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The implementation gap: what is needed to ensure the effectiveness of quality improvement interventions in Indigenous primary health care?

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PHC Research conference, Brisbane
August 2017

Background

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Improving the effectiveness of continuous quality improvement (CQI) to support high quality care is an important factor in supporting Indigenous primary health care in Australia

Aims

- **Identify** "high-improving" services
- **Understand how** contex[illegible]al factors interact to improve [illegible]lity of [illegible]

Learn from secrets of their success

Our partners

Menzies, AMSANT & NT Dept of Health

PHC site A

PHC site B

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Case studies

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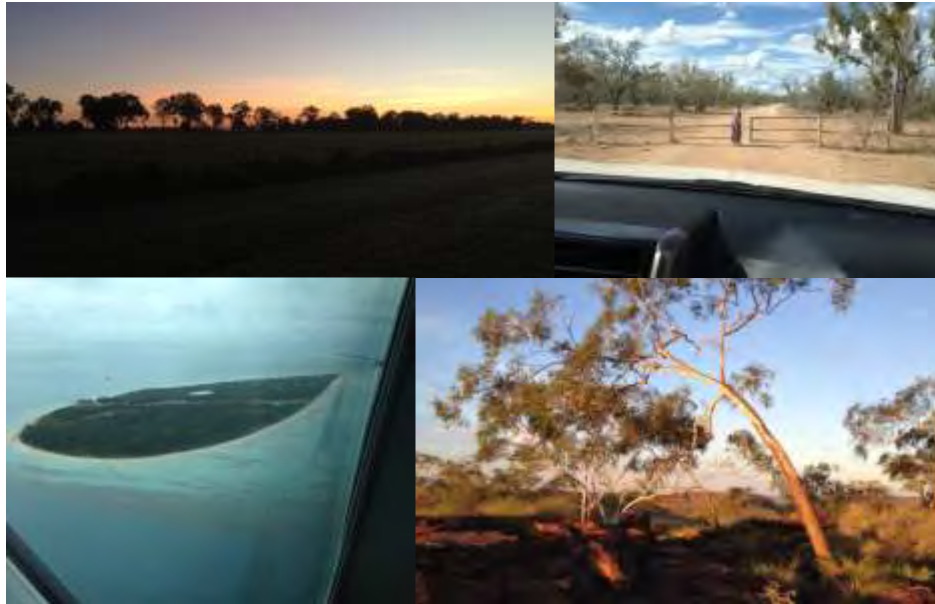

Methodology

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Stage 1: Identification of 'high improving' Indigenous primary health care services

--A 'high improving service' defined as demonstrating consistent improvement over three or more audits in two or more audit tools (six services identified)

-Quantitative analysis of historical audit data and system assessment tools data for high improving services conducted to identify predictors for high improvement

Stage 2: Cross jurisdictional multiple case study methodology with participatory approach

-Documentary analysis (strategic plans, population profile data, site and service data, staff retention/turnover, staff participation in CQI process)

-Semi structured interviews with service providers, managers and service users at each service (n=134)

-Non-participant observation

Analysis and feedback

-Inductive thematic analysis to explore themes at macro, meso and micro system level within and across cases

-Informed by systems theory, reinforcing loops used to explore interactions between themes-Mapping against National CQI Framework

Ongoing verification of findings with services

Qualitative data collection

Site	Site A	Site B	Site C	Site D	Site E	Site F	Total
Health service staff	7	12	12	7	4	12	55
Health service user	8	10	8	9	6	10	51
Regional Managers/ stakeholders	5	4	8	0	4	3	23
Total	20	26	28	16 (+5)*	14 (+5)*	25	134

*** Five additional interviews were conducted with regional stakeholders**

Summary of findings

- No statistically significant consistent association with size of service, remoteness, governance model or accreditation status and being a high improving service (Larkins et al 2015)
- Each health service was unique
- Health services operationalised quality improvement quite differently
- Cross case analysis found committed staff leadership and shared purpose, systems and supportive policies all important, but also cultural embeddedness and mechanisms for community to drive health improvements.

Factors that support quality health care

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Linkages/ partnerships with external organisations

Supportive health service policies

Understanding & responding to historical/ cultural context

Health service CQI supports

Teamwork & collaboration

Prepared workforce

Users/ community engaged with the service

Caring staff

BROADER CONTEXT

HEALTH SERVICE LEVEL

COMMUNITY / INTER-PERSONAL LEVEL

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- Each system had features (a partnership or unique staffing combination) at the meso and micro level that supported QI.
- Mesosystem support was important in some cases in mitigating against workforce instability.
- In jurisdictions with less supportive macro policies it appeared that impetus was gained through generating local solutions to overcome challenges.
- Reinforcing loops operated- for example strong team functioning reinforcing staff commitment to QI; strong community partnerships driving QI.

Why is the service continuously improving?

- Staff factors
  - Consistent staff/leadership
  - Teamwork/partnerships
- Community factors
  - Community driving quality improvement
  - Culturally secure and embedded PHC service
- CQI factors
  - Supportive structure/embedded CQI
  - Resourcing

Four implementation levers for policy and practice

1. The purpose of quality improvement should be explicit and shared across all levels of the health system with a focus on improving client care and health outcomes.

We're here for our people out in our communities and how do we provide the service best we can ... we respond to their needs and wants [Deputy CEO]

2. Institutionalise CQI and supports

- Institutionalise CQI: Support it at all levels through collaborative decision making and embedding it in orientation, staff training, regular team meetings and regional partnerships (e.g. collaboratives).
- Ensure that health service operational systems and IT systems support the routine practice of CQI by all health service staff.

CQI it's a learning curve all the time but it's really good. It's working [Administrator]

3. Appropriate workforce

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- Facilitate an appropriate and prepared workforce with attention to Indigenous and non-Indigenous workforce mix in recruitment and orientation. This is likely to support staff retention

"I think a supportive environment is good and everyone participating and everyone being a team player and everyone takes responsibility" [Remote Area Nurse]

4. Allow community to "drive health":

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- Support the community and health workforce to develop meaningful two-way linkages. Then improvement processes are embedded in culture and incorporate genuine engagement mechanisms.

"Our culture is our foundation" [Aboriginal Health Practitioner]

"We come from the ground really – from the community - what they- what the community want…." (AHP, ACCHS)

Conclusions:

- Role of community in driving QI is under-appreciated
- Key health system processes and supports are necessary to successfully implement quality improvement
- Need to ensure the purpose of quality improvement is explicit and shared with the health service team with a focus on improving client care and health outcomes
- "Two-way learning culture" rather than "compliance culture"
- Now exploring implications for scale-up and how this works in other services

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This work is supported by
NHMRC Project grant 1062377
(2014-2016)
and is part of the NHMRC CRE –Integrated Quality Improvement in Indigenous Health (GNT1078927)

Thank You
Health centre staff, managers and patients
CQI coordinators
One21seventy and ABCD National Research Partnership

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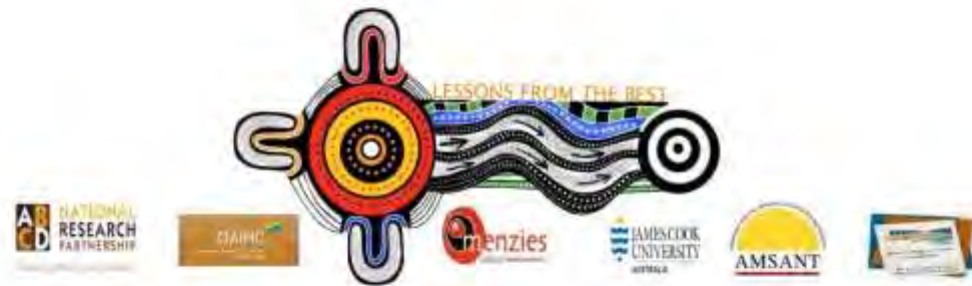
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