Priority evidence-practice gaps & stakeholder views on barriers & strategies for improvement in Aboriginal and Torres Strait Islander chronic illness care

Veronica Matthews, Christine Connors, Alison Laycock, Anna Sheahan, Jodie Bailie, Ross Bailie

2014 NHMRC Research Translation Symposium, Melbourne
Overview

1. **Context**
   CQI Aboriginal & Torres Strait Islander PHC

2. **Aims & Methods**
   Engaging Stakeholders Project (ESP)

3. **Key findings - Chronic illness care**
   • priority evidence-practice gaps
   • barriers and enablers
   • strategies for improvement

4. **Learnings/next steps**

---

**ABCD National Research Partnership**

**Aims 2010-2015**

• analyse aggregate de-identified CQI data to identify variation in quality of care between health centres and regions
• investigate factors underlying the variation
• work with stakeholders to identify effective strategies in improving clinical performance
• disseminate and translate findings for local implementation & wide-scale change
CQI in Aboriginal & Torres Strait Islander PHC

Audit & Best Practice for Chronic Disease

12 health centres NT Top End

2002

ABCD Extension

69 health centres nationally

2005

ABCD NRP

175 health centres

2010

Service Support

One21seventy/ABCD data (to 2014)

<table>
<thead>
<tr>
<th>Audit Type</th>
<th>Health Centres*</th>
<th>Audit Records</th>
<th>System Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Illness</td>
<td>163</td>
<td>19,051</td>
<td>421</td>
</tr>
<tr>
<td>Child Health</td>
<td>141</td>
<td>14,545</td>
<td>310</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>138</td>
<td>17,010</td>
<td>360</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>106</td>
<td>4,451</td>
<td>241</td>
</tr>
<tr>
<td>Rheumatic Heart Disease</td>
<td>63</td>
<td>2,602</td>
<td>109</td>
</tr>
<tr>
<td>Mental Health</td>
<td>35</td>
<td>946</td>
<td>29</td>
</tr>
</tbody>
</table>

*ABCD Research Health Centres
ESP Aim & Methodology

Aim
To engage a range of stakeholders in the interpretation and use of aggregated CQI data for the purpose of achieving wider system change.

Objectives
1. To disseminate and encourage engagement with aggregated CQI data to a range of stakeholders.
2. To obtain input from stakeholders on the interpretation of priority evidence-practice gaps, based on the analysis of the aggregated data.
3. To capture the ‘tacit’ knowledge of stakeholders on the barriers and enablers to addressing the identified priority evidence-practice gaps, and on strategies for improvement.

Target stakeholders
- PHC workers
- Medical specialists
- CQI facilitators
- Managers
- Policy makers
- Researchers
ESP Aim & Methodology

3 cycles report & feedback (online surveys)

Priority aspects of PHC

Child health
Chronic illness care
Preventive health
Mental health
Rheumatic heart disease
Maternal health

Stakeholder Engagement Cycles

Phase 1
Priority evidence-practice gaps

Phase 2
Barriers to improvement

Phase 3
Strategies for improvement

Review
Final report

Final report for dissemination

Other dissemination products

...report refinement

Stakeholder feedback...
ESP Theoretical Framework

Who needs to do what differently?
(Improvement ← behaviour change ← intervention development)

ESP PHASE 1
Identify priority evidence-practice gaps (EPGs)
Evidence-base
Aggregate CQI data from last 2 years eg Chronic illness
123 centres; 6,523 patient records

ESP PHASE 2
Identify barriers & enablers relevant to priority EPGs
Trend CQI data (8-9 yrs)
Theoretical domains (different levels)
Staff: (eg skills, knowledge)\(^3\),\(^4\)
Health centre & systems:
(eg finance, facilities, human resources)\(^5\),\(^6\)

ESP PHASE 3
Identify strategies for improvement
Evidence brief
summarising research on barriers, enablers & strategies for using CQI to improve PHC quality

## ESP Chronic Illness – Engagement

### Snowballing distribution technique

<table>
<thead>
<tr>
<th>Approx no of stakeholder responses</th>
<th>Phase 1 (n=201)</th>
<th>Phase 2 (n=60)</th>
<th>Phase 3 (n=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisations:</strong></td>
<td>community controlled and government sector PHC organisations, general practice and medicare locals, non-government and community organisations and research institutions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respondents:</strong></td>
<td>health practitioners, managers, policy-makers, researchers, Board and community members</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


## Phase 1 – Identifying EPGs

### ‘Current status of delivery’
**Chronic Illness CQI data (2012-2013)**

>80 indicators of quality chronic illness care  (n=123 centres; 6,523 records)

<table>
<thead>
<tr>
<th>Management plans &amp; scheduled services</th>
<th>% service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza vaccination (within 12 months)</td>
<td>![Box plots for management plans and scheduled services]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors/Brief Interventions</th>
<th>% service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waist circumference (within 6 months)</td>
<td>![Box plots for risk factors and brief interventions]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional wellbeing assessment &amp; provision of support</th>
<th>% service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of EW screening using standard tool</td>
<td>![Box plots for emotional wellbeing assessment]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigations &amp; follow-up</th>
<th>% service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of medication adjustment for abnormal HbA1c</td>
<td>![Box plots for investigations and follow-up]</td>
</tr>
</tbody>
</table>
### Six Priority Evidence-Practice Gaps

<table>
<thead>
<tr>
<th>Follow-up of abnormal findings</th>
<th>Brief interventions/Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• six monthly HbA1c checks</td>
<td>• cardiovascular risk assessment</td>
</tr>
<tr>
<td>• follow-up plans &amp; medication review for abnormal HbA1c, cholesterol &amp; BP results</td>
<td>• healthy weight indicators</td>
</tr>
<tr>
<td></td>
<td>• brief interventions &amp; referrals eg physical activity &amp; quit smoking programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adherence to evidence based current treatment guidelines</th>
<th>Adult vaccinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• strengthen efforts to encourage practitioners to adhere to treatment guidelines</td>
<td>• improve coverage of adult vaccinations (influenza &amp; pneumococcal)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional wellbeing assessment &amp; provision of support</th>
<th>Health centre systems improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• strengthen EW screening &amp; support</td>
<td>• systems for more effective links between health centres &amp; communities</td>
</tr>
</tbody>
</table>
Phase 2 – Identifying barriers & enablers

**Trend CQI data (2006-2013)**
**Chronic Illness (n=160 centres; 17,879 records)**

**Theoretical domains**

**Health centre & systems relevant to Indigenous PHC:**
Financing; facilities; workforce; teamwork; training & development; self-management; patient-centred care; population health; decision support; clinical information systems; quality improvement; community capacity, engagement & mobilisation; leadership & management


**Staff:**
Knowledge; skills; social/professional role & identity; beliefs about capabilities; optimism; beliefs about consequences; intentions; memory, attention & decision processes; social influences; emotion

Phase 2 – Results (~60 respondents)

Barriers & Enablers

Health centre and system attributes are of at least equal or greater importance compared to staff attributes

Common across all priority evidence practice gaps:

<table>
<thead>
<tr>
<th>Health centre &amp; systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community capacity, engagement &amp; mobilisation</td>
</tr>
<tr>
<td>Staff/workforce, recruitment &amp; retention</td>
</tr>
<tr>
<td>Training &amp; development</td>
</tr>
<tr>
<td>Patient-centred care</td>
</tr>
<tr>
<td>Quality improvement systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills regarding provision of best practice chronic illness care</td>
</tr>
<tr>
<td>Emotion/optimism</td>
</tr>
</tbody>
</table>

“Staff anxiety is due to workforce shortages & requirement to prioritise acute presentations”
Phase 3 – Identifying strategies

Evidence Brief

Improving the quality of Aboriginal and Torres Strait Islander primary health care

What the research shows

This draft evidence brief has been prepared for the ‘Engaging Stakeholders in Identifying Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP)’ project. You are invited to provide feedback to refine the brief, using the online project questionnaire.

The Aboriginal and Torres Strait Islander primary health care (PHC) sector has embraced continuous quality improvement (CQI) as a way of improving the overall quality of care delivered to Aboriginal and Torres Strait Islander Australians, in order to improve health outcomes. This evidence brief presents an overview of findings from local and international research about barriers, enablers and strategies for using CQI to make improvements in PHC quality.

Local research has reflected the diversity and complexity of Aboriginal and Torres Strait Islander PHC delivery – geographic diversity, remote-rural-urban health care settings and community-controlled, government, non-government or private providers. Data have been gathered in settings in which political, cultural, social, educational, technological, emotional and ideological factors interact in complex ways. Despite this diversity and complexity, there are some common messages from the research findings, which are supported by international literature about CQI.

Who is this evidence brief for?
Primary health care policy makers, managers, clinical governance groups. The information will also interest providers and practitioners.
### Phase 3 – results (~73 respondents)

#### Strategies to address common barriers

<table>
<thead>
<tr>
<th>Category</th>
<th>Suggestive Action</th>
<th>Summary</th>
</tr>
</thead>
</table>
| Community capacity, engagement & mobilisation | “More community involvement & programs led by Aboriginal health practitioners” | • Community participation in service planning  
• Invest in Aboriginal & Torres Strait Islander workforce within community |
| Staff/workforce, recruitment & retention | “Workforce turnover is a killer of quality systems” | • Introduce workforce measures as a KPIs  
• Flexible professional development systems eg inter-organisational approaches |
| Patient centred care/Staff skills | “...current focus on immediate needs without consideration of the ‘bigger picture’ of a patient’s health.” | • Enhance provision of holistic care through integration of services  
• Modify roles & career pathways of AHWs/ATSIHPs towards provision of comprehensive care |
Developmental evaluation
- running concurrently to improve ESP processes
- eg workshops vs online surveys

Limited generalisability of results Phase 2/3
- valuable tacit knowledge from workers in sector
- further work to examine suggested strategies, supported by literature

Engaged stakeholders across all levels of PHC system
- begun a dialogue on most important areas requiring improvement & how to achieve it

Encourage stakeholders to take on key messages & utilise reports to implement & document strategies & advocate for change at local, regional, national levels
References:

Contact: veronica.matthews@menzies.edu.au
ph: 07 3169 4201
http://www.menzies.edu.au/abcd

*Our thanks to all who have contributed to the chronic illness ESP process & the many partners participating in the project; NHMRC Partnerships Projects (ID No. 545267); Lowitja Institute, a collaborative partnership partly funded by the CRC Program of the Commonwealth Department of Innovation, Industry, Science and Research.*