NACCHO

EXAMPLE OF AN ACCHO "CQI ACTION PLAN"

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Charleville & Western Areas Aboriginal Torres Strait Islander Community Health Limited

addressing the 5 Minimum Elements required by DoH

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CWAATSICH Ltd
2015-18 CQI ACTION PLAN
For the Australian Government Department of Health

QUALITY ASSURANCE				
Aims **What are you trying to achieve?**	**Strategies** **How will you do this?**	**Performance Indicators** **How will you measure performance?**	**Targets** **What are your targets?**	**Timeframe** **When will this be delivered?**
CQI processes facilitate the improvement of clinical data systems to improve clinical care health outcomes.	Identify and target key health interventions known to improve health.	Review clinical information to identify baseline data and potential targets.	80% of patient and service data for planning targeted client care.	12 month implementation and evaluation process.
	Deliver care in line with Clinical Guidelines.	Evaluation progressed through PDSA Cycles by Clinical Audits conducted.	Monthly internal audits conducted.	
	Utilise bench mark reports for improved best practise in clinical care.	Increased usage of benchmark reports to improve best practice clinical care.	Monthly bench mark reports evaluated as evidence in PDSA Cycle planning and reviews.	
	Maintain safety and quality in line with national standards.	Increased usage of benchmark reports to improve best practice clinical care	QIP/QGPAL Accreditation maintained.	

	Implementation of National Key Performance Indicators (NKPI’s).	Monitor key performance indicators against NKPI standards.	>20% annually increased overall on NKPI’s.	
	Maintain Clinical Governance Best Practices	Uptake of external & internal best practice evidence based care ensuring that community needs are met.	Attend internal & external Clinical Governance/Lead Clinicians Meetings.	

REPORTING:

- **(Reflect number of PDSA cycles)**
- **(Measurements against targets)**

FINANCIAL MANAGEMENT				
Maintain Financial Management and Reporting systems to enable informed decision making.	Review CWAATSICH Action Plan and Operational Budget quarterly.	Maintain compliance with financial accountabilities as per financial audit and funding agreement.	100% compliance with legislative requirements. Quarterly audits to measure 100% compliance.	12 month Implementation and evaluation process.
	Financial operations adhere to reporting requirements.		Unqualified Audit Report.	
REPORTING: • **(Reflect number of PDSA cycles)** • **(Measurements against targets)**				
HUMAN RESOURCE MANAGEMENT				
Maintain and improve workforce sustainability to meet the demands of the organisation.	HR Policies & processes support Staff Training & Development.	Identify, develop and deliver ongoing Professional Development in response to the duties of each position.	100% of staff undertake Training Needs Analysis	12 month Implementation and evaluation process.
	Recruitment and retention. Effective and efficient deployment of staff in multi-disciplinary teams. Implementation of regular in-service training.	Conduct regular training on issues identified through audit processes.	Number of Professional Development Training Programs delivered and attended.	
	Access to external training and development to maintain best practice.		100% of staff completing mandatory training requirements.	
REPORTING: • **(Reflect number of PDSA cycles)** • **(Measurements against targets)**				

<table>
<tr><th colspan="5">LINKAGES AND COORDINATION</th></tr>
<tr><td>Improve comprehensive Primary Health Care delivered to CWAATSICH's clients across the region with a key focus on identified priorities</td><td>Liaise and collaborate with service providers/stakeholders to ensure effective planning, management, delivery and review of Allied Health and Primary Health Care services.</td><td>Leverage mainstream health system initiatives to improve access to mainstream primary, secondary and tertiary health care programs and services.</td><td>10% increase of collaborative partnerships that strengthen and enhance CWAATSICH's service delivery.</td><td>12 month Implementation and evaluation process.</td></tr>
<tr><td></td><td>Formalise relationships with stakeholders and partners.</td><td>Establish MOU's and Service Agreements.</td><td>100% of new relationships with stakeholders and partners formalised.</td><td></td></tr>
<tr><td colspan="5">REPORTING:
• (Reflect number of PDSA cycles)
• (Measurements against targets)</td></tr>
<tr><th colspan="5">COMMUNITY INVOLVEMENT</th></tr>
<tr><td>Maintain commitment to client and community participation and decision making.</td><td>Engage with Aboriginal Torres Strait Islander peoples to ensure the delivery of services and programmes to meet the Community needs.</td><td>Increased level of engagement and participation from the communities across the region.</td><td>To increase the level of participation and engagement of the local community by 50%.</td><td>12 month Implementation and evaluation process.</td></tr>
<tr><td></td><td></td><td></td><td>20% increase in the level of access to services across each of the CWAATSICH sites post events.</td><td></td></tr>
<tr><td colspan="5">REPORTING:
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• (Measurements against targets)</td></tr>
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SERVICE DELIVERY - PRIMARY HEALTH CARE PROJECT (includes Healthy for Life)				
Maintain a culturally appropriate clinical service to improve access for Aboriginal and Torres Strait Islander peoples to effective Primary Health Care Services, to contribute to improving health and life expectancy**.**	Implement and coordinate comprehensive clinical service delivery including Provision of continuity of care and access to:- - Aboriginal Health Practitioners/Aboriginal Health Workers; -GP Services; -Referrals and follow up care; - Specialist and allied health services; - Health promotion and education programs; -Maintenance of patient information and recall systems.			12 month Implementation and evaluation process
To target key priorities identified through the Indigenous Health checks (715's).		Indicator PI 03 Increase the uptake of 715 health checks in the:- • 4 years • 5-14years • 15-54years • 55+ years.	10% Increase MBS billing revenue. 20% increase in the number of 715's conducted to identify risk factors to reduce Chronic Disease.	

Risk factors for Chronic Disease including substance abuse including tobacco and alcohol, nutrition, physical activity.		Increase in the number of Type II Diabetes Risk Assessments.	20% increase in the number of Type II Diabetes Risk Assessments.	
		Effective utilization of MBS items.	10% improvement 6 monthly.	
		Monthly extraction of PIRS and NKPI Data to monitor performance.	100% accuracy and consistency in data entry.	
		To monitor compliance and conduct minimum monthly audits for CQI in all clinical service areas.	Accreditation status maintained for AGPAL and QIP. Number of Quality Assurance activities and innovative practices initiated.	
		Bi-monthly Clinical Governance Meetings.	80% of meetings in the register held and attended.	
Provide comprehensive Primary Health Care including the identification of risk factors for chronic disease, and intervention and prevention to reduce those identified risk factors.	Promote and deliver annual flu campaigns and immunization. Influenza program to include: - Community awareness campaign Information brochures - Utilize Recall and Reminder System in MD3 to identify clients for annual campaign. - Promotional incentive for participation.	Indicator PI 15 Improved access and vaccination rates in target groups. Number of regular Indigenous clients who are immunized against influenza. Indicator PI 14 Number of regular Indigenous clients aged over 50years who are immunized against influenza.	95% of regular clients with chronic disease immunised for the 2016 Flu Program. 25% increase in the number of regular clients immunized against influenza for 2016 Flu Program. 25% increase in the number of clients aged over 50yrs immunized against influenza for 2016 Flu Program	6 month Implementation and evaluation process- February to June 2016.

	Early detection and management of Chronic Disease to reduce the risk factors of:- -respiratory -cardio vascular -diabetes -renal -cancer. Promote and deliver: - health check education and promotion program - health kids - speech and hearing health checks - improve student retention.	Improved identification and management of chronic disease evidenced in registers, practice health atlas. Clinical audits of clinical staff including GP's. Monthly data quality reports from Cat 4 system to identify data discrepancies.	100% accuracy and consistency with data entry Monthly clinical audits with a minimum 10% improvement where result is less than 100%. 100% improvement in data entry where the result is less than 100% for regular Indigenous clients. 100% improvement in data entry where the result is less than 100% for regular Indigenous clients.	12 month Implementation and evaluation process.
	Provide smoking session programs that target individual groups • School age • Ante natal • Young adult • Clients with identified risk factors from the 715 • Clients with a chronic disease	Indicator PI 09 Number of Regular Indigenous clients with smoking status recorded. Indicator PI 10 Number of Regular Indigenous clients with a smoking status result.	5% decrease in the number of current smokers in all age groups of regular Indigenous clients. 5% increase in the number of ex – smokers in all age groups of regular Indigenous clients. 5% increase in the number of never smoked in all age groups of regular Indigenous	12 month Implementation and evaluation process.

			clients. 5% increase in the number never smoked in the age group < 18 years for regular Indigenous clients. 5% increase in the number of never smoked and ex-smoker for regular Indigenous antenatal clients.	
	Ongoing Well Women's Health Program targeting pap smears, breast screening and the Indigenous Health Check	Indicator PI 22 Number of female Indigenous clients who have had a pap smear.	100% increase in the number of pap smears recorded	
		Indicator PI 16 Number of regular Indigenous clients with alcohol consumption status has been recorded.	5% decrease in the number of binge drinking regular Indigenous clients. 5% increase in the number of ex –drinkers. 5% increase in the number of clients within safe drinking levels.	
		Indicator PI 12 Number of regular clients who are classified as overweight or obese.	5% increase in the number of clients in the healthy weight range across all age groups. 5% decrease in the number of clients in the obese	

			category to the overweight and healthy weight range.	
		Number of regular Indigenous clients who attend Allied Health Services for: • Dietician • Exercise physiology.		
REPORTING: • **(Reflect number of PDSA cycles)** • **(Measurements against targets)**				

CHILD AND MATERNAL HEALTH: NEW DIRECTIONS				
Culturally appropriate Child and Maternal Programs (Antenatal and Post Natal Care, early detection and screening for growth failure, parent/family support, baby clinics, home visiting and education).	Deliver education and health promotion programs/activities relating to Child and Maternal Health, including:- -Nutrition and physical activity; -Injury prevention; -Immunisation promotion; -Social and emotional development; -Self-development and personal care; -Parenting programs; -Ear health, Oral health and skin care.	Increase in the number of mums, fathers and Bubs attending CWAATSICH Child and Maternal Health related promotions and programs. Indicator PI 03 Increase in the number of clients in the 0-4 age group who completed a 715.	50% increase in number of regular clients attending programs. 50% increase in the number of 715's completed in the 0-4 age group against the numbers completed in 2015.	12 month Implementation and evaluation process.

	Kindergarten and primary schools to facilitate Allied Health support in their centers.	Number of children accessing OT and Speech services prior to school entry.	100 % access to a healthy kids check for all children starting school in 2016. 80% have completed their healthy kids check prior to starting school.	
	Support families accessing existing services.	Number of Health Information Sessions held on the effects of substance abuse during pregnancy.	50% increase in the number of information sessions and attendance rates.	
		Increased health services access & opportunities from coordination and support for Aboriginal & Torres Strait Islander Health Services.	50% Increase in referrals to other health and community service providers.	
Clinical Child and Maternal Services	Child and Maternal Clinical services, including but not limited to Birth Weight NKPI's.	Indicator PI 13 Number of regular Indigenous clients who had their first ante-natal care visit within: • < 13 weeks • From 13 weeks – (20 weeks) • 20weeks and > • No record	50% Increase in number of regular Indigenous babies accessing CWAATSICH services against 2015 data. Less than 10% of babies in the low birth weight range Working towards 80% of babies in the normal birth weight range. Less than 10% of babies in the high birth weight range.	12 month Implementation and evaluation process.

	Ante Natal and Post Natal KPI's -infant care; -breastfeeding and infant and child nutrition; -safe infant care sleeping practices; -immunisation and promotion; -growth monitoring and developing screening; -social and emotional screening -injury prevention. SWHHS midwife services to assist with the ante- natal care of clients.	Number of regular Indigenous clients who have attended at least 5 antenatal visits	50% increase in the number of clients accessing CWAATSICH for antenatal services.	12 month Implementation and evaluation process
	Reduce complication of gestational diabetes.	Number and proportion of women with gestational diabetes.	50% increase in the number of clients with at least 5 antenatal visits.	
	Reduce smoking, alcohol and other substance at risk behaviours.	Number and proportion of mothers who continued to smoke or engaged in other risk behaviours (alcohol and other substances) at: • 13 weeks gestation • 20 weeks gestation	80% increase in number and proportion of mothers who ceased smoking . 80% increase in number and proportion of mothers who ceased alcohol consumption.	
		Number and proportion of women: - Breast fed; - Bottle fed; - Both breast and bottle fed.	50% increase in the number of breast fed infants.	

	Promote healthy ears.	Number of Hearing Health Checks in the clinic.	100% increase in hearing screening and tympanometry for the 3 mth to 5 years in the clinic.	
	Increase Physical Activity focus on child development, physical activity and positive parenting for families.	Number of underweight and overweight children recorded. Number of school based, vacation health promotion activities.	50% increase in the number of children with a healthy weight. 50% increase in community support to improve physical activity in the family.	

REPORTING:

- **(Reflect number of PDSA cycles)**
- **(Measurements against targets)**

CHRONIC DISEASE				
To reduce the complications of chronic disease through investment in preventative, social marketing activities, expansion of the Indigenous health sector and building the capacity for health care services to deliver effective services.	AOW to provide practical assistance in the support of chronic disease self-management to improve prevention in the areas of:- -GP Management plans for clients with a chronic disease.	Indicator PI 07- Number of regular Indigenous clients with a current GP Management Plan (target 95%).	95% increase in the number of home visits for education and support every quarter. 95% of clients with Chronic Disease to have a current GPMP and TCA.	Monthly Review
Provide a comprehensive chronic disease prevention and management program through coordinated service delivery.	Coordinated Allied Health service delivery:- -diabetes; -cardio vascular; and -respiratory.	Indicator PI 08- Number of regular Indigenous clients with a current Team Care arrangement (723) (target 95%).	10% Improvement in NKPI's for chronic disease management as per QAIHC report.	

	AOW's and AHW's to provide community liaison in the early detection and management of chronic diseases by implementing the well persons screening:- - Diabetes; - STI's; - Blood Pressure;	100% of patients with chronic disease on PIRS. Number of clients registered for the Indigenous Health Incentive payment. Level of Tier 1 and Tier 2 incentive payments received from Medicare.	Monthly data extraction. 95% of the regular clients registered for the IHI. 50% increase in the level of Tier 1 and Tier 2 payments received from Medicare.	
	- Smoking intervention. Utilize the monthly QAIHC data extraction to monitor performance against national KPI's each month and review strategies to achieve targets.		To achieve benchmarks set by QAIHC for data collection in the 12 month period.	
	Provision of Eye Health Screening.	Increased client access to the I.D.E.A.S. Van. Number of referrals to the I.D.E.A.S. Van.	At least 21 referrals to the Ideas Van each visit. 10% increase in the Number of referrals to Ophthalmological services.	
	Provision of Hearing Health Services to early years learning, school of distance and local community. Improve access to Allied Health Care Professionals.	Number Opportunistic clinic screenings and referral pathways.	50% increase in the number of opportunistic screenings in clinics.	

	Maintaining and implementing the Diabetes annual cycle of care.	Maintain visiting Diabetes Educator (SWHHS) services. Percentage of annual cycle of care MBS Items.	50% increase in the number of education sessions provided from Allied Health referral to AHW Hearing Health.	
	Maintaining the Diabetes Register.	Number of clients on the Diabetes Register.	10% increase improvement in data information utilising the CAT 4 data tool.	
	Improvement in the Diabetes key measures to reduce the complications of diabetes and renal disease.	Indicator PI 05 Number of regular Indigenous clients with Type II diabetes who had a HbA1c measurement result recorded.	Bi monthly Clinical Audits and System Assessments completed.	
		Indicator PI 06 Number of regular Indigenous clients with Type II diabetes whose HbA1c measurement • <= 7% (<=53 mmol/mol) • >7% but <=8% (>53 but <= 64mmol/mol) • 8% and <10% (>64 but <86mmol/mol) • >= 10% >=86mmol/mol)	25% increase in the number of clients with a HbA1c =/< 7%. 10% decrease in the number of clients with a HbA1c >7% but <= 8%. 15% decrease in the number of clients with a HbA1c >/=10%.	
		Indicator PI 18 Number of regular Indigenous clients with a current renal function test.	25% increase in the number of clients with current renal function pathology recorded.	

		Indicator PI 19 Number of regular Indigenous clients who have an eGFR measurement recorded with results within specific levels.	25% increase in the number of clients with eGFR measurements recorded within specific levels.	
		Indicator PI 23 Number of Indigenous regular clients with Type II diabetes who have a blood pressure measurement result recorded.	25% increase in the number of Indigenous regular clients with Type II diabetes who have a blood pressure measurement result recorded.	
		Indicator PI 24 Number of regular Indigenous clients with Type II diabetes whose blood pressure was < or = to 130/80 mmHg.	25% increase in the number of regular Indigenous clients with Type II diabetes whose blood pressure was < or = to 130/80 mmHg.	
Development and implementation of health activities and health promotion/prevention programs for community members which focus on healthy eating, exercise and improving lifestyle.	Actively promoting and participating in key national health initiatives:- - Close the Gap -Sorry Day and National Reconciliation week -NAIDOC -Indigenous Children's Day	Number of national and local health promotion events promoted and supported by CWAATSICH across our region.	80% community involvement and participation.	
	Significant Health awareness/ Promotion days as per DOH calendar for 2016 -Heart Week -Diabetes -Healthy Weight week -World No Tobacco Day -Kidney week - National Youth Week		80% increase in number of surveys completed and evaluated	

	Implementation of health promotion programs through social and marketing media outlets.	To provide awareness to the wider community about CWAATSICH our health services, relevant health issues through a regular newsletter. Improved media exposure through the local radio stations, television, newspapers and community newsletters. Maintain and update our website including services and latest news, staff and board profiles.		
Social And Emotional Wellbeing:- To provide counselling and support, health promotion and early intervention services to promote social and emotional wellbeing in the community.	To provide access to culturally appropriate mental health services and support to the community.	Number of clients accessing psychologist services Number of clients accessing AHW allied health services identified through MBS Items. Refer to IAS Safety and Wellbeing Action Plan.	100% increase in programs delivered and attended in Social & Emotional Wellbeing. Refer to IAS Safety and Wellbeing Action Plan.	
REPORTING: • **(Reflect number of PDSA cycles)** • **(Measurements against targets)** **Refer to IAS Safety and Wellbeing Action Plan**				