CQI Tools and Resources Project

Learning Manual – For the Learner

Orientation and Induction to CQI

MODULE 2

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

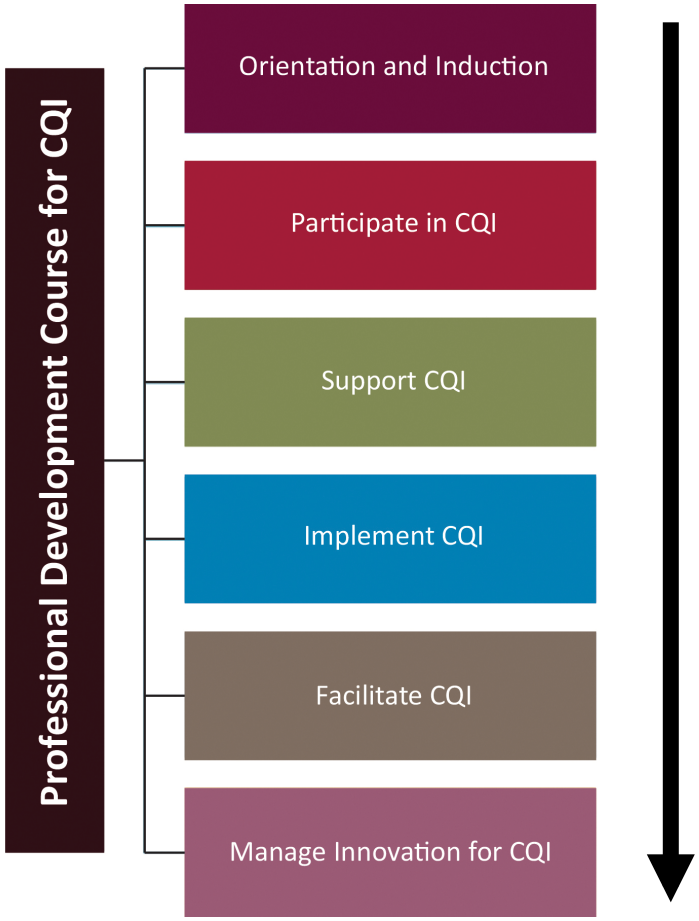
The learning modules were developed by the ThinkThrough team led by Dr Sanchia Shibasaki and Dr Beverly Sibthorpe, with contributions from Dr Jacki Mein, Ms Kerry Copley, Ms Carolyn Renehan, Professor Ross Bailie and Mr Alistair Harvey.

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.

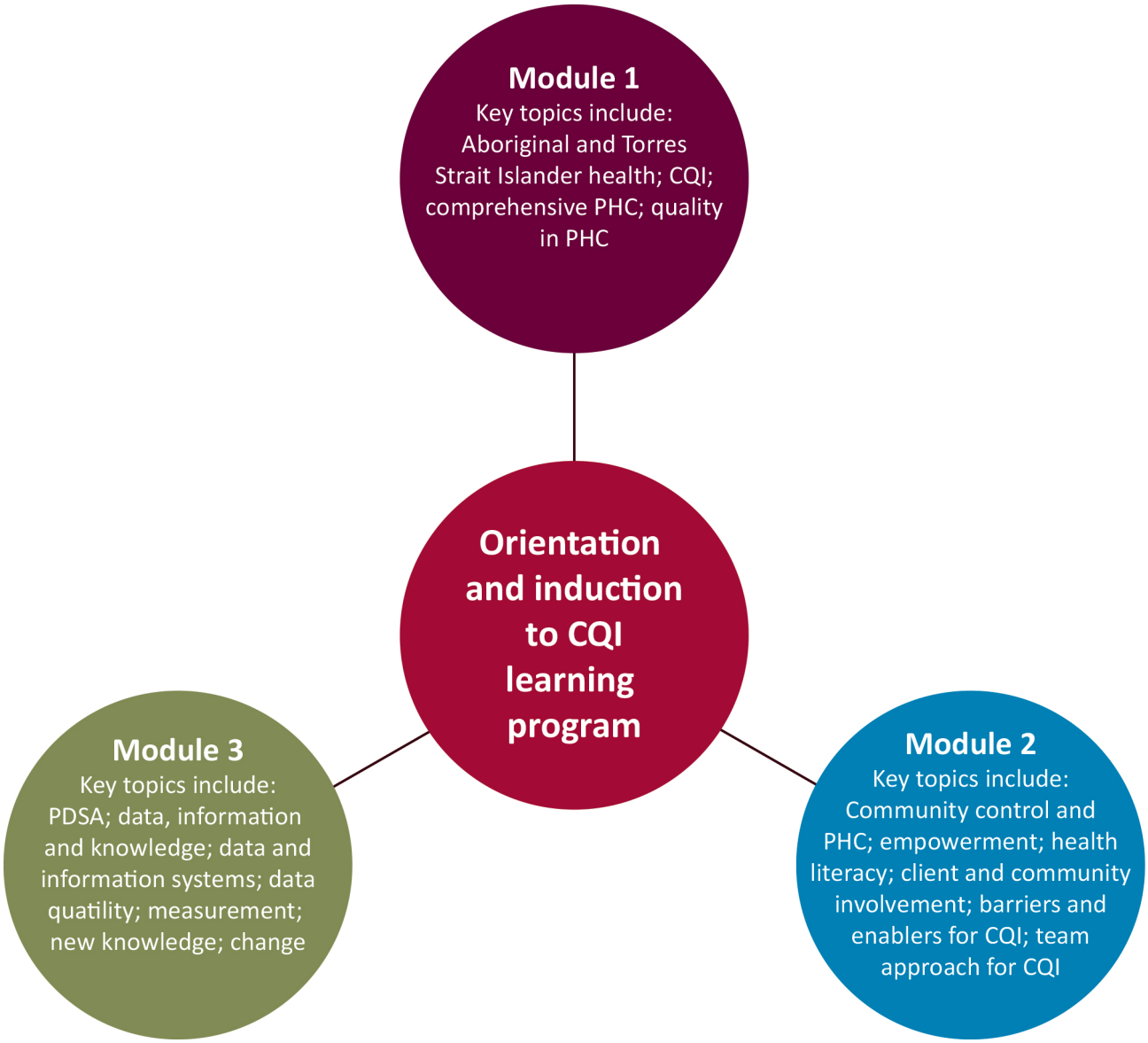
The Orientation and Induction Learning Program is one of six learning programs in the Professional Development Course Outline for CQI (Figure 1). The learning programs are designed to build on each other. As you progress through the Professional Development Course Outline for CQI (Figure 1), the learning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



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 contains 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 2 you should be able to:

- Define community control
- Define primary health care as system and process
- Identify the main primary health care service structures and processes
- Describe the roles of the client and community in CQI
- Define empowerment including roles, rights and responsibilities
- Define health literacy
- Identify organisational policies and procedures that apply to client and community involvement in primary health care
- Identify the main organisational barriers and enablers for CQI
- Define team and teamwork
- Identify and describe organisational roles and responsibilities for CQI
- Describe own role and responsibility as it applies to CQI within an organisation
- Describe the key enablers and barriers to teamwork in CQI, and
- Describe the key principles of working with people of different ages, gender, race, religion or political persuasion.

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.

Community Control and Primary Health Care

Community Control is a process that allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community (NACCHO 2014a).

An Aboriginal Community Controlled Health Service is:

- An incorporated Aboriginal organisation
- Initiated by a local Aboriginal community
- Based in a local Aboriginal community
- Governed by an Aboriginal body which is elected by the local Aboriginal community
- An organisation that delivers a holistic and culturally appropriate health service to the community which controls it. (NACCHO 2014a)

ACCHSs were initiated by communities in the 1970s, they were both a reflection of the aspirations of Aboriginal people for self-determination and a response to the urgent need to provide decent, accessible health services to Aboriginal populations (NACCHO 2015). They are responsive to community health needs, maximise community empowerment through participation (Dwyer, Shannon & Godwin 2007) and foster Aboriginal community governance and action (Couzos & Thiele 2009). A holistic view of health and the delivery of comprehensive primary health care are the cornerstones of their philosophy.

In 2015, there were over 150 ACCHSs across the country. The ACCHS sector comprises local, and in some areas regional, organisations and is supported by state/territory peak bodies and NACCHO, which are very active in sector and service development and advocacy. ACCHSs provide services to an estimated 51 per cent (2011–12) of the Aboriginal and Torres Strait Islander population (NACCHO 2014b).

Learning Activity

To Do

Open the following link and watch 'What does Aboriginal Community Controlled Health mean to NACCHO members?' https://youtu.be/P1tiYB5EWE8

- Identify and describe some meanings from the video

Your Notes

What is Primary Health?

There are several ways to describe primary health care such as:

- The first level of contact individuals, families and communities have with the health care system
- A type of model or sector that has different governance, funding, administrative and workforce arrangements such the ACCHS sector, general practices and state and territory government funded clinics; or
- The type of services and programs offered and delivered, for example, comprehensive primary health care.

Primary health care services, clinics or practices can also be described as a **system and process**. A system may range from very simple to very complex. Generally speaking, there are numerous types of system. For example, there are biological systems, ecological systems, and social systems. Systems have inputs, processes, outputs and outcomes, with ongoing feedback among these various parts. If one part of the system is removed or changed, the nature of the whole system is changed.

As a **system**, the primary health care service, practice or clinic, consists of components or parts that interact with each other to achieve an overarching goal. These components include people (e.g. human resources), money (e.g. financial systems), buildings and equipment (e.g. infrastructure), computers and software (e.g. technology systems) and so on. Changes in one part or parts of the system will affect the system as a whole.

CQI requires us to move beyond thinking about what we have in front of us. CQI requires us to 'zoom out' and to view the service, practice or clinic, as a system made up of interconnecting parts. A manager and team that makes a change to one part of the organisation will affect the organisation as a whole.

In terms of **process**, there are many processes involved in primary health care. For example, there are processes for making appointments, doing health assessments, making diagnoses, and so on. There are many activities that make up these processes. CQI requires us to look at activities and to chunk them up into steps. A change in one process or step will create a ripple effect to other parts of the process.

Learning Activity

To Do

1. What are the components in your primary health care service?
2. Reflect on your role. Describe the processes you may be involved in.
3. Imagine you arrive to work one day and find that the whole appointment making process has changed. What other parts of the system may be effected by this change?

Your Notes

What Is the Role of the Client and Community?

Clients and communities are at the centre of the health system, and the decisions that they make and the actions that they take are a vital component for ensuring that society achieves good health outcomes and safe and high quality health care (NHHRC 2009).

The way in which clients and communities make decisions and take action about health and health care is influenced by the individuals' ability to make decisions and have control over their personal life (**empowerment**) and their own skills, capacities and knowledge; and by the environments in which these actions are taken (**health literacy**).

Clients, carers and the community play an important role in CQI because they are the only people who really experience the patient pathway from start to finish and can, if effectively tapped into as a knowledge base provide key insights into: **'What is good care?'**

The importance of client and consumer involvement in primary health care was recognised many years ago in two important international agreements: the Declaration of Alma Ata and the Ottawa Charter for Health Promotion (WHO 1978, WHO 1986). In Australia, the ACCHS model incorporated this approach and more recently, client and community involvement is reflected in the National Safety and Quality Health Service Standards, accreditation requirements and the National Aboriginal and Torres Strait Islander Health Plan (ACSQHC 2012, Commonwealth of Australia 2013).

A small but significant body of evidence demonstrates client and community participation in primary health care is associated with improved health outcomes (Bath & Wakerman 2013). In activities where there was a lot of client and community participation (i.e. where community members are actively involved in determining priorities and implementing solutions), there appears to be an association with improved health outcomes (Sare & Kirby 1999; Hancock et al. 2001; Nikniaz & Alizadeh 2007; Draper, Hewitt & Rifkin 2010), service quality (Uddin et al. 2001), and access (Tyrrell et al. 2003).

Levels of client and community involvement in CQI may include:

- Gathering **information**, for example through community consultation processes and at the service level through client satisfaction forms and complaints
- Obtaining **advice** about service redesign, for example from a client or community advisory committee, and
- **Partnering**, for example establishing active partnerships with community organisations.

While there is policy support for client, public or community involvement in health services in Australia, it is unclear at the local level how participation is enacted and about the role of community, consumer or user representatives in health service processes. There also appears to be differences in perspectives between staff and health service-users about the purpose and scope of client and community involvement (Rutter et al. 2004).

What is Empowerment?

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision making, and achieve political, social and cultural action to meet those needs. Through such a process people see a closer connection between their goals in life and a sense of how to achieve them, and a relationship between their efforts and life outcomes.

There are two types of empowerment:

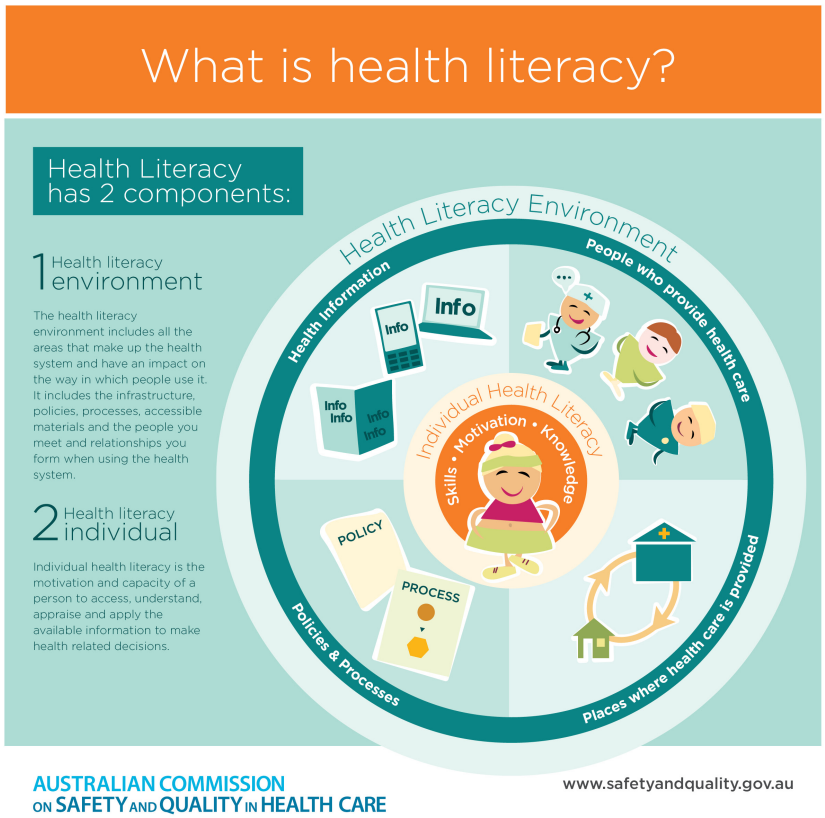
1. Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Individual empowerment includes elements such as self-worth, hope, choice, autonomy, identity and efficacy, improved perceptions of self-worth, empathy and perceived ability to help others, the ability to analyse problems, a belief in one's ability to exert control over life circumstances, and a sense of coherence about one's place in the world (Zimmerman & Rappaport 1988, Wallerstein 1992).

2. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health (WHO 1998).

What is Health Literacy?

Having individuals, families and communities who are partners in the processes of health and health care is necessary for safe and high quality care (ACSQHC 2014). Health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action (Figure 1). Health literacy plays an important role in enabling effective partnerships. In order for partnerships to work, everyone involved needs to be able to give and receive, interpret and act on information such as treatment options and plans. When these conditions exist, there is the potential to not only improve the safety and quality of health care, but also to reduce health disparities and increase equity.

Figure 1: What is health literacy? (ACSQH 2014)



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

Learning Activity

To Do

Watch 'health quality council' videos. Here is the link:

https://youtu.be/uBCP0CgewHY?list=PLsmd5sbzhSch5TpQ_ZnPlWAkLtYuElNEU

1. How were clients and communities involved in CQI events?
2. What was involved in the rapid process improvement workshops?
3. What are some barriers and enablers to client and community involvement in CQI?
4. What were the benefits of these activities for the clients and communities?
5. Identify your organisation's policy and procedures that apply to client and community involvement in primary health care.

Your Notes

What Are the Barriers and Enablers for CQI?

Healthcare organisations face 10 key challenges in trying to implement CQI programs (Dixon-Woods, McNicol & Martin 2012):

1. Convincing people that there is a problem
2. Convincing people that the solution chosen is the right one
3. Getting data collection and monitoring systems right
4. Over-ambitious goals and giving the impression that the improvement activity is unlikely to survive the time-span of the project
5. The organisational context, culture and capacities
6. Strong allegiance and lack of staff engagement
7. Leadership
8. Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions
9. Securing sustainability, and
10. Considering the side effects of change.

The barriers and enablers for CQI in Aboriginal and Torres Strait Islander primary health care are summarised in the following table (Lowitja Institute 2014).

Enablers	Barriers

• Commitment and support:
  ○ From the leadership team and senior management
  ○ To implement CQI cycle and steps
  ○ Use CQI for business planning, and
  ○ For training and development of information systems and practice-based networks.
• Approach
  ○ Systematic, no-blame, systems-oriented, incremental steps
  ○ Experienced based and learning
  ○ Achievable targets, and
  ○ Integration of CQI data collection with other reporting requirements.
• Staff expertise and interest and identified roles in the service to negotiate implementation of action plans
• Champions
• Infrastructure such as established information systems
• Clear framework and structure for implementation
  ○ Clearly defined objectives and expectations
  ○ Clear defined roles/responsibilities for CQI
  ○ Defined objectives for using clinical performance data in quality reporting structures at local, regional, state and national levels.
• Quality network for developing and sharing expertise and resources for CQI.
	• High staff turnover
	• Burden of disease and balancing demands of acute care with those for chronic disease
	• Difficulty in providing/receiving enough training and technical support
	• 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
	• Lack of a single integrated data reporting system across services delivering care
	• Manual audits and systems assessment that are time consuming
	• Perceived lack of control to change clinic routines in support of action plans, and
	• Lack of teamwork.

Who in your Organisation Is Responsible for CQI?

Addressing the barriers to CQI requires organisational commitment and **whole team** involvement to improve service processes for delivering care. The key organisational roles that are responsible for driving and embedding CQI in Aboriginal and Torres Strait Islander primary health care includes:

- Board of Directors
- Leadership team such as Chief Executive Officer, Senior Managers, Program Managers, Health Centre Manager, RN or Senior Aboriginal Health Worker
- Clinical leader such as the Senior Medical Officer
- Clinical governance team, and
- CQI Lead.

There are also roles external to the organisation that drive and support CQI in Aboriginal and Torres Strait Islander primary health care. The roles may be based in partner organisations, regional and state/territory organisations or national organisations. Roles include external CQI facilitators, public health medical officers, and so on.

Why a Team Approach to CQI?

Teamwork

1. Watch 'The Power of Union' on YouTube

2. Here is the link: https://youtu.be/jop2I5u2F3U

CQI is a team function, so embedding CQI in everyday practice requires everyone – health professionals, managers, leaders and administrative and support staff – to learn and apply new knowledge and skills (Lowitja Institute n.p.). Teams are necessary to deliver comprehensive primary health care, especially for chronic disease. In the area of quality improvement, the team is the primary vehicle through which problems are analysed, improvements are generated and change is evaluated (Sollecito & Johnson 2013).

Research suggests the presence of strong CQI teams and collaborative teamwork as crucial factors in successful programs (Fox 2007, Chin et al. 2008, Gardner et al. 2010; Lob et al. 2011). Likewise, lack of teamwork is a barrier to CQI (Lowitja Institute 2014).

Key Roles in CQI

The key roles in helping to embed CQI in primary health care include: Clinical Leader, CQI Lead, and External CQI Facilitators.

Clinical Leader

The clinical leader role is recognised as fundamental for driving service redesign and improving patient outcomes at the service level (Garrubba, Harris & Melder 2011, Zachariadis et al. 2013). The clinical leader leads a team that is the formal organisational structure where managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care (Lowitja Institute n.p.).

CQI Lead

The CQI Lead role is the designated quality lead at the individual primary health care provider level and/or at the regional level. The CQI lead aims to ensure that CQI activities have a 'driver' and can be embedded into routine practice over time. The team is vital for successful improvement efforts and may vary in size and composition and the context of the primary health care service.

External CQI Facilitators

In the Australian context, CQI has often been the responsibility of External CQI Facilitators rather than of the staff managing clinical care within health services. External CQI Facilitators provide support of organisations, primary health care providers, teams and individual health professionals that is tailored to meet specific needs and different levels of CQI capacity (Lowitja Institute n.p.).

Team Approach for CQI Requires Diversity

Good leaders help to foster teamwork by clearly defining roles, responsibilities and objectives for team members, setting structured time aside for CQI activities and motivating teams to participate in CQI activities (Wang et al. 2004, Gardner et al. 2011). Clinician champions can also play a critical role in motivating staff participation as can dedicated clinic managers or administrative staff who help support CQI teams by ensuring that service priorities are translated into actions, and by holding the team accountable for CQI processes (Wang et al. 2004, Bray et al. 2009, Gardner et al. 2010). To work efficiently, CQI teams need diversity: people with different skills, experience, knowledge and viewpoints.

The concept of diversity includes acceptance and respect (Patrick & Kumar 2012). It means understanding that each individual is unique and recognising our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. It is the ability to explore these differences in a safe, positive, and fostering environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

Diversity is a set of conscious practices that involve understanding and appreciating interdependence of humanity, cultures, and the natural environment; practicing mutual respect for qualities and experiences that are different from our own; understanding that diversity includes not only ways of being but also ways of knowing; recognising that personal, cultural, and institutionalised discrimination creates and sustains privileges for some while creating and sustaining disadvantages for others; and building alliances across differences so that we can work together to eradicate all forms of discrimination (Patrick & Kumar 2012).

Workplace diversity refers to the variety of differences between people in an organisation (Patrick & Kumar 2012). That sounds simple, but diversity encompasses race, gender, ethnic group, age, personality, cognitive style, tenure, organisational function, education, background and more. Diversity not only involves how people perceive themselves, but how they perceive others. Those perceptions affect their interactions. For a wide assortment of employees to function effectively as an organisation, they need to deal effectively with issues such as communication, adaptability and change.

Learning Activity

To Do

1. Go to your organisation's website, annual report, policy and procedure manual or to your supervisor. Answer the following questions:

- **Which are the key roles responsible for CQI in your organisation?**
- **Who is the leader for clinical governance?**

2. Reflect on your role – describe the responsibility your role has in CQI?

Your Notes

Let’s Summarise and Reflect

Your Notes

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