectives, expectations and roles/responsibilities for CQI • Adopting an incremental approach to CQI • Defined objectives for using clinical performance data in quality reporting structures at local, regional, state and national levels.
<p>Barriers</p> <ul style="list-style-type: none"> • High staff turnover in some services • Burden of disease and balancing demands of acute care with those for chronic disease • Difficulty in providing enough training and technical support when number of participating services increase • Lack of engagement among key staff especially clinic managers, who did not consider CQI to be part of their role, and engagement of GPs who are perceived as being the hardest to engage • Multiple patient record systems • All CQI activities across services delivering care are not currently being tracked through a single integrated data reporting system • Manual audits and systems assessment that are time consuming • Perceived lack of control to change clinic routines in support of action plans • Lack of teamwork. <p>These barriers and enablers were synthesised from program evaluation and research about CQI in Aboriginal and Torres Strait Islander PHC.^{8,19,39,42–52}</p>

Table 10: Strategies to address barriers

Strategies to address barriers to effective implementation of CQI in Aboriginal and Torres Strait Islander PHC have evolved within different CQI programs but to date have not been systematically applied across the system. Strategies and lessons learned include:

- CQI programs in Aboriginal and Torres Strait Islander PHC that had implemented ‘learning circles’ or ‘improvement networks’ were highly valued.
- Different CQI aspects of the different CQI programs were valued, as was flexibility in choosing programs or aspects of programs most fit for local context.
- To be sustainable, CQI needs to be aligned with the strategic objectives of the front-line service, and integrated into its other activities.
- Tapping into the intrinsic motivation of health service providers (CQI ‘for us’, not for performance reporting) is a key way in which CQI ‘works’ as a strategy to improve care.

Availability and use of data is an important driver of change, but health services have widely varying capacity in their ability to access and use data as a tool for improvement.

3.4 Articulate what CQI means in the context of providing quality PHC for Aboriginal and Torres Strait Islander people, including cultural capability

There are many factors that influence the extent to which Aboriginal and Torres Strait Islander people receive quality PHC services. Quality of care can be described in terms of safety, effectiveness, patient-centeredness, timeliness, efficiency and equity of care,³⁶ as well as whether care is culturally appropriate and accessible. From the consultations, it was clear that a national CQI framework could play a vital role in articulating what good quality care means in the context of Aboriginal and Torres Strait Islander peoples’ access to and experience of PHC services.

Whilst some of the core elements of clinical CQI tools and processes can be adapted, cultural considerations, including cultural safety and Aboriginal conceptions of health need to be included at all levels of a national CQI framework for Aboriginal and Torres Strait Islander PHC. It was evident from the consultations that unless services address underlying impediments to high quality care, such as cultural safety, barriers to access, family and social determinants of health, and other issues, quality of care will not improve. The need for this to be acknowledged and embedded at all levels of a framework was strongly related to the underlying philosophy of CQI: that it taps into the existing motivation of health services for improvement rather than imposing external standards.

The inclusion of broader aspects of quality in a framework that aims to improve health outcomes for Aboriginal and Torres Strait Islander people is consistent with recommendations from the NT CQI Strategy Evaluation. The evaluation recommended that the NT CQI approach be broadened from its (then) predominant focus on clinical practice, to include other aspects of quality (as mentioned above).³² In relation to a national framework, the consultations heard from those who currently use primarily clinical indicators for CQI that these indicators provided a starting point for discussion, but that this was ‘only the very beginning’. Participants expressed their desire that CQI in a national framework should be sufficiently broad to capture the different priorities that services may have, for example, outreach, health promotion, spirituality, and country. Some felt that measurement/inclusion of these broader service items in a CQI process would be of benefit to the quality of the services.

these things we do [health promotion, outreach etc.] can also benefit from a CQI process. (Clinician, ACCHO)

The consultations also indicated that including a broader scope of care in a national CQI framework could help to ensure recognition of the public health value of these different aspects of service provision. This contrasted to the anxiety many spoke about in relation to the nKPIs, where it was felt the narrow scope of indicators did not reflect the range of work that they were engaged in and feared inappropriate judgment would be made about the quality of their service provision as a result.

A national CQI framework should also provide guidance in embedding a clear focus on Aboriginal and Torres Strait Islander health within generic CQI programs used in private practice, and/or in encouraging alternate approaches for use in this sector that build on key aspects of quality for Aboriginal and Torres Strait Islander people, such as improving cultural safety.

we feel quality has to start with cultural respect and cultural safety. Without that you cannot be providing a quality service to Aboriginal people. (PHMO, Affiliate)

Principle: Identify what cultural capability means for CQI: embed cultural safety and Aboriginal and Torres Strait Islander perspectives on health and health care into all levels of the framework. This has implications for the scope of PHC covered by a framework.

3.5 A collaborative approach, led by the ACCHO sector but for the PHC system

A strong theme that emerged from all of the consultations was that the ACCHO sector needed to play a central role in the development and implementation of a national CQI framework for improvement of quality of care for all Aboriginal and Torres Strait Islander people. The National Partnership Agreements (NPAs) provides an example of the importance of strong participation of Aboriginal and community organisations in governance of system-wide initiatives that are directed at improving Aboriginal health.⁵³ Evidence from a study of the NPAs showed that strong links between Aboriginal organisations, and strong links between Aboriginal organisations and mainstream organisations were key factors associated with improved health care delivery to Aboriginal people.⁵³

From the consultations, whilst participants varied in the extent to which they thought it was feasible to include the whole PHC system under a single 'umbrella' framework, there was general willingness from participants in all sectors represented in the consultations that options for working together under a national framework should be explored. From the ACCHO sector, for example one participant stated:

we need to be mature enough as a sector to realise that we cannot provide all services needed to our mob. We need to work with others to make sure that the services provided to our mob are appropriate. (CEO, ACCHO)

Possible roles of the ACCHO sector in providing leadership in CQI for Aboriginal and Torres Strait Islander PHC were discussed, and are outlined below.

3.5.1. Strengthening cultural safety aspects of CQI and influencing other sectors

At a system-level, from one of the regional consultations, there was some discussion that if the ACCHO sector was appropriately resourced, it could play a role in strengthening the cultural safety aspects of mainstream accreditation standards. It was felt by some participants that this was one useful aspect of whole-of-system work that a national framework could support. Whilst participation in CQI is required by the Royal Australian College of General Practice (RACGP), currently there is no requirement for CQI processes specifically in relation to improving care for Aboriginal and Torres Strait Islander people – either for all services, or for services participating in CtG programs. There was some discussion about a possible role of a CQI framework in helping to make sure that those private General Practice sector organisations who were receiving Aboriginal health funding, were engaged in improving quality of care for Aboriginal and Torres Strait Islander people. This may include working with the Aboriginal Faculty of the RACGP, and other agencies.

3.5.2. Demonstrating leadership and providing opportunities for innovation by strengthening multi-sectoral cross-jurisdictional and inter-jurisdictional networking and support for CQI

The history of innovations to improve quality of PHC developed and trialled by ACCHO services and supporting organisations over the past decades was referenced by a number of participants. This innovation includes the development and use of formal CQI tools and also other less formal approaches. Within broad parameters of a national framework, the ACCHO sector could help to support or extend CQI programs to:

- Incorporate internationally accepted strategies for reducing health disparities through CQI programs
- Improve cultural capability of services and other aspects of quality particularly relevant to Aboriginal and Torres Strait Islander experience of health services.

Possible approaches to supporting CQI in privately run General Practices that provide care for Aboriginal and Torres Strait Islander people are outlined below.

3.5.3. CQI to improve PHC for Aboriginal and Torres Strait Islander people receiving care in the private General Practice sector

Most of the evidence relating to feasibility and outcomes of CQI for improvement of Aboriginal and Torres Strait Islander health has, unsurprisingly come from the ACCHO and state-run PHC services specifically set up to provide care for Aboriginal and Torres Strait Islander patients. There is less evidence available for ‘what works’ in engagement of the private General Practice sector in improving Aboriginal and Torres Strait Islander health.

The APCC has shown that it is possible to engage good numbers of Divisions/Medicare Locals and health services in diabetes improvement. However this work has not to date included a significant focus on Aboriginal health (further details below). The QAIHC General Practice Queensland CtG Collaborative included eight General Practices in a collaborative wave with ACCHOs. However there is very limited experience in Australia of engaging privately-run General Practice in quality improvement for Aboriginal and Torres Strait Islander people specifically.

To achieve impact on health outcomes for Aboriginal and Torres Strait Islander people, different service sectors may need to take different journeys in CQI. Expert international consensus recommends that mainstream organisations seeking to reduce disparities in

care implement a basic QI structure and process, make equity an integral component of QI,⁵⁴ and develop and test multi-faceted interventions for reducing care disparities.⁵⁵ In the Australian PHC system, this would suggest that any CQI programs in mainstream PHC should at a minimum consider the persistent inequalities in health outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians as a serious quality problem – and seek to address these within a CQI process.

A significant issue of concern in the Australian context is the under-identification of Aboriginal and Torres Strait Islander people in General Practice, and the completeness and consistency of this information in clinical information systems. The extent to which private General Practice can report on their CQI data separately for Aboriginal and Torres Strait Islander patients is not known. Work carried out as part of evaluations of the Australian Government's Indigenous Chronic Disease Package (ICDP),³⁴ and publications from the APCCs, suggest there is still a way to go before this is possible in Australia.

Including Aboriginal and Torres Strait Islander health in mainstream CQI is consistent with and may support several recommendations contained in the National Audit Commission's review of Aboriginal and Torres Strait Islander programs.⁵⁷ For example, the Commission recommended that stronger mechanisms should be introduced to ensure mainstream programs are working effectively for Aboriginal and Torres Strait Islander people, including suggesting a requirement that mainstream services both publicly report on Aboriginal and Torres Strait Islander access and outcomes. This reporting is unlikely to be feasible for many services at present.

A 'blanket' approach to engaging General Practice in CQI for Aboriginal health is unlikely to be resource-efficient. Although reliable data on patterns of service use by service sector are not available, indications are that many privately run General Practices see few or no Aboriginal and Torres Strait Islander clients. Whilst improving the quality of services for Aboriginal and Torres Strait Islander people provided by all services in which Aboriginal people receive care, is clearly the ideal, the findings of the ICDP evaluations in relation to private General Practice participation in the ICDP, suggested that efforts to improve services for Aboriginal people through private practices should be focused on those General Practices that have an interest in, and potential to provide high quality PHC to significant numbers of Aboriginal and Torres Strait Islander people.⁵⁶ A staged approach that focuses on 'innovators and early adopters' is consistent with recommendations for accelerating the rate of diffusion of innovations, being to identify and support sound innovations, invest in 'early adopters,' make early adopter activity observable, trust and enable reinvention, create slack for change, and lead by example.⁵⁸

Principle: A collaborative approach led by the ACCHO sector, for best practice PHC for Aboriginal and Torres Strait Islander people across the PHC system.

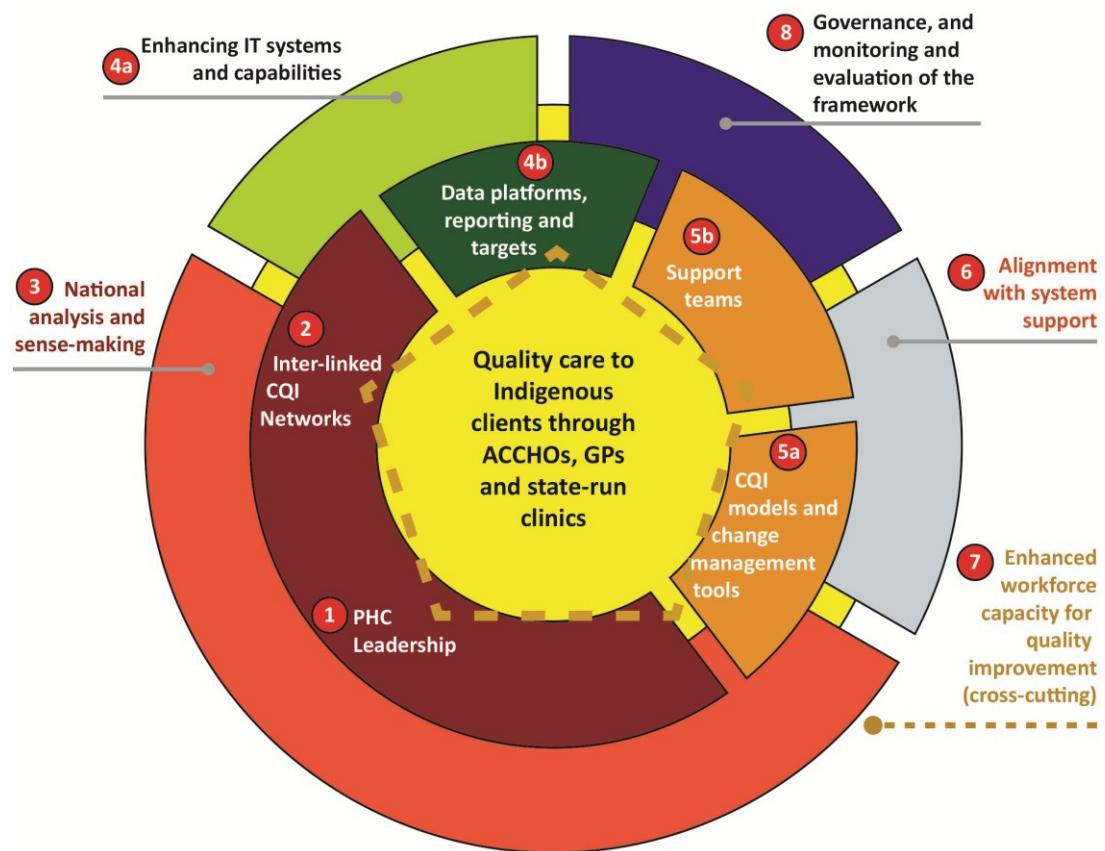
3.6 System-wide support for CQI and linkages between components of support

3.6.1 System-wide 'building blocks'

Evidence suggests multi-level CQI models – operating at different levels of the health system – work best.¹⁰ Potentially, a multi-level CQI model might include: national level benchmarking and target setting; regional network support; support for health services to

interpret and use data, and to implement improvements. Possible components of support for a national CQI framework that were discussed in the consultations are shown in Figure 7. These represent core elements of what stakeholders in the consultations, and in the project team, considered would be needed to support development of a multi-level CQI model to improve quality of PHC for Aboriginal and Torres Strait Islander people at scale and with the greatest chance of improvement in health outcomes. Sections 3.7 to 3.12 include more detailed discussion of these core components.

Figure 7: Proposed components of support for implementation of a system-wide national framework for CQI in Aboriginal and Torres Strait Islander Primary Health Care



The concentric circles in Figure 7 illustrate a multi-level approach to supporting services to improve quality of care for Aboriginal and Torres Strait Islander clients that could be articulated and supported by a national CQI framework to achieve large scale change. As illustrated by the Figure, Aboriginal and Torres Strait Islander clients, supported by their health care providers, are at the centre of the circle. Health providers are supported to improve quality of care by organisations at the regional and/or jurisdictional level, referred to here as the 'meso' level. Meso-level organisations may include for example, the NACCHO affiliates, regional umbrella bodies or larger ACCHOs that provide support to a number of organisations across a region, and professional organisations. Components of support operating at the meso-level may include networks for improvement, CQI models and change management tools, a support team, shared data platforms, reporting and targets. Different models may be appropriate in different jurisdictions to fit context – for example, a support team covering an entire jurisdiction may not be feasible in a large state. Health service level and meso-level activities are supported by initiatives that require national level leadership and co-ordination, including national analysis and sense making of CQI data, linked-up and enhanced IT systems to improve care quality, alignment with

system support, for example recognition of CQI as part of Continuing Professional Development, and governance, and monitoring and evaluation of the CQI framework. Also as shown in the Figure, workforce capacity development for QI cuts across the different components of support, and also intersects each level of the health system.

A multi-level approach to supporting PHC services to improving quality can help to overcome the barriers to CQI in Aboriginal and Torres Strait Islander PHC that were identified in earlier sections of this report (see sections 3.1.2-3.1.6 and 3.3.1). Most significantly, capacity for delivering high quality care to Aboriginal and Torres Strait Islander people, and for CQI, is spread unevenly across the PHC system. There is wide variation in how care is delivered, and in how services understand and engage in quality improvement. Co-ordinated and focused support for CQI at different levels of the system, including CQI activity at national and meso-levels, is a critical mechanism to spread the benefit of CQI to services with lesser capacity

3.6.2 Take a ‘systems thinking’ approach to consider how the components of support are linked up and interact with one another and with other parts of the health system

Importantly, progression of these components will need to pay attention to how they are linked up and interact with one another and with the broader health system around them. This is consistent with ‘systems approaches’ to health systems strengthening which require consideration of the synergies and ‘spaces between’ components of a system.⁵⁹ In other words, a framework could allow for the relative emphasis on these different support components to differ in different jurisdictions, different sectors, or at different times, but should clearly articulate their linkages with one another and with other aspects of the system. Alternate depictions of the possible core components of a national CQI framework are shown in Annex 2, Figures 1a and 1b. These reflect discussion at the national workshop, and show the applicability of components at different levels of the PHC system and the need to focus on the linkages between components.

Should the Department proceed to Stage Two of this work, it is recommended that the components of support for a national framework are refined through a consultative process with key stakeholders. Using systems thinking approaches,⁵⁹ a process of refinement may include a process in which key stakeholders:

- collectively deliberate on possible system-wide effects of any area of intervention in relation to these components;
- develop a conceptual pathway mapping how a system-wide intervention in each area may affect health and the health system; and
- adapt and redesign the components of support to optimise synergies and minimise any potential negative effects.

Recommendation 5: Successful implementation of a national framework will require support systems and activities to grow the ‘building blocks’ of effective CQI.
(Recommendations 7–9 cover specific components of support that may be required.)

Recommendation 6: Development and implementation of a national CQI framework should take a ‘systems approach’ to thinking about the ways in which the building blocks of support for CQI link up and interact with one another – in order to optimise synergies and minimise potential negative effects.

3.7 Leadership and support networks

Any improvement initiative needs to identify and mandate suitable leaders to spearhead its activities and drive change at different levels. Leadership at system level is important, and so is leadership of clinicians in relating to clinical care, managerial leadership, and Aboriginal health worker leadership. Leadership and support networks, or networks for improvement, are closely linked.

3.7.1. Improvement leadership in Aboriginal and Torres Strait Islander PHC

Various types of leaders can contribute to (or detract from) improvement efforts. In driving innovations and improvement, leaders are not just those in leadership positions within organisations. Opinion leaders can be outside organisations but nonetheless influential in regard to particular innovations e.g. academics, and peers respected for their know-how in clinical practice.³⁷ It is critical that a CQI national framework recognises the leadership and expertise of the ACCHO sector in delivering quality PHC to Aboriginal and Torres Strait Islander people, and it is also the case that to achieve change across the PHC system, a national CQI framework should recognise and allow opportunity for development of leadership across the system. For example, it will be important to have improvement leadership from clinicians with credibility amongst clinical peers in state-run services, private General Practice and the ACCHO sector, Aboriginal Health Worker groups, allied health and other core groups, and quality managers and supporting organisations.

Research suggests that successful improvement leaders are guided by common principles:⁶⁰

- a belief in the need for improvement, which is demonstrated in their behaviour
- inspiring and motivating all staff to take responsibility and action for improvement, and influencing those who are hindering improvement
- defining the constraints within which staff must work for improvement and setting priorities and targets in consultation
- developing competencies and time for improvement in staff and themselves
- providing resources, especially for data collection, analysis and expertise
- ensuring project accountability and use of methods
- aligning incentives and systems to support improvement.

The role of clinical leaders in supporting and driving CQI was noted to have been critical in those jurisdictions (NT and Queensland) where CQI has been established for longer and has more system-wide support than in other states or territories. These jurisdictions have shown higher performance overall on the nKPIs than other jurisdictions.⁵ A potential role of a national framework in the important work of fostering and supporting leadership for CQI in Aboriginal and Torres Strait Islander PHC across Australia, perhaps by working through lead clinicians' groups, was discussed in some of the consultations.

3.7.2. Improvement networks

Internationally, there is a growing interest in networks as a mechanism to support improvement in health care.

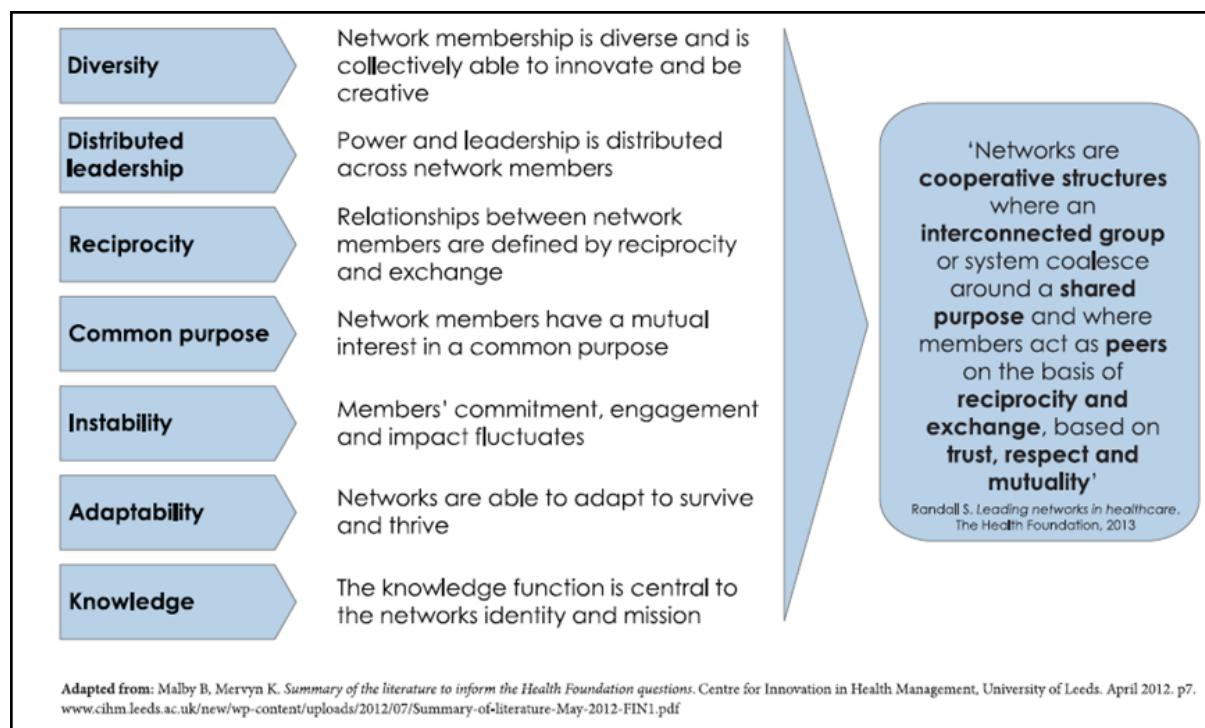
Properly designed, improvement networks provide an in-built mechanism to spread successful change quickly, leveraging the power of social and professional connections rather than relying on the formal chain for command of a hierarchical organization.

(Foreword: *Effective networks for improvement learning report 2014*, Health Foundation, p.4)³⁵

To date there has been little systematic support for networks as a mechanism to support quality improvement in Aboriginal and Torres Strait Islander PHC. This has meant that networks that have been established have been difficult to sustain. It has also meant that their scope has necessarily been directed by the requirements of funders or auspicing organisations. For example, some CQI networks in Aboriginal and Torres Strait Islander PHC have focused on the needs of a specific sector or group, whilst others have had a research focus. It is difficult for these kinds of networks to provide a neutral environment for collaboration across different constituencies and disciplines. From the consultations, front-line service providers who had been part of ‘collaborative’ efforts (such as those run by AMSANT), highlighted that peer-to-peer sharing supported by networks has been particularly valuable in relation to CQI. There was hope expressed that a national framework would profile this function, and extend it to other regions and levels of the system.

Distinctive features of networks for improvement have been described (Figure 8).

Figure 8: Distinctive features of networks for improvement



International evidence suggests that not all QI networks function equally well. Effective networks have a common purpose, a cooperative structure, critical mass, collective intelligence and community building.³⁵ In the CQI context, networks need to be ‘managed’ networks, not ‘natural’ networks (these will exist anyway), and they need to be well supported and resourced, with an identifiable network leader, and a network coordinator or facilitator, with protected staff time. The network must develop a well-organised work plan with identified deliverables or targets, and there is a need for ongoing monitoring and evaluation of performance. More effective networks also have resources to bring network members together through regular meetings, preferably with some of these being face-to-face meetings. Resources are also required to achieve work plans. They have strong,

effective communication and engagement across members and stakeholders, as well as brokerage and bridging roles to ensure dissemination of information in and out of the network. Effective QI networks will also need to engage with clinical experts and researchers to ensure that their work is cutting-edge and evidence-based. The networks should include consumer representation, have multidisciplinary clinical and non-clinical (e.g. organisational or service planning) representation. Clear articulation of the core purpose and activities of networks at different levels will help to guide decisions about the appropriate structure and governance of the networks.³⁵

Given the diversity in implementation environments across and within service sectors and jurisdictions in the Australian PHC environment, it is likely that more than one network will be needed, as different issues need to be addressed to support to CQI. Networks for improvement typically operate at different levels, and in relation to different enablers.

Recommendation 7: Foster leadership and support networks for CQI at all levels of the system. Support networks should be evidence-based, linked up with one another, accountable, and coordinated, and their functioning regularly reviewed.

3.8 Strengthening workforce capacity

Ultimately the successful implementation of CQI across the system in a way that improves care will be determined by the competent and committed service providers who engage with Aboriginal and Torres Strait Islander clients on a day to day basis. A national CQI framework needs to consider workforce capacity across each of the components of support for a CQI framework (shown in Figure 7, above). As shown in the Figure, workforce capacity could be considered in relation to capacity for leadership, using data, using specific CQI models, and managing change. As shown in the outer ring, workforce engagement in CQI can be supported by improvements in IT systems and capabilities and alignment of CQI with broader system support, and a well-governed and effective CQI framework.

3.8.1. Workforce capacity for leadership in CQI - a focus on Aboriginal and Torres Strait Islander leadership

The NT CQI Strategy evaluation³² and the national appraisal of CQI in Aboriginal and Torres Strait Islander PHC⁶ identified gaps in the Aboriginal and Torres Strait Islander PHC QI workforce including a need for increased Aboriginal and Torres Strait Islander leadership and practitioner involvement in CQI. The NT CQI Strategy evaluation, suggested there was considerable untapped potential of the Aboriginal health workforce in guiding culturally competent approaches relevant to CQI.³²

3.8.2. Workforce capacity in relation to data and IT for CQI

The need for development of skills of the existing and new workforce in relation to effective use of clinical information systems to support quality clinical care, and skills in interpreting and using clinical data are discussed in Section 3.9.

3.8.3. Capacity to use CQI and change management tools

Both the consultations and the literature review highlighted there has been considerable experience gained across the CQI programs in workforce training for CQI. Some of the programs (for example One21seventy) are aligned with Continuing Professional

Development systems, offering professional development points with professional organisations such as the Australian College of Nursing, Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine. The NT CQI Strategy approach has more recently included training tailored to engagement of Aboriginal health workforce in CQI.

Greater national coordination of workforce training for CQI and alignment of recognition of competencies may lead to greater efficiencies and a stronger system. Specifically since many struggling services have high staff turnover, a common training/understanding will help build continuity in CQI practice.

From the consultations, workforce capacities in driving and managing change, and in using data for improvement, are particular gaps. The national appraisal of CQI in Aboriginal and Torres Strait Islander PHC noted that much of the training in CQI to date had been of a technical nature rather than the conceptual or social learning needed to drive change.⁶

3.8.4. Workforce engagement supported by the broader system

Consultations identified areas for input and support at a national level that could be explored in relation to workforce included in-service and pre-service training in CQI, aligning participation in CQI with professional development requirements, and embedding CQI expectations in any workforce investment that is specific to Aboriginal and Torres Strait Islander health. These areas were considered critical to the longer-term sustainability of CQI as a tool for improvement at scale. Also evident at various points in this report was that CQI, as an unfunded activity, results in lost Medicare income for services, and since this can be a disincentive for engagement in CQI, some consideration needs to be given to this issue in a national framework.

Recommendation 8: Build the capacity of front line services to undertake CQI including through training in CQI, use of data systems for improvement, and managing and leading change. Ensure workforce engagement in CQI is supported by the broader system.

3.9 Flexibility in CQI tools and approaches

A principle of local control, or at least shared responsibility and control with local services having a meaningful say in what CQI approaches and models they use, is a core requirement of sustainable and successful quality improvement in health systems.¹⁰ The importance of a national CQI framework adhering to a principle of flexibility of methods and approaches was a strong theme across all of the consultations, with stakeholders strongly opposed to any possibility of imposition of particular CQI models or approaches.

Some workshop participants considered that a role for a national framework could be to establish and maintain a ‘repository’ of CQI methods and approaches, and possibly work towards greater complementarity between the different approaches. Participants also emphasised that the key distinction between CQI and Accreditation, was that CQI was about locally relevant quality improvement needs, not standards imposed from the outside – underscoring the importance of local flexibility in the selection and application of CQI.

...one of the reasons we didn't want to be part of the collaborative model (APCC) is that we didn't just want to involve just the GP and the practice manager – we knew we needed to have something with the whole of the PHC team. (PHMO, Affiliate)

Other services have worked within the available CQI models, whilst working to adapt them to be fit for context, with varying degrees of success. One of the Affiliate PHMOs described their experience of trialling the APCC model in five services, recognising that it needed a lot of adaptation, so taking elements of that model and developing their own approach.

Some participants noted difficulty in engaging GPs in CQI as they may be time poor and be concerned about different issues in different places. For example in some environments GPs have concerns over whether team members all have skills to do what they are expected to do. Those engaged in supporting CQI spoke of how identifying key concerns of GPs in particular service environments and working with these, can be a useful way to increase engagement by GPs in CQI processes.

Principle: Support the principle of flexibility of use of CQI tools and approaches (and indicators) with health services supported to use tools that are a good fit for their needs and context.

3.10 Data platforms and clinical information systems to support CQI

The use of electronic medical records has made much data available for reviewing whether care delivered in PHC matches clinical best practice. Whilst collection and use of data alone do not constitute quality improvement, measurement is a key component of clinical CQI programs. Data can help to identify gaps between what is currently being done, and guideline best practice, and to assess the impact of changes as part of improvement cycles. Evidence suggests that high performing PHC organisations monitor progress using data systems that track:

- clinical performance e.g. diabetes management, antenatal care
- operational performance – access, billing data
- patients' experience metrics.

It is recognised that how data on performance are used and interpreted at different levels of the health system is important.

From the Affiliate perspective, the major gap at present is the lack of leadership by the ACCHO sector or at least recognition of the role the sector can play in harnessing technology, shaping the data platform to underpin clinical CQI work and bringing to bear the knowledge of the sector and broader public health expertise to develop meaningful interpretation of data.

3.10.1. Quality use of clinical information systems

The value of a supportive IT platform for quality delivery of comprehensive PHC and for CQI is increasingly recognised. How well IT links into other components of a service system is a strong influence on what can be achieved in relation to delivery of good chronic illness care – a supportive IT system is a key pillar of the evidence-based Chronic Care Model,⁶¹ a model endorsed by several Australian health departments and other agencies.

Some participants in the consultations, particularly those involved in developing CQI programs and supporting their uptake, strongly argued that quality use of clinical information systems should be considered an integral part of a national CQI framework, not separate from it. Caveats were that IT solutions should not hold up progress with a national CQI framework, and that electronic medical records and what could be extracted from them, should not drive CQI, but should act in a support role.

An important aspect determining quality use of information systems is staff capability and consistency in using the relevant systems at the local level. This includes staff knowledge, skills and application in how to enter data correctly, how to interpret data, trouble-shoot quality issues, and use data for improvement purposes. Consultations suggested that capability of front-line staff in using relevant IT systems is not only a matter of acquiring the relevant technical skills, but requires a shift in mindset from writing clinical notes for one's own use (as a GP or health care provider), to documenting relevant information in a way that can be accessed for a variety of purposes, including billing, sharing care with team members, generating recall and reminder lists, providing indicators for quality improvement, and accountability and reporting. This 'mindset shift' is a large-scale change effort that can be supported by a national CQI framework.

The limited evidence on the effectiveness of training in improving data quality in PIRS indicates that short-term, low intensity training has limited impact.⁶² As for other areas of behaviour change and skills development, substantial improvements in data quality are likely to require more intensive training and other strategies that are specifically designed to overcome the barriers to improvement as relevant to local contexts.⁶³ CQI itself can support improved data quality - there is also some evidence that using data in CQI can result in improvements in data quality, providing insight into data quality issues and motivation to address them.^{39,32}

Efforts to improve quality use of clinical information systems needs to include visiting services, such as specialists, allied providers and locum staff. In consultations, health service managers spoke of the challenges of incorporating data on these services as part of CQI and reporting processes.

We have doctors who record their services on their own laptops and take them away. [this means] this data is not in our systems – we can't report on these services in our nKPIs. (Manager, ACCHO)

A key constraint on greater use of the nKPI data as a CQI resource at local level was the perception that the data did not have good validity. The specific concern raised was the validity of the denominator figures obtained using the standard definition of 'regular client'. Many health services across a number of jurisdictions reported being unable to reconcile the standard definition required with their clinic populations, particularly where populations were mobile or transient and used a number of different services. To address this issue, a couple of health services had obtained expertise to generate the nKPIs using their own denominator data (used internally, not for reporting purposes), but this solution was not widespread.

There are also likely to be gaps in staff capability in understanding and using data for improvement at all levels of the system. Commenting on the potential for Healthy for Life reporting to inform state-wide analysis and planning, the Healthy for Life evaluation (2009) noted that the capacity for the then state and territory offices of OATSIH to accurately interpret service reports (or indeed state-level reports if they were to exist) was likely to

be variable. The general point is that staff at different levels of the system who are expected to use data for improvement would benefit from targeted training and support in interpreting available data for improvement and planning purposes.²⁶ The supportive infrastructure proposed as part of a future national CQI framework in our recommendations, could go some way to addressing this issue.

From the consultations it was noted that a CQI framework could have a role in improving the flow and use of data within the system, and contextualise and provide a framework for governance of the data. Participants spoke about some of the frustrations of supplying data, not having it fed back to them in a useable form, and being concerned that interpretations of aggregate data could be damaging and misleading when taken out of context. It was considered by some that if a framework was well designed, it could help to address some concerns around indicator data – for example, helping to address the danger of 'tunnelling' of vision to fit what is measurable through putting what is measured into a wider context.

...it is easy to measure the things that are easy to measure, but these are not necessarily the right things. (Clinician, ACCHO)

At present, there can be a tension between the selection of indicators of quality, the state of development of automated data extraction tools and health service capacity to use PIRS and to conduct CQI. For example, One21seventy clinical audit tools include a large range of indicators across the scope of care, but many of these indicators cannot yet be automatically extracted from the major PIRS. The consultations heard from users of One21seventy tools, that having to do audits manually made auditing a time-consuming task. Auditing became even more onerous where centralised health service management (external to the health centre) required audits across numerous areas of care within for example a week-long period of auditing.

3.10.2. Coordination and governance of investment in clinical information systems to support CQI

Our consultations identified a range of different IT solutions to generating data for CQI that are separately negotiated, sometimes with disappointing results. Whilst decentralised decision making about IT can mean that CQI programs (and health services who use them) can choose solutions that they feel are a good fit with their needs, without having to compromise with others on the decision, there are also some drawbacks – including procuring many similar but separate solutions, with decreasing pricing leverage and increasing procurement costs. It also makes it harder to bring together a balanced team of public health expertise, clinical expertise and IT technical expertise to solve challenges – as there are pockets of expertise spread around the system that are not working together, and asking IT vendors for slightly differing solutions. There does not seem to be a current forum for those developing and supporting CQI programs in Aboriginal and Torres Strait Islander PHC to come together with IT vendors to make decisions about wise investments in IT that could support delivery of quality clinical care. An advantage of linking a coordination structure into a national CQI framework is the potential it brings to include mechanisms to trouble shoot IT issues that services experience, identify common concerns across services or groups of services, and help develop a coordinated solution. During consultations there was discussion of a potential role for members of a leadership group of a national CQI framework in Aboriginal and Torres Strait Islander PHC working with the National Electronic Health Transition Authority to ensure that items relevant to Aboriginal

and Torres Strait Islander health are given adequate attention in the development and roll out of IT systems in PHC across service sectors.

Greater coordination and governance of initiatives to support workforce capacity in use of information systems (discussed elsewhere) may also enhance the effectiveness of these initiatives, and bring greater efficiencies.

3.10.3. Adequacy of IT infrastructure to support CQI

There have been no representative studies assessing the adequacy of commonly used IT platforms to support CQI for Aboriginal and Torres Strait Islander people across the PHC system in Australia. The summary of jurisdictional-specific CQI presented in Section 2 suggested that within most jurisdictions, ACCHOs were using fairly standardised software and that software systems were adequate to support entry and extraction of at least a set of indicators useful for CQI – although there were concerns raised about lack of knowledge in the quality of data obtained through automatic extraction tools. The state of development of IT infrastructure and clinical information services used by state and territory PHC services and by General Practices that provide care to Aboriginal clients appears to be more varied.

In-depth research including eight PHC services in NSW, Queensland and Central Australia,⁶⁴ reported that many staff in ACCHOs considered IT infrastructure to be sub-standard, and that this was a major barrier to supporting a culture of quality improvement in chronic care. Concerns included frequent outages and support services being inadequate to troubleshoot problems when they arose. The study, published in 2012, included only a small sample and may now be out dated, but does suggest that it is important not to assume adequacy of IT infrastructure across the board, particularly in respect of services with lower capacity for CQI who may need support for improvement the most.

3.10.4. Data for action and linkage with CQI models and change management tools

The role of benchmarks in CQI was discussed at some length in several of the consultations, with both opportunities and concerns identified. It was noted that some benchmarks could be a spur to action. For example, a GP noted that the RACGP standard for accreditation specifies that data on whether patients were Aboriginal or Torres Strait Islander or not, needed to be recorded for 75 per cent of their patients. This requirement spurred the practice to come together to consider how they could meet this target.

In discussing concerns about benchmarks, participants highlighted the high variability in service resourcing, and service delivery environments, and that comparison by outsiders who lacked knowledge of context was inappropriate. Related to this, some noted that depending on the service configuration, benchmarks could be inappropriate - for example some benchmarks would not be relevant to services with limited access to GPs, or services with an emphasis on certain areas such as social and emotional wellbeing. Some considered that a framework could play a role in ensuring appropriate use of benchmarks – for example some benchmarks could be useful to advocate for greater GP resourcing in certain areas, depending on the underlying quality problem. Some participants reflected that ‘benchmark’ may not be the right word for these kinds of measures because ‘benchmark’ implies that there is a common standard that all services could conceivably reach. However there was general agreement that some common data ‘indicators’ were likely to be useful to track progress overall.

CQI approaches need to use data and information for the specific purpose of improving health care, to achieve better health outcomes. This means focusing on what data mean, not simply what they measure. The evaluation of the NT CQI Strategy warned of a risk that the ‘improvement’ part of CQI could be overshadowed by an overemphasis on data alone. Skills in analysis and contextualisation of data at the local level, along with broad staff engagement, are critical to identifying and prioritising areas for improvement, measuring change and building a shared vision and story about improvement across a health service. This process of ‘sense-making’ has been shown to be an important enabler to a culture of quality improvement. Promoting regional collaboration, in which data are shared and regional ideas and solutions developed, was recommended as a solution to difficulties faced by health services in developing meaningful improvement strategies based on their data.³²

A CQI framework should also encourage the use of data for improvement purposes at different levels of the system. System-wide barriers to good care may only be modifiable at regional, jurisdictional and national levels of the health system. However there can be tensions between the use of data for local improvement purposes and broader use at other levels where data can become decontextualised. For example, concern was expressed across the stakeholder consultations that the Aboriginal and Torres Strait Islander PHC CQI effort could be weakened by fears that CQI data might be used punitively by governments in order to assess performance. Jurisdictional or national analysis requires use of consistent indicators across individual services, which may conflict with allowing services complete freedom to focus on local priorities. At the same time, there are recognised advantages in being able to examine patterns of care across regions, jurisdictions and nationally, and over time. Data sharing can help to increase health care providers’ motivation to improve services, to identify and address common barriers and enablers and to facilitate a regional response to problems that lie beyond the capacity of individual services to solve.²⁵

There was strong consensus during consultations that any data collected as part of a CQI framework need to be owned and used locally and the data may be strategically shared at different levels. A role of a framework could be to provide some leadership and clarity about sharing data, with some participants in consultations noting that some services were still reluctant to share data.

The NT CQI Strategy Evaluation made a number of suggestions in relation to building a culture in which data are shared and used. These reflect the concerns and issues raised in the sections above and are likely to be applicable beyond the NT, and include:

- capturing the role of data as part of the program logic
- clearly articulating what data should be shared at different levels and with whom and the goals of this sharing and data use
- identifying how the data will be used for CQI, specifically developing mechanisms to promote shared learning between health services and developing data sharing protocols
- considering how to account for contextual factors in data interpretation, and
- articulating what action/s could be taken to support services that appear to have low performance to help to lift performance.

Recommendation 9: Enhance coordination and governance mechanisms of clinical information systems to support CQI.

- Recognise that quality use of clinical information systems is an essential component of a CQI framework, not separate from it.
- Enhance coordination and governance of investment in clinical information systems to support CQI. This will achieve:
 - efficiency in expenditure
 - better data quality
 - improved linkage of indicators and CQI tools to clinical guidelines and best practice
 - better dissemination of local innovations to harness technology
- Acknowledge that data for CQI is data for action and not for accountability. This will drive:
 - best practice care
 - improved planning at local and regional levels
 - closer relationships with research teams
- Any use of data must value CQI models and change management tools.

3.11 Whole-of-quality system

Participants – particularly quality managers, and those who had been involved in support roles in accreditation – noted that there would be some work to do to make sure that 'everything lines up' in the broader quality system. There was some discussion of the importance of making sure that a national CQI framework could support and be supported by accreditation and clinical governance systems. It was considered that a useful role of a CQI framework for Aboriginal and Torres Strait Islander PHC would be to unpack how these different parts of the system fit together (risk assessment, CQI, accreditation). This would then be helpful to services in investing wisely in quality activities as they would be able to see the whole picture. Accreditation has been seen as a way to improve quality of services, but as noted by one participant, it does not provide the entire picture.

...[in accreditation] the culture of quality, the planning and reflecting on your services, on how you can do a better job with the services that you have – this is the stuff for me that is missing. (Accreditation support personnel, ACCHO)

Specifically related to involvement of the private General Practice sector in improving quality of care, participants in the workshops noted that most accreditation processes do not consider the appropriateness or quality of the service in relation to the needs of Aboriginal and Torres Strait Islander patients, for example, capacity to provide culturally appropriate care. There is also little research available on appropriateness of accreditation processes for Aboriginal and Torres Strait Islander people.

Whilst a national CQI framework for Aboriginal and Torres Strait Islander PHC can do much to address the barriers and strengthen the enablers of effective implementation of CQI, and through this, to improve the quality of care for Aboriginal and Torres Strait Islander people across the PHC system, it cannot improve quality on its own. There is a need for support from a variety of stakeholders, and alignment with other efforts. Several areas

where alignment will help to strengthen the impact of a national framework were identified, and there may be others.

Consultations found emerging interest amongst stakeholders for greater integration between the related concepts of organisational quality and clinical governance, of which CQI forms a part. Those working in services in different roles felt that there is likely to be greater value obtained from different quality initiatives if a framework could map out their relationships and provide a picture of a quality system, with CQI as an approach to problem solving across the system. Some considered that a clearer distinction between indicators of ‘business sustainability’ (such as Medicare billing), and quality measures of care could be useful.

Alignment with the work of ACSQHC, should also be further developed. The Commission’s work in coordinating national improvements in quality of care for Aboriginal patients specifically, has to date been fairly limited. However, following the introduction of the NSQHS Standards, and assessment against these Standards in the acute sector, some work has commenced in relation to improving quality of care for Aboriginal people within mainstream services.

Aligning and clarifying the respective roles and relationships of CQI and other elements of the quality system may also help to ensure sustained commitment to CQI for Aboriginal and Torres Strait Islander PHC and for the broader PHC system. Long-term commitment is required to embed CQI in the health system and gain the benefits of sustained, large scale change. A 10-15 year timeframe for a national CQI framework for Aboriginal and Torres Strait Islander PHC would signal that CQI is as much a part of the quality system as, for example, accreditation. This will give a powerful signal for the competent and committed service providers – and those who support them to do so – to pursue their intrinsic motivation to deliver the best possible care for Aboriginal and Torres Strait Islander people.

Recommendation 10: Develop longer-term strategies for aligning CQI with other quality initiatives including accreditation, service governance, and existing and emerging national policies and plans in Aboriginal and Torres Strait Islander health and the PHC system as a whole.

Principle: CQI in Aboriginal and Torres Strait Islander PHC requires sustained commitment and a national CQI framework needs a 10-15 year timeframe.

3.12 Support to services with limited capacity for CQI

The capacity to engage effectively in CQI varies widely across different organisations.¹⁰ Support models and frameworks have generally acknowledged this, but there have been few systematic approaches to identifying and supporting organisations with limited capacity for CQI. The current design of the Healthy for Life program (considered innovative and successful in many respects by external evaluation), does not favour participation by lower performing services. The 2009 evaluation of this program identified that there was a high demand from eligible services for the funding, but principally barriers to obtaining the

funding related to organisational issues. These included services being too busy to apply for funding, or having poor internal mechanisms to identify and respond to funding opportunities.²⁶ In qualitative research associated with the ABCD research program, key informants noted that the low performance of some health centres were those managed by a central organisation that had experienced high turnover in the CEO position, with limited management commitment to CQI, and consequent delays and interruptions to CQI processes. These health services were staffed by nurses and health workers, did not offer any on-site GP services, and serviced transient and mobile populations. Several other health centres shared these additional characteristics, but had more stable and capable management greater commitment to using data for CQI, and these services had achieved significant improvement in delivery of some services by establishing partnerships with local General Practices.³⁹

The NT CQI Strategy Evaluation highlighted the diversity of CQI capacity amongst health services (in the NT), and suggested finding ways to target and tailor support to services based on their 'CQI competence'.

Stakeholders consulted as part of this project reported that any implementation of a systematic criterion-driven approach to targeting and tailoring support to health services on the basis of CQI capacity would need to be responsive and flexible, since CQI competence of an organisation, however it is defined, is unlikely to be static.

Defining characteristics and standards can nonetheless be useful in helping clarify a path towards increased capacity, and could lead to tailoring of CQI support for greatest impact – as suggested by the evaluation of the NT CQI Strategy. There are a range of tools that have been developed to assess various aspects of organisational capacity for CQI⁶⁵ or CQI maturity.⁶⁶

Finding ways to enable those services with least capacity is a challenge that will require more discussion with key stakeholder groups, specifically with the Affiliates and other entities with roles in supporting services in the different service sectors.

Recommendation 11: Ensure there is a focus on tailoring strategies and approaches to meet the needs of health services at differing levels of development in relation to CQI recognising that health services are at different points in their quality journey.

4. Conclusions and Recommendations

The overall goal of this project was to develop a shared understanding amongst key stakeholders about what the advantages (or disadvantages) would be to developing a national CQI framework and to recommend an approach that would have broad-based support by major stakeholders, is evidence-based, and will contribute to stronger PHC services and improved health outcomes for Indigenous people.

With a clear focus on supporting front-line service providers to improve the quality of PHC for Aboriginal and Torres Strait Islander people wherever they receive care, the project team concluded that implementation of a national system-wide CQI framework for Aboriginal and Torres Strait Islander PHC has the potential to significantly contribute to closing the health gap between Aboriginal and Torres Strait Islander people and the general Australian population. Implementation of a framework as outlined in this report could also support a better national understanding of the quality of PHC delivered to Aboriginal and Torres Strait Islander people, and the factors that enhance quality of care. A national framework would enable more opportunities for using data for improvement at different levels of the system, a process that requires adequate time to build a culture of improvement at all levels of the system, and clear agreements with data providers about the way in which data are used, and the purpose of use.

In all of the consultations, there was widespread support for development of a national CQI framework for Aboriginal and Torres Strait Islander PHC. A multi-level and integrated approach to supporting CQI that can be articulated in and supported by a national framework is well supported by the evidence reviewed in this report.

We therefore make the following recommendations and propose a set of guiding principles.

Summary of recommendations:

Recommendation 1: The Department should proceed with supporting the development of a national CQI framework for Aboriginal and Torres Strait Islander PHC.

Development and implementation of the framework should take into account the guiding principles and specific recommendations identified through this project. These reflect the concerns of key stakeholder groups, and are informed by international evidence about ‘what works’ in supporting improvements at scale.

Recommendation 2: An implementation plan for the framework should be developed. To ensure that the framework takes effect, it needs to be supported by an implementation plan including the identification of resources across the PHC system (not only within Aboriginal and Torres Strait Islander-designated funding).

Recommendation 3: All key stakeholders should be engaged in the development of the framework and implementation plan. A useful early step could be the development of a ‘model of change’ or program theory and/or logic that will help to surface assumptions from different stakeholder groups about the medium and longer term outcomes expected, and how these outcomes might be achieved. The consultations and evidence review informing this report have begun this process.

Recommendation 4: The implementation of the framework should also include a rigorous and useful monitoring and evaluation process. A formative or developmental evaluation could run alongside the framework development and implementation and assist with real-time refinement and improvement.

Recommendation 5: Successful implementation of a national framework will require support systems and activities to grow the ‘building blocks’ of effective CQI.
(Recommendations 7-9 cover specific components of support that may be required.)

Recommendation 6: Development and implementation of a national CQI framework should take a ‘systems approach’ to thinking about the ways in which the building blocks of support for CQI link up and interact with one another – in order to optimise synergies and minimise potential negative effects.

Recommendation 7: Foster leadership and support networks for CQI at all levels of the system. Support networks should be evidence-based, linked up with one another, accountable, and coordinated, and their functioning regularly reviewed.

Recommendation 8: Build the capacity of front line services to undertake CQI including through training in CQI, use of data systems for improvement, and managing and leading change. Ensure workforce engagement in CQI is supported by the broader system.

Recommendation 9: Enhance coordination and governance mechanisms of clinical information systems to support CQI.

- Recognise that quality use of clinical information systems is an essential component of a CQI framework, not separate from it.
- Enhance coordination and governance of investment in clinical information systems to support CQI. This will achieve:
 - efficiency in expenditure
 - better data quality
 - improved linkage of indicators and CQI tools to clinical guidelines and best practice
 - better dissemination of local innovations to harness technology
- Acknowledge that data for CQI is data for action and not for accountability. This will drive:
 - best practice care
 - improved planning at local and regional levels
 - closer relationships with research teams
- Any use of data must value CQI models and change management tools.

Recommendation 10: Develop longer-term strategies for aligning CQI with other quality initiatives including accreditation, service governance, and existing and emerging national policies and plans in Aboriginal and Torres Strait Islander health and the PHC system as a whole.

Recommendation 11: Ensure there is a focus on tailoring strategies and approaches to meet the needs of health services at differing levels of development in relation to CQI recognising that health services are at different points in their quality journey.

Principles:

The key principles identified in this report (refer Recommendation 1) are:

1. Build on momentum already established in CQI and learn from past experience.
2. Focus on strengthening enablers to CQI, not imposing specific models or standard approaches.
3. Identify what cultural capability means for CQI: embed cultural safety and Aboriginal and Torres Strait Islander perspectives on health and health care into all levels of the framework. This has implications for the scope of PHC covered by a framework.
4. A collaborative approach led by the ACCHO sector, for best practice PHC for Aboriginal and Torres Strait Islander people across the PHC system.
5. Support the principle of flexibility of use of CQI tools and approaches (and indicators) with health services supported to use tools that are a good fit for their needs and context.
6. CQI in Aboriginal and Torres Strait Islander PHC requires sustained commitment and a national CQI framework needs a 10-15 year timeframe.

Should the Department decide to proceed with the development of a national CQI framework for Aboriginal and Torres Strait Islander PHC as proposed in this report, it would entail a number of inter-linked areas of work, including a range of stakeholder groups with relatively limited experience of working together constructively towards a common goal. However we believe that the successful development of this initial phase of work is ‘proof of concept’, and that given the momentum already established, and the range of CQI activity and expertise available, there is a strong possibility of high returns in respect of better use of existing resources and improved Aboriginal and Torres Strait Islander health outcomes, even if an initial investment was relatively modest.

Based on our review of the literature and consultations with a range of stakeholders, the timing is right for development of this framework, as well as specification of needed resources and an implementation strategy. If we are able to build on the current momentum, we anticipate that completion of a national CQI framework for Aboriginal and Torres Strait Islander PHC would take approximately 8–12 months.

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6. Annexes and Appendices

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Annex 1: Background Paper: What is a ‘Framework’ and how are frameworks used to support quality initiatives in health care?

This short discussion paper seeks to provide some background in defining and describing frameworks and to discuss how they might be used in this project. The Oxford Dictionary defines frameworks '*as the basic structure underlying a system, concept, or text*'.

Frameworks in health care have been used for a variety of purposes including research where they are called conceptual frameworks, which can represent and define key factors of interest and their interplay and interdependence. A second use is to guide the development of policy. A third use is to guide the development and provision of clinical services.

Several benefits are noted with the use of a framework including

- Identification and definition of the key concepts relevant to the initiative contemplated allowing for a common language among stakeholders
- Ensuring that a sufficiently wide range of factors will be considered to inform development of interventions or plans. This might include for example contextual or cultural factors.
- Facilitating consideration of multi-level impacts such as those at the individual, health service or government levels.

There appears to be no standard format for defining a framework. However viewing different health related frameworks in areas close to that of this project show commonalities. This includes:

- A literature review of the topic including both peer reviewed literature and relevant grey literature.
- Definitions of key concepts. This can be provided by the working team or as a consensus from relevant stakeholder groups.
- Statement of values and principles. This is included in some frameworks particularly those with a more strategic focus.
- Mapping of these concepts and their interrelationships. This often includes feedback from stakeholders in developing a draft framework.
- A formal process such as stakeholder meetings and review by relevant organisations and interested individuals to facilitate broad input into the framework and to generate a consensus regarding the framework
- Some frameworks include strategies for the implementation of the framework and a few incorporate specific plans and resources (strategic plan) required for their implementation.
- Some frameworks define the program logic of the initiative including anticipated outcomes and how they might be measured and tracked over time.

Frameworks are very similar to models of care (e.g. the Chronic Care Model of Wagner et al) and some believe they are synonymous.

Examples of Frameworks

There are many examples of frameworks. Some examples of frameworks that might be used to inform the development of the CQI framework for this project include:

Royal Australian Quality Framework. This framework defines the elements of quality for GPs in Australia and is used to guide continuing professional development and accreditation. <https://rnzcgp.org.nz/assets/documents/News--Events/Friday-1150-C-Mitchell-12-Feb-Quality-Framework-Presentation-Final.pdf>

Queensland Department of Health Organisational cultural competency framework. This framework defines the action areas of cultural competency and is an element of the Queensland Health Strategic Plan for Multicultural Health 2007-2012. It demonstrates the overlap between frameworks and strategic plans in Australia.
http://www.health.qld.gov.au/multicultural/contact_us/framework.asp

Department of health (England). A framework for personalised care and population health for nurses, midwives, health visitors and allied health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326984/PHP_Framework_Version_1.pdf

Implications of this discussion of frameworks for the Aboriginal and Torres Strait Islander Primary Health Care CQI scoping project.

In 2013, Allen + Clarke, a private evaluation company wrote the “Northern Territory Continuous Quality Improvement (CQI) investment strategy: Final Report”. This report evaluated the impact of CQI interventions in improving Aboriginal and Torres Islander health in the NT and provided recommendations for additional work in this area and provided recommendations for additional work in the area. Their first recommendation was to “Develop, agree and communicate a plan or framework for the CQI Strategy which sets out the partners’ (AMSANT, DoH [NT], and DoHA [Federal]) expectations in terms of short and long term outcomes, timeframes, indicators for monitoring CQI activities and impacts, and that describe the context for CQI activities”. Their second recommendation was the development and implementation of a phased CQI implementation model that “targets support for services based on whether they are at a growing or mature phase in terms of the CQI capability and capacity”. As part of this recommendation they suggested, “defining the characteristic and standards expected of a CQI competent NT Aboriginal PHC service”.

From initial discussions there was interest expressed by many of the stakeholders to have the framework development be the first step in a broader process for strategic planning around measuring and improving quality of care in the Aboriginal and Torres Islander PHC sector perhaps along the lines suggested by Allen + Clarke.

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20 July 2014

Annex 2: Proposed components of support or ‘building blocks’ for development and implementation of a national CQI framework in Aboriginal and Torres Strait Islander Primary Health Care

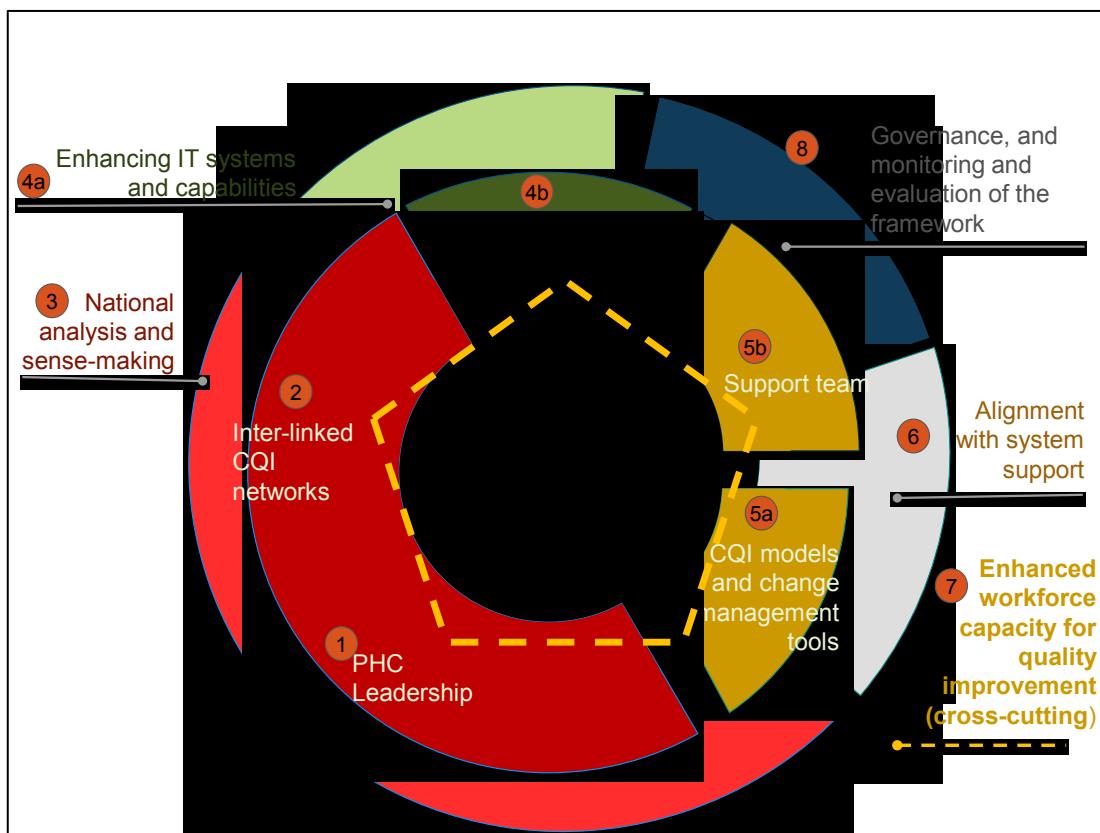
The findings presented in the report of the project ‘Provision of CQI in Aboriginal and Torres Strait Islander PHC’ suggested that successful implementation of a national framework in this area would require specific attention to strengthening several ‘building blocks’ or components of support in the PHC system. These components of support or building blocks represent the broad areas of focus that would be needed to support an overall vision of a national CQI framework. This document provides additional details and recommendations around these proposed components of support for implementation. Additional components may be added to this list and further refinements are likely.

This figure shown below (Figure 1) was presented in earlier draft form to the participants at the project’s national consultation conducted as part of this project in Canberra on 23rd July 2014. The version shown here incorporates several refinements suggested at that workshop, including:

- addition of a cross-cutting workforce capacity development component (represented by the dotted pentagon)
- enlargement of the central circle to better reflect the overall intent of the framework, being to support front-line services
- expansion of leadership to include leaders and managers across the PHC workforce, not only clinical leadership
- wording adjustment to better reflect the intent of various components.

Specific recommendations in relation to each component for implementation are provided below the Figure. Any progression of these components will also need to pay attention to how they are linked up with one another. Alternate depictions of the components which reflect some of the discussion at the national workshop show the applicability of these components at different levels of the PHC system, and the need to focus on the linkages between these different components (Figures 2a and 2b at the end of this document). Recommendations in relation to each component were discussed in the national workshop, and are provided below. These are consistent with, and expand upon, the broader recommendations of the project provided in the main project report.

Figure 1: Proposed components of support for implementation of a system-wide national framework for CQI in Aboriginal and Torres Strait Islander Primary Health Care



1.1. Supporting PHC leadership to drive CQI for improving Aboriginal health outcomes

Any improvement initiative needs to identify and mandate suitable leaders to spearhead its activities and drive change at different levels. Leadership at system level is important, and so is leadership of clinicians in relating to clinical care, managerial leadership, and Aboriginal health worker leadership.

In order to create an enabling environment for wide-scale CQI to improve PHC for Aboriginal peoples, we recommend that the Department:

- Establish and resource a core leadership group to drive development of a national CQI framework. In recognition of the experience of the core role of the ACCHO sector in providing quality PHC specifically for Aboriginal people, it is considered that the ACCHO sector should play a central role in this leadership group and be adequately resourced to do so. The leadership group should reflect the principle that key stakeholders should be part of the process of developing and implementing strategies, and include partners at all levels of the PHC system with relevant expertise and experience. It should be closely aligned with already established national leadership structures.
- Foster leadership for CQI that includes different aspects of leadership at different levels of the system. Whilst the role of an overall core leadership group will be critical, there is also a need for specific strategies to develop other leadership. For example, a framework should recognize and allow opportunity for development of leadership in improvement from clinicians with credibility amongst clinical peers in state-run services, private General Practice and the ACCHO sector, Aboriginal Health

Worker groups, allied health and other core groups, and quality managers and supporting organisations.

1.2 Designing and resourcing inter-linked CQI networks

Properly designed, improvement networks provide an in-built mechanism to spread successful change quickly, leveraging the power of social and professional connections rather than relying on the formal chain of command of a hierarchical organization.
(Foreword: Effective networks for improvement learning report 2014, Health Foundation)

There has to date been little systematic support for networks as a mechanism to support quality improvement in Aboriginal and Torres Strait Islander PHC. This has meant that networks that have been established have been difficult to sustain. It has also meant that their scope has necessarily been directed by the requirements of funders or auspicing organisations. For example, some CQI networks in Aboriginal and Torres Strait Islander PHC have focused on the needs of a specific sector or group, whilst others have had a research focus. It is difficult for these kinds of networks to provide a neutral environment for collaboration across different constituencies and disciplines. Distinctive features of networks for improvement, and different types of networks for different purposes have been described (Figures 2 and 3 below).

Recommendations from this project in relation to CQI networks for improving Aboriginal PHC through a CQI framework include:

- **Define and work towards adequate resourcing for evidence-based partnership** models (or networks for improvement). More than one network will be needed, as different issues need to be addressed for support to CQI across diverse implementation environments across and within jurisdictions and service sectors. Networks for improvement typically operate at different levels, and in relation to different enablers. Development of a national framework along the lines proposed should outline the types of networks needed and their inter-relationships. It should also ensure that the networks themselves are linked up, accountable, and co-ordinated. Clear articulation of the core purpose and activities of networks at different levels will help to guide decisions about the appropriate structure and governance of the networks.
- **Ensure that evidence is brought to bear on the design of networks and that their functioning is regularly reviewed.** Not all QI networks function equally well. Effective networks have a common purpose, a cooperative structure, critical mass, collective intelligence and community building. In the CQI context, networks need to be ‘managed’ networks, not ‘natural’ networks (although these will exist anyway), and they need to be well supported and resourced, with an identifiable network leader, and a network coordinator or facilitator, with protected staff time. The network must develop a well-organised work plan with identified deliverables or targets, and there is a need for ongoing monitoring and evaluation of performance. More effective networks also have resources to bring network members together through regular meetings, preferably with some of these being face-to-face meetings. Resources are also required to achieve work plans. They have strong, effective communication and engagement across members and stakeholders, as well as brokerage and bridging roles to ensure dissemination of information in and out of the network. Effective QI networks will also need to engage with clinical experts and researchers to ensure that their work is cutting-edge and evidence-based. The networks should include

consumer representation, have multidisciplinary clinical and non-clinical (e.g. organisational or service planning) representation.

- Use existing structures and those organisations already engaged in supporting quality improvement for Aboriginal clients in PHC wherever appropriate, rather than setting up new structures.

1.3 National analysis, interpretation and sense making

CQI approaches need to use data and information for the specific purpose of improving health care, to achieve better health outcomes. This means focusing on what data mean, not simply what they measure. The evaluation of the NT CQI strategy warned of a risk that the ‘improvement’ part of CQI could be overshadowed by an overemphasis on data alone. Skills in analysis and contextualization of data at the local level, along with broad staff engagement, are critical to identifying and prioritizing areas for improvement, measuring change and building a shared vision and story about improvement across a health service. This process of ‘sense-making’ has been shown to be an important enabler of a culture of quality improvement. A CQI framework should also encourage the use of data for improvement purposes at different levels of the system. System-wide barriers to good care may only be modifiable at regional, jurisdictional and national levels of the health system. However there can be tensions between the use of data for local improvement purposes and broader use at other levels where data can become decontextualized. For example, concern was expressed across the stakeholder consultations that the Aboriginal and Torres Strait Islander PHC CQI effort could be weakened by fears that CQI data might be used punitively by governments in order to assess performance. Jurisdictional or national analysis requires use of consistent indicators across individual services, which may conflict with allowing services complete freedom to focus on local priorities. At the same time, there are recognised advantages in being able to examine patterns of care across regions, jurisdictions and nationally, to identify and address common barriers and enablers, to measure system-wide progress and to help build a shared story about improving Aboriginal health.

- It is recommended that a CQI framework should enable more formalized opportunities for using data for improvement at different levels of the system, while taking into account that it can take time to build a culture of improvement in which data for improvement are shared openly.

1.4 Enhancing IT systems and capabilities - data platforms, reporting and targets

The value of a supportive IT platform for quality delivery of comprehensive PHC and for CQI is increasingly recognized. How well IT links into other components of a service system is a strong influence on what can be achieved in relation to delivery of good chronic illness care (Appendix 10).

The major gap at present is the lack of resourcing for epidemiological and Aboriginal-health expert leadership in harnessing IT technology to underpin clinical CQI work and guide interpretation of quantitative data. This area would benefit from a greater input from the ACCHO sector and public health expertise.

General principles and recommendations in relation to supporting development of this component of a framework are:

- 1. Recognise that quality use of clinical information systems is an essential component of a CQI framework, not separate from it.** Implications of this may involve working with the National Electronic Health Transition Authority to ensure that items relevant to Aboriginal and Torres Strait Islander health are given adequate attention in the development and roll out of IT systems in PHC across service sectors. There are also implications for workforce capabilities in relation to IT (discussed below).
- 2. Enhance co-ordination and governance mechanisms of clinical information systems to support CQI.** This will achieve:

- efficiency in expenditure
- better data quality
- improved linkage of indicators and CQI tools to clinical guidelines and best practice
- better dissemination of local innovations to harness technology.

Currently decisions about how to spend money on developing capability of clinical information systems to support CQI are made by a variety of staff across different organisations, operating individually within a market economy. There does not seem to be a current forum for those developing and supporting CQI programs in Aboriginal and Torres Strait Islander PHC to come together with IT vendors to make decisions about wise investments that could lead to quality clinical care. Our consultations identified a range of different IT solutions to generating data for CQI that are separately negotiated, sometimes with disappointing results. Whilst decentralized decision making about IT can mean that CQI programs (and health services who use them) can choose solutions that they feel are a good fit with their needs, without having to compromise with others on the decision, there are also some drawbacks – including procuring many similar but separate solutions, with decreasing pricing leverage and increasing procurement costs. It also makes it harder to bring together a balanced team withof public health expertise, clinical expertise and IT technical expertise to solve challenges – as there are pockets of expertise spread around the system that are not speaking to one another, and asking IT vendors for slightly differing solutions. An advantage of linking a co-ordination structure into a national framework is the potential it brings to include mechanisms to trouble shoot IT issues that services experience, identify common concerns across services or groups of services, and help develop a co-ordinated solution.

- 3. Acknowledge that data for CQI is data for action and this is different from data for accountability.** Using data for improvement purposes often results in change in the data, as inactive clients are removed from patient lists, definitions are tightened up, and documentation of care processes is improved. This will drive best practice care and improved planning at local and regional levels. Currently use of clinical information systems is variable across the PHC system. Front line health services struggle with establishing good practice in use of clinical information systems – staff turnover, locum staff, and visiting staff, unfamiliar or unwilling to use existing systems being underlying factors that make it difficult for even the best resourced data extraction tools to provide quality data. These kinds of processes mean that using CQI data for accountability is not ideal – questions were raised in the consultations if this (at this stage of development) was even possible. A framework

should allow for and facilitate responsible use of data for improvement purposes at national, jurisdictional and regional levels, as well as recognizing the prime role of CQI data at the local level. This will help to provide population level perspectives as well as informing what works and system wide barriers/enablers to quality care.

1.5 CQI models and change management tools

There are a large number of CQI models and tools developed and emerging. It is strongly recommended that a CQI framework needs to foster a ‘learning culture’ in relation to tools and resources, and be open to change and new developments. Specific recommendations in this area include:

- Support the principle of flexibility of use of CQI tools and approaches (and indicators) with health services supported to use tools fit for local context. Part of the next phase of work could be to develop and trial and a ‘repository’ of tools and resources to support CQI for improvement in quality of PHC for Aboriginal people across the system. This would need to be a ‘living resource’ with mechanisms built in for review and updating at least annually. The focus of those supporting implementation should be on coaching health services to look across different tools and select the best fit for purpose, and implement improvement. Given the strategic and targeted effort required to achieve improvement in Aboriginal health, efficient and effective outcomes may be best secured through support services with a specific focus on Aboriginal health, such as larger AMSs with expertise in CQI, or affiliates and partner organisations.
- Recognise that providing tools and resources alone is a necessary but not sufficient condition for improvement (tools need to go along with other dimensions of capacity including training, supportive processes etc.). A next phase in development of a national CQI framework could develop strategies for disseminating and meshing available CQI tools with other aspects of capacity in CQI – for example, at a system level ensuring that the tools and approaches are consistent with accreditation requirements, requirements for award of Continuing Professional Development points etc. Capacity in leading and managing change is particularly important.
- Ensure there is a focus on tailoring strategies and approaches to meet the needs of health services at differing levels of development in relation to CQI. Health services are at different points in their quality journey. Establishing a Total Quality Management approach within the health service itself is vitally important, along with a systems approach and a quality/safety culture, and cultural safety in the Aboriginal and Torres Strait Islander context - then CQI tools, and improvement networks can be a useful addition.

1.6 Leverage broader PHC and system support

Whilst a national CQI framework for Aboriginal and Torres Strait Islander PHC can do much to address the barriers and strengthen the enablers of effective implementation of CQI, and through this, to improve the quality of care for Aboriginal and Torres Strait Islander people across the PHC system, it cannot improve quality on its own. There is a need for support from a variety of stakeholders, and alignment with other efforts. Several areas where alignment will help to strengthen the impact of a national framework were identified, and there may be others.

- First, there was a strong recommendation that a future phase of work **map relationships between existing CQI models, standards and accreditation**. There is emerging interest amongst stakeholders for greater integration between the related concepts of organisational quality and clinical governance, of which CQI forms a part. Those working in services in different roles felt that there is likely to be greater value obtained from different quality initiatives if a framework could map out their relationships and provide a picture of a quality system, with CQI as an approach to problem solving across the system. Some considered that a clearer distinction between indicators of ‘business sustainability’ (such as medicare billing), and quality measures of care could be useful.
- Alignment **with the work of Australian Commission on Safety and Quality in Health Care (ACSQHC)**, should also be further developed. The Commission’s work in co-ordinating national improvements in quality of care for Aboriginal patients specifically, has to date been fairly limited. However, following the introduction of the National Safety and Quality Health Service (NSQHS) Standards, and assessment against these Standards in the acute sector, some work has commenced in relation to improving quality of care for Aboriginal people within mainstream services.

1.7 Enhanced workforce capacity for quality improvement

Ultimately the successful implementation of CQI across the system in a way that improves care will be determined by the competent and committed service providers who engage with Aboriginal clients on a day to day basis. The enthusiasm and commitment of service providers needs to be harnessed at all levels of the system.

We consider that enhancing workforce capacity for quality improvement will be a core part of the work of each of the components of support outlined above. The following additional recommendation relevant to workforce capability is proposed.

- Recognise that access to quality data about service provision, including clinical data, is a key foundational element of CQI and build workforce capability in this area. At the service provider level, there needs to be a shift in mindset from writing clinical notes for one’s own use (as a GP or health care provider), to documenting relevant information in a way that can be accessed for a variety of purposes, including billing, sharing care with team members, generating recall and reminder lists, and providing indicators for quality improvement, and accountability and reporting. This ‘mindset shift’ is a large-scale change effort. We consider that this change effort could benefit from being more closely integrated with a national CQI framework for Aboriginal and Torres Strait Islander PHC. Specific areas of activity may include advocating for greater emphasis of the importance of using clinical information systems correctly as part of good clinical care in in-service and pre-service training for health practitioners. It also may involve integrating training in how to cleanse and support good data entry into CQI training.

Annex 2: Supplementary figures

Figure 1a: Alternate depiction of support model for implementation of a national CQI framework (1)

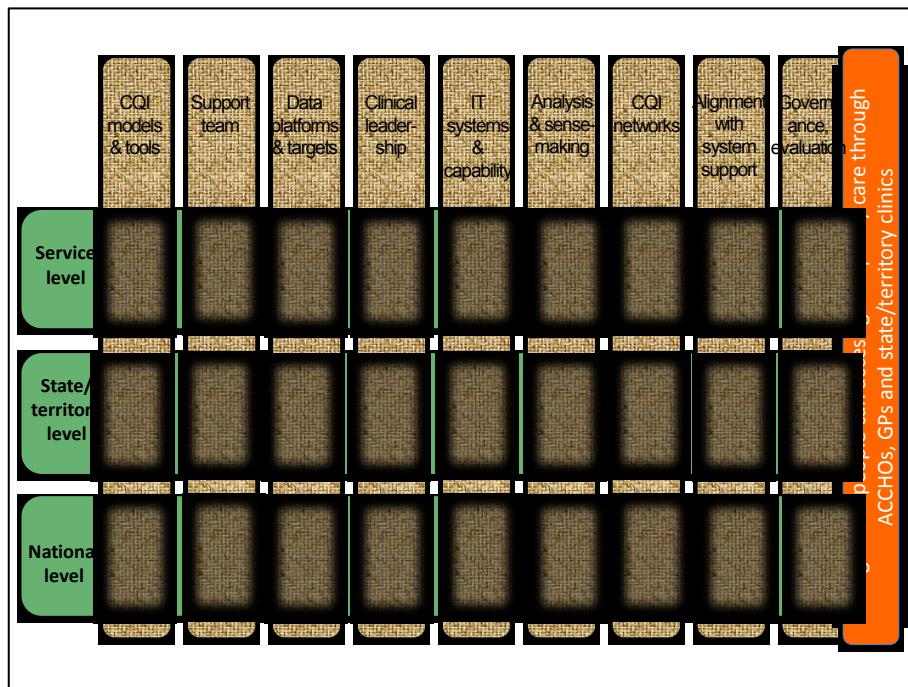


Figure 1b: Alternate depiction of support model for implementation of a national CQI framework (2)

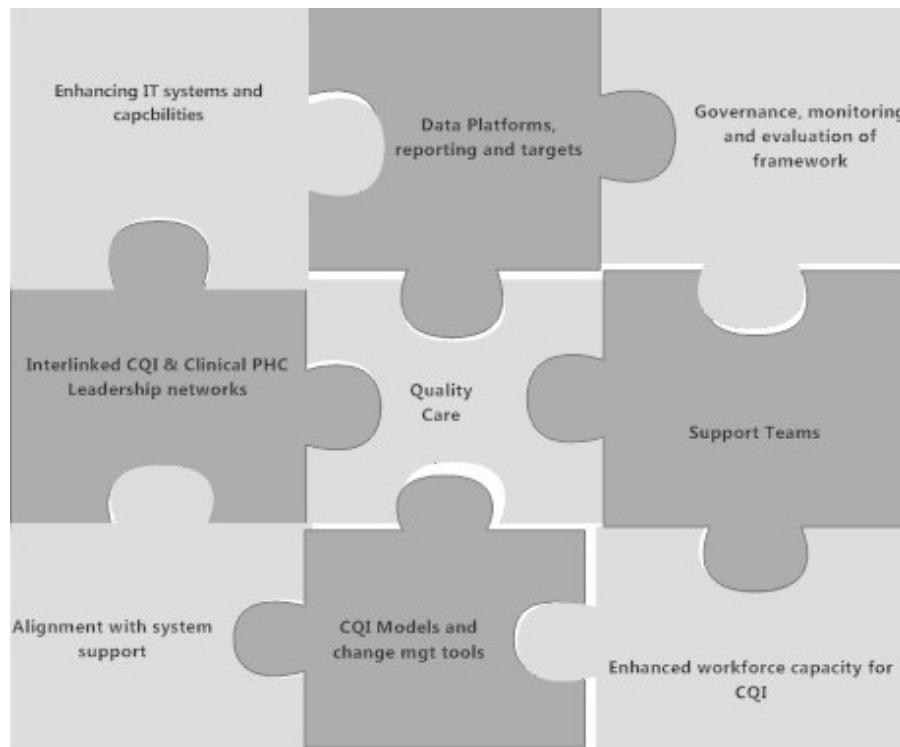


Figure 2: Distinctive features of networks

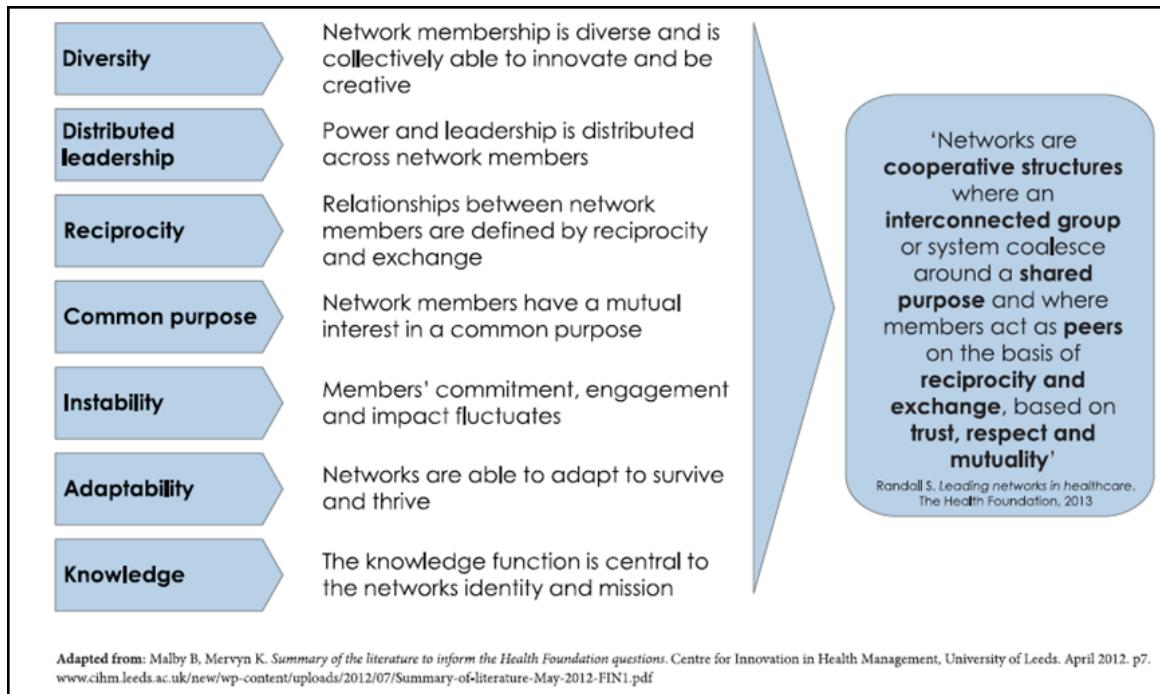
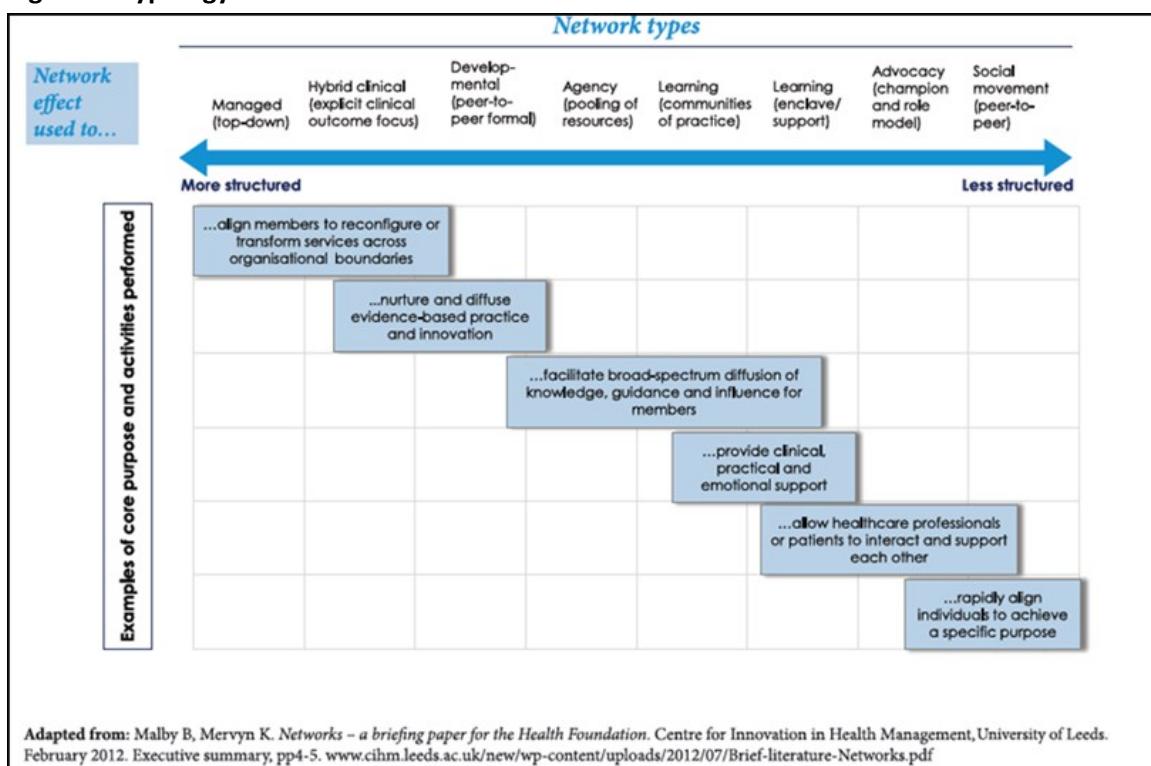


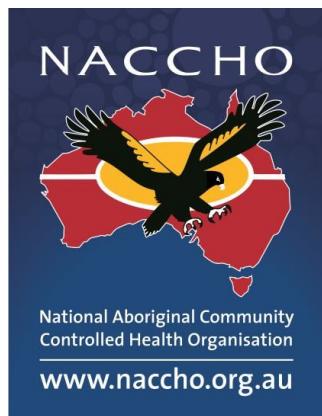
Figure 3: Typology of networks in health care



Appendix 1: List of Steering Committee members

Organisation	Contribution	Representative/Proxy/Contact
Lowitja Institute CQI Project Leader	Chair of SC Associate Director, Knowledge Exchange and Research	Michael Tynan
National Aboriginal Community Controlled Health Organisation (NACCHO)	Subcontractor Katie, Health Information PHMO Catherine, National Policy Manager Lisa Briggs, CEO	Katie Panaretto Catherine Wright as proxy;
Affiliates VACCHO, AHCWA, AHCSA, Winnunga, QAIHC, AMSANT, Tasmanian Aboriginal Centre	Subcontractors Four members on Steering Committee, representing current CQI work (AHCSA, QAIHC, AMSANT, AHMRC)	AHCSA: Paul Ryan, David Scrimgeour as proxy QAIHC: Lynette Anderson, Aaron Hollins as proxy AMSANT: Kerry Copley AHMRC: Jenny Hunt
Australian Indigenous Doctors' Association Ltd (AIDA)	Joint representation of AIDA and RACGP	Mark Wenitong
Royal Australian College of General Practitioners (RACGP)		
Australian Department of Health		Alison Killen Bridget Carrick as proxy
Menzies School of Health Research	Subcontractor	Veronica Matthews Frances Cunningham as proxy
Flinders University	Subcontractor	Judith Dwyer (08) 8201 7762 Richard Reed as proxy
National Aboriginal and Torres Strait Islander Health Standing Committee	Information flow to State/T governments.	Shane Nichols
Australian Primary Health Care Research Institute (APHCRI)	APHCRI	Karen Gardner (02) 6125 7875
Improvement Foundation	Dr Dale Ford, Principal Clinical Advisor and Chair	Dale Ford
Kirby Institute (UNSW)	Independent view of CQI.	James Ward
Non SC attendees		
Menzies	Lead Researcher/writer on project Attendance on SC to gather information for research role	Gill Schierhout
Administration support	Note-taking	Luella Monson-Wilbraham

Appendix 2: Regional workshops pre-reading ‘policy issues’ paper



Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

Regional Workshops

Continuous Quality Improvement (CQI) workshops Background reading

1. What is this project about?

Currently, there is no national framework and associated support for CQI in Aboriginal and Torres Strait Islander Primary Health Care (PHC). There are multiple CQI models in the sector with some services being less advanced in their CQI programs than others. While there is value in approaches that increase the capacity to address local, regional or state level issues, there is also value in complementarity across models. An analysis of existing CQI activity (including ACCHO, mainstream and international activity) will inform future policy development and potentially drive support for organisations working towards improving CQI quality and program delivery across jurisdictions.

The overall objectives of the project are:

- To prepare a report identifying PHC system-wide CQI enablers, barriers and linkages across the Aboriginal and Torres Strait Islander PHC sector, including an appraisal of any existing mainstream (services with both high and low numbers of Aboriginal and Torres Strait Islander patients) and international models.
- In partnership with NACCHO, its affiliates and all key stakeholders, explore the scope and benefits of a national CQI framework.

2. What we want from the workshops?

The goal of the workshop is to identify the benefits of, and the enablers and barriers to, the potential development of a national system-wide Aboriginal and Torres Strait Islander CQI framework. See guiding questions below.

3. Definition of CQI

Continuous quality improvement (CQI) programs are part of a broader set of activities and initiatives that operate under the banner of ‘quality’ and aim to improve the overall delivery of health care. In the Australian primary health care sector these include CQI, accreditation, and national reporting against key performance indicators. Although these programs are distinct and have different origins and purposes, they are increasingly being linked through the broader policy agenda.

For example, accreditation promotes improvement through setting standards for achieving improvements in the quality of organisational systems but now includes a requirement for services to conduct continuous

improvement activities. CQI and performance reporting programs both use KPI data to promote quality but CQI programs focus on achieving internal improvements in service delivery while performance programs allow the service to use data to compare performance across services, regions and the nation. Data obtained through CQI can be aggregated for comparing performance and the community controlled health sector is rapidly implementing the technologies that enable them to assist services to compare performance so that improvement strategies can be shared.

Although there is no internationally agreed definition of CQI, it is useful to distinguish what the core components of a CQI program are and how these contribute to an overall quality framework. Consensus is emerging that CQI programs include some or all of the following activities:

Definitely CQI

- involves an iterative development and testing process such as PDSA (Plan-Do-Study-Act)
- uses systematic data-guided activities to achieve improvement
- involves feedback of data to intervention designers and/or implementers
- aims to change how care is organised, structured, or designed
- identifies one or more specific methods (e.g., change strategies) aimed at producing improvement
- is designed and implemented with and for people at the local level.

Possibly CQI

- is designed and/or carried out by teams
- aims to change the daily work or routine within an organisation by redesigning work processes
- can use multiple change management strategies
- uses available previously established evidence relevant to the target quality improvement problem or goal
- seeks to create a culture or mindset of quality improvement
- is shaped by clearly defined and desired outcomes/targets.

For the purposes of this consultation the Department has developed the following working definition of CQI:

CQI is an important component in identifying gaps and generating improvement to support best clinical practice in PHC. It is an ongoing internal process at the service level that includes the collation and analysis of accurate, timely, de-identified patient data, to identify needs/gaps by measuring activity against an agreed set of regional or national benchmarks or goals set by the organisation itself.

It is also important to consider the place of CQI with clinical governance more broadly. ‘Clinical governance’ describes a systematic approach to maintaining and improving the safety and quality of patient care within a health system. At the service level, the main focus is on complying with processes and quality systems. It includes the ability to effect change so that high quality care is achieved and maintained.

In the Australian context:

- a. *What are the components of CQI that you think are essential?*
- b. *Is it a key part of clinical governance?*
- c. *Can we build on, refine or improve the above working definition of CQI?*

4. Environmental scan of current clinical CQI programs

According to the definition of CQI above the Commonwealth government has supported CQI through a variety of programs. There are a small number of CQI programs which have documented use of PDSA cycles in the primary health care sector and other state and locally developed CQI programs, as well as research projects, using other quality improvement processes. A recent scan of national CQI programs serving predominantly Aboriginal populations identified One21Seventy and its predecessors ABCD/E, the QAIHC Close the Gap Collaborative, the NT CQI Strategy, the AHCWA Continuous Care Improvement project, and the

National/Australian Primary Care Collaboratives (N/APCC). Other quality improvement programs identified that may or may not include PDSA cycles include Healthy for Life, STRIVE (STI in Remote communities: ImproVed and Enhanced primary health care), The Health Tracker Decision Support project, programs in Cape York and the Torres Strait; and in Derby WA. The successes of these programs indicate that it is timely to consider the need for a comprehensive systemic approach.

- d. What clinical CQI programs are happening in your state? Or research programs that have CQI frameworks?*
- e. What are their strengths and weaknesses?*
- f. Do they integrate well with programs led by your state affiliate?*

5. What would be the core components of a national CQI framework to make it sustainable and embedded in PHC health services across the system?

Like their counterparts overseas, CQI programs in Australia have achieved variable levels of improvement in clinical service delivery. A key problem is sustaining core activities, especially in areas where staff turnover is high and there are many competing demands for service delivery. While the burden of reporting can impact significantly on the capacity of services it has also been shown that accreditation and CQI can increase the capacity of services to drive quality care.

International evidence suggests that improvements are greatest when multiple strategies at different levels of the health system are aligned. These include incentives, electronic information systems and support for extracting and using data for improvement, performance indicators, feedback of information to clinicians and communities, best practice guidelines, organisational interventions for improving multidisciplinary teamwork and care redesign.

To date services have struggled to support the key elements outlined in section three and there is a shift toward developing clinical governance structures within state based organisations to support CQI, drive quality and safety initiatives and influence change across the range of areas required to improve quality.

- g. What infrastructure is needed to support a national CQI framework? For example: Information systems, staffing, tools, incentives.*
- h. What could be the role of state based organisations and regional networks in supporting CQI?*
- i. What are realistic expectations of 'success' of CQI and how can this be communicated?*
- j. How can clinical governance structures support CQI?*

6. A Measurement platform: data, electronic CQI tools and integrated decision making tools

The use of electronic medical records has made data more easily available for reviewing whether care delivered in PHC matches clinical best practice. Whilst collection and use of data alone do not constitute quality improvement, measurement is a key component of clinical CQI programs to assess the impact of changes to care delivery. Evidence suggests that a characteristic of high performing PHC organisations is that they monitor progress using data systems that track:

- clinical performance, e.g. diabetes management, antenatal care
- operational performance, e.g. access, billing data
- patients' experience metrics.

It is recognised that how data on performance is used and interpreted at different levels of the health system is important. Experience from the National Key Performance Indicators program (nKPIs) suggests clinical CQI programs in some states have resulted in higher clinical performance. Technology is also evolving quickly. In this context:

- k. How could data systems be harnessed and used more effectively?*
- l. Are electronic decision making tools a useful part of clinical CQI work?*

- m. Do we need generic tools e.g. for systems assessment, clinical audits and/or process mapping? Or are the current tools available adequate?*
- n. Who should help design these tools (if required)?*
- o. How do the nKPIs fit into a clinical CQI work program? What could be improved?*
- p. Should other measurement/data sets be used for clinical CQI in Aboriginal PHC?*
- q. Is patient feedback important?*
- r. Are tools that review billing performance useful?*

7. Cross sector collaboration on clinical CQI: What value is there in working together across sectors (mainstream, state and ACCHO), and across jurisdictions? What are the risks?

There is broad policy agenda that all PHC service sectors, including ACCHOs, privately run general practice, and state and territory services need to work together to improve access and quality of PHC for Indigenous people. A diversity of CQI models and approaches has been used in different jurisdictions and sectors to date. If we were working together going forward, with cross sector partnerships appropriately structured, would there be tangible benefits for patients, services, GPs and state based clinics? In this context:

- s. Are there any successful models on cross sector collaboration?*
- t. What are the opportunities in working together to develop a national framework, and to implement it?*
- u. Where should we have national consistency? What can be flexible?*
- v. What would be non-negotiable for different parties? What would be areas of commonality?*
- w. Are there common data sets we could all agree to use?*
- x. What governance models would be appropriate?*
- y. Do we currently have clinical champions? Do we need to foster more?*

8. What advantages and benefits would a national framework for CQI in Indigenous PHC bring?

The goal of a proposed national CQI framework for Aboriginal PHC could be to improve the overall health outcome of Aboriginal patients by:

- Improving the clinical performance of PHC teams, and
- Facilitating and enhancing the delivery of best practice, evidence based care for Aboriginal people.

Whilst not being directly transferable, the Institute for Healthcare Improvement (IHI) in the United States suggests that focusing on three critical objectives will help deliver better healthcare – the ‘Triple Aim’ approach:

- Improve the health of the defined population
- Enhance the patient care experience (including quality, access and reliability)
- Reduce, or at least control, the per capita cost of care.

Key components to realise these objectives include:

- A focus on individual and family centred care
- Improving the patient experience or journey
- Low cost data acquisition to monitor progress.
- A population health perspective – essentially community level programs, e.g. Maternal and Child Health.

Evidence suggests multi-level CQI models work. Potentially, this might include: national level benchmarking and target setting; regional network support; support for health services to interpret, use data, and implement improvements. The purpose of these consultations is to consolidate the evidence that a framework will improve health outcomes for Aboriginal and Torres Strait Islander people and can be supported by all key stakeholders.

Appendix 3: Regional workshops invitation and sample agenda



Workshop invitation

CQI in Aboriginal and Torres Strait Islander Primary Health Care – Is there a role for a national CQI framework?

CQI has demonstrated improved clinical outcomes in a wide range of settings. The goal of the workshop is to identify enablers and barriers to the potential development of a national system-wide Aboriginal and Torres Strait Islander CQI framework.

Examples of issues to be discussed by key stakeholders engaged in supporting quality improvement across all jurisdictions.

- What is needed to enable effective models of CQI to be sustainable and embedded in PHC services across the system, including ACCHOs, state-run services, and General Practices?
- How will the different service sectors work together under a national framework?
- A working definition of CQI is ‘CQI is an important component in identifying gaps and generating improvement to support best clinical practice in PHC. It is an ongoing internal process at the service level that includes the collation and analysis of accurate, timely, de-identified patient data, to identify needs/gaps by measuring activity against an agreed set of regional or national benchmarks’. The workshop will build on and refine this definition.
- What are the barriers and enablers (e.g. quality data and workforce) to the effective implementation of CQI?
- What are the benefits and risks of a national approach?

Adelaide – Tuesday, 1 July 2014

Cairns – Friday, 4 July 2014

Perth – Friday, 18 July 2014

Canberra – Monday, 21 July 2014 **[NEW!]**

We appreciate your commitment to reply and commit to attending. Please respond to the survey by 20 June 2014.

Contact Communio

Sarah Rosas Monsalve

e: events@communio.com.au

fax: 02 9922 7666

Stakeholder interviews are available to those unable to attend. To organise an interview please contact:

Gill Schierhout e: gill.schierhout@menzies.edu.au

For further information

Contact [Yvette](#), or Michael Tynan at the Lowitja Institute e: michael.tynan@lowitja.org.au

Project team

The project is commissioned by the Australian Government Department of Health, and led by the Lowitja Institute, in partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO) and the State and territory governments, Menzies School of Health Research, Flinders University and the University of Melbourne

Sample Agenda



WORKSHOP PROGRAM

Workshop consultations on a national framework for CQI in Aboriginal and Torres Strait Islander Primary Health Care
9am – 4pm, 18 July 2014, Aboriginal Health Council of Western Australia, Highgate

We respectfully acknowledge the people, the traditional owners of the land on which we meet

8.30am	Registration
9.00am	Welcome to Country Acknowledgments and introductions AHCWA
9.15am	Current state of CQI in Western Australia

	AHCWA
9.45am	Project Overview
9.50am	Session 1 – Foundation principles Definition of CQI Do we need a national framework for CQI in Aboriginal and Torres Strait Islander PHC?
10.30am	Morning Tea
11.00am	Session 2 – Identifying opportunities, risks & concerns in relation to a National CQI framework Small group discussions
12.30pm	Lunch
1.15pm	Session 3 - What could a national CQI framework look like? How will it build on what has gone before?
2.30pm	Afternoon tea
2.50pm	Session 4 – Group discussion on what a national CQI framework could look like
4.00pm	Close

Appendix 4: National workshop briefing paper

National workshop briefing paper Continuous Quality Improvement Aboriginal and Torres Strait Islander Primary Health Care – Is there a role for a national framework?

PROJECT GOAL

The overall goal of the project is to develop a shared understanding amongst key stakeholders about what the advantages (or disadvantages) would be to developing a national CQI framework for Indigenous Primary Health Care and to recommend an approach that would have broad-based support by major stakeholders, is evidence-based, and will contribute to stronger PHC services and improved health outcomes for Indigenous people.

This paper has been prepared for the national consultation to be held in Canberra on 23 July 2014. Its purpose is to provide participants of the National Workshop with a summary of the outcomes of regional consultations in order to enable focused and informed discussion and to facilitate the development of draft recommendations.

1. Key themes arising in workshops and consultations

Strong consensus has emerged in the consultations that the development of a national CQI framework for Indigenous PHC has potential to:

- help leverage the expertise of the ACCHO sector in improving care for Aboriginal people across the PHC system.
- reduce the fragmentation and duplication in efforts to support CQI to improve care, and therefore lead to greater efficiencies
- connect existing CQI programs more effectively with front-line services
- provide national leadership and give a ‘collective voice’ to what is already happening on the ground.

However a number of key principles and important caveats were raised. These are outlined below (expressed as ‘key themes’)

1.1 Driven by the ACCHO sector

A national framework for CQI to improve PHC for Indigenous people needs to recognise the expertise and long-standing innovation in CQI in the ACCOs sector, and to support leveraging this experience; firstly to provide leadership and develop a more comprehensive and sustainable CQI focus across the ACCSs sector and secondly to influence CQI activity across the system. A national CQI framework must situate CQI within the policy and practice context and must recognize the key differences between CQI and related performance systems. CQI systems are sector driven internal systems that use data as a tool for promoting learning, investigation and self-reflection, leading to improvements in health care. There was strong consensus in the workshops that the ACCHO sector should

lead the development of a framework – and this may include input from other stakeholders, perhaps through some form of tri-partite governance model or advisory structure. Possible contributions of the ACCHO sector and partners in spreading learning across the PHC system, as raised in the workshops included:

- Strengthening the cultural safety aspects of CQI
- Providing leadership for CQI, by further developing expertise, engaging stakeholders and communities, and securing resources to build a sustainable network for CQI in ACCSs
- Influencing other sectors including private General Practice sector organisations who were receiving Aboriginal health funding, to engage in improving quality of care for Indigenous people
- Establish CQI networks that provide resources and expertise in quality aspects of care specific to reducing health disparities; for example supporting or extending:
 - CQI programs to incorporate internationally accepted strategies for reducing health disparities through CQI programs
 - focused initiatives to improve cultural appropriateness and other aspects of quality.
- Some additional caveats were that:
 - over-specification and over-standardisation across different service sectors (and across jurisdictions) would not be helpful
 - existing QI initiatives, including those in the different Affiliates, and those run through different state departments and other bodies needs to be brought to bear in shaping and implementing a national framework.

1.2 Identifying what cultural capability means for CQI

Whilst some of the core elements of clinical CQI tools and processes can be adapted, cultural considerations, including cultural safety, and Aboriginal conceptions of health need to be included at all levels of the framework. Workshop discussions emphasised that unless services addressed underlying impediments to high quality care, such as cultural safety of services, barriers to access, family and social determinants of health, and other issues, quality of services would not improve. This was strongly related to the underlying philosophy of CQI, is that it taps into the existing motivation of health services for improvement rather than imposing external standards. Areas for consideration raised in the workshops were:

- Clinical indicators provide a starting point for team discussions which aim to improve care: they are not the end point
- Cultural capability as a cross-cutting standard at all levels of a framework;
- Ethical use of data and reporting – including being guided by:
 - principles of data use in Aboriginal health research and evaluation
 - knowledge of context and contextual differences over time and between sub-groups
 - knowledge of how to analyse and report on complex data sets in a responsible and ethical way

- A focus on delivering outcomes for Indigenous people specifically (not just general improvement);
- Recognition of and support to models of comprehensive PHC, as outlined in the Alma Mater definition of comprehensive PHC;
- Recognition of Aboriginal conceptions of health, spirituality etc.

1.3 Strengthening enablers to CQI, not imposing specific CQI models

In general, participants felt that the role/s of a national framework should focus on strengthening the enablers of CQI, rather than imposing a specific nationally-endorsed model or approach. Some health services have already developed quite extensive strategies for CQI and would not want the framework to be overly prescriptive. Areas identified where it may be appropriate to have national consistency included:

- *Establishing an agreed system-wide vision for CQI in Indigenous PHC* – this could provide legitimacy for efforts, sustain commitment at different levels of the system during times of change, and set the scene for the long-term change effort that is needed to improve systems for chronic disease prevention and management
- *Developing strategies to up-skill and engage the workforce in CQI* (to ensure long-term sustainability of CQI at scale. For example:
 - considering in-service and pre-service training in CQI;
 - aligning participation in CQI training with professional development requirements (e.g. CPD points);
 - embedding CQI approaches/expectations in any workforce investment for Indigenous health;
 - strengthening the involvement of Aboriginal Health Workforce, and other workforce.
- Enhancing common data platforms and clinical information systems to support CQI - including
 - improving the flow and use of data within the system;
 - contextualize and provide a framework for governance of the data;
 - ensuring responsible development and use of benchmarks able to be adapted to different service environments;
 - ensuring strong local ownership of data for CQI (although data may be strategically shared at different levels)
 - ensuring data in any common data platform could support CQI efforts, but should not drive them.
- *Re-focusing and re-allocation of resources to support quality of service delivery*; there was a strong hope expressed in the workshops that a national framework would help to sharpen and focus use of existing resources, and lead to longer-term support for CQI infrastructure. Investment considerations put forward included:
 - Leadership and infrastructure support for ‘quality networks’ – at regional and other levels;
 - Recognition that participating in CQI costs money (lost Medicare income), and even modest reimbursement for this loss can make a big difference to services’ ability to participate in CQI activities – including ACCHOs and private practices;

- Looking for better synergies with programs that aim to promote quality such as Healthy for Life;
- Developing expectations that all health services should undertake CQI as part of their core work; but recognizing that better resourced services will have greater capacity;
- Avoiding over-dilution of resources.
- *Whole-of-quality system* – ensuring alignment between a national CQI framework and the broader quality system in PHC – for example making sure that a national CQI framework is aligned with developments in accreditation and clinical governance systems.
- *Clinical leadership* – fostering and supporting clinical leadership for CQI in Indigenous PHC across Australia, perhaps working through lead clinician's groups.

1.4 Flexibility of methods and approaches

Some workshop participants considered that a role for a national framework could be to establish and maintain a 'repository' of CQI methods and approaches, and possibly work towards greater complementarity between the different approaches. The underlying value of CQI (tapping into the intrinsic motivation of health service providers, rather than imposing external standards) was strongly emphasized in the consultations. It was considered that this key aspect of CQI would be undermined if CQI participation was mandated, or if specific CQI models were imposed on services.

We don't need to motivate health service providers. We need to tap into what already motivates them. (GP, regional consultation)

1.5 Building on what has gone before

A 'top down' initiative could squash achievements and risk disengagement, if not seen to be working from the base already established. In building on the foundations already in place, the role for a national framework raised by participants included:

- Promoting efficiency and learning through greater sharing of lessons and approaches from tried and tested CQI support models and specific CQI programs – locally, and at regional, jurisdictional and cross-jurisdictional levels.
- Spreading learnings to ensure a focus on Indigenous health within mainstream CQI, and/or to develop alternate approaches that build on key aspects of quality for Indigenous people using mainstream services, such as improving cultural safety.
- Building on investment for Aboriginal PHC across the system to bring greater improvement focus, and health system strengthening focus to this investment.

1.6 Longevity

A framework needs a 10–15 year timeframe—i.e. long-term commitment. This is consistent with the reality that much work in PHC is around chronic disease; turning around risk factors for chronic disease takes a long time.

1.7 Demonstrating outcomes and accountability

There were different understandings and expectations about what a national framework might include – highlighting the importance of early identification of key purpose and

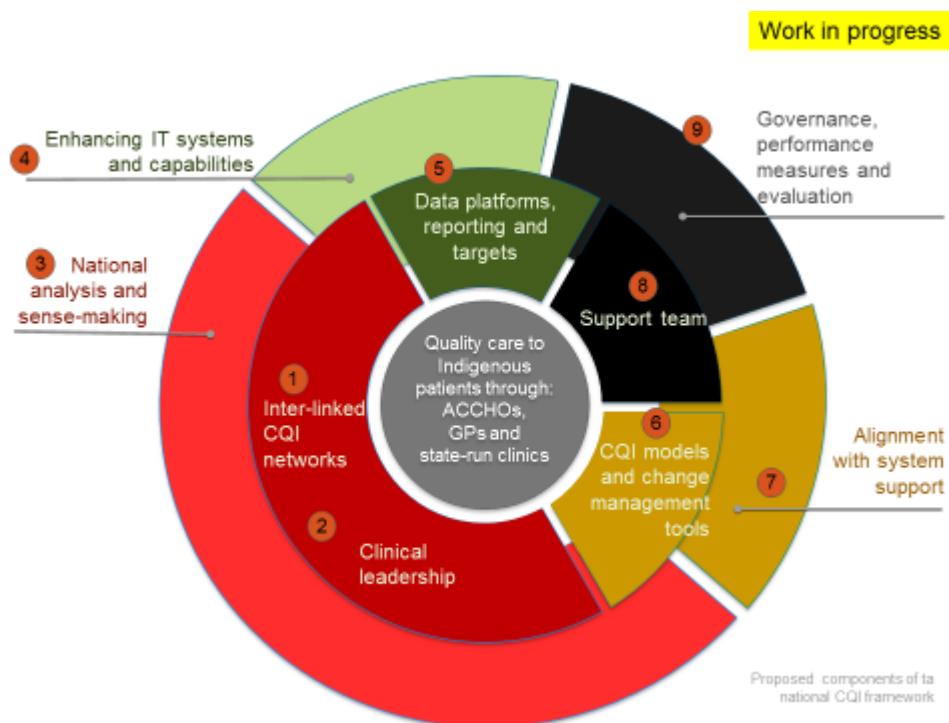
intended outcomes and the means through which these would be expected to be achieved. Considerations included:

- Accountability to community, including sufficient time allocated to consultation in any next phase of development and implementation of a framework;
- Flexibility, and ability to adapt;
- Development of greater clarity about how outcomes and accountability will be demonstrated

2. Possible components of a national framework

Based on the consultations, and review of the CQI literature, the project team are proposing nine elements which may contribute to a possible national framework. This is illustrated in Figure 1.

Figure 1 Proposed elements of a system-wide national framework for CQI in Indigenous Primary Health Care



Questions for consideration include:

Overall

- Do these elements capture the major ‘building blocks’ for the development of a national CQI framework for Indigenous PHC? Is there anything important not reflected here?
- How to make sure that these work ‘as a system’, i.e. have strong linkages between them?
- How could services with lesser capacity in CQI be supported for improvement?

Elements 1–3: Inter-linked CQI networks; clinical leadership and national analysis and sense-making:

- What could these look like? Who are the major stakeholder groups that need to be included?
- What kinds of ‘categories’ or overlapping sub-networks could be envisaged? (e.g. workforce theme, chronic disease, maternal health, mainstream?)
- What kinds of infrastructure to support CQI networks would be needed, and how can this build on what already exists?

Elements 4-5: IT systems and capabilities, data platforms, reporting and targets:

- Is there support for data sharing? How? What types of information and at what level?
- Opportunities and challenges to leverage economies of scale in enhancing IT platforms to support CQI?
- Workforce capabilities in relation to effectively using IT for CQI and how to address these?

Elements 6-7: CQI models and change management tools, alignment and compliance:

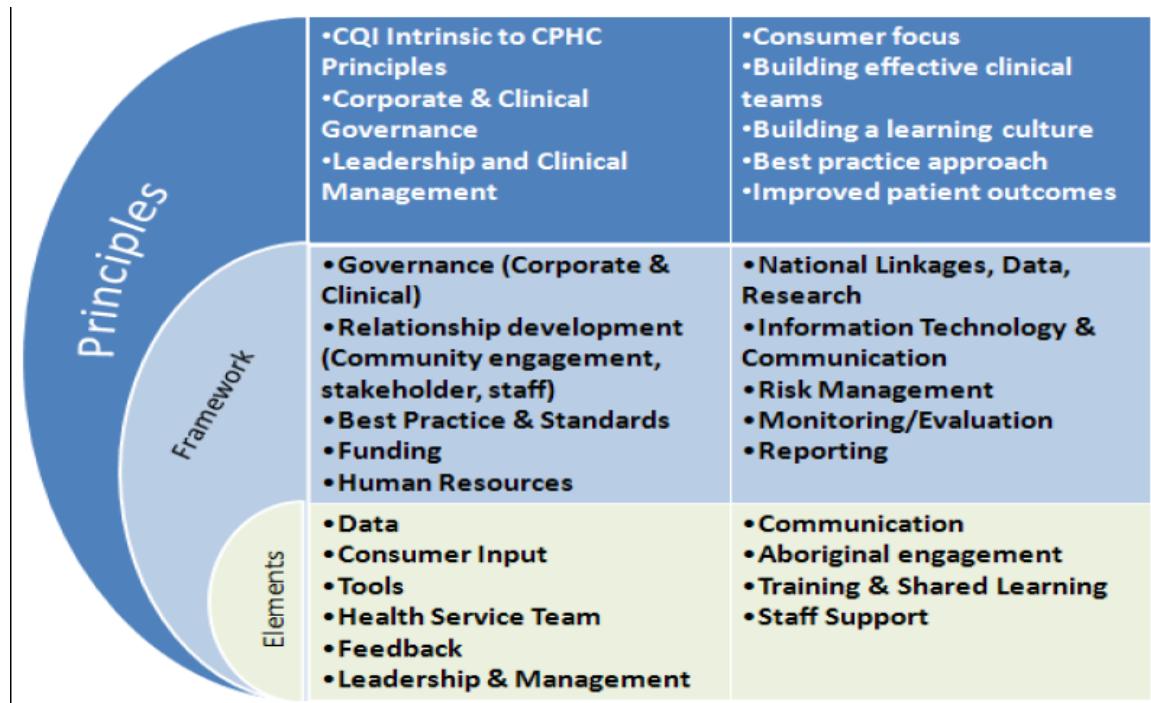
- How to increase spread and availability of models that work for different services in different contexts and with different capacities in CQI?
- How can linkages between CQI and other initiatives (such as nKPIs, large data platforms), and large scale programs), and CQI application at health services be better supported?

Elements 8-9:

- How does a CQI framework interact with other quality and reporting processes (eg accreditation and the nKPIs)

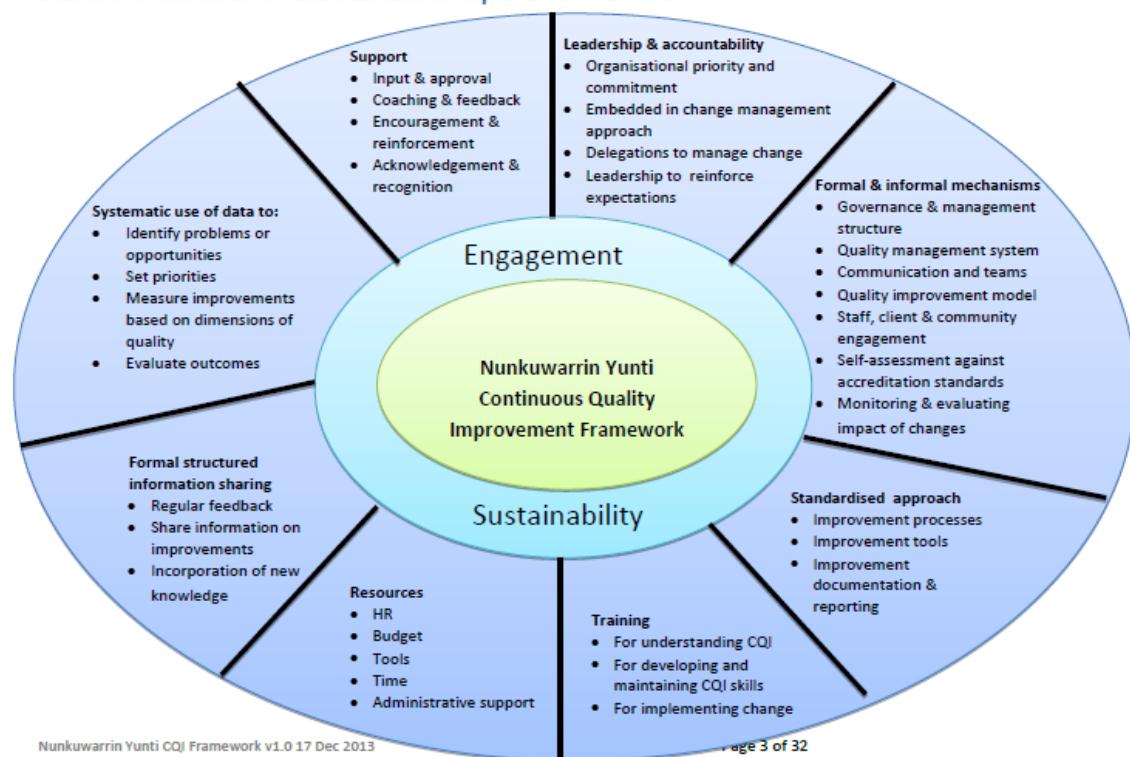
Appendix 5: Extracts from overarching CQI frameworks and models of integration of CQI into broader quality systems

NT CQI Strategy Framework - intended to be refined and modified over time



Extracts from Nunkuwarrin Yunti's CQI Framework (1)

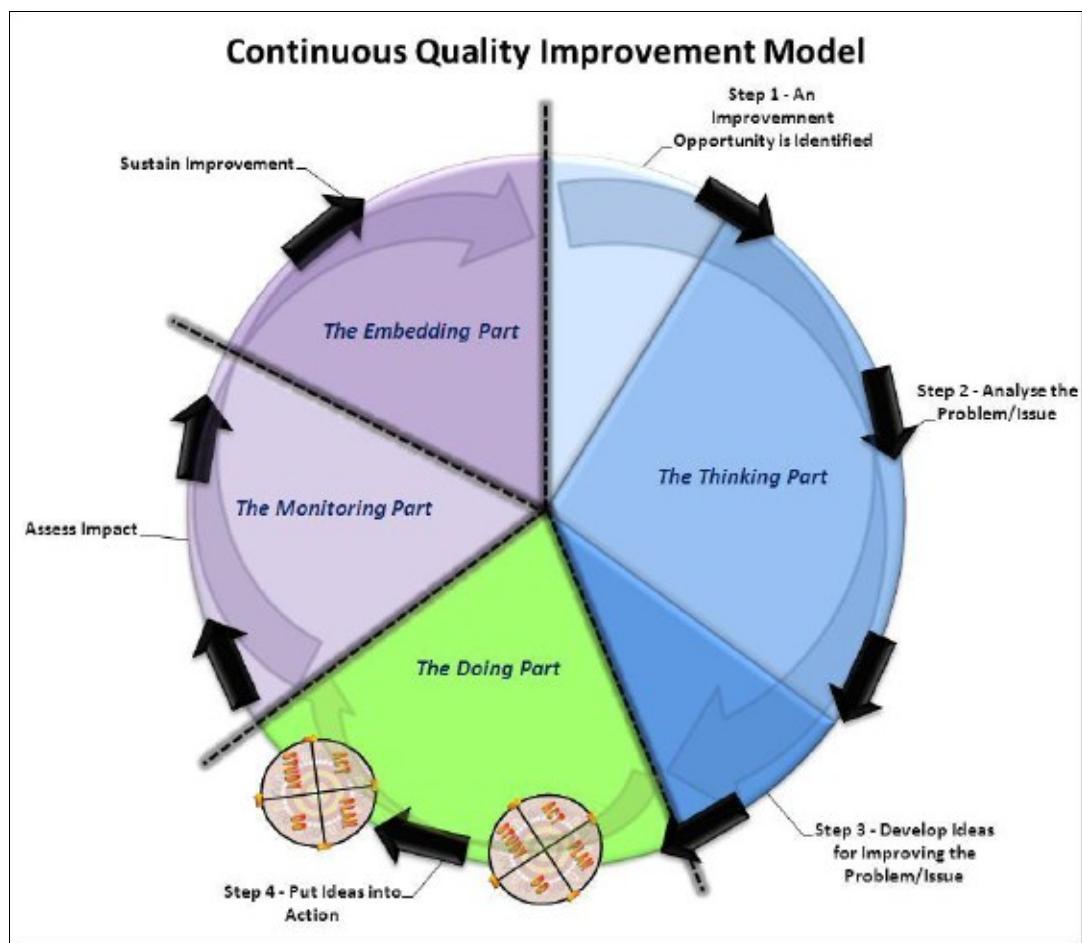
Overview of Nunkuwarrin Yunti's Continuous Improvement Framework



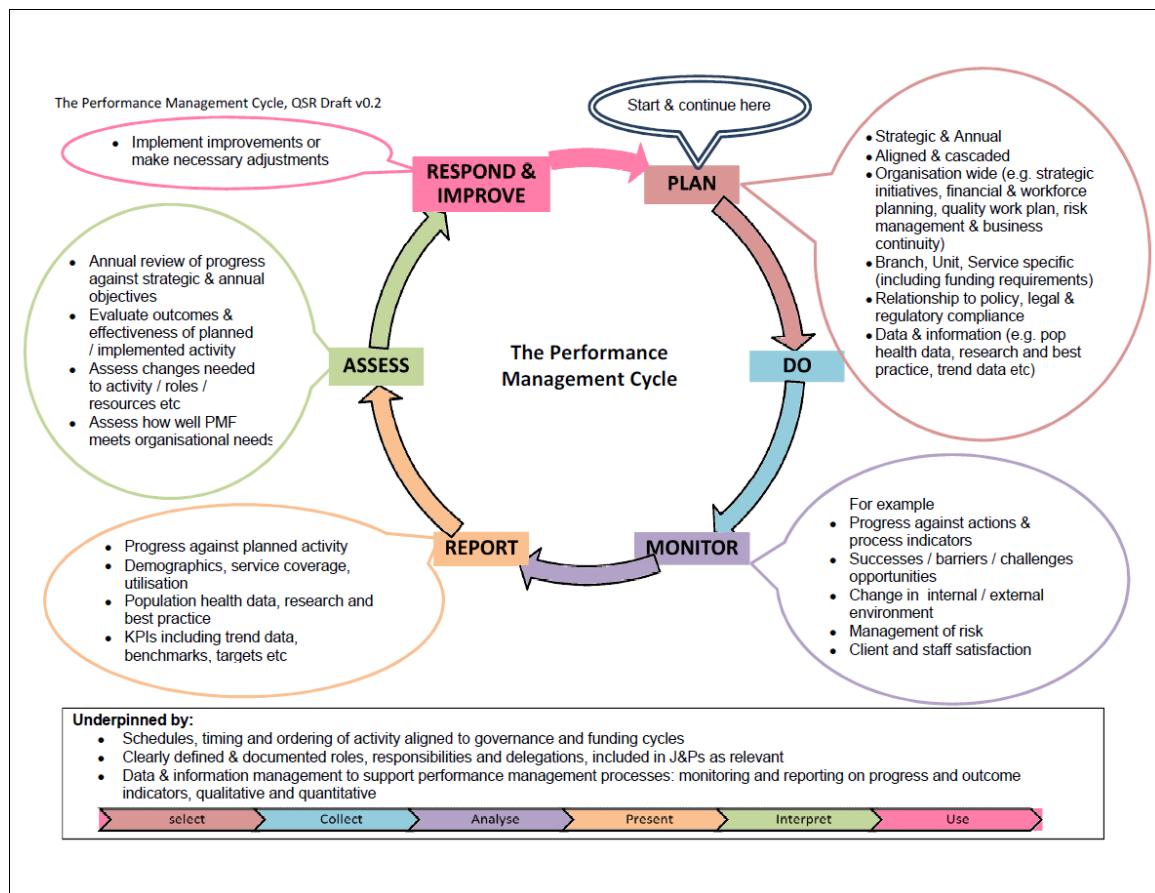
Nunkuwarrin Yunti CQI Framework v1.0 17 Dec 2013

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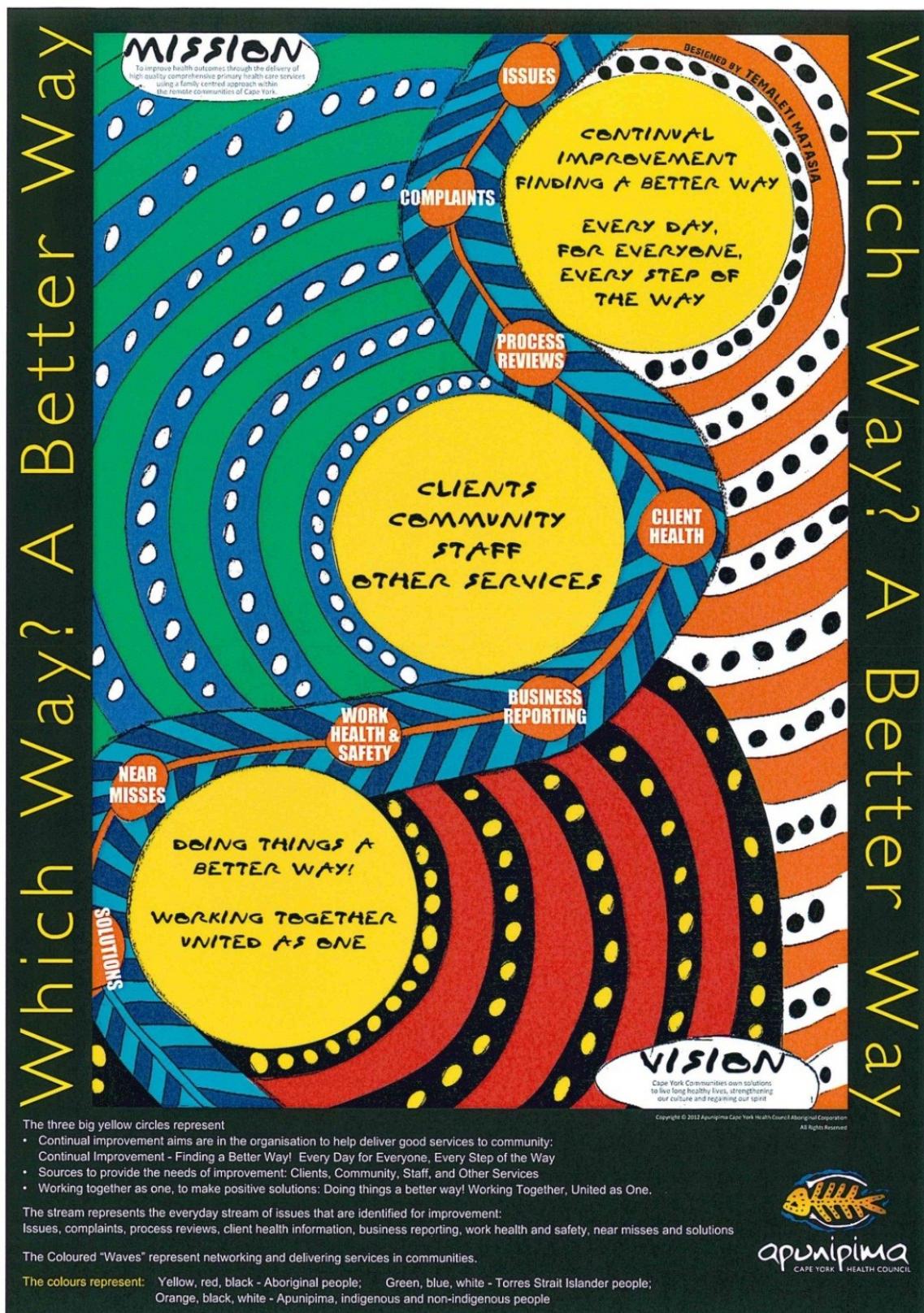
Extracts from Nunkuwarrin Yunti CQI Framework (2)



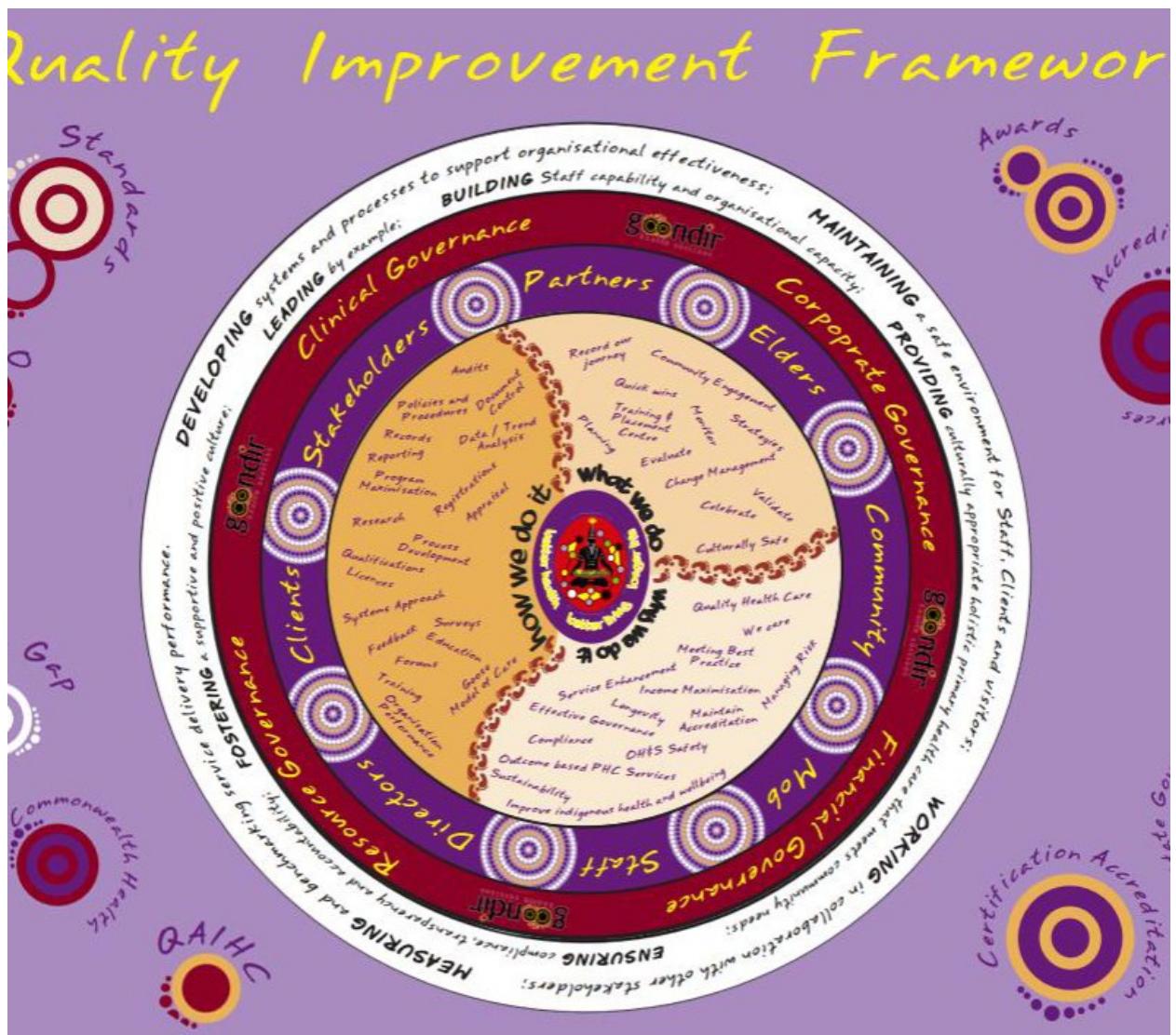
Extracts from Nunkuwarrin Yunti CQI Framework (3) - Integration in the Performance Management Cycle



Apunipima Cape York Health Council depiction of CQI framework (presented at National CQI Conference 2014)



Goondir Quality Improvement Framework – depiction of key elements



Appendix 6: Criteria for describing levels of CQI competence of services

Typology of capability and capacity of health sector personnel to undertake CQI (from evaluation of NT CQI strategy); and definition of ‘CQI competent’ and ‘CQI mature’ organisations

High capability and capacity in CQI	Periodic engagers	Active resistors
<ul style="list-style-type: none"> a small number of health centre managers and clinicians, particularly those working at large health centres centralised roles in the NT DoH and large ACCHOs CQI Facilitators regularly attend CQI training and networking opportunities confident in their ability to undertake CQI use a range of CQI techniques and processes act as advocates and ‘champions’ of CQI able to give clear examples of changes to practice as a result of undertaking CQI relatively small group 	<ul style="list-style-type: none"> majority of health centre managers and clinicians, particularly those in small/remote clinics may have attended training but more likely to have been exposed to CQI ‘on the job’ able to articulate theoretical benefits of CQI have participated in basic CQI processes such as PDSA cycles or One21seventy audit cycles see CQI as a ‘program’ to which time needs to be periodically assigned majority of health sector personnel are in this group 	<ul style="list-style-type: none"> a small number of health centre managers and clinicians unfamiliar with CQI concepts, tools, and techniques limited participation in CQI activities or have not participated at all view CQI as an accountability tool and a ‘report card’ on performance see CQI as taking time away from other, more important work small and decreasing group

	CQI competent organisation	CQI mature organisation
Description	CQI embedded in clinical services	CQI fully integrated into core practices
Scope	Identifies problems Collects accurate data Analyses data Discusses solutions/plans and implements them Reviews the implementation of solutions/plans	... and extends scope of CQI to include: <ul style="list-style-type: none"> referral systems community views other dimensions of quality
Engagement processes	High degree of staff engagement, including Aboriginal staff	... and community (including board) engagement (e.g. community and consumer input and feedback)

Health Service Organisational Quality System Maturity Scale (Cathy Balding, 2013)

Characteristics	
1. Informal	<ul style="list-style-type: none"> • Lack of systematic approach: random improvement activities based on minimal and poor data. • Managerial response to quality problems largely dependent on staff ‘trying harder’. • Limited staff input into identifying problems and improvements.
2. Compliance	<ul style="list-style-type: none"> • Problem based and reactive approach with minimal systematic collection or analysis of data on key issues. • Focus on compliance with external/funding requirements. • ‘Doing quality’ is staff code for auditing and other data collection with little implementation or follow up. • Lack of relationship between quality system mechanics and quality of care – ‘quality’ still seen as the responsibility of the quality manager.
3. Reactive risk	<ul style="list-style-type: none"> • Focus on risk management and compliance with accreditation and other external requirements. . • Systematic tracking of key indicators, consumer feedback and incident reporting. • Evidence of some system improvement and follow up. • No agreed change and improvement model in use. • Reliance on policy shifts and education as key change tools. • Leaders are developed to improve safety.
4. Proactive continuous improvement	<ul style="list-style-type: none"> • Quality system is a key component of clinical/quality governance system and is integrated at operational level, with plans for improvement at organisation-wide and local levels. • Lack of common and uniting goals with the improvement program comprising a series of (possibly unrelated) monitoring, improvement and redesign projects. • Minimum dataset reported across all quality dimensions, • Data are analysed and reported through the organisational levels to the governing body, and there is evidence of effective systems improvement as a result. • Strategies in place for developing leaders to engage staff and consumers in improvement across the dimensions of quality.
5. Strategic	<ul style="list-style-type: none"> • The desired quality of the consumer experience at point of care is defined with staff and consumers, and achieving it is a strategic priority. • The organisational quality plan is designed and systematically implemented to create the defined quality consumer experience, through developing people and improving systems. • Roles and responsibilities at all levels of the organisation for creating the quality consumer experience are described and supported. • •Governance systems are owned by the governing body and executive team and designed to support staff to create the quality consumer experience. • •A model for change and improvement is in use.

Appendix 7: List of participants in regional consultations, national workshop, and group consultations

REGIONAL CONSULTATIONS

Adelaide	
Chaired by the Aboriginal Health Council of South Australia, 1 July 2014	
Maria Barredo	Watto Purrunna Aboriginal Health Service
Nancy Bates	Central Adelaide and Hills Medicare Local (CAHML)
Lauren Cordwell	Royal Australian College of General Practitioners (RACGP)
Tanya Darke	Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation (CKAHSAC)
Grewal Deepinder	Sanjam Medical Clinic
Zell Dodd	National Aboriginal & Torres Strait Islander Health Worker Association (NATSIHWA)
Angela Dufek	Pt Lincoln Aboriginal Health
Lana Dyda	Aboriginal Health Council of South Australia (AHCSA)
Odette Gibson	Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute (SAHMRI)
Virginia Healy	Nunkuwarrin Yunti
Helen Hewett	National Aboriginal & Torres Strait Islander Health Worker Association (NATSIHWA)
Isaac Hill	Aboriginal Health Council of South Australia (AHCSA)
Bruce Hocking	Wurli-Wurlinjang Health Service
Beth Hummerston	Aboriginal Health Council of South Australia (AHCSA)
Emma Jervis	Central Adelaide and Hills Medicare Local (CAHML)
David Johnson	Spinifex Health Service
Janet Kelly	Flinders University
Nicolle Marchant	ASE Consulting
Michael McCabe	Nunkuwarrin Yunti
Jacinta McKenzie	Watto Purrunna Aboriginal Health Service
Jo Newham	University of South Australia
Mary Porter	New England Medicare Local
Letitia Robinson	Mallee District Aboriginal Service (MDAS)
Kerry Rogers	Aboriginal Health South Australian Government
Sarena Ruediger	Quality Innovation Performance (QIP)
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Jackie Sincock	Central Adelaide and Hills Medicare Local (CAHML)
Samantha Smorgon	Inner North West Melbourne Medicare Local (INWMML)
Sarah Wrzeszczynski	Improvement Foundation
Project team members: Kate Kelleher (Facilitator, KC Consultancy Services), Michael Tynan and Luella Monson-Wilbraham (Lowitja Institute), Richard Reed and Tania Shelby-James (Flinders University), and Gill Schierhout (Menzies School of Health Research)	

Cairns

Chaired by the Queensland Aboriginal and Islander Health Council, 4 July

David Baker	Mulungu Aboriginal Corporation Medical Centre
Ruth Bullen	Royal Flying Doctor Service (RFDS)
Julie Bulst	Mulungu Aboriginal Corporation Medical Centre
Ruth Connors	Townsville Aboriginal and Islanders Health Service (TAIHS)
Peter Crow	The Hastings Clinic
Frances Cunningham	Menzies School of Health Research
Amelia Dobbins	Townsville-Mackay Medicare Local (TMML)
Carl Grant	Townsville-Mackay Medicare Local (TMML)
Garry Hansford	Goondir Health Services
Chris Henaway	Queensland Aboriginal and Islander Health Council (QAIHC)
Karen Henderson	North Shore General Practice
Aaron Hollins	Queensland Aboriginal and Islander Health Council (QAIHC)
Theunis Kotzee	Townsville Aboriginal and Islanders Health Service (TAIHS)
Joanne Loader	Goondir Health Services
Nancy Long	Wuchopperen Health Service
Lynda Mannering	CCMT
Leigh-Anne Metcalfe	Townsville-Mackay Medicare Local (TMML)
Roberta Newton	Apunipima Cape York Health Council
Annette Panzera	James Cook University (JCU)
Hannah Scope	Cape York Hospital and Health Service (CYHHS)
Katherine Stock	Mornington Hospital
Lauren Trask	Queensland Aboriginal and Islander Health Council (QAIHC)
Patricia Walsh	Townsville Aboriginal and Islanders Health Service (TAIHS)
Ellaina Wingate	Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH)
Cindy Woods	James Cook University (JCU)

Project team members: Kate Kelleher (Facilitator, KC Consultancy Services), Richard Reed (Flinders University), and Gill Schierhout (Menzies School of Health Research).

Perth

Chaired by the Aboriginal Health Council of Western Australia, 18 July

Patricia Bushby	Aboriginal Health Council of Western Australia (AHCWA)
Sharon Bushby	Aboriginal Health Council of Western Australia (AHCWA)
David Busuttil	Nganampa Health
Mike Civil	Royal Australian College of General Practitioners (RACGP)
Kerry Copley	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Nadia Currie	Aboriginal Health Council of Western Australia (AHCWA)
Estelle Dawes	University of Western Australia (UWA)
Mia Dhillon	Improvement Foundation
Karen Edmond	University of Western Australia (UWA)
Troy Edwards	Broome Regional Aboriginal Medical Service (BRAMS)
Elizabeth Ellis	Communicare
Suzanne Evans	Ochre Health
Chantal Ferguson	Aboriginal Health Council of Western Australia (AHCWA)

Perth

Chaired by the Aboriginal Health Council of Western Australia, 18 July

Karen Gardner	Australian Primary Health Care Research Institute (APHCRI), Australian National University
Umesh Garg	Primacare Family Medical Centre
Jo Hall	Galambila Aboriginal Health Service
Cheryl Hayward	North Metropolitan Health Service
Charmaine Hull	WA Country Health Service
Jacqui Jamieson	Aboriginal Health Council of Western Australia (AHCWA)
Wayne Johnson	Bega Garnbirringgu Health Service
Ben Lacey	Aboriginal Health Council of Western Australia (AHCWA)
Christine May	Carnarvon Medical Service Aboriginal Corporation (CMSAC)
Kimberley McAuley	University of Western Australia (UWA)
Justin McNab	Australian Primary Health Care Research Institute (APHCRI)
Barbara Nattabi	Western Australian Centre for Rural Health (WACRH)
Louise Patel	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Jacqueline Roberts	Ngaanyatjarra Council
Beverly Sibthorpe	Australian Primary Health Care Research Institute (APHCRI)
Adrian Stoker	Communicare
Sandra Thompson	Western Australian Centre for Rural Health (WACRH)
Marelda Tucker	Aboriginal Health Council of Western Australia (AHCWA)
Xandra Tunbridge	Aboriginal Health Council of Western Australia (AHCWA)
Kyla Ulmer	Aboriginal Health Council of Western Australia (AHCWA)
Heather Woods	Women and Newborn Health Service (WNHS)/ Aboriginal Maternity Services Support Unit (AMSSU)
Marie Yau	Aboriginal Health Council of Western Australia (AHCWA)
Annie Young	Aboriginal Health Council of Western Australia (AHCWA)

Project team members: Kate Kelleher (Facilitator, KC Consultancy Services), Tania Shelby-James (Flinders University), and Gill Schierhout (Menzies School of Health Research).

Canberra

Chaired by the Winnunga Nimmityjah Aboriginal Health Service, 21 July

Adriana Ballardin	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Devin Bowles	Australian Institute of Health and Welfare (AIHW)
Michelle Cretikos	NSW Health
Ash Gupta	St Vincent's Hospital
Ingrid Hammer	Australian Government Department of Health (DoH)
Mary Ellen Harrod	Kirby Institute
Kiel Hennessey	Agency for Clinical Innovation
Ana Herceg	Winnunga Nimmityjah Aboriginal Health Service
Jenny Hunt	Aboriginal Health and Medical Research Centre (AH&MRC)
Balan Iyngkaran	Flinders University
Trish Jean	National Aboriginal Community Controlled Health Organisation (NACCHO)
Cate Kildea	Australian Government Department of Health (DoH)
Cecil Lester	Condobolin Aboriginal Health
Unna Liddy	20/20 Integrated Solutions

Canberra

Chaired by the Winnunga Nimmityjah Aboriginal Health Service, 21 July

Katie Maskiell	Centre for Aboriginal Health
Jill McDonald	Many Rivers Alliance
Robert Menzies	National Centre for Immunisation Research & Surveillance (NCIRS)
Caroline Sharpe	NSW Health
Sonam Shelly	Australian Institute of Health and Welfare (AIHW)
Eunice Simons	Agency for Clinical Innovation
Julie Tongs	Winnunga Nimmityjah Aboriginal Health Service
Colina Waddell	Brien Holden Vision Institute
Colleen Wykes	Wellington Aboriginal Corporation Health Service (WACHS)
Project team members: Kate Kelleher (Facilitator, KC Consultancy Services), Michael Tynan and Luella Monson-Wilbraham (Lowitja Institute), and Gill Schierhout (Menzies School of Health Research)	

National workshop

Chaired by the National Aboriginal Community Controlled Health Organisation, 23 July, Canberra

Astrid Addai	Australian Government Department of Health (DoH)
Jason Agostino	National Aboriginal Community Controlled Health Organisation (NACCHO)
Adriana Ballardin	Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Devin Bowles	Australian Institute of Health and Welfare (AIHW)
Kate Bradbury	Australian Institute of Health and Welfare (AIHW)
Lisa Briggs	National Aboriginal Community Controlled Health Organisation (NACCHO)
Sharon Bushby	Aboriginal Health Council of Western Australian (AHCWA)
Bridget Carrick	Australian Government Department of Health (DoH)
Darren Clinch	Victorian Department of Health
Claire Clode	Australian Government Department of Health (DoH)
Christine Connors	Northern Territory Department of Health
Matthew Cooke	Queensland Aboriginal and Islander Health Council (QAIHC)
Kerry Copley	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Lauren Cordwell	Royal Australian College of General Practitioners (RACGP)
Frances Cunningham	Menzies School of Health Research
Karen Gardner	Australian Primary Health Care Research Institute (APHCRI), Australian National University
Rebecca Gooley	Katherine West Health Board
Virginia Healy	Nunkuwarrin Yunti
Ana Herceg	Winnunga Nimmityjah Aboriginal Health Service
Isaac Hill	Aboriginal Health Council of South Australia (AHCSA)
Jenny Hunt	Aboriginal Health and Medical Research Centre (AH&MRC)
Trish Jean	National Aboriginal Community Controlled Health Organisation (NACCHO)
Cate Kildea	Australian Government Department of Health (DoH)

National workshop

Chaired by the National Aboriginal Community Controlled Health Organisation, 23 July, Canberra

Alison Killen	Australian Government Department of Health (DoH)
Yvonne Mills	ACT Health/NATSIHSC Lead Member
Janine Mohamed	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
Majella Murphy	Menzies School of Health Research
Sumithra Muthayya	Sax Institute
Shane Nichols	Victorian Department of Health/National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) Member
Louise Patel	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Mark Pemberton	Royal Australian College of General Practitioners (RACGP)
Paul Ryan	Aboriginal Health Council of South Australia (AHCSA)
Rod Schreiber	Australian Government Department of Health (DoH)
Vicki Sheedy	Australian College of Rural and Remote Medicine (ACRRM)
Beverly Sibthorpe	Australian Primary Health Care Research Institute (APHCRI)
Alison Sinclair	Quality Innovation Performance (QIP)
Sonam Shelly	Australian Institute of Health and Welfare (AIHW)
Emma Trewin	
Kyla Ulmer	Aboriginal Health Council of Western Australian (AHCWA)
Catherine Wright	National Aboriginal Community Controlled Health Organisation (NACCHO)
Project team members: Kate Kelleher (Facilitator, KC Consultancy Services), Katie Panarett (NACCHO/QAIHC), Michael Tynan and Luella Monson-Wilbraham (Lowitja Institute), Judith Dwyer, Richard Reed and Tania Shelby-James (Flinders University), Jenny Brands and Gill Schierhout (Menzies School of Health Research).	

Group Consultations

Northern Territory CQI Steering Committee meeting – 19 June, Darwin

Jodie Campbell	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Bridget Carrick	Australian Government Department of Health
Christine Connors	NT Department of Health
Kerry Copley	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Karen Davidson	Anyinginyi Health Aboriginal Corporation
Tanya Davies	Sunrise Health Service
Bec Gooley	Katherine West Health Board
Britt Hallenrud	NT Department of Health
Miriam Heath	NT Department of Health
Leonie Katekar	NT Department of Health
Liz Moore	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Louise Patel	Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Rosalie Schultz	CAAC Remote

Group Consultations

Northern Territory CQI Steering Committee meeting – 19 June, Darwin

Jeni Stubbs

Miwatj Aboriginal Health Corporation

Project team members: Gill Schierhout and Jenny Brands (Menzies School of Health Research)

NACCHO Summit – 24 and 26 June, Melbourne

Organisations represented, including:

Aboriginal Health Council of South Australia
Aboriginal Health Council of Western Australia
Aboriginal Medical Services Alliance Northern Territory (AMSANT)
Apunipima Cape York Health Council
Australian Government Department of Health
Central Australian Aboriginal Congress
CREATE/Joanna Brigs Institute, University of Adelaide
Galambila Aboriginal Health Service
Improvement Foundation
Mallee District Aboriginal Services
Menzies School of Health Research
Miwatj Health Aboriginal Corporation
Victorian Aboriginal Health Service (VAHS)
Victorian Department of Health

Project team members: Katie Panaretto (Queensland Aboriginal and Islander Health Council), Margaret Kelaher (University of Melbourne), Gill Schierhout (Menzies School of Health Research), Michael Tynan, Luella Monson-Wilbraham and Cristina Lochert (Lowitja Institute), Kate Kelleher (Facilitator)