CQI Tools and Resources Project

Learning Manual – For the Learner

Orientation and Induction to CQI Learning Program

MODULE 1

This is a professional development learning program for all staff, Board members and others working in Aboriginal and Torres Strait Islander primary health care services.

June 2016

Contents

Acknowledgments

The Project

The CQI Tools and Resources project was commissioned by the Australian Government Department of Health (Indigenous Health Division) to support the National Continuous Quality Improvement Framework for Aboriginal and Torres Strait Islander Primary Health Care. The project was conducted by the Lowitja Institute, together with a Project Team of representatives from partner organisations, NACCHO and each state and territory peak body, with advice from a project Technical Panel of experts in CQI in the Aboriginal community controlled health sector.

Development Team

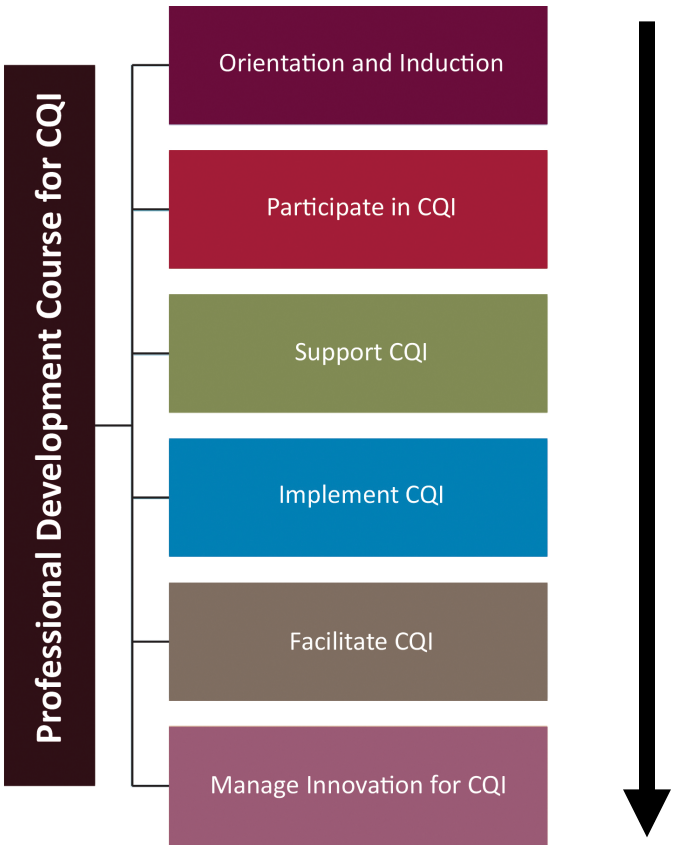
The learning modules were developed by the ThinkThrough team led by Dr Sanchia Shibasaki and Dr Beverly Sibthorpe, with contributions from Dr Jacki Mein, Ms Kerry Copley, Ms Carolyn Renehan, Professor Ross Bailie and Mr Alistair Harvey.

About the Orientation and Induction to CQI Learning Program

The Orientation and Induction to CQI is a professional development (non-credentialed) learning program for all staff, Board members and others working in Aboriginal and Torres Strait Islander primary health care services. The learning program provides the foundational knowledge and skills to prepare you for work in continuous quality improvement in primary health care and as such, the content focuses on broad CQI topics. It is anticipated this learning program is delivered at your workplace **as part of the overall orientation and induction to the workplace.** The program may be delivered to a group or on a one to one basis.

The Orientation and Induction Learning Program is one of six learning programs in the Professional Development Course Outline for CQI (Figure 1). The learning programs are designed to build on each other. As you progress through the Professional Development Course Outline for CQI (Figure 1), the learning programs will provide further exploration and detailed discussions of concepts and topics.

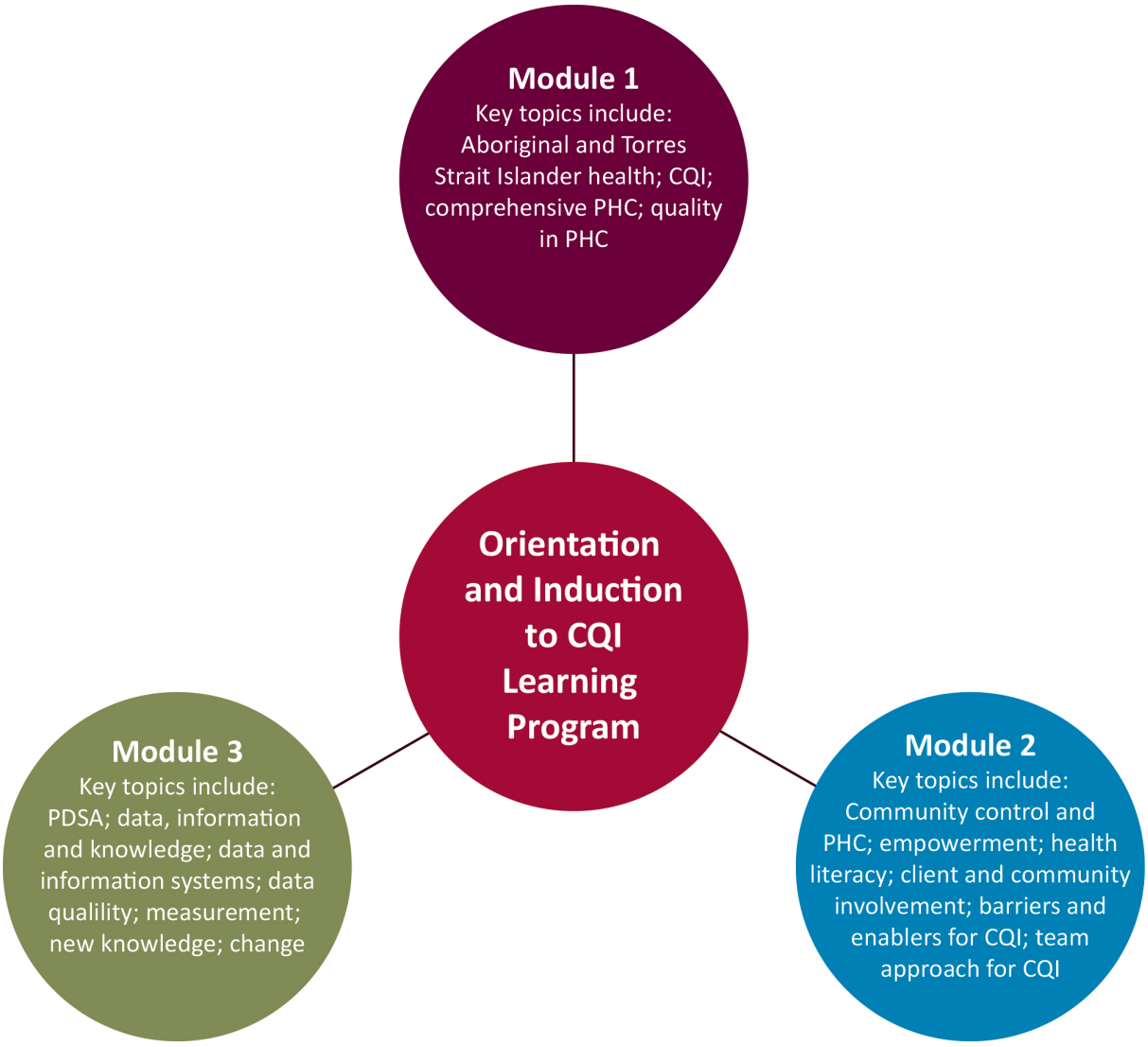
Figure 1: Outline of Professional Development Course Outline for CQI



Learning Modules

The Orientation and Induction Learning Program is made up of three modules:

Figure 2: Learning Modules



Learning Tools and Resources

The tools recommended to support your learning journey include:

- Learning manuals – The learning manuals are tools for the learners. The manuals contain information and tasks to support participants achieve the learning outcomes.
- PowerPoint presentations – The PowerPoint presentations are tools to support the trainer to deliver the learning program to you. The presentations identify and describe the key points for each topic area. The presentations also support the trainer by incorporating information on adult learning principles, learning activities, and so on.

The authors of the learning manuals and PowerPoint presentations acknowledge there is significant variation and diversity between Aboriginal and Torres Strait Islander peoples, communities and community controlled primary health care services. This variation and diversity has implications on the type of terms used and the differing interpretations of terms. For the purposes of this learning module, several terms are used to be consistent with terms used in the Vocational Education and Training sector and to be adaptable to individual and group contexts. For example, the term 'client' is used in lieu of 'patient' to describe individuals who may be interested in using the service; individuals that live in the service catchment area; and/or patients. The term 'learning' is used where possible to describe training.

Please note, your organisation may tailor the learning content and delivery to meet your work environment and the learning styles of participants. In doing so, it is recommended in all cases of tailoring the tools, that the quality of content and the intended outcome of the tool is maintained and where relevant consistent with the National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care.

Learning Outcomes

When you have completed Module 1 you should be able to:

- Define CQI
- Describe the history of CQI and its uptake in primary health care
- Describe the common characteristics of CQI
- Define comprehensive primary health care
- Identify the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and *Implementation Plan*
- Identify the *National CQI Framework for Aboriginal and Torres Strait Islander Health Care 2015–2025*
- Identify the role and drivers of quality in primary health care
- Identify the principal internal and external mechanisms of quality management in primary health care
- Define clinical governance
- Describe the key attributes of clinical governance
- Identify what is meant by a population health approach in primary health care, and
- Identify the main social and cultural determinants of health for Aboriginal and Torres Strait Islander people.

Should you require support or assistance with language, reading, writing and/or using numbers, please let your supervisor know so that your workplace can identify ways to support your learning needs.

Aboriginal and Torres Strait Islander Health

Stories from the Australian Aboriginal and Torres Strait Islander Health Survey 2012-13

Source: YouTube video - https://youtu.be/miU9Tr-V80k

> *Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of life view and includes the cyclical concept of life-death-life.*
>
> (National Aboriginal Health Strategy Working Party 1989)

Aboriginal and Torres Strait Islander people and communities are diverse, including gender, age, languages, backgrounds, sexual orientations, religious beliefs, family responsibilities, marriage status, life and work experiences, personality and educational levels. The culture of Aboriginal and Torres Strait Islander people is dynamic and continues to evolve and develop in response to historical and contemporary circumstances. (Commonwealth of Australia 2013)

In terms of health, the life expectancy of Aboriginal and Torres Strait Islander people is around 10 years lower than for other Australians (ABS 2013). Aboriginal and Torres Strait Islander people are also more likely to experience disability and reduced quality of life because of ill health.

Several historical and contemporary events such as dispossession, interruption of culture, intergenerational trauma, and racism have significantly impacted the health and wellbeing of Aboriginal and Torres Strait Islander people (Dudgeon et al. 2010, Commonwealth of Australia 2013).

There are also social and cultural factors that have affected the health and wellbeing of Aboriginal and Torres Strait Islander people.

Social determinants of health

Social determinants are the conditions in which people are born, grow, live, work and age (Commonwealth of Australia 2013). These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. For example, poor education and literacy are linked to low income and poor health status (e.g. ear disease), and affect the capacity of people to use health information; poverty reduces access to health care services and medicines; overcrowded and run-down housing associated with poverty contributes to the spread of communicable disease; and smoking and high-risk behaviour is associated with lower socio-economic status (Jarvis & Wardle 1999).

Cultural determinants of health

Cultural determinants are conditions that

> *…acknowledge strong connections to culture and country, build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety.* (Brown 2014)

Cultural determinants include, but are not limited to (Lowitja Institute 2014a):

- Self-determination
- Freedom from discrimination
- Individual and collective rights
- Freedom from assimilation and destruction of culture
- Protection from removal/relocation
- Connection to, custodianship, and utilisation of country and traditional lands
- Reclamation, revitalisation, preservation and promotion of language and cultural practices
- Protection and promotion of Traditional Knowledge and Indigenous Intellectual Property, and
- Understanding lore, law, traditional roles and responsibilities.

Why Is CQI Important for Aboriginal and Torres Strait Islander health?

Ongoing access to **quality** health services is one important contributor to improving the health and wellbeing of Aboriginal and Torres Strait Islander people (AIHW 2011). Addressing such differences in health outcomes requires widespread action at multiple levels of government, and organisational and community action.

The Australian Government has given a commitment to closing the gap in Indigenous life expectancy within a generation and halving mortality rates for children under five within a decade (COAG 2016). In the context of health care, this commitment places a greater focus on **improving quality** and a reliance on measuring and monitoring change in outcomes over time. CQI processes have an important role to play in achieving this.

Learning Activity

To Do

1. Do a search on your web browser for the *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015–2025*

2. What is the overarching vision of the *National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care 2015–2025*?

3. What are the essential building blocks for embedding CQI in primary health care?

Your Notes

What Is CQI?

Source: Cartoonstock https://www.cartoonstock.com/directory/h/hospital.asp (hospital cartoon 9 of 3267)

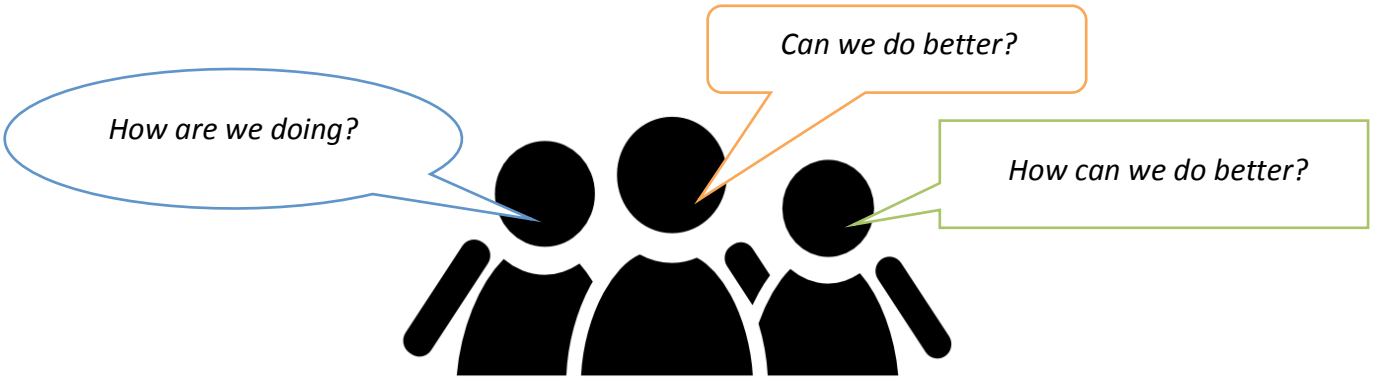
CQI is short for **C**ontinuous **Q**uality **I**mprovement. CQI is the central approach to improve health care quality (Colton 2000).

CQI is a **continuous,**

forward looking, process of

ongoing learning and sharing.

CQI encourages the team and you to ask within a **blame free** context the following questions (Edwards et al. 2008, Lowitja Institute n.p.):



Source: http://clipartix.com/wp-content/uploads/2016/04/Group-of-people-clipart-clipartion-com.png)

How Can We Recognise CQI?

Here are some common characteristics of CQI (Rubenstein et al. 2013):

Learning Activity

To Do

1. Watch the German Coast Guard on YouTube: https://youtu.be/yR0lWICH3rY
2. Imagine you are the Coast Guard. Answer the following questions:
   - How did we do?
   - Could we have done better?
   - How could we have done better?
3. What does 'no blame' mean to you?

Well done!!! You've started a CQI cycle

Your Notes

Why Comprehensive Primary Health Care?

Aboriginal and Torres Strait Islander people need good access to both Aboriginal and Torres Strait Islander-specific and mainstream primary health care that is comprehensive.

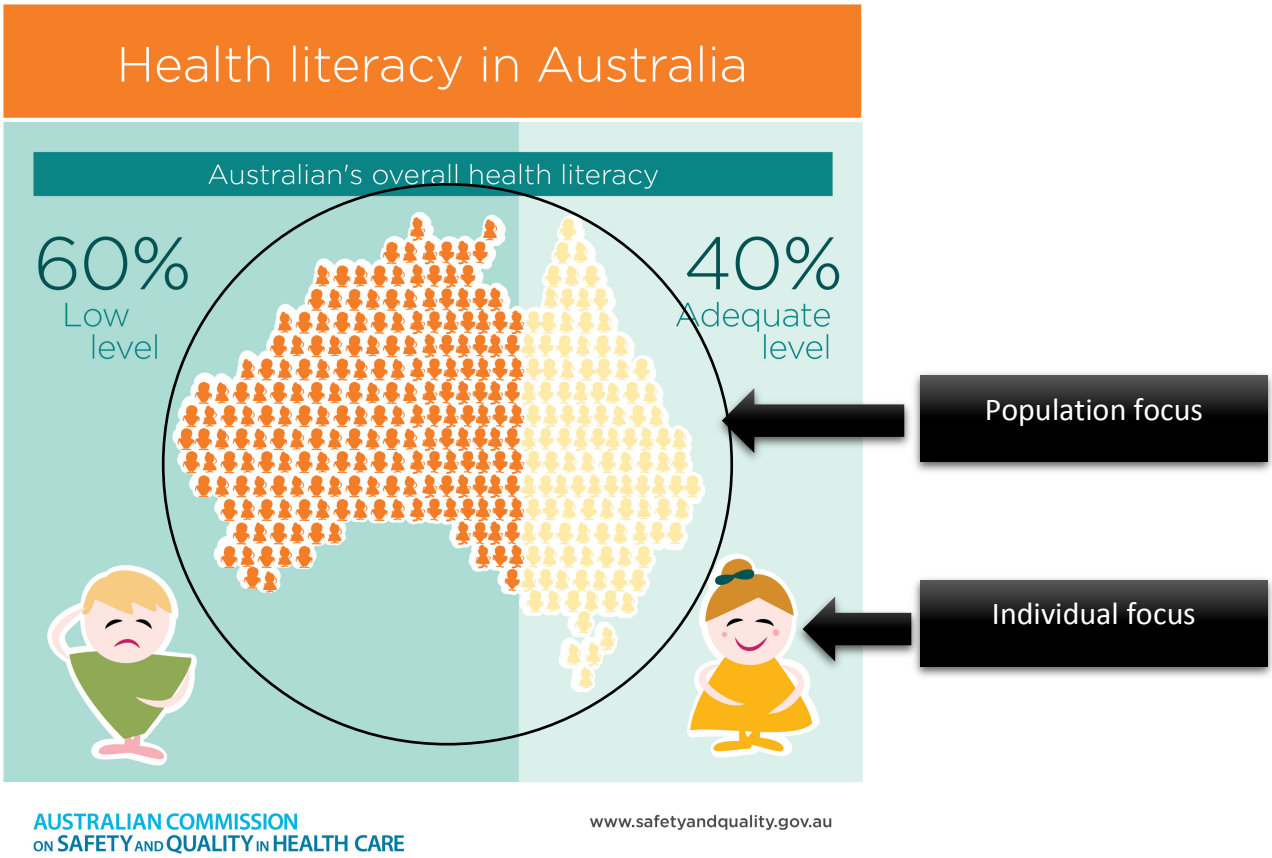
> *Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.* (PHCRIS 2016)

While this definition is broadly accepted, the comprehensive primary health care approach in Aboriginal Community Controlled Health Services (ACCHSs) is somewhat broader in scope. In addition to primary clinical care and preventive and health promotion activity, ACCHSs usually include education and development in relation to workforce training, and governance and community capacity building (Wakerman et al. 2008).

Primary health care takes a population health approach. Population health is defined as

> *the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.* (Health Canada 1997 in Dunn & Hayes 1999, p.7)

Population health focuses on understanding health and disease in community, and on improving health and wellbeing through priority health approaches addressing the disparities in health status between social groups (AIHW 2016). It considers the social and cultural determinants of health and wellbeing including history, culture, housing, education, employment and safety including racism. A population health approach in CQI focuses on groups of clients and community members, rather than individuals, in terms of their needs, access, care and outcomes.



Source: http://www.safetyandquality.gov.au/wp-content/uploads/2015/07/Infographic-Health-literacy-in-Australia.jpg)

Learning Activity

To Do

Take a look at the infographic: Alcohol and Drugs Affect Everyone

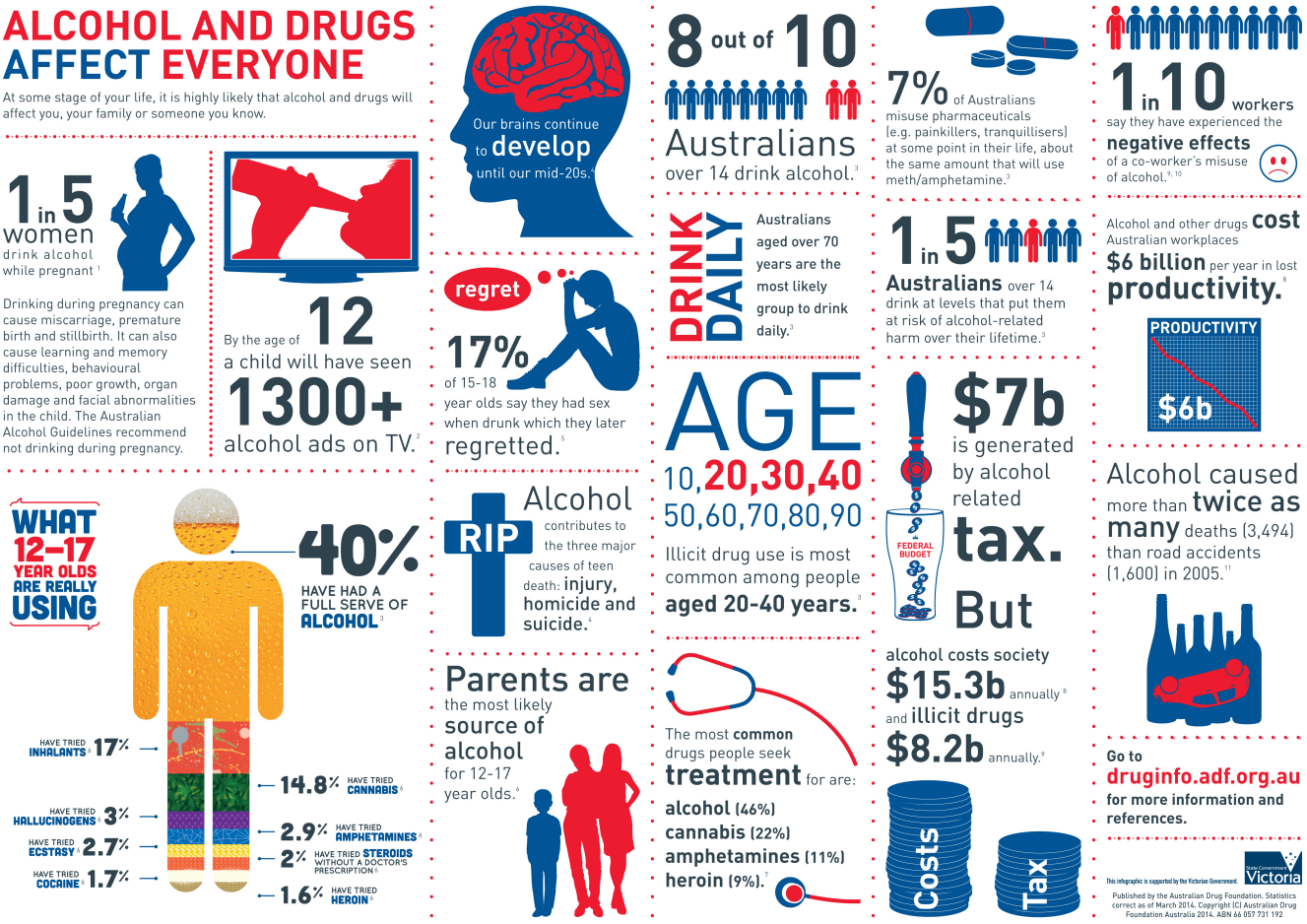
1. Illicit drug use is most common in what population age group?

2. What proportion of Australians misuse pharmaceuticals?

3. What group is most likely the source of alcohol for 12 to 17 year olds?

4. How could CQI in primary health care address this issue?

Your Notes



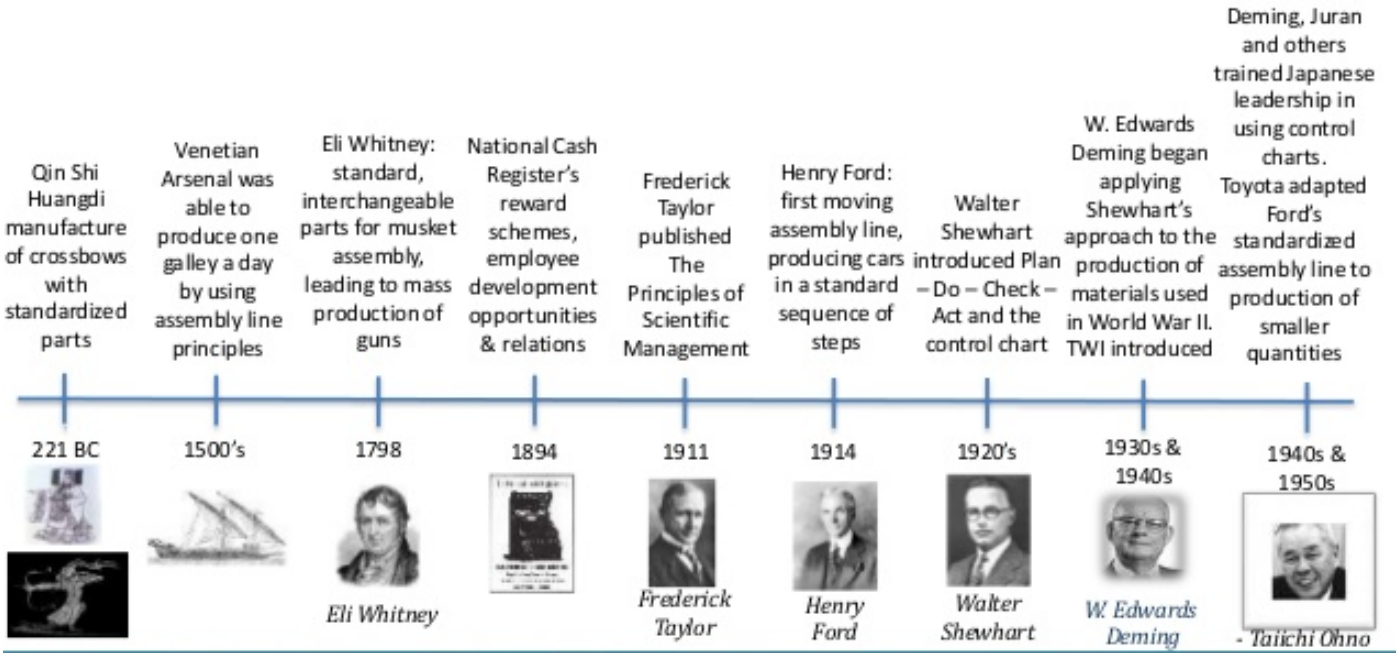
Source: http://www.druginfo.adf.org.au/attachments/article/1489/15A934_AU_DrugFoundation.pdf

History of CQI

Most of today's quality improvement methods were developed in industry and adapted for use in other sectors, such as health. The roots of quality improvement approaches can be traced back to the thinking about production quality control that emerged in the early 1920s. Pioneers for quality improvement include: Walter A. Shewhart, W. Edwards Deming, Joseph M. Juran, Armand Feigenbaum and Kaoru Ishikawa (Chassin & O'Kane 2010, Health Foundation 2013).

Quality improvement was first introduced into health care in the 1980s. Healthcare organisations started moving away from looking and assessing **past** health care activities such as care processes and outcomes. This type of assessment is known as quality assurance. Organisations began using **proactive** and **forward looking** methods like CQI based on the idea that improving the service as a whole (that is the service systems) and steps in providing care (that is care processes) in a **continuous ongoing manner** can lead to better outcomes. CQI has now evolved as a global approach for improving health care quality (Colton 2000, Sollecito & Johnson 2013, Lowitja Institute n.p.).

Quality Improvement Timeline



Source: Price, M. 2014. The Story of Improvement and the Role of Culture and Standards. TMI Enterprises. http://www.slideshare.net/MarkLeeson/mike-price-the-story-of-improvement-and-the-role-of-culture-and-standards

Drivers and Mechanisms of Quality in Primary Health Care

Source: https://abroadalways.files.wordpress.com/2015/03/umbrellla-red-london-rain.jpeg

CQI Programs are a part of a broader family of activities and initiatives that operate under an umbrella known as **'quality'**. Quality activities and initiatives, such as quality planning, quality control, quality assurance, and quality improvement, aim to **improve the overall delivery of health care**. In Aboriginal and Torres Strait Islander primary health care, quality activities include CQI, accreditation, and national reporting against key performance indicators (Lowitja Institute 2014b). CQI differs from both accreditation and performance reporting in that it is **internally assessed** as opposed to externally assessed (Lowitja Institute n.p.).

The drivers to embed quality into health care is primarily due to increased client and community expectations and increased recognition that CQI is a global approach for improving health care quality and that this leads to better outcomes. There are several internal and external mechanisms to help embed quality activities into primary health care services.

Internal mechanisms include:

- An organisation's compliance with relevant legislation such as Commonwealth and State and Territory Acts and laws
- Professional registration and accreditation protects the public by setting standards and policies that all registered health practitioners must meet. For example, the standards set by the Australian Health Practitioner Regulation Agency to regulate several health professions
- Organisational policy and procedures
- Accreditation
- Clinical governance
- CQI, and
- Key performance indicator reporting.

External mechanisms include:

- Key policy drivers such as the Closing the Gap inter-governmental agreement and targets, the National Aboriginal and Torres Strait Islander Health Plan, and the National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care
- Government payments to GPs and pharmacists as incentives for particular quality improvements (for example, the Practice Incentives Payment [PIP] for GPs), and
- Quality standards that describe the specifications and procedures designed to ensure products, services and systems are safe, reliable and consistently perform the way they were intended to (ACSQHC 2012).

Learning Activity

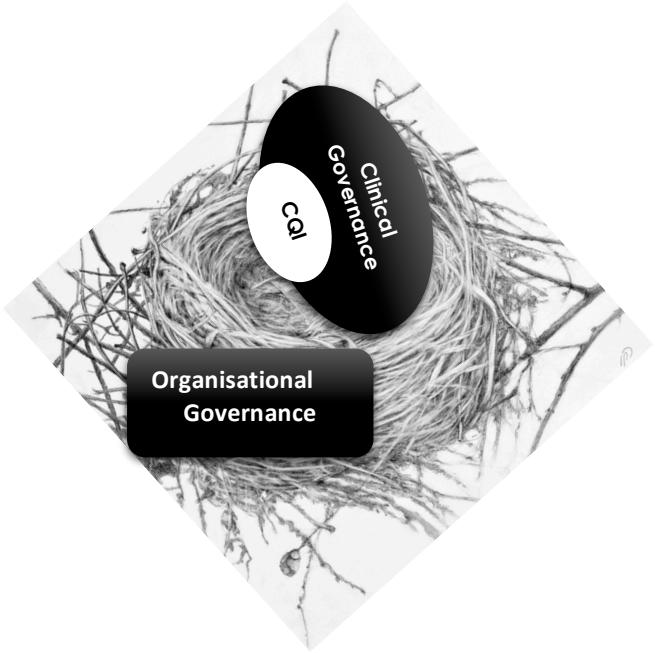
To Do

1. Do a search on your web browser for the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and the *Implementation Plan*
2. What are the overarching goals of the Plans?
3. What are the Priorities for Health Enablers?

Your Notes

So how Is CQI Linked to other Quality Activities?

CQI is a process nested within **clinical governance** that is in turn nested within organisational governance (Lowitja Institute 2014). Clinical governance involves formal structures and processes that attend to corporate (Board) and organisational governance and leadership, workforce capacity and competence, clinical leadership, clinical integration and coordination, clinical monitoring and evaluation including CQI, and client and community participation (IUIH 2012).



Clinical governance is the mechanism that links organisational governance and management with clinical care, and accreditation with CQI. (Lowitja Institute n.p.)

Clinical governance is defined as –
a system by which the governing body, managers and clinicians share responsibility and are held accountable for client care, for minimising risks to [clients], and for continuously monitoring and improving the quality of clinical care.' (ACHCS 2004)

Through clinical governance, Boards and senior managers and clinicians can act as champions and opinion leaders to drive a whole of organisation approach to quality including CQI. Elements of clinical governance commonly include education, clinical audit, clinical effectiveness (evidence-based practice), risk management, research and development and openness (RACGP 2010).

CQI Is not Accreditation. Accreditation Is not CQI

Accreditation is the formal process in which certification of competency or credibility is achieved. In practice the accreditation of ACCHSs provides formal recognition and credit that quality standards, processes and systems are being maintained (AMSANT 2016). While both are concerned with quality, as shown in Table 1, there are several differences between CQI and accreditation.

Table 1: Critical differences between CQI and accreditation. (Sibthorpe, Gardner & McAullay 2015)

CQI	Accreditation
Focuses on improving client care and outcomes	Focuses on improving organisational and clinical administration
Determined by local needs and priorities	Determined by national and international consensus
Internally assessed	Externally assessed
Prospective and ongoing review	Retrospective review
Data for dialogue	Data for certification
Measures, including quality indicators, with changeable targets	Sets of standards
Results vary over time	Yes/no result
Short cycles	Long cycles

CQI Is not National Key Performance Indicator (nKPI) Reporting

A key performance indicator is a type of measure to understand how a service or program is doing in regard to a set of defined goals and objectives. Both performance reporting and CQI play an important role in improving quality in health service delivery. However, there are several differences between the two systems as highlighted in Table 2 (Sibthorpe, Gardner & McAullay 2015).

Table 2: Critical differences between CQI and performance reporting (Sibthorpe, Gardner & McAullay 2015)

CQI	Performance Reporting
Quality internally assessed	Performance externally assessed
Data for dialogue and action	Data for external accountability (+/- ranking and league tables)
Data published internally, shared among networks	Data published by external agencies
Quality indicators +/- informal, changeable targets and benchmarks	Performance indicators +/- official, fixed targets and benchmarks
Addresses any health issue	Addresses only priority health issues
Incentives: • Quality of care and outcomes • Clinical and client satisfaction • Collegial competition between clinicians and services • Service reputation	Incentives: • Earned autonomy • Access to competitive funds • Pay for performance

Learning Activity

To Do

1. Is your service accredited? If yes, please describe the type of accreditation and standards.
2. What are the nKPIs for Aboriginal and Torres Strait Islander primary health care?
3. Does your ACCHS participate in any CQI activities?

Your Notes

Let's Summarise and Reflect

Your Notes

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