The aim of the CQI Strategy is to embed CQI across Aboriginal Primary Health Care in the Northern Territory.
To ensure CQI is core business for every Primary Health care service.
To make CQI Everybody's business!

NT CQI Strategy Program Logic – background paper

A program logic for the NT CQI Strategy has been developed by the CQI Steering Committee in response to the Allen+Clarke Evaluation Report. *Recommendation 1 Develop an agreed plan or program logic for the CQI Strategy which includes partners' expectation in terms of short and long term outcomes, timeframes and indicators for ongoing evaluation.*

The program logic:

- Illustrates the logic or theory behind the CQI Strategy
- It clarifies and allows us to focus on and be accountable for the outcomes
- It supports CQI
- It is a framework to support evaluation processes
- It helps to identify gaps
- Makes assumptions explicit

What is a Program Logic?

- It's a picture of why and how you believe a program will work
- It is the foundation of program planning and the key tool of program evaluation
- Allows for shared understanding of a program between different stakeholders
- It provides a chain of reasoning linking investment with results
- It's a one page diagram
- It illustrates and describes the causal relationships among program elements
- It looks at the key activities intended to achieve program goals
- It links outcomes (both short and long-term) with program activities and processes and the theoretical assumptions/principles of the program.

Context and Assumptions of the NT CQI Strategy Program Logic Framework

Context

The NT CQI Strategy Program Logic is being implemented in the context of geographical remoteness, cultural diversity, high workforce turnover and the influence of social determinants on health outcomes. These things all present challenges to embedding CQI.

The NT CQI Strategy has been implemented in the NT Aboriginal PHC setting for 5 years and even prior to that many PHC services had been undertaking a range of CQI processes and activities which were identified through the initial NT CQI Needs Analysis (October 2009) and which informed the development of the NT CQI Approach.

The NT CQI Strategy has had demonstrated success in the NT and is now influencing the development of a National CQI Framework.

Assumptions:

The NT CQI Strategy Program Logic is built upon the following assumptions:

- Cultural Safety underpins the NT CQI Strategy
- CQI will contribute to improved patient outcomes
- To embed CQI there needs to be commitment and involvement at all levels of the PHC system.
- Requires change management processes
- PHC Services have differing capacity and expertise around CQI and need different levels of support.
- Data informs and guides CQI activity
- To effectively engage teams in CQI requires a learning culture NOT a blame culture
- Flexible approach
- CQI is not meant to be a stand-alone project but part of normal PHC function
- CQI involves an on-going cycle of gathering data to understand how well organisational systems are functioning then developing and implementing plans for improving the systems, and monitoring and assessing the effectiveness of the plans in order to inform the next improvement cycle.

<u>What are the key outcomes expected of the NT CQI Program? What difference does the program make?</u>

Short-term Outcomes (1-3 years):

- Recognition that CQI is core business for all PHC teams/staff
- Increased expertise and participation in CQI
- Increased engagement in quality activities by Aboriginal staff
- Data informing CQI implementation
- Tailored support to PHC services

It has been agreed by the CQI Steering Committee (Meeting dated 11.12.2014) that the short-term outcomes have been achieved and we are now focusing on the medium and long-term outcomes.

<u>Medium and long term outcomes of the CQI Strategy</u>

Recognition from all levels of PHC that CQI is core business – Medium term outcome 4-6 years

Since the beginning of the NT CQI Strategy in 2009, the aim has been to "embed" CQI so that it is recognised as core business by all management and staff, at all levels, of the PHC system. This means that CQI is part of everyday business, everyone's role and not seen as optional work to be done when and if there is time. CQI is "Everybody's business".

NT Culture of CQI and systems improvement – long-term outcome 7-10 years

The ultimate aim of the NT CQI Program is to improve health outcomes for Aboriginal people living in the NT. A long term outcome of the NT CQI Strategy is that CQI is not only core business but is part of the 'culture' in PHC right across the NT. This means that the following are the norm:

- Client/patient focus and involvement
- Clinical Governance – including CQI
- Accountability – all roles have appropriate CQI functions

- Team involvement, communication and empowerment
- Measurement and feedback for performance
- Problem Solving and process improvement
- Resources allocated to quality
- Best practice standards
- Accreditation/risk management/quality and safety

Accreditation is supported and complemented by the CQI program, although there are separate funding and support processes for accreditation.

All levels of workforce are skilled and engaged in CQI – Medium term outcome 4-6 years

Staff support is a key element for successful implementation of the CQI Strategy. For PHC staff to engage and actively participate in CQI they need to be up-skilled in the many and varied tools and processes used for CQI in the NT, e.g., NTAHKPIs, nKPIs, PDSA, Traffic Light report, one21seventy. Opportunities for further learning in CQI – such as one21seventy, CQI Workshops for ATSI health workforce, CQI Collaboratives, leadership and management workshops – will be delivered to PHC staff on site through CQI facilitators and supplemented by regional workshops and NT wide workshops.

The NT CQI Strategy provides ongoing support to build the skills and confidence of clinicians and health service staff to extract good quality, meaningful data from their clinical information systems (CIS) and to analyse and interpret the data to identify areas of strength, weaknesses and gaps to enable health services to identify priorities for improvement. Health services are trained and supported to implement changes to improve their systems of care delivery. The NT has a set of Key Performance Indicators (NT AHKPIs) that every PHC service reports on twice a year. All PHC services also report on the nKPIs twice a year through Ochre Streams. The NT AHKPIs, nKPIs and One21Seventy data, along with other data collected by health services form the basic data sets used to inform and drive quality improvement activity.

Health Service teams lead CQI – Long term Outcome 7-10 years

All members of the PHC team can and should be involved in CQI – evaluating the effectiveness and efficiency of the services delivered. Empowering staff to identify opportunities for improvements and to take a multidisciplinary team approach in problem solving and taking action, at the same time ensuring CQI is patient centred, driven by information and organised for safety. (Three core principles of the Australian Safety and Quality Framework for Health Care. CQI tools and techniques enable the PHC team to identify weaknesses or gaps in service delivery – using a range of data or anecdotal evidence – and then undertake work on system improvements.

CQI contributes to improved clinical indicators

The NT CQI Strategy aims to improve health outcomes for Aboriginal people through improving the systems of healthcare delivery by using National and Territory PHC standards and protocols.

Continuous Quality Improvement (CQI) process is designed to empower staff to work together to achieve improved quality through the following processes:

- Identifying and solving barriers to service delivery and achieving outcomes
- Build knowledge through data and reports on how the PHC services performance contributes to achieving outcomes for those accessing the service
- The development of action plans for improvement
- Implementation of changes that could lead to improvement
- An ongoing process to evaluate and review the effectiveness of the changes implemented

Evidence that CQI Processes have contributed to improved outcomes – Long term Outcomes 7-10 years

Integration of CQI into core business and using data from recognised sets of KPIs in quality improvement activities will be evidenced by development of and improvements to systems, service delivery and the health outcomes of those who use the PHC in the NT

- Improvements in KPIs

- Increased retention rates of PHC staff, increased staff satisfaction
- Better control of chronic diseases – BP, HbA1c, weight, lipids, smoking, alcohol, renal indicators
- Increased ownership by the clients of their chronic disease
- Strong functioning Corporate and Clinical Governance

Reduced variation in health service delivery (KPIs) – Long term outcome 7-10 years

With the consistent approach to CQI – fostered by the NT CQI Strategy and demonstrated in strategic and operational plans – reduced variation should be seen in the delivery of health services and their outcomes and this will be reflected in key performance indicator data.

The CQI program supports the use of clinical protocols, and monitor practitioner compliance with agreed protocols (e.g. CARPA standard treatment manual).

Active Involvement of Aboriginal workforce (Medium term outcome)

An aim of the NT CQI Strategy is to have Aboriginal staff at all levels of PHC involved in continuous quality improvement. This means that Aboriginal staff have a good understanding of what CQI is, how CQI supports the delivery of good quality PHC, the tools and processes available to support the implementation of quality improvement initiatives and the confidence and opportunity to be active participants in the planning and implementation of quality improvement activities in the workplace.

Sustainable CQI in Aboriginal PHC Services requires engagement, leadership, input, advice and participation from local Aboriginal people. Engagement and support from Regional Health Boards, the Community and local Aboriginal Health Centre Staff will be promoted through:

- **Acknowledge that AHPs local to the community are key to CQI sustainability in the health centre** - therefore these valuable resources needs to be empowered and skilled in CQI.
- **Empowerment of AHPs** - to become skilled and confident in CQI tools and techniques, professionally developed to take on a CQI champion role.
- **AHP's commitment and involvement** – Foster and encourage AHPs to have strong engagement in CQI planning at regional and operational levels of the Aboriginal PHC sector in the NT. (e.g. AHP involvement at the CQI Steering Committee and other CQI meetings. Encourage Aboriginal leadership in regional workshops including the involvement of board members)
- **Acknowledgement of importance of AHP's experience** – clinical, cultural AHP training at both undergraduate and postgraduate level

Effective engagement with Communities and consumers - long-term outcome 7-10 years

- The NT CQI strategy has been underpinned by the key principles outlined in the "Pathways to Community Control "document which sets out a road map for increasing Aboriginal control over the planning and delivery of Aboriginal primary health care services. Feedback strategies to clients and communities will be developed with strong Aboriginal input so that they are culturally appropriate. Services will be supported to work on improving the way that they seek the views of their patients and communities on health care delivery to identify areas for improvement.

- Section 2 of the ACSQHC's 2011 *National Safety and Quality Health Service Standards* relates to partnering with patients, carers and other consumers to improve the safety and quality of care. The document specifies several standards of good practice relating to consumer participation in health care, including partnering with consumers to design the way care is delivered to better meet patient needs (standard 2.5); informing consumers about the organisation's quality performance in a format that can be understood and interpreted independently (standard 2.7); and supporting consumer participation in the analysis of performance information and the development and implementation of action plans (standard 2.8).

CQI included in under graduate training Medium term outcome 4-6 years

In discussion, the CQI Steering Committee has agreed that it is essential that the topic of CQI is included in the curriculum of undergraduates who, in their professional career, may be employed in a NT primary health care service. Those entering the NT PHC system need to be aware:

- that a key priority, identified by NTAHF, was to embed CQI into PHC right across the NT
- of the NT CQI Strategy/Model
- of the tools used in CQI, e.g., NTAHKPIs, nKPIs, audit tools, Traffic Light reports, PDSA
- of the expectation (for some, as per their job description) that all staff will actively participate in CQI activities at health service level
- of the opportunities to share learnings across the NT PHC service

Strong Aboriginal engagement on SC - Medium term outcome 4-6 years

The NT CQI Strategy has an ongoing focus on ensuring Indigenous input into the CQI Steering Committee and CQI policies and strategies at a NT wide, regional and service level.

The NT CQI Steering Committee provides guidance on the development and implementation of a sustainable and integrated CQI model. The CQI model (CQI Approach) aims to ensure that both community controlled and NT Government PHC services have an agreed and shared approach to CQI embedded as a key function within Aboriginal PHC in the NT, that will guide long-term service improvement.

The terms of reference reflect the aim of keeping a balanced representation across government and community control and to ensure there is strong Aboriginal representation on the committee.

Strong Aboriginal leadership and participation in CQI Long-term outcome 7-10 years

Strong Aboriginal leadership and participation in CQI is the key to sustainability of CQI processes and ensuring that improvements and system changes implemented are respectful of culture and relevant for the communities where the services are delivered. Good representation of Aboriginal people on the CQI Steering Committee and other groups that make decisions about CQI in the NT.

Boards and PHC teams using data for systems improvement

The ability to measure, analyse and evaluate outcomes and process data at the local level is an enabler for continuous improvement activity; data provides a clear idea of how a health service is functioning and can be used to guide ongoing systems thinking and process improvement to bring about change. Without measurement it is impossible to know whether you have improved.

Regular feedback, review and reflection enables Boards, Management and PHC teams to evaluate the progress being made towards achieving goals and priorities. Data needs to be used at all levels of PHC organisations. At the operational level data should be reviewed and discussed with staff as an input into identifying opportunities for improvement within systems and processes to improve health care delivery and individual and population health care outcomes.

Relevant, reliable data supports CQI - Long Term Outcomes 7-10 years

Clinical data, gathered through the NT AHKPI, nKPI, Traffic Light and One21seventy reports and other CQI tools, is being used in service planning and to identify training needs. Ensuring that PHC Boards, Management and teams have access to relevant and reliable data is essential for effective quality improvement.

Applying CQI in the PHC system context requires using good quality data on systems, processes and outcomes (Bailie 2012). As well as being accurate, data used for CQI must be timely (Powell et al. 2008) and available for use as close to real time as possible (Baker 2011).

To enable access to good quality data to inform CQI processes, effective clinical information systems and established administrative processes are vital. PHC staff need to have confidence in the reliability of their data, that it is an accurate reflection of what has taken place to be able to use it to inform planning and improvement cycles.

“According to Donaldson and Darzi (2012), successful CQI needs the correct level of appropriate data to draw reliable and valid conclusions, but the resulting analysis cannot be too technically challenging to avoid overwhelming its users, as well as the potential consumers. At the same time a balance needs to be achieved to ensure that the less

complex data and messages are not too simplistic and misleading. It is also noted that the quality of data is essential and that poor quality data can lead to lack of confidence in the data, and ultimately rejection of the findings derived from it.
Donaldson and Darzi further note that it is important that there are system wide indicators that provide insight into the quality of care being provided, but that it is equally important that front-line clinical teams have data that they use in response to their own, local needs. Local control over interpretation of the data and the development of actions to address these are seen as critical for stimulating improvement (Gardner et al. 2010)" (Allen+Clarke Evaluation of the NT CQI Strategy, Page 33, 34)

CQI Funding secure - Medium term outcome 4-6 years
NT PHC services have ongoing funding/resources to support active participation in quality improvement activities within their services and to participate in regional and NT wide CQI learning networks and workshops. This funding may enable employment of dedicated CQI positions or be used to resource their particular CQI aims and priorities for improvement.

CQI adequately resourced - Long-term outcome 7-10 years
We acknowledge that continuous quality improvement is a process that takes time. Long-term financial commitment to resource CQI support, training and activity is required to enable the NT to achieve the intended outcomes of the CQI Strategy.

CQI expertise, knowledge and leadership growing - Medium term outcome 4-6 years
Overall CQI competence in the NT has increased as a result of the CQI Strategy, but there is differential growth in the capacity of those that drive CQI at the higher level and of front line health staff (Allen+Clarke)
There is evidence that the implementation of the CQI Strategy has led to an increased interest in data at the health centre level, and that health centre managers, clinicians and board members are becoming better able to interpret and use clinical data.(Allen+Clarke).
Where the focus on data analysis has previously been at individual health service level, the importance of transparency, comparison and benchmarking of data across the sector is growing.
The development of the agenda and use of data at regional level CQI Collaboratives demonstrates a willingness to share data and develop strategies across the sector. The NT CQI Evaluation found that there is recognition of the value of data sharing and active efforts to encourage this.
Clinical data is also used by health service boards to plan, support decision making and, in some cases, provide feedback to the community. Boards tend to receive reports of data outlining clinic performance (for example the results of One21severty audits), often twice yearly in conjunction with the NT AHKPI reports. (Allen+Clarke)
The quality of clinical data has improved markedly over the past two years, and was generally seen as suitable to support CQI processes. The fact that all clinics in the NT now use computerised patient management systems, rather than paper based filing systems, has increased confidence in the quality of the data. (Allen+Clarke)

CQI expertise, knowledge and leadership evolving - Long Term Outcomes 7-10 years
There is increased confidence in the quality of NT AHKPI data amongst those in management positions in the DoH and OATSIH, and this is translating to a desire to increase the use of KPI data at the regional and NT level.
The need for more clearly defined goals and objectives for the CQI Strategy was identified in the Allen+Clarke Evaluation of the NT CQI Strategy. This has been addressed in the recently developed Program Logic.
Structures to use the NT AHKPI information are being developed. Clinical Public Health Advisory Groups (CPHAGs) are seen as a useful vehicle for this. CPHAG meetings include a focus on looking at KPI data across government and ACCHO services to identify issues at a regional level and develop plans to support all services in this region. We have also been informed that regional level reports developed by CPHAGs may be provided to OATSIH to inform decisions on planning and, potentially, to support funding decisions. (Allen+Clarke)