General Practice QUEENSLAND

QAIHC
Queensland Aboriginal and Islander Health Council

First Year Report | July 2011

Closing the Gap Collaborative

Quality Improvement in Primary Health Care Services for Aboriginal and Torres Strait Islander People in Queensland

A partnership between QAIHC and GPQ, supported by the IF

Preventative Health Unit QAIHC

improvement foundation

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Acknowledgements

Many people have contributed to the success of the Closing the Gap Collaborative.

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What is the Queensland Close the Gap Collaborative?

The Queensland Close the Gap Collaborative is a primary health care quality improvement initiative. It is designed to help clinical teams work together to reduce lifestyle risk, improve clinical outcomes and help maintain good health for all Aboriginal and Torres Strait Islander peoples in Queensland.

What is its relevance?

There remain very significant gaps between the health of Aboriginal and Torres Strait Islander people and other Australians. Aboriginal and Torres Strait Islander people suffer a burden of disease that is two-and-a-half times greater than the burden of disease in the total Australian population.[1] Non-communicable (i.e. chronic) diseases explained 70% of this health gap including cardiovascular disease (23%), diabetes (12%), mental disorders (12%) and chronic respiratory diseases (9%). Maternal and neo-natal conditions accounted for 6% of the health gap.[2] The Australian Government has made a significant commitment to closing these gaps through the Council of Australian Governments (COAG) 'Closing the Gap' reform. This has targets of closing the life expectancy gap within a generation and halving mortality rates for children under 5 within a decade.

Primary health care services, whether Aboriginal and Islander Community Controlled Health Services (AICCHSs) or mainstream general practices, play an essential and significant role in the close the gap effort. These services need to be supported to deliver the highest quality care to their Aboriginal and Torres Strait Islander clients.

One of the cornerstones of high quality primary health care is quality improvement. This involves building into routine practice the collation, analysis, reporting and review of health services' data and use of this information to improve client care.

Who runs it?

The Close the Gap Collaborative is a partnership between the **Queensland Aboriginal and Islander Health Council** (QAIHC) and **General Practice Queensland** (GPQ) supported by the **Improvement Foundation** (IF).

QAIHC and GPQ saw that they shared responsibility for responding to the challenges set by COAG. Both also recognised the value of using an evidence-based approach to quality improvement such as that provided by the IF. The Close the Gap Collaborative offered a concrete activity with measureable outcomes that could unite the community controlled and general practice sectors in common purpose around Indigenous health disadvantage, led by QAIHC. Through it a strong, respectful quality improvement partnership has developed between the two organisations at all levels.

Importantly, the partnership has resulted in linkages between Closing the Gap programs in Queensland, particularly Divisions of General Practice based Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers. Divisions and the community controlled sector have also shared resources. This has streamlined and enhanced coordination and delivery of services.

What are the key messages?

The Queensland Close the Gap Collaborative:

- Addresses a Council of Australian Governments policy agenda with ambitious targets;
- Is based on an internationally accepted model of quality improvement;
- Brings together community controlled health services and private general practice in a concrete, system-wide effort with measureable outcomes to reduce Indigenous health disadvantage across Queensland;
- Promotes and develops team work, knowledge transfer and innovation within and between services and practices, all critical to the future effectiveness and efficiency of primary health care and involving Aboriginal Health Workers and other Indigenous staff;
- Has demonstrable achievements in its first year;

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1 Australian Bureau of Statistics. 2010. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2010. Australian Bureau of Statistics. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4704.0/ Accessed 20/08/10.

2 Vos T, Barker B, Stanley L, Lopez AD. 2003. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples. Brisbane: Centre for Burden of Disease and Cost-Effectiveness School of Population Health, University of Queensland.

- Is fostering the development of 'lead clinicians' and 'lead clinician groups' with a high level of Aboriginal Health Worker participation in both, providing a *broad–based* model of how these individuals and groups might function under Medicare Locals;
- Through strong Indigenous participation can provide a mechanism through which the quality improvement agenda can increasingly be 'owned' by communities;
- Is potentially sustainable over the long term with a modest investment of funds; and
- Could be readily expanded to other states and territories.

Why is it so practical and effective?

To date, AICCHSs have done a lot of data collation and reporting but this has largely been to meet accountability requirements - the information generated has been of limited value to the services themselves and has not supported quality improvement. At the same time, mainstream general practices have had variable capacity to address the health needs of their Aboriginal and Torres Strait Islander clients and have often not known how best to improve.

As a quality improvement initiative the Queensland Close the Gap Collaborative has the following attributes that make it practical and effective:

- flexible orientation and participation for services/practices
- seamless data collection and submission that can be done very easily
- short, focused quality improvement cycles with fully flexible implementation that link well with improving daily practice - i.e. small areas that may need improvement that are readily understood by staff at all levels; rapid turnaround that allows momentum to build
- clinical themes for quality improvement selected by a steering committee in keeping with local priorities and national policy
- automated extraction and transmission of de-identified clinical data to the web based information system
- monthly data reports to monitor progress accessible to services/practices through a web portal
- inclusion of data for all clients, not just samples
- comparisons of service/practice data with averages for all services/practices
- reports that are very visual which allows easy presentation to staff at all levels
- data can be interpreted in the context of a global understanding of the service's/practice's clients including access/coverage, numbers of regular clients, disease prevalence etc[3]
- an associated software package allows services and practices to 'drill down' to see which clients need which interventions
- team work, knowledge transfer and innovation within and between services and practices is promoted and developed, all involving Aboriginal Health Workers and other Indigenous staff
- the Collaborative's structures and processes are themselves subjected to ongoing review and improvement

When did it start?

The Close the Gap Collaborative started in July 2010. It is envisaged that it will be ongoing. Funding is being sought from governments to further support this initiative from 1 July, 2011 (see below). With relatively modest financial support the stakeholder commitment, ICT infrastructure, service support network and evidence-based improvement model are all in place to carry this initiative on into the future. Even when the health gap is closed there will always be a need for quality improvement in Indigenous primary health care.

3 This is critical to improving quality – e.g. diabetes management may be good, but the numbers of diabetic clients being seen on a regular basis does not fit with the size of the service's catchment population and the known prevalence of diabetes.

How many services and practices are participating?

Of the 21 AICCHSs with medical clinics, 13 (62%) are participating along with 17 general practices from 7 Divisions of General Practice in areas with high Aboriginal and Torres Strait Islander populations. Distribution of these services and practices is shown in Appendix 1.

With further funding from 1 July, 2011 there are plans to enrol a further 8 AICCHSs and around 15 more general practices, the latter again concentrated in areas with high Aboriginal and Torres Strait Islander populations.

How many Aboriginal and Torres Strait Islander clients does it cover?

As of May 2011, the participating AICCHSs and general practices were collectively seeing around 40,000 Aboriginal and Torres Strait Islander clients. The AICCHSs have around 30,000 clients and the general practices 10,000. Together they provide care for approximately 30% of the Aboriginal and Torres Strait Islander people in Queensland.

With future expansion, AICCHS clients covered will total around 55,000 and general practice clients around 20,000 giving a total of around 70,000 regular clients or approximately 50% of the Queensland Indigenous population.[4]

What does it involve?

The Queensland Closing the Gap Collaborative is based on the Australian Primary Care Collaborative (APCC) which is now in its second Phase. APCC is in turn based on the Breakthrough Series Collaborative methodology, first developed in the USA by the Institute of Healthcare Improvement. Originally applied to healthcare systems in the USA, it has been adopted in other countries, including the UK, Scotland, Canada and New Zealand.

The Collaborative Model for Improvement[5] provides a framework for developing, testing and implementing changes to improve quality. It helps to break down the change effort into small, manageable chunks which are then tested to ensure that things are improving and that no effort is wasted. It consists of two equal parts; the first part, the "thinking part", consists of three fundamental questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement? [6]

PDSA (Plan, Do, Study, Act) is the model used for testing the ideas generated by question 3. It is designed to test ideas for improvement quickly and easily based on existing ideas, research, feedback, theory, review, audit, etc or practical ideas that have been proven to work elsewhere. Change is measured so that improvements can be demonstrated.

Core components of the Queensland Close the Gap Collaborative are:

- A fully functioning information platform with electronic extraction, transmission, analysis and graphic display (including comparisons with other services and practices) of de-identified, routinely collected client clinical data to measure effectiveness;
- Support for change for participant services and practices through a number of strategies.

How is support for change provided to services and practices?

The Close the Gap Collaborative supports change through:

- Commitment and leadership within the three partner organisations;
- Quality improvement support coordinators based at QAIHC, GPQ and the IF;

4. A significant proportion of Indigenous clients in Queensland are currently clients of Queensland Health clinics, e.g. in Brisbane, Cape York, Torres Strait, Yarrabah, Palm Island, the Gulf.

5 Langley, Nolan, Nolan, Norman & Provost (1996) "The Improvement Guide" Jossey Bass, USA.

6 http://www.apcc.org.au/about_the_APCC/the_model_for_improvement/ Accessed 30/05/11

- A network of support officers working 'at the coalface' in services, Divisions and practices (currently funded through a number sources);
- 2-day learning workshops every 6 months (see below under 'Early Achievements');
- Face-to-face and web based seminars for training (and in future, orientation);
- An electronic discussion forum hosted by the IF; and
- A monthly electronic newsletter that includes 'hot tips'.

Quality improvement support coordinators Melvina Mitchell (QAIHC), Melissa Williams (GPQ), Lynette Anderson (QAIHC) and Michelle Costello (GPQ)

What sort of strategies have been adopted by services and practices to improve access and care?

Examples include:

- providing cultural awareness training for staff
- reviewing the appointment system to ensure it is appropriate to meet the needs of the local Aboriginal and Torres Strait Islander community
- distributing material on the correct way to ask clients about their ethnicity
- identifying inactive clients
- improving recall of 'at-risk' clients
- dedicating one day per week for health assessments
- allocating an Indigenous Health Worker to run diabetic clinics and visit clients in their homes

- reviewing the transport policy so that eligible Aboriginal and Torres Strait Islander patients have access to transport services
- running a mini expo at a local state high school to educate the Aboriginal and Torres Strait Islander students and their families about the Closing the Gap initiative.

What are some of the early achievements?

The Closing the Gap Collaborative has been running for just one year but can already demonstrate its effectiveness in terms both of changing organisational cultures and delivering better care. The key early achievements are:

- Attendance at the learning workshops
- Use of data to inform practice
- More clients seen and registered
- More complete recording of clinical information
- More health assessments done

Attendance at the learning workshops

The engagement of services and practices in this initiative is demonstrated by attendance at the learning workshops that are a very important part of the Collaborative. Three 2-day workshops have been held in the first year, the first two focusing on access, identification and health assessments (July and October 2010) and the third on chronic disease prevention and self-management including tobacco use (April 2011). Run over a Friday and Saturday, attendees have included GPs, practice managers and nurses, health workers and CEOs (Table 1).

Table 1. Attendance at Closing the Gap Collaborative learning workshops

	Workshop 1 July 2010		Workshop 2 July 2010		Workshop 3 July 2011	
	AICCHS	**GP**	**AICCHS**	**GP**	**AICCHS**	**GP**
No of Services Attending	**14**	**16**	**13**	**14**	**16**	**13**
Staff attendees by type						
GPs	10	9	10	9	8	6
Practice Managers/ Practice Nurses	11	22	10	19	9	17
Health Workers	14		13		20	
CEOs	4		1		3	
Total service/practice staff	**39**	**31**	**34**	**28**	**40**	**23**
QAIHC, GPQ & Divisions	**19**		**15**		**17**	
Total number of participant attendees	**89**		**77**		**80**	

Workshop content includes guest speakers (experts in their health fields), presentations on best practice and innovation by participating services and practices, and formulation of ideas for implementation in the following 'activity period' using the 'Plan, Do, Study, Act' approach. The workshops, which have high levels of participation by Aboriginal Health Workers (and other Indigenous staff), provide a *broad-based* model of how the 'lead clinicians groups' to be established under the Medicare Locals reform might function.

QAIHC members at the Close the Gap Collaborative Workshop, July 2010

Participation in the workshops also fosters the development of individual 'lead clinicians' and quality improvement 'champions' in services and practices, including developing capacity among Aboriginal Health Workers to take on these roles. Again, this offers a model of a broad-based approach to these roles under Medicare Locals.

Satisfaction with the workshops is demonstrated by the proportions rating the content overall as excellent (21%), very good (41%) and good (32%). 78% of respondents to a comprehensive survey for the first year thought that the content of the learning workshops helped them to improve everyday practice.

Use of data to inform practice

Routine use of good quality information to inform practice constitutes a major change in organisational culture and is critical to carrying the quality improvement agenda forward. Participating services and practices have accessed and used two sets of information available through the Closing the Gap Collaborative. These are based on automated, monthly transmission of de-identified client data for a wide range of variables relating to maternal and child health and chronic disease.

First there are reports based APCC data that are accessible to services and practices via a web portal on the APCC pages. The APCC measures collect summary information for all of the clients of a service or general practice irrespective of ethnicity. The reports allow services and practices to monitor from month to month the effectiveness of the changes they are implementing in their short PDSA cycles in the activity periods between workshops.

Second there are reports available via the same web portal on the **QAIHC Core Indicators** pages (see Appendix 2 for a list of the QAIHC Core indicators). These indicators have been developed by QAIHC to provide a high level, sector-wide snapshot of overall service performance, focusing on the priorities identified in Close the Gap. These display data aggregated for the service or practice, over time and benchmarked, for regular Aboriginal and Torres Strait Islander clients (clients with 3 visits in the previous 2 years).

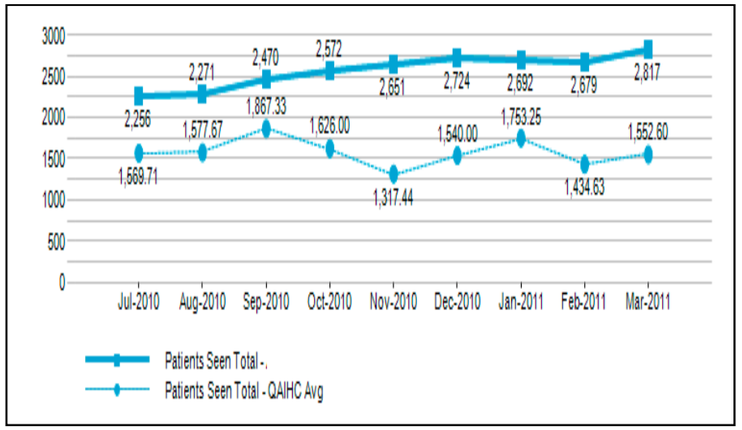
A particular achievement of the Collaborative that is a testament to the shared vision of QAIHC and GPQ is that participating general practices are also reporting on the QAIHC core indicators. They therefore provide a snapshot for both the community controlled and general practice sectors. Further, services and practices in other states involved with APCC have opted to report on these indicators displayed through the QAIHC pages. Much valued aspects of the QAIHC Core Indicators reports are comparisons with other (de-identified) services and practices and increasingly, benchmarks that are being developed against which services and practices can assess their relative performance.

Screen views for three of the 'tabs' on the QAIHC Core Indicator pages – the 'key summary', 'indicators' and 'benchmarking' tabs - are shown in Appendix 3.

More clients seen and registered

There has been an increase in the number of clients seen by some participating AICCHSs (Figure 1).

Figure 1. Increase in the number of clients seen each month by an AICCHS and the QAIHC average, July 2010 - March 2011



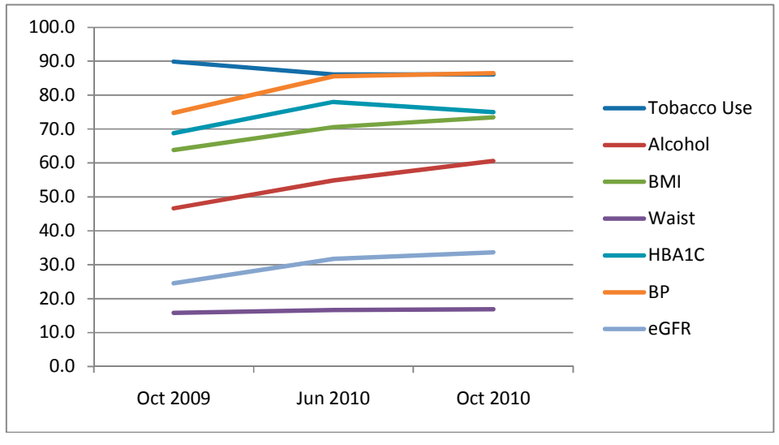
Client registrations in participating general practices have also increased.

"We are now a [general] practice where Aboriginal and Torres Strait Islander patients are comfortable to visit. We now have just under 400 Aboriginal and Torres Strait Islander patients registered. This was [partly] due to extensive community engagement with local Indigenous groups and local elders."

More complete recording of clinical information

Figure 2 shows the trends in completeness of recording of risk factors and clinical status following the start of the Collaborative in June 2010. The lines show improvement for most of the measures, but also the long way still to go for some of them (e.g. alcohol consumption).

Figure 2. Trends in the recording of risk factors and clinical status following the start of the Collaborative in June 2010

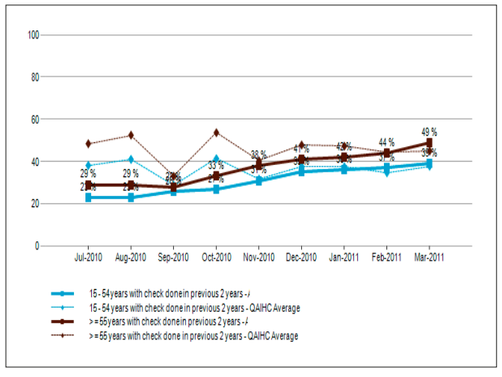


More health assessments done

Significantly more Aboriginal and Torres Strait Islander adult and child health assessments (MBS Item 715) have been done by participating AICCHSs (Figure 3). This has likely contributed to Queensland's record of health assessments compared to other states and territories (Figure 4). The trend in the last two quarters in Queensland will be partly attributable to the natural disasters which had significant impacts on some services and practices.

Figure 3. Increases in the numbers of Aboriginal and Torres Strait Islander adult (3a) and child (3b) health assessments (MBS 715) by individual AICCHSs and the QAIHC services averages, July 2010 - March 2011

3a.



3b.

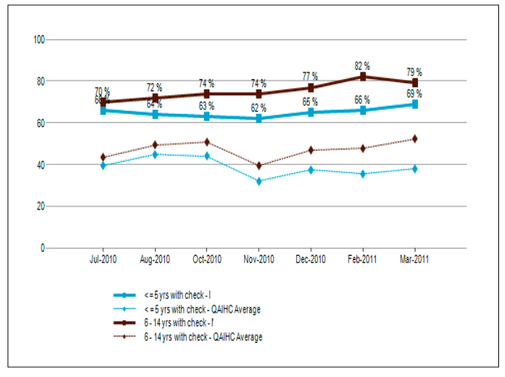
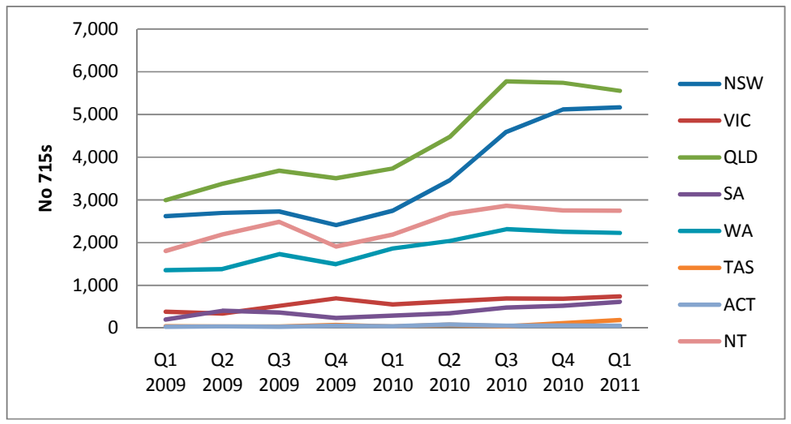


Figure 4. Numbers of Aboriginal health assessments (MBS Item 715) by states and territories each quarter in participating AICCHSs, 2009-2011



"The clinical team is much more focused on providing comprehensive primary health care, and offering and/or conducting Adult Health [Assessments]. They are also focused on reading patient history when screening to ensure that if the patient has a chronic disease, all checks are up to date - no excuses anymore."

"By increasing the number of Health [Assessments] conducted, we have and continue to build a clearer picture of patient needs. As a result our care is much more patient focused. Our systems for chronic disease patient care have also been improved and as a result, quality of care has improved."

How has the first year of the Closing the Gap Collaborative been funded?

The financial costs of the first year have been covered by combining funds from the three partners from a number of different program sources. These include particularly Australian Government Close the Gap funding to Divisions for Indigenous Health Program Officers and Indigenous Outreach Workers, and support officers funded by the IF using APCC funds. The learning workshops have been supported using Department of Health and Ageing funds QAIHC and GPQ received to improve the uptake of health assessments. QAIHC and GPQ have also made substantial in-kind contributions particularly for leadership and administration.

What are the challenges?

The health challenges to Close the Gap are immense. Improving access, knowing who your regular clients are, reaching out to regular clients you have not seen for some time, recording risk behaviours such as tobacco use and risky alcohol consumption, promoting behaviours and linking clients to services that can reduce risk behaviours, ensuring early access to ante-natal care for mothers, conducting health assessments, making care plans and team care arrangements, following up abnormal test results, properly monitoring child growth and development and adult health outcomes such as blood sugar, blood pressure and renal function …. these are just some of the small but significant changes services and practices can make to improve health outcomes for Aboriginal and Torres Strait Islander peoples and Close the Gap. They all lend themselves to short, focused PDSA cycles that can be tailored to meet the evolving needs and priorities of the organisation over time.

Nevertheless, services and practices often struggle to find the time to participate in the PDSA cycles not least because of understaffing and the pressures of dealing with acute care needs. Managerial and clinical leadership of the quality improvement agenda and team commitment and engagement remain uneven across both sectors. Both are critical to its success.

"We held brainstorming meetings that resulted in everyone sitting around saying "I don't know" when trying to come up with ideas. We walked away without being able to come up with any solid or creative ideas."

"I did struggle initially to get the whole practice involved. But once the importance of the collaborative was explained everyone was happy to come on board and support it."

There is high turnover of staff which underlines the need for enduring *organisational systems* to address quality. IT hardware is good in some settings and limited in others, which creates problems for data upload and accessing reports – this is important because frustration with these processes can put busy staff off participating.

At the same time the expectations of improved quality – from communities, clients, governments and the services and practices themselves – increase year on year, and become much more specific and visible with the introduction of clinical and other measures that help monitor performance, increasingly accompanied by targets. Just to meet the targets for health assessments alone (currently at about 30% of eligible clients within the QAIHC sector and expected by the Australian Government to reach 80%) services will have to conduct thousands more assessments and put in place systems to maintain this effort for the long haul (health assessments should be completed every two years). These kinds of changes can only be achieved through ongoing support for quality improvement structures and processes.

What could the future hold for the Closing the Gap Collaborative and what would it cost?

QAIHC and GPQ are seeking government funding to support consolidation and extension of this important initiative from July 1, 2011.

We are planning an expansion (outlined above) to include a total of 21 AICCHSs and 33 general practices in Queensland. Recruitment of general practices will target locations with large numbers of Aboriginal and Torres Strait Islander people or where there are few primary health care providers e.g. the North and West areas of Queensland, Wide Bay and additional areas in Brisbane. We anticipate coverage of around 50% of the Indigenous population of Queensland.

Extension of the initiative to other states will be explored for both the AICCHS and mainstream sectors. There are early indications of interest in joining from community controlled services and general practices in Victoria and New South Wales and community controlled services in South Australia.

Orientation and training will continue to be delivered face-to-face or by web based seminar. Additional best practice tools will be 'clipped on' to the service/practice clinical information systems. IF will continue to manage the information communication technology and improve the reports to services and practices. The quality improvement management team and network of support officers will continue as a joint effort working across community controlled services and general practices, led by QAIHC. A minimum of 2 clinical theme based workshops focused on health priorities will be held each year.

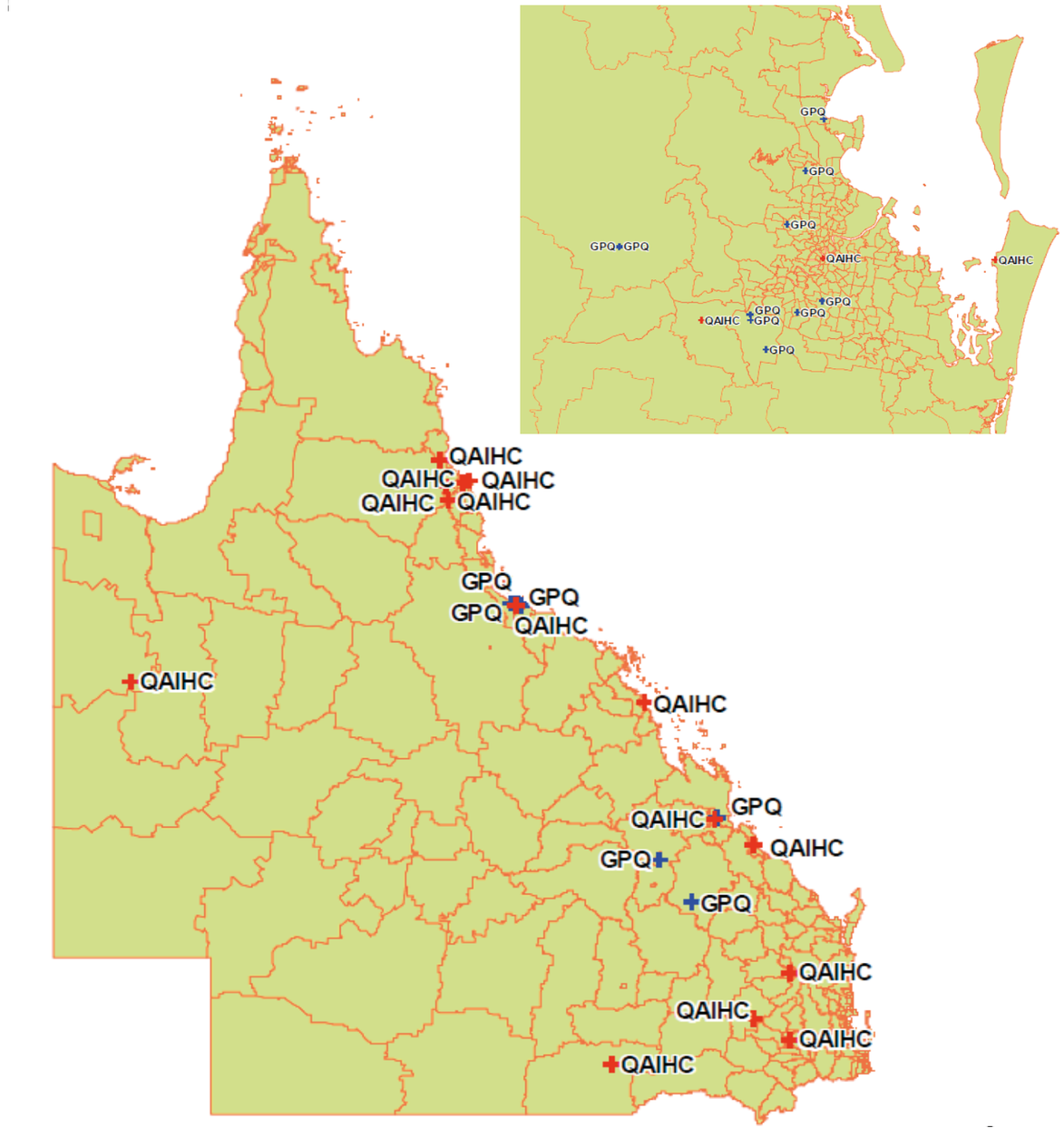
Consolidation, expansion and extension of the Close the Gap Collaborative will:

- Build on a successful partnership and effective program;
- Increase the reach of services and practices in Queensland and potentially spread to other states/territories;
- Measure improvements in care and health outcomes for approximately 70,000 Aboriginal and Torres Strait Islander clients using these services;
- Identify and support local 'champions' to enhance uptake;
- Continue to embed quality improvement in every day practice;
- Further enhance cooperation between community controlled health services and general practices to address the particular health needs of all Aboriginal and Torres Strait Islander people; and
- Continue to address national and state policy objectives and targets to close the health gap by improving access, care and outcomes for Aboriginal and Torres Strait Islander peoples.

For the **expanded Queensland initiative**, we estimate the costs needing direct funding to be approximately **$27,805 per service per annum,** or **$21 per client.** This would cover the costs of the learning workshops, quality improvement coordination, quality improvement field support (1 officer to every 5 services/practices), staff training, staff travel, a data manager, ongoing IT infrastructure development in services and practices to ensure they have ongoing capacity to participate (direct payment to services/practices, based on size and averaging $7,500 per service per annum) and communications technologies (web-based seminars and podcasts). Leadership would continue to be an in-kind contribution from the lead organisations. No direct payments would be made to services and practices to implement PDSAs. There are IF costs currently covered by its funding arrangements – including maintenance and development of the information platform and development of service reports - that are not included in these figures.

Appendix 1

Queensland Close the Gap Participating services and practices, May 2011



Appendix 2

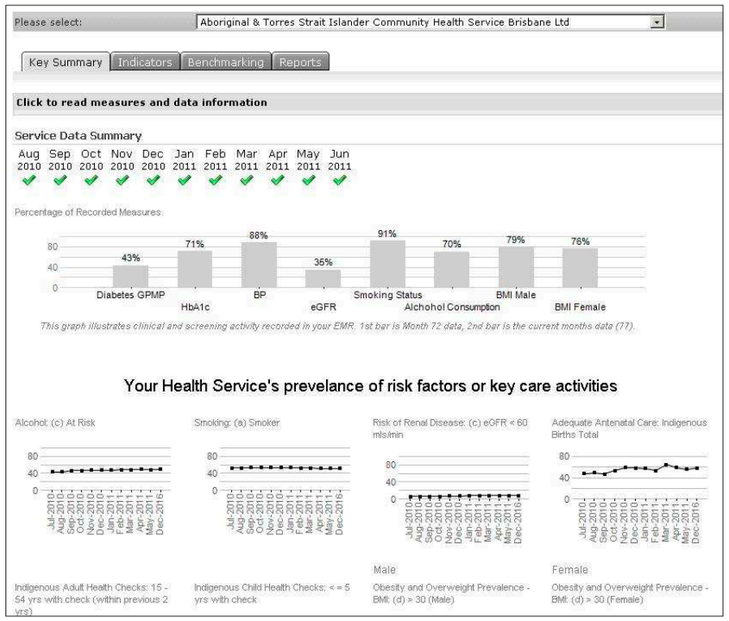
QAIHC Core Indicators - 2011

Domain	Why	What – The Indicators	Evidence
Workload and access	Planning and monitoring service capacity (overall)	Numbers of clients seen in clinic: adults & children Proportion Indigenous clients Episodes of care by staff categories	OATSIH Service Report Common sense/consensus
Health determinants, risk loads/ prevention	Planning and monitoring service capacity (health promotion/allied health/BI capacity) Monitor progress in risk load reduction	Smoking prevalence Prevalence of 'at risk' alcohol consumption Prevalence of overweight/obesity Level of physical activity Health assessments: adults and children – 4 age categories	Burden of Disease - Vos Accessing cost effectiveness in prevention – Vos & Carter Screening gaps – George Institute
Chronic disease care	Monitor workloads Monitor quality of care delivered and health outcomes	Number of diabetic clients and prevalence in service population Diabetic clients on GP Management Plan Glycaemic control: HbA1c completion and values Coronary Heart Disease clients on GP Management Plan BP: Checking BP for all adults, prevalence of hypertension BP: Management of hypertension – checking BP and medication use Risk of renal disease: eGFR, ACR – completion and renal function status	Best Practice – Royal Australian College of General Practice, Diabetes Australia, National Heart Foundation; Kidney Australia Screening gap - George Institute Prescribing gap - George Institute
Maternal and Child Health	Monitor workloads Monitor quality of care delivered and health outcomes Monitor progress in risk load reduction	Antenatal care access: number pregnant women seen/ gave birth Timing of antenatal care Adequate antenatal care Proportion of low and high birth weight babies Proportion of preterm/term births Under and overweight children	Best practice – World Health Organisation; Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Workforce	Planning and monitoring service capacity (overall)	Accreditation % Aboriginal and Islander staff Student placements FTE Vacant Positions	Beyond the Blame Game, consensus

Appendix 3

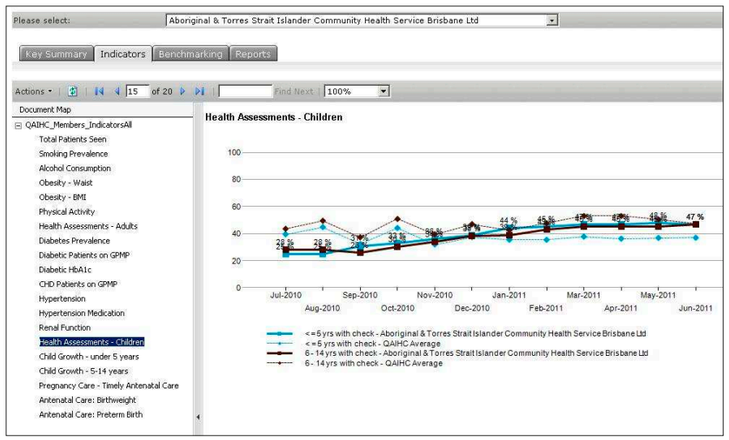
Screen Shots from the Close the Gap Collaborative Web Based Information System

Screen Shot 1 - QAIHC Core Indicators key summary information



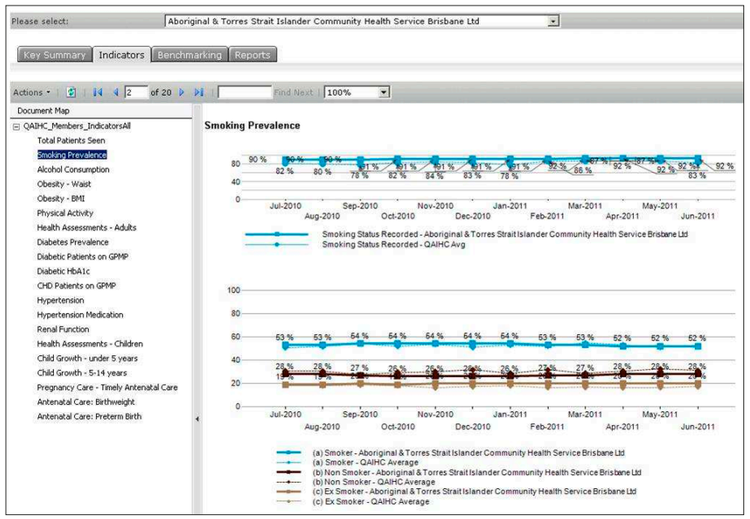
Screen Shot 1 shows a 'key summary' view displaying the months the service has submitted data and key summary information for the last month and all months for which data have been submitted.

Screen Shot 2 –QAIHC Core Indicators service performance and QAIHC average - child health assessments

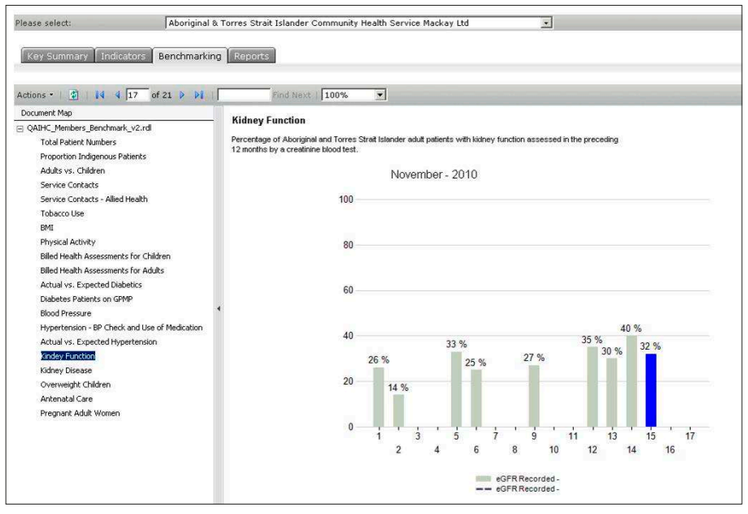


Screen Shots 2 and 3 show 'indicators' views displaying the service's performance (solid lines) compared to the QAIHC average (dotted lines) for two of the indicators - child health assessments and smoking prevalence.

Screen Shot 3 –QAIHC Core Indicators service performance and QAIHC average – smoking prevalence



Screen Shot 4 –QAIHC Core Indicators service benchmarking view – kidney function



Screen Shot 4 shows a 'benchmarking' view which allows the service to compare its performance to other de-identified QAIHC services.

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