National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023

NACCHO

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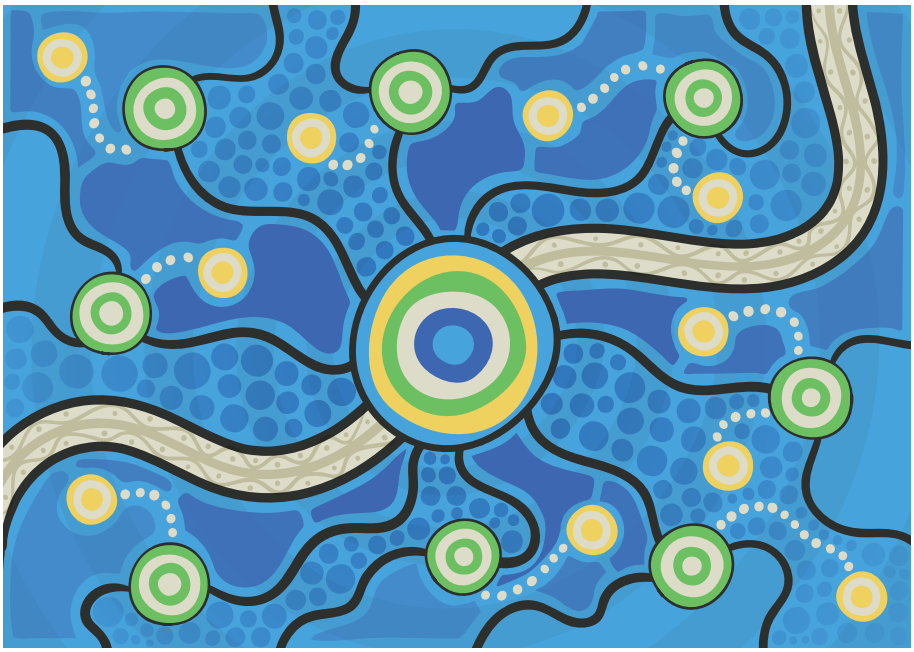
Many individuals and organisations have contributed their expertise to the Framework's co-design, including the foundation work of the Lowitja Institute in 2014 and 2015.

Cover Artwork:

The artwork by Jordan Lovegrove, Ngarrindjeri, of Dreamtime Creative, depicts NACCHO's involvement in Continuous Quality Improvement for Aboriginal health. NACCHO, represented by the large central meeting place, is working with the states and territories of Australia, represented by the pathways. Together, they are building a sustainable, coordinated and responsive primary health care system to provide culturally safe, high quality, comprehensive primary health care services.



FOREWORDS

Aboriginal and Torres Strait Islander people have the right to high quality and comprehensive primary health care that meets their personal, community and cultural needs.

The new National Framework for Continuous Quality Improvement (CQI) in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023. is an enormous step forward to help address the significant, but not intractable, health care issues facing First Australians.

The CQI framework will help build the capability of primary health care organisations so they can better deliver high quality, responsive and culturally appropriate health services to meet the specific needs of Aboriginal and Torres Strait Islander people.

This framework is the result of a lot of hard work by Aboriginal and Torres Strait Islander people and communities, governments, health services and organisations working together and learning from each other. Finalisation of the framework meets a deliverable under the Implementation Plan to the National Aboriginal and Torres Strait Islander Health Plan (2013-2023).

Through sharing knowledge and experiences, continuously examining local needs and data, and adapting services and programs to suit individual community expectations, this framework is a substantial body of work. It will help close the gap in health outcomes as we deliver a better, more strategic model of primary health care for Aboriginal and Torres Strait Islander people across the country.

The Government's commitment to improving health outcomes for First Australians can be seen in the 2018-19 Budget, which better targets investment in Indigenous health programs —with funding of $3.9 billion over the four years to 2021-22 — an ongoing increase of around four per cent per year.

I thank NACCHO, the Aboriginal Community Controlled Health Organisation Sector Support Organisations, the Lowitja Institute and all stakeholders that contributed towards the development of the CQI Framework.

The health of First Australians is everyone's business and this new framework will support better health outcomes for Aboriginal and Torres Strait Islander people, wherever and whenever they seek care.

Ken Wyatt AM
Minister for Indigenous Health

The National Framework for Continuous Quality Improvement (CQI) in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023 recognises the importance of best practice in primary health care for Aboriginal and Torres Strait Islander people, provides a basis to plan and prioritise improvements in comprehensive care, and reflects the experience of the Aboriginal Community Controlled Health Organisations.

Improvements in Aboriginal and Torres Strait Islander people's health have been made in recent years, however significant challenges remain. Aboriginal and Torres Strait Islander people have three-fold higher levels of preventable hospital admissions and deaths than other Australians and the burden of disease for the Aboriginal and Torres Strait Islander population is 2.3 times higher. A significant driver behind these numbers is that Aboriginal and Torres Strait Islander peoples can often feel unsafe in accessing the health care they need. The Aboriginal Community Controlled Health Sector emerged to address this unmet need in the early 1970s with the establishment of the first Aboriginal Health Services delivering accessible and culturally sensitive health services to Aboriginal and Torres Strait Islander people. Nearly 50 years later, ACCHOs have become the model of best practice in Aboriginal and Torres Strait Islander healthcare. Mainstream health care settings and training institutions are also lifting their game and continually working out ways to better support Aboriginal and Torres Strait Islander peoples.

The development of this CQI Framework provides an excellent vehicle to continue to work in primary health care settings – both Aboriginal community controlled and mainstream settings – to support comprehensive and culturally safe primary health care for Aboriginal and Torres Strait Islander patients.

NACHHO is proud to have worked with Aboriginal peak organisations and Government to produce the Framework.

Pat Turner
Chief Executive Officer

National Aboriginal Community Controlled Health Organisation
November 2018

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INTRODUCTION

The National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023(the Framework) provides practical support for health care providers and policy makers to embed Continuous Quality Improvement (CQI) into primary health care for Aboriginal and Torres Strait Islander people.

Improvements in Aboriginal and Torres Strait Islander people's health have been made in recent years, however significant challenges remain. Aboriginal and Torres Strait Islander people have three-fold higher levels of preventable hospital admissions and deaths than other Australians and the burden of disease for the Aboriginal and Torres Strait Islander population is 2.3 times higher.

High-quality, culturally-responsive and safe care is vital in the primary health care setting to improve the health outcomes of Aboriginal and Torres Strait Islander people. Research demonstrates that Aboriginal and Torres Strait Islander people are more likely to access care; get the care and support they need; and return for follow treatment if the primary health care provider is culturally responsive to the needs of Aboriginal and Torres Strait Islander people.

Aboriginal Community Controlled Health Organisations (ACCHOs) arose in the early 1970s in response to the failure of mainstream health services to meet the needs of Aboriginal and Torres Strait Islander people and the aspirations of Aboriginal people for self-determination. ACCHOs were the first organisations to offer comprehensive and culturally-appropriate primary health care in Australia. They provide 2.6 million episodes of care each year for 370,000 Aboriginal and Torres Strait Islander people in areas ranging from very remote to metropolitan across Australia.

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national organisation that represents 145 member ACCHOs. There are NACCHO Affiliates (also known as Sector Support Organisations) in each state and territory that provide support for CQI, clinical, financial and operational governance of the ACCHO sector.

The other major sources of primary health care services for Aboriginal and Torres Strait Islander people are private general practices and state and territory government services.

The Framework recognises the importance of best practice in primary health care for Aboriginal and Torres Strait Islander people and provides a basis to plan and prioritise improvements in comprehensive care, which reflects ACCHO sector experience.

The Framework focuses not just on the direct delivery of clinical and other primary health care services but on what is required at the health system level to support an effective approach to CQI for Aboriginal and Torres Strait Islander people. The Framework is not intended as a one-size-fits-all guide and its implementation will need to be tailored to meet the needs of individual service providers and policy makers, including ACCHOs, private general practices, government clinics and other primary health care services to support ongoing improvements in primary health care delivery.

Further information about the history, evidence base, tools and resources for CQI in the Aboriginal and Torres Strait Islander and other primary health care contexts is readily available through primary health care support organisations and academic institutions and has not been included in the Framework.

Continuous Quality Improvement

Continuous Quality Improvement (CQI) is part of a range of activities that support and improve quality in health care. CQI drives service improvements through continuous and repeated cycles of changes that are guided by teams, using data to identify areas for action, develop and test strategies, and implement service re-design. It works alongside accreditation, governance, monitoring and evaluation to improve health care and outcomes. CQI is most effective when it is embedded as part of the core business of providing health care.

CQI is underpinned by a philosophy that emphasises the importance of organisational commitment and whole team involvement to improve service systems and processes for delivering care. It encourages team members to continuously ask: 'How are we doing?'; 'What problem are we trying to solve?'; 'Can we do it better?'; 'How will we know if it is better?'. A CQI environment is one in which data is collected and used to make positive changes – even when things are going well.

NACCHO and Affiliates, Primary Health Networks, Aboriginal Health Services, state and territory government clinics and private general practices are funded to drive service improvements and improved health outcomes for Aboriginal and Torres Strait Islander people, using a broad range of initiatives to achieve, maintain and improve the quality of health care.

To be effective CQI requires:

- sustained commitment to ongoing improvement in health care services for Aboriginal and Torres Strait Islander people by government, primary health care support organisations (e.g. NACCHO and Affiliates, Primary Health Networks) and primary health care service providers
- recognition of what is required to appropriately and effectively meet the health care needs of Aboriginal and Torres Strait Islander people
- a coordinated approach to CQI as a priority for comprehensive primary health care, including ensuring a trained and supported workforce with roles for CQI leadership and teams
- the ability to collect, analyse, share and use good quality data relevant to improving Aboriginal and Torres Strait Islander health
- access to the evidence, tools and resources that inform and support high quality improvements to health care and health outcomes.

Policy Context

The Framework is one part of a suite of policies, programs and initiatives that together aim to Close the Gap in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

Key Aboriginal and Torres Strait Islander health policies and initiatives include:

- Closing the Gap

  Under the National Indigenous Reform Agreement[1] the Council of Australian Governments is committed to achieving six targets for Closing the Gap in health, education and employment outcomes. The two health-specific targets are:

  1. to close the gap in Aboriginal and Torres Strait Islander life expectancy within a generation (by 2031)
  2. to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five years of age within a decade (2018).

- Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023[2]

  This plan outlines the actions to be taken by the Australian Government, the Aboriginal Community Controlled Health Organisation sector and other key stakeholders to give effect to the vision, principles, priorities and strategies of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

- Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health[3]

  This framework commits the Commonwealth Government and all states and territories to embed cultural respect principles into their health systems to ensure they are accessible, responsive and safe for Aboriginal and Torres Strait Islander people.

- National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care)[4]

  These standards for health care safety and quality must be met by health service organisations. The second edition of the Standards has actions that specifically address better health care for Aboriginal and Torres Strait Islander people. These actions are to set safety and quality goals, achieve cultural competence in care, create safe and welcoming environments, ensure effective communication through partnering with consumers, improve identification rates and to provide comprehensive care.

Other Standards and Frameworks relevant to the CQI in the primary health care context include:

- Indigenous Australians' Health Programme Guidelines[5] (Australian Government, 2018); includes guidance for ACCHSs and Affiliates on CQI and other activities to support quality improvement.
- Primary Health Network Performance and Quality Framework[6] (Australian Government, 2018); includes guidance and indicators for Primary Health Networks (PHNs) on health systems improvement and sector support activities.
- Standards for General Practices[7] (RACGP 5th edition, 2017); the standards and criteria used for accreditation of general practices, including in the ACCHS context. They include a specific module on quality improvement.

  Australian Health Practitioner Regulation Agency requirements for ongoing professional development and registration of the health professionals who work in primary health care, including Aboriginal and Torres Strait Islander health practitioners, medical practitioners and nurses.

  Available from https://www.ahpra.gov.au/

THE FRAMEWORK

Aim

To foster a collective commitment by all governments and organisations to build a sustainable, coordinated and responsive primary health care system that uses best practice, evidence based and CQI approaches to provide culturally-safe, high-quality, comprehensive primary health care services.

Audience

The Framework has relevance across the Australian health system for health care providers and decision makers and can provide guidance for organisations and health professionals who are committed to continual improvements of health care services for Aboriginal and Torres Strait Islander people.

The primary audience for the Framework includes:

- primary health care service providers in the ACCHO, private and government sectors
- health professional organisations
- primary health care support organisations including NACCHO and Affiliates, and PHNs
- Australian, state and territory governments.

For ACCHOs the CQI focus is on increasing their capability to continue to improve and deliver high-quality primary health care to Aboriginal and Torres Strait Islander people. For many private general practices, Aboriginal and Torres Strait Islander clients are usually a smaller proportion of the practice population. These clients will benefit from CQI being used to contribute to increased health equity, improved cultural safety and ensuring that high-quality, comprehensive primary health care services address the increased burden of disease and premature mortality.

Principles

The Framework recognises the contribution that the health care system, particularly comprehensive primary health care, makes to improving health and decreasing health inequities. It places primary emphasis on the role of culturally-safe and comprehensive primary health care in supporting improved health outcomes for Aboriginal and Torres Strait Islander people and recognises ACCHOs as best practice leaders in this regard.

The Framework is underpinned by the following principles:

- Aboriginal and Torres Strait Islander people are at the centre of care with respect for their experiences, choices, dignity and rights.
- The ACCHO sector provides expertise in CQI and its leadership and guidance in implementing the Framework is recognised.
- There is a need for flexibility in approaches and tools to meet the needs of local communities and health care services.
- There is recognition of the need for partnerships and collaboration within and between primary health care sectors.

Domains

The main focus areas of CQI to support improvements in health care and health for Aboriginal and Torres Strait Islander people are outlined in the following four domains:

1. Being culturally respectful in CQI
2. Doing CQI
3. Supporting CQI
4. Informing CQI.

The focus, actions and outcomes for each Domain are shown in the tables on pages 10–20.

Primary health care services and their sector support organisations, along with governments, have specific and sometimes overlapping roles and responsibilities for implementation of CQI. To encourage the use of the Framework as a guide, the table's shaded columns indicate the areas where different parts of the health system can support implementation of the CQI Framework.

National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023

The Framework recognises the rights of Aboriginal and Torres Strait Islander people to access health care that is high quality, safe, effective, responsive and culturally respectful.

VISION

Aboriginal and Torres Strait Islander people have access to and receive the highest attainable standard of primary health care wherever and whenever they seek care.

AIM

To foster a collective commitment by all governments and organisations to build a sustainable, coordinated and responsive primary health care system, which uses best practice, evidence-based and CQI approaches to provide culturally-safe, high-quality, comprehensive primary health care services.

PRINCIPLES

Aboriginal and Torres Strait Islander people are at the centre of care with respect for their experiences, choices, dignity and rights.

The ACCHO sector provides expertise in CQI and its leadership and guidance in implementing the Framework is recognised.

There is a need for flexibility in approaches and tools to meet the needs of local communities and health care services.

There is recognition of the need for partnerships and collaboration within and between primary health care sectors.

DOMAIN 1:

BEING CULTURALLY RESPECTFUL IN CQI

Culturally respectful CQI ensures that Aboriginal and Torres Strait Islander people, communities and health care services are actively engaged in identifying priorities and developing policies and programs that lead to improved access, high-quality care, positive experiences and better health outcomes.

DOMAIN 2:

DOING CQI

CQI to improve health care services for Aboriginal and Torres Strait Islander people is embedded as part of organisational and clinical governance, in the roles and responsibilities of staff and teams, and in the use of indicators, data and patient information management systems.

DOMAIN 3:

SUPPORTING CQI

Partnerships between government, the ACCHO sector and PHNs provide leadership, resources and a collaborative environment for CQI.

CQI capability is supported through investment in data analysis and interpretation, CQI tools and resources, and workforce.

DOMAIN 4:

INFORMING CQI

Quality indicators and benchmarks that align with evidence for good practice in primary health care are used to inform CQI planning, implementation and reporting.

CQI research and knowledge translation supports improved primary health care services and health outcomes.

Domain 1: Being culturally respectful in CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Providing culturally respectful primary health care	The Cultural Respect Framework outlines the organisational, communication, workforce, consumer, stakeholder, and evidence that underpins culturally respectful health service delivery.	Primary health care is culturally safe, and changes made to health centre systems and processes work well for Aboriginal and Torres Strait Islander communities.			
Cultural respect in the design and implementation of CQI	Aboriginal and Torres Strait Islander people, communities and health services are actively engaged in identifying priorities and in developing policies and programs that lead to improved access, high-quality and culturally-safe care, positive experiences and better health outcomes. Partnerships are established and maintained with Aboriginal and Torres Strait Islander communities and organisations to ensure CQI implementation is responsive to their needs and aspirations.	Cultural respect is understood, valued and embedded by all organisations including PHNs and general practices in the planning, resourcing and implementation of CQI in Aboriginal and Torres Strait Islander primary health care.			
Cultural safety is embedded in organisational culture and supported through effective governance, policies and procedures	Governance structures within organisations are inclusive of Aboriginal and Torres Strait Islander people and their representative organisations. Organisations have identified and acted on priorities for improving the cultural safety of their services. Training and support are provided to ensure that staff members are competent in the design and delivery of culturally safe services	Aboriginal and Torres Strait Islander people receive culturally safe health care wherever and whenever they seek it.			
Client experience is used to inform CQI	Health care service providers establish formal culturally-appropriate and effective mechanisms for obtaining and using feedback from Aboriginal and Torres Strait Islander clients about quality of health care services and use the information to inform and improve service delivery as part of CQI processes.	CQI initiatives are informed by client experience and feedback.			

P = Providers of primary health care services including Aboriginal health services and general practice.

S = Support organisations including NACCHO, Affiliates, PHNs, Local Health Networks.

G = Governments including state, territory and national.

Domain 2: Doing CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Organisational governance	Primary health care providers include Aboriginal and Torres Strait Islander representatives in their governance structures or have other appropriate arrangements to promote organisational cultural safety. Organisational Boards and senior managers are equipped to play a leadership role in embedding an organisational culture of culturally-respectful CQI. CQI is embedded across all aspects of the organisation, including in organisational governance systems.	All levels of governance and management play an active role in CQI and have effective strategies to engage with Aboriginal and Torres Strait Islander people, communities and health services.			
Connecting organisational and clinical governance with CQI	Clinical governance is integrated in corporate and financial governance processes, organisational planning and decision making. Improving health care and health for Aboriginal and Torres Strait Islander people is prioritised within an accountable, systematic and integrated approach to improving safety and quality, and managing risk and performance in health care service delivery. Clinical services are continually reviewed and updated to reflect clinical best practice and meet Australian health care safety and quality standards, with regard to guidelines and standards about health care for Aboriginal and Torres Strait Islander people.	Organisational policies, systems and processes embed CQI in organisational and clinical governance and support health care delivery in accordance with relevant guidelines and standards about health care for Aboriginal and Torres Strait Islander people.			

Domain 2: Doing CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Everyone in the organisation understands their role in CQI and is supported and resourced to do it	CQI roles and responsibilities for board members, practice owners, management, health promotion, clinical and administrative staff and teams are clearly defined and supported by management and boards. All staff have access to ongoing professional training to build CQI capability across clinical, administrative, management and other teams. Resources and time are allocated to plan, do and review CQI. A culture of learning is encouraged through sharing of experiences at team meetings, networks and other forums.	Organisations champion a culture of 'CQI is everyone's business'.			
All staff involved in providing health care services are empowered to effect change through participation in CQI activities and networks that promote innovation, collaboration and shared learning	Quality improvement activities and cycles are embedded in everyday practice. CQI and Aboriginal and Torres Strait Islander health is a standing item on meeting agendas. A team-based approach with Aboriginal and Torres Strait Islander input to ensure cultural relevance is undertaken in the design, development, testing and implementation of improvement strategies.	Everyone in the organisation knows how to contribute to CQI and are empowered and resourced to do so.			
Patient information management systems are used to support CQI	Primary health care services have the necessary patient information systems and capacity to collect, analyse and report data to establish baselines and support implementation of CQI.	Health care services have the information systems, staff and support to enable data about health care provided to Aboriginal and Torres Strait Islander clients to be identified, collected and analysed for CQI planning and evaluation.			

Domain 2: Doing CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Relevant data is used to inform and evaluate CQI	Data is collected by health services that is relevant and meaningful to improving Aboriginal and Torres Strait Islander health and to local priorities and community needs. Aboriginal and Torres Strait Islander people and/or organisations are appropriately involved in decision making about indicators, data collection and analysis. With appropriate privacy protections and data governance arrangements, data is shared and discussed amongst networks and used to inform the development of CQI benchmarks. Benchmarks are used to support the ongoing design, implementation and monitoring of CQI. Although benchmarks are context specific, they are often based on recognised indicator sets such as national or regional key performance indicators.	Clinical and population health data ensure CQI activities are strategically directed at areas where health services can improve health outcomes for Aboriginal and Torres Strait Islander clients and the local community.			
Organisational commitment to CQI is sustained over time	Ongoing systems improvement at all levels will increase health care access and quality for Aboriginal and Torres Strait Islander people for the longer term.	CQI is embedded as a core feature of PHC planning and service delivery.			

Domain 3: Supporting CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Organisational partnerships	NACCHO, Affiliates and PHNs provide leadership, commitment and support to ensure their organisations support and advocate for CQI in primary health care and better health outcomes for Aboriginal and Torres Strait Islander people. Local or regional health networks provide this support for state and territory health services. Agreements such as Memorandums of Understanding can be used by ACCHOs, Affiliates and PHNs to underpin collaborative work to ensure that CQI work is done in a culturally respectful way. National, state/territory and regional health care policy and delivery is informed by the evidence about what works in CQI in Aboriginal and Torres Strait Islander primary health care.	CQI is delivered through a collaborative approach involving governments and primary health care support organisations recognising the experience and expertise of the ACCHO sector.			
Government support	Governments recognise the value of good organisational CQI practices in achieving significant improvements in Aboriginal and Torres Strait Islander health outcomes and consider how CQI can be incorporated in program guidelines and delivery. Governments encourage primary health care service providers to embed CQI practices across all levels of their business operations and management (e.g. clinical and governance). Governments support primary health care services to provide high-quality, comprehensive and accountable services that are responsive to local Aboriginal and Torres Strait Islander health needs.	Governments work together to deliver a health system that provides primary health care, which is evidence based, culturally safe, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander people.			

Domain 3: Supporting CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Affiliate and PHN support	Aboriginal and Torres Strait Islander leadership in CQI is supported through involvement of Aboriginal and Torres Strait Islander consumers, workforce and organisations. Affiliates and PHNs are able to provide support for analysis, interpretation and benchmarking of health service and population health data for their constituent ACCHSs, general practices and other primary health care providers. Affiliates and PHNs are able to provide population health advice and support for decision making about priorities for CQI in ways that support health services to ensure that CQI efforts are relevant to their context and directed at improving Aboriginal and Torres Strait Islander health. NACCHO, Affiliates and PHNs are able to provide access to training, advice, tools and other resources for CQI activities. Effective networks are in place to support CQI in Aboriginal and Torres Strait Islander primary health care at local, regional, state/territory and national levels. These networks promote innovation, collaboration and shared learning. CQI collaboratives within and between sectors are used to scale up local CQI activities and successes to a national, regional and state-wide level.	PHNs and Affiliates have the population health expertise required to: support health services with CQI; ensure CQI is well informed by data and ACCHO expertise; lead to improvements in Aboriginal and Torres Strait Islander health care and health outcomes.			
Organisations build a strong and supported Aboriginal and Torres Strait Islander health workforce	The essential role of Aboriginal and Torres Strait Islander health practitioners and workers is recognised and supported by primary health care providers and support organisations. Health care organisations develop specific Aboriginal and Torres Strait Islander workforce strategies including recruitment, training and mentoring for all health disciplines and support roles.	Aboriginal and Torres Strait Islander staff are prominent in CQI leadership and implementation to support a culturally respectful and responsive approach to service improvement.			

Domain 3: Supporting CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Organisations build the cultural competence of the primary health care workforce	Primary health care organisations are accountable for ensuring cultural competency of their workforce and provide the underpinning leadership, training and support.	Primary health care organisations can demonstrate the cultural competency of their workforce and the use of ACCHOs or other culturally appropriate sources of workforce training.			

Domain 4: Informing CQI					
Focus Area	**What does it look like?**	**Quality Outcome**	**P**	**S**	**G**
Reviewing and using the evidence	Meaningful quality indicators that align with the evidence for good clinical practice are used to inform CQI planning, implementation and reporting. When reviewing existing indicators or developing new ones, consultation with the ACCHO sector will help ensure the relevance and appropriateness of indicators to improving Aboriginal and Torres Strait Islander health care. Service providers use data and evidence to inform best practice comprehensive primary health care for Aboriginal and Torres Strait Islander clients and populations.	Quality indicators that align with the evidence for good clinical practice and comprehensive models of care are used to inform CQI planning, implementation and reporting.			
Informing priorities for CQI in practice using population and service level data	NACCHO, Affiliates, PHNs, ACCHSs and general practices use Aboriginal and Torres Strait Islander expertise, research, evidence and data to promote positive health gains for Aboriginal and Torres Strait Islander communities. Sharing of data must be underpinned by a data governance framework that is agreed between parties.	CQI priorities are informed by research, evidence and data to promote positive health gains in their communities and services.			
Building and using the evidence base	Knowledge gained through implementation of CQI is used to build the CQI evidence base and is used to guide and inform Aboriginal health policy, investment, support and innovation at the local, regional, jurisdictional and national levels.	The learning outcomes from CQI are shared amongst networks and used to inform change in policy and practice in health services and the wider health system.			

CASE STUDIES

The following case studies demonstrate CQI in action to directly improve health and health care for Aboriginal and Torres Strait Islander peoples.

1. VACCHO supporting CQI in Victorian Aboriginal Community Controlled Organisations

Note on terminology: The acronym ACCO is used in Victoria for Aboriginal organisations delivering health care. In other sections of the CQI Framework similar organisations are referred to as ACCHSs.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Health Evidence Team seeks to embed CQI in all ACCO activities with a statewide, collaborative and data-driven approach, to assist staff in all Victorian ACCOs improve patient health outcomes and the sector's sustainability.

Three-month VACCHO Improvement Cycles

One of the key engagement and improvement methods is a regular three-month series of webinar-based content delivery and discussion, called VACCHO Improvement Cycles (VICs). These are open to all ACCOs and their staff, including AHWs and AHPs, nurses, GPs, medical reception and administrative staff, allied health providers and management.

How are VICs developed?

The VICs maintain Aboriginal cultural relevance and community control through sector engagement in design and delivery of each series. Each VIC topic is chosen by the statewide Data Advisory Group (DAG), which includes representation from a majority of VACCHO members. The DAG meets by webinar every six weeks to keep up to date with sector news, share ideas and models as well as support and advise VACCHO and each other. Each topic is supported by a suite of engagement and improvement strategies across the calendar year, including extensive training and support, audits, resources and communities of practice, as well as the annual statewide Movement by Improvement Forum.

To date the VICs have focused on alcohol (VIC 1), diabetes (VIC 2), asthma (VIC 3) and chronic disease management (VIC 4), examining what has worked and what has not.

Once a VIC topic is confirmed, baseline 'dashboards' are developed and sent to each ACCO, which compares their performance with other ACCOs and with guidelines and/or targets. Each dashboard is a one-page infographic or visual representation of meaningful and relevant data synthesised from PAT CAT – VACCHO's data repository, which receives primary health care data monthly from every Victorian ACCO with a medical service. PAT CAT is a comprehensive data source that allows a wide range of indicators to be selected to monitor performance and integrates directly with clinical CQI tools CAT4 and Topbar, widely used by Victorian ACCOs.

VACCHO develops three-month programs for each VIC and seeks feedback from the DAG prior to commencement. High performing ACCOs are identified and interviewed and often guests present their model and experiences in the webinar series. VICs support improved processes and patient care through relevant assistance in:

- effective models of primary health care service delivery
- PIRS (Communicare/Medical Director/Best Practice) guides, training and support
- Pen CAT4 and Topbar guides, training and support
- Plan–Do–Study–Act (PDSA) cycles and engaging and leading organisational change
- data analysis, interpretation and planning
- understanding and effectively using relevant Medicare Benefits Schedule (MBS) items
- accreditation, clinical guidelines and best practice
- other relevant topics raised by ACCOs and DAG.

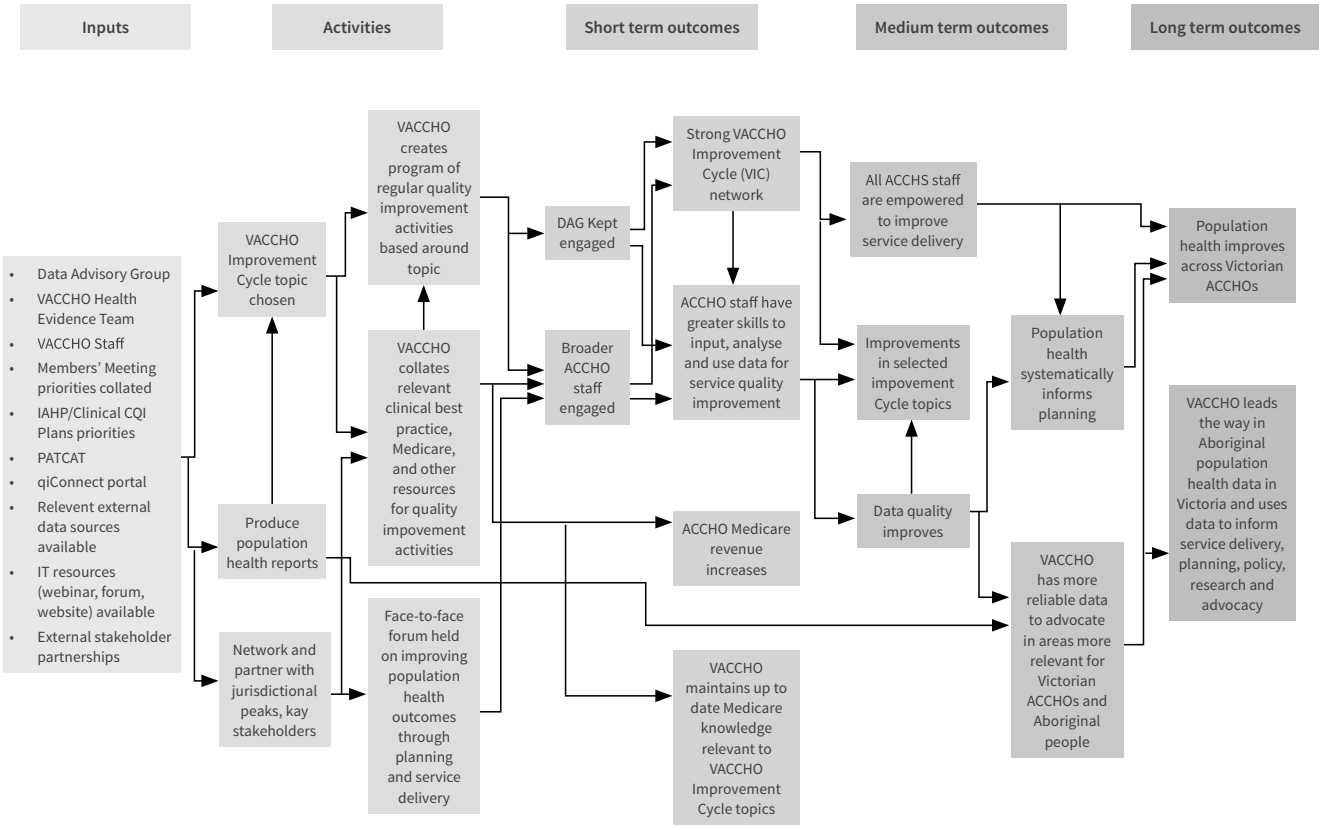
What happens following VIC implementation?

At the end of a VIC, follow-up dashboards are developed and sent to every ACCO to identify and measure change since the VIC's start, and how that compares to other ACCOs. The VICs encourage friendly competition, with awards presented for most improved. Dashboards are sent every six months to continue to monitor each topic and encourage long-term change. Many ACCOs present the CQI activities they have developed during each VIC at the annual Movement by Improvement Forum.

All webinars are recorded and, along with all presentation slides, uploaded to VACCHO's online resource library. An extensive range of supporting templates, policies, resources, practical how-to guides, fact sheets and more are accessible to all Victorian ACCO staff on demand.

Every VIC has been associated with statewide improvements, with measures such as alcohol status records, diabetes cycle of care indicators, asthma cycle of care indicators, GP Management Plans and Team Care arrangements all increasing – some significantly – over the three-month series.

VICs are integrated with other clinical CQI activities and reporting; the reports are used to advocate for better policy and funding.



2. A CQI Collaborative hosted by Aboriginal Health and Medical Research Council (AHMRC) of NSW to support increased use of brief interventions for smoking in member ACCHSs

What's the problem to be solved?

Several ACCHSs in NSW identified their need to build greater capacity in delivering brief interventions for tobacco cessation.

Who was involved?

AHMRC and eight ACCHSs in NSW, and external agencies involved in tobacco control and Aboriginal health.

How was the situation better understood?

AHMRC established a coordinator (a public health medicine trainee) and project support group to:

- review the evidence around what works in tobacco resistance and control, particularly for Aboriginal people and communities
- gather relevant evidence, tools, resources and training opportunities
- support member ACCHSs with CQI efforts to strengthen delivery of brief interventions
- facilitate collaborative CQI efforts and sharing of successes
- gain approval from AHMRC Ethics Committee as part of ensuring cultural appropriateness.

What indicators measured success of the CQI Collaborative projects?

CEOs and staff of participating ACCHSs were asked about their satisfaction with tools and resources, support from AHMRC, workshops and other networking opportunities. Process indicators were:

- completion of Plan Do Study Act (PDSA) cycles by participating ACCHSs
- number of staff trained in delivery of brief interventions
- capacity of ACCHSs to use their Patient Information Management Systems to record delivery of brief interventions.

How did the Collaborative enable the CQI projects?

To enable the Brief Intervention CQI projects, the Collaborative:

- recruited ACCHSs by contacting CEOs and promoting the project through newsletters
- asked CEOs to nominate a CQI lead and gather a multidisciplinary team to plan and implement
- supported the design, implementation and reporting of PDSA cycles by each participating ACCHS
- promoted engagement and sharing through teleconferences, email, site visits and workshops
- supported tracking of brief interventions by working with ACCHSs and vendors to standardise Communicare and Medical Director 'patches' and providing training in their use at each ACCHS
- alleviated concerns about data privacy and control by supporting each ACCHS to collect, analyse and hold their own data about brief interventions with no need to report to external agencies
- collated, updated and provided resources that support culturally-appropriate and evidence-based approaches to tobacco control in Aboriginal communities (e.g. A-TRAC Framework and Yarning tool)
- arranged training in CQI and Quit skills provided by culturally-competent providers from AHMRC, Aboriginal Quitline and Aboriginal Health College
- organised workshops to enable presentations and sharing about the projects
- involved external agencies to provide support, including Cancer Council, Heart Foundation, Aboriginal Quitline, Ninty One, Agency for Clinical Innovation
- coordinated evaluation to understand what worked well and why and what could have been better
- supported the writing of newsletter articles, reports, case studies, conference presentations
- supported ACCHSs to obtain funding from Cancer Council NSW to continue tobacco control CQI
- developed an AHMRC Collaborative Toolkit with program logic, templates, documents, resources and reports from the brief intervention CQI project, to enable future collaboratives to run more effectively.

3. Increasing immunisation rates in a remote NT Primary Health Care Service

What's the problem to be addressed?

Drop-in immunisation rates for children over 4 years old were identified at a clinic meeting that was reviewing data from the clinical information system.

What did they want to accomplish?

To improve timeliness of immunisation for children over 4 years old.

Who was involved?

- Clinical team at the ACCHS
- The Board – reported data highlighted an area that needed to be explored and improved.

What changes can they make for improvement?

The clinic team met to discuss changes that could lead to improved immunisation rates and came up with lots of ideas:

1. carry out data cleaning to ensure the database/ population list is accurate and staff know which children they are responsible for
2. compare the clinic data with the national immunisation register for accuracy
3. run an audit of 4-year + old kids

   - run reports from the clinical information system or medical record to see who is due or overdue for immunisations and target those children to help bring them up-to-date

   - audit data is cross-checked with national immunisation data to ensure the medical record is correct

4. an immunisation 'blitz' in the community and at schools

   - the aim of a blitz is to provide immunisations or health checks to as many people as possible

   - it could include setting up an immunisation clinic every day for a week at the school, the local shop or somewhere else people tend to congregate; it can also be done in the health centre with every staff member doing their best to offer and provide the required immunisations to every person who attends for any reason (where appropriate, of course)

5. put recalls on the records of all their children 4 years and over
6. ensure all staff are trained and up-to-date with their About Giving Vaccines (AGV) certification
7. set weekly targets to encourage staff to do more immunisations.

After doing the data cleaning, the team chose option 6 as their first choice for action – ensuring all staff are up-to-date with their AGV certification. This includes Aboriginal Health Practitioners (AHP), Remote Area Nurses (RANS) and clinical program leads for child health and chronic conditions.

They decided to use a PDSA (Plan–Do–Study–Act) approach.

How will they know if the changes have led to improvements?

Baseline data from their clinical information system can show improvement or decline in their next reporting cycle.

What is the plan?

Plan:

At the next clinical meeting the Health Centre Manager requested that all clinical staff provide a copy of their AGV certification, by the following staff meeting, to be kept on file. This would show how many are certified and how many need to update their certification.

Do:

All staff complied within the week.

Study:

Of the seven clinical staff members, five were currently certified to provide immunisations.

Act:

The two staff members who are not up-to-date must complete the course online within the next month and provide their certification to the health service manager. This will be a new PDSA in the cycle.

The five who are certified will participate in another PDSA for idea no. 7 – set weekly targets to encourage staff to do more immunisations.

In this remote primary health care service, a CQI cycle or PDSA might result from: analysis of data; patient or staff feedback; direction or feedback from the board, CEO or community, or because management has identified an issue or opportunity to makes some changes. Data can come from outreach staff, from KPIs at Northern Territory and national levels or from the clinical information system.

4. Aboriginal Medical Services in the Northern Territory – supporting CQI for their members

This case study reflects the Northern Territory (NT) perspective and we acknowledge that CQI support can look different in other states and territories. In the NT we have developed an agreed-upon CQI strategy or model to implement and embed CQI across all Aboriginal Primary Health Care Services; both Aboriginal Community Controlled and those delivered by the NT Government. The NT CQI Strategy includes key components that all PHC services are encouraged and supported to consider when implementing CQI. An example of how this might work is around systematic use of data to inform and drive CQI activities at the Primary Health Care level.

How is CQI support provided?

We frequently assist services to interpret and analyse their clinical data. This might be the nKPIs, the NT Aboriginal Health KPIs or other data that the service is interested in using to inform and evaluate their progress. In practice this could be facilitating a meeting with the Health Centre Manager, CQI Facilitator and team to review their data to identify areas of strength and gaps or 'opportunities for improvement'. Sometimes further data will need collecting from the clinical information system or elsewhere (national data sets, systems assessment tool, patient or community feedback etc.).

Often this process reveals significant learnings for the health centre. Areas of strength will clearly show what is working well and this knowledge can be transferable to other areas. When gaps or weaknesses are identified a CQI tool can break down the problem and clarify the cause; the next step being to consider how to bring about an improvement. This is where the Plan–Do–Study–Act (PDSA) may come into play.

This is a team activity. If the team becomes involved in a reflective practice with its data, often it can clearly identify what the priorities for improvement should be and will have greater input and ownership of the CQI process and PDSAs.

What is the role of Affiliates?

As Affiliates working with services and their data, we often become aware of concerns or issues that are broader than for a single PHC service. These can be included as themes or topic areas for the NT CQI Collaborative – a once-a-year, 2-day workshop where members from each service are invited to come and present their CQI work and participate in workshops. The purpose is to ensure learnings from across the Territory are disseminated broadly for all to benefit, and to provide a forum to consider specific issues through a CQI lens. An aim is to identify strategies for improvement that can be adopted system-wide.

Part of our role as Affiliates is to deliver training in CQI principles and tools and to provide support and mentoring to PHC services and their staff. This may be through face-to-face workshops in regions or as in-service sessions with individual services. Our role is to be responsive to their needs and priorities.

An example of CQI facilitation

Jim, a health centre manager, was encouraged to have as many staff as possible participate in reviewing the local NT AHKPI report. Led by CQI facilitator and supported by the Affiliate CQI coordinator, participants were the Aboriginal Health Practitioners and Community Based Workers, Remote Area Nurses, the GP and program leaders. Jim agreed it was essential to have input from all the team to enable interpretation and analysis of their KPI data. The staff were all aware of the NT AHKPI report as it was pinned up on the staff noticeboard after its release and they had talked about it at meetings.

The CQI facilitator enabled them to identify KPIs where they were doing well and those where results were not as strong. They looked at trends over time, benchmarking themselves against the NT average and the health service delivery areas. The staff were able to 'tell the story' behind each KPI – what was happening in the community, what staffing levels were like, whether it was wet season or roads had been closed, whether Sorry Business or other cultural business had kept people away from the health centre.

The NT AHKPIs:

- where they were doing well included:
  - AHKPI 1.8.1 HbA1c Tests
  - AHKPI 1.10 Adult aged 15–54 Health Check
  - AHKPI 1.11 Adult aged 55 and over Health Check
  - AHKPI 1.15 Rheumatic Heart Disease
- showing gaps or need for improvement included:
  - AHKPI 1.19 Retinal Screening
  - AHKPI 1.5 Underweight Children
  - AHKPI 1.12 Pap Smear
  - AHKPI 1.18 Cardiovascular Risk Assessment
- seen as higher priority to the community and the health centre were:
  - AHKPI 1.8.2 HbA1c Measurements
  - AHKPI 1.5 Underweight Children
  - AHKPI 1.6 Anaemic Children
  - AHKPI 1.4.1 Fully Immunised Children

Underweight Children KPI

After much discussion, the team decided to focus on just one KPI for their next cycle of improvement:

1.5 Underweight Children. Using the PDSA change management tool, they answered the questions:

1. **What are we trying to accomplish?** To increase the number of children's weight being measured.
2. **How will we know that a change is an improvement?** Before starting, they would print off a list of identified children who had not been weighed. After four weeks, they would run another report from their Clinical Information System of children who had not been weighed.
3. **What changes can we make that will result in an improvement?**
   i. Clean up the population list
   ii. Signs around the community that all children should be weighed, so bring them to the health centre
   iii. Set up a stall at the shop and weigh children as they come by with their parents
   iv. Work with the school and weigh children on Friday mornings for one month
   v. Review the importance of following CARPA protocols for underweight children.

They agreed to focus on the fourth option: **Work with the school and weigh children on Friday mornings for one month.**

- After a meeting with the school principal, staff participating in this activity were identified; one Aboriginal Health Practitioner, one Community Based Worker and one RAN. All parents to be informed that this is happening. Children will attend the school between the hours of 9–11 on the next four Friday mornings.
- All children whose names appear on the list and are attending school will be weighed.
- The population list will be used to identify all eligible children. This will show the current weights of all children. Those without a current weight will be transferred to an active list of those who need to be weighed. Weights of all children measured at school will be recorded on the spreadsheet and entered into the Clinical Information System at the Health Centre for further action if required.
- Follow up actions may well be the next PDSA cycle. After reviewing the findings of this PDSA cycle the team may decide to continue a series of PDSA cycles, each one building on the previous one. This enables gradual, realistic cycles of change that add up to significant improvement over time.

5. Danila Dilba Health Service – A CQI approach to improving organisational governance

Danila Dilba Health Service (DDHS), Darwin's only Aboriginal Community Controlled Health Service, was established in 1991 under the Corporations (Aboriginal & Torres Strait Islander) Act 2006 (CATSI Act).

What governance issue/s had been identified?

In 2013 Danila Dilba was faced with a number of challenges that required reforms to governance and management practices.

A risk assessment conducted by the major funder Department of Health (Office of Aboriginal and Torres Strait Islander Health (OATSIH)) deemed Danila Dilba to be 'high risk'. The Department had subsequently appointed an independent auditor to undertake a forensic audit of the organisation's financial management and accounting practices.

Operationally, services were not keeping pace with growth in demand, service quality had declined and there were significant staffing issues, including low staff morale, high levels of absenteeism and difficulties in recruiting key personnel such as GPs, AHPs and community services staff.

A new CEO and new CFO were appointed in early 2013 and shortly after this changes in Board membership were necessitated by the death of the long-term chairperson and retirement of a number of other long-term directors.

Who was involved in planning how to assess and implement improvements?

The new CEO, working closely with the newly appointed chairperson and the Board, led the response to the Department, including development of a comprehensive action plan responding to the risk assessment and forensic audit.

The CFO was closely involved in all financial matters and a consultant was engaged to develop a new strategic plan and work with the CEO and management on a range of reforms.

What measures/indicators were used to assess the problem?

The OATSIH Risk Assessment Profile Tool and the forensic audit by the independent auditor appointed by the Department provided both clear evidence on areas of concern and recommendations on minimum required improvements.

The Board completed the Indigenous Governance Analysis Tool developed by the Australian Institute of Company Directors, which provided a framework for effective corporate governance.

The McKinsey Organisation Assessment Tool was used to conduct a comprehensive audit of DDHS governance and management systems. Other sources of data used to assess the issues included internal quality audits, performance reports and client feedback and complaints.

What cycles of improvement were planned, implemented and reviewed?

Governance reforms included a review of the organisation's rules (constitution) and policies and procedures, resulting in the following changes:

- ensuring appropriate levels of accountability and due diligence, most notably through the Board Charter, which previously didn't exist, to document the responsibilities, powers and governance framework

- introducing position/ role descriptions for Board members to clearly define responsibilities, together with a comprehensive induction program for new Board members and ongoing training and development for all Board members
- adopting compulsory disclosure of interests and a register of declarations of interest for directors and staff
- ensuring Board members have no family connections or financial interests in Danila Dilba and that there are no family connections between Board members and senior staff
- introducing clear processes for strategic and operational planning, budgeting, risk management and financial and non-financial reporting
- establishing and supporting Board sub-committees, including an Audit and Risk committee, to assist the Board in fulfilling its duties and to further augment the skills of the Board
- enshrining principles of community control, clear separation of roles between Board and management, integrity and accountability, and community engagement.

Danila Dilba worked closely with the Office of the Registrar of Indigenous Corporations (ORIC) to implement the reforms and engaged governance advisory company VUCA to assist with ongoing review of Board policies and performance and to facilitate the CEO annual performance review.

Coinciding with improvements in governance the Board developed a new strategic plan that led to significant changes in management including:

- a new management structure and newly appointed team
- effective HR policies and practices, combined with a much greater focus on professional development, skills development and employment pathways
- service design principles to ensure all services are evidence based
- a quality and safety framework including whole-of-organisation accreditation with the Quality Improvement Council
- improved management of financial and corporate services including IT, facilities, fleet, etc.

What worked/ what were the outcomes?

Following the organisation's immediate response to the 2013 risk assessment and forensic audit, the Department reduced the risk level from high to moderate. This 'bought time' to implement the broader series of reforms.

The governance reforms have ensured an appropriate separation of governance and day-to-day operations, enabling management and the Board to support each other in order to effectively fulfil their roles. Board renewal has been instilled by limiting tenure of directors to 6 years.

The appointment of independent non-member directors has brought wide-ranging expertise to the Board, including community development, law and accounting. This has resulted in greater capacity to manage the increasing complexity in Aboriginal health care. The position of a Larrakia Officer was retained as acknowledgement and respect for the Larrakia as the Traditional Owners of Darwin. Training is ongoing for all Board members, and new Board members must complete the Australian Institute of Company Director's 5-day director's course.

The result of these changes has been a more effective and cohesive Board with clear strategic priorities, captured in the Strategic Plan and Annual Business Plan, which is reviewed each quarter, and aligned with the annual budget. Membership has been built from 250 members to more than 600 members. Community engagement and accountability has been greatly enhanced with quarterly newsletters and an Annual Report that provides detailed information on performance across all aspects of the organisation.

These changes have enabled Danila Dilba to grow and develop, with the establishment of 4 new clinics in the last 2 years, an increase in client numbers and episodes of care. There is now greater satisfaction among clients, and members and staff are much more engaged.

Increased Medicare income under s 19.2 of the Health Insurance Act 1973 together with more rigorous financial management has helped to ensure the long-term financial sustainability of the organisation.

6. Child ear health at Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation

What's the problem to be addressed?

Following a review of child ear health screening (otoscopy and tympanometry) data, the team identified that improvements could be made.

What did they want to accomplish?

To increase the provision of ear health services with a focus on screening (otoscopy and tympanometry) rates to enable early identification and management of middle ear disease.

Who was involved?

- Child Health Team at the ACCHS
- South Australian Department for Education
- Local childcare centres
- Local hospital

What changes were made?

To increase the provision of ear health services with a focus on increasing screening rates, the following changes amongst the Child Health Team (the Team) were undertaken:

- **Talking:** the Team discussed children's health with colleagues to identify what the issues were. Several issues were identified, which led to the development of a multi-pronged approach to improve access and screening rates for children under 5 years of age.
- **Training:** the Team was provided with additional training, which proved invaluable for each team member.
- **Partnerships:** the Team met with local childcare centres and local schools (Department for Education) and arranged regular outreach clinics at their locations. There are three schools in their catchment area, and the Team visit these schools twice a year.
- **Engagement:** to engage children during consultations, the Team used a video otoscope to show children their ears. Children found this fascinating and for many it was a first time experience. This was also used as an educational tool to assist with parent and/or guardian education, which stimulated conversations about healthy ears.
- **Follow-up:** after each school screening, the Team would send letters home to parents to advise of findings and what the next steps were for the parents (i.e. bring their child into the clinic for follow-up). If there had been no parent contact after a short period (i.e. 14 days), a member of the Team would phone or visit the parent and child to sit down and discuss the follow up care required. It is important to highlight that as part of the school screenings, numerous follow ups were identified, which meant for some children that ongoing care was required. The Team worked very closely with AHCSA RNs and the Rural Doctors Workforce Agency (RDWA).
- **Capacity building:** Following training, the Child Health Team, provided in-house workshops to other Aboriginal Health Workers/Practitioners within their Health Service.
- **Specialist services:** The Child Health Team implemented a new documented referral process for children and families to access ENT services who visit the Regional Hospital once a month.

Senior management also negotiated with RDWA to have an ENT visit the health service twice a year to improve access for Aboriginal children and families. Without these additional visits, clients would have to travel to Adelaide (800kms away) for ear health-related surgery.

Outcomes

1. Due to the training undertaken, clinical staff have the skills and confidence to assess children's ears and develop care plans to manage chronic ear disease.
2. Otoscopy screening increased by 111% and Tympanometry increased ten-fold.
3. There are now multiple pathways for families to access child ear health services, including specialists in primary health and acute health care settings.
4. Children and parents are more interested and aware of the importance of ear health and ensuring children receive follow up care. This was largely as a result of using the video otoscope as an engagement tool.
5. The Child Health Team are connecting better with families and community, both in the clinic and with home visits.

Take home notes

Quality improvement was successful in this case study due to:

- Staff who are dedicated and passionate about improving children's health.
- The team approach to care – it took many health service staff at various levels of the organisation to make these improvements; as a result, the Child Health Team became leaders in the training and education of ear health for other staff.
- Senior management of the Health Service were supportive of the changes required; this was evident through their support of staff to undertake further training, allocation of additional resources and support to implement projects.
- Key partnership development – working with other organisations/stakeholders to ensure that health services were accessible to Aboriginal families and children was imperative to the success of these improvements.
- Access to Child Health funding for the health service was critical to support this focus on addressing issues that affect child health and wellbeing.
- An integrated holistic Model of Care was designed in consultation with all operational teams responsible for business functions, cultural safety and quality assurance.

GLOSSARY OF TERMS

Aboriginal Community Controlled Health Organisations (ACCHOs): in some contexts, the terms ACCHOs and ACCHSs are interchangeable. In this CQI Framework the acronym ACCHSs is used to describe the organisations delivering health care; ACCHOs describe the regional, statewide or national Aboriginal community controlled organisations that support the efficacy of ACCHSs to achieve improved health outcomes for Aboriginal and Torres Strait Islander people.

Aboriginal Community Controlled Health Services (ACCHSs): Aboriginal organisations initiated and based in a local community, governed by an Aboriginal body, elected by the local Aboriginal community, and delivering a holistic and culturally-appropriate health service to the community that controls it.[8]

Aboriginal health: understood to include the physical, 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 wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.[8]

Accreditation: recognition that an organisation meets the requirements of a defined set of criteria or standards. Accreditation standards used in primary health care include those of the Royal Australian College of General Practitioners, Quality Improvement Council and International Organisation for Standardisation.

Affiliates, also known as NACCHO Affiliates or as Sector Support Organisations: provide support for CQI, clinical, financial and operational governance of the ACCHO sector.

Australian Commission on Safety and Quality in Health Care: a government agency that leads and coordinates national improvements in safety and quality in health care across Australia.

Clinical governance: defined by ACSQHC as 'the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services. Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.[4]

Closing the Gap: a commitment made by Australian governments in 2008 to improve the lives of Aboriginal and Torres Strait Islander people. COAG agreed to seven specific targets and timelines regarding health, education and employment.

Continuous Quality Improvement: CQI is part of a range of activities that support and improve quality in health care. CQI drives service improvements through continuous and repeated cycles that are guided by teams using data to identify areas for action, develop and test strategies, and implement service re-design.

CQI Framework, the Framework: abbreviations for National Framework for Continuous Quality Improvement (CQI) in Primary Health Care for Aboriginal and Torres Strait Islander People, 2018-2023.

Cultural respect: the "recognition, protection, and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander people. Cultural respect is achieved when the health system is accessible, responsive, and safe for Aboriginal and Torres Strait Islander people, and cultural values, strengths and differences are respected".[3]

Cultural safety: the provision of care that is respectful of a person's culture and beliefs and that is free from discrimination.

Dashboard: an infographic or visual representation of meaningful and relevant data.

Governance: see clinical governance and organisation governance.

National Aboriginal Community Controlled Health Organisation (NACCHO): the peak body representing Aboriginal Community Controlled Health Services (ACCHSs) across Australia.

Organisational governance: the system by which an organisation is governed, run and held accountable. It includes clinical governance as well as strategic and service planning, risk management, financial, human resources and performance management.

Plan–Do–Study–Act (PDSA) cycle: a change management tool used used for quality improvement in health care.

Primary Health Care (PHC): in the Australian context PHC is provided in community-based settings including general practices, ACCHSs, community health centres and small office-based practices. There is a large variation in the range of services provided by different PHC professionals and organisations. This CQI Framework has been designed for comprehensive models of PHC as provided by Aboriginal health services and many general practices.

Primary Health Networks (PHNs): regional organisations established by the Australian Government to increase efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time.

Quality assurance: in health care refers to services and programs aimed at guarantee of improvement in quality of care in a defined setting.

Sector Support Organisations (SSOs) include NACCHO and Affiliates, Primary Health Networks and State/Territory government Local Health Networks. The NACCHO Affiliates provide support for CQI, clinical, financial and operational governance of the ACCHO sector.

ABBREVIATIONS / ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACCO	Aboriginal Community Controlled Organisation
ACSQHC	Australian Commission on Safety and Quality in Health Care
AGV	About Giving Vaccines (certification)
AHMRC	Aboriginal Health and Medical Research Council
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
AMSANT	Aboriginal Medical Services Alliance Northern Territory
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CQI	Continuous Quality Improvement
DAG	Data Advisory Group
KPI	Key Performance Indicator
NACCHO	National Aboriginal Community Controlled Organisation
NT	Northern Territory
PDSA	Plan-Do-Study-Act
PHN	Primary Health Network
RAN	Remote Area Nurse
SSO	Sector Support Organisation
VACCHO	Victorian Aboriginal Community Controlled Organisation
VICs	VACCHO Improvement Cycles

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Aboriginal health in Aboriginal hands

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