Literature review

Best practice approaches for implementing clinical guidelines in both Aboriginal Community Controlled Health Organisations and mainstream general practices.

Purpose

For the information of the Project Reference Group and to inform project activities, this paper provides findings from a literature review conducted by Dr Tim Senior exploring Best practice approaches for implementing clinical guidelines in both Aboriginal Community Controlled Health Organisations and mainstream general practices.

Background

As part of the project to implement the third edition of the NACCHO/RACGP *National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander people* (National Guide), a two-part review of the literature was performed to inform approaches to ensure that the best available evidence was being used to implement changes across the system.

The first part of the review looked at best practice approaches for implementing clinical guidelines, both in the ACCHO sector and in the mainstream general practice sector. Findings are reported in this paper.

The second part of the literature review identifies challenges and barriers face by mainstream general practices in providing care for Aboriginal and Torres Strait Islander patients. This is still in progress and findings will be reported to the Project Reference Group in due course.

It should be noted that these literature reviews are an environmental scan of the literature, and not a systematic review. Many of the publications are reports (classified as grey literature) rather than published in peer-reviewed journals. The overall project is one of practical implementation, with the goal of widespread use of a guideline, rather than an overview of the academic literature regarding implementation science, and limits of time and capacity have made this is a pragmatic literature review, as is appropriate for a project of this sort.

Overview of findings and lessons for the National Guide project

Across a diverse range of research studies, methods and settings, there are some findings that are consistent. Continuous Quality Improvement programs can enhance the care provided in services, and this can be sustained, though perfection is rarely attained. The program should have the ability to engage the local community in the program where required, and will be driven by good and timely data collection, reporting and feedback.

The services will need facilitated support to improve. While a lot of the research stresses the importance of taking local context into account, this author finds the view compelling, that the local context is not an external framing, but *is* the situation. In their perspective article, McCalman and colleagues(16) set out a Framework where CQI can include local outside agencies, and this may be useful in informing the implementation of a health assessment that takes in to account not just biomedical assessment, but social determinants of health too.

Search Strategy

The RACGP library performed the literature search on PubMed, with results supplemented by research and reports known by the team responsible for the project. The searches were run separately for the two parts of the literature review.

Findings of the literature review

The literature looking at best practice approaches for implementing clinical guidelines is diverse, using a range of methodologies. This report will give a narrative overview of the findings and summarise the implications from this research for implementing the National Guide.

Much of the research into effective quality improvement in the health system is qualitative research performed at the level of individual services, and drawing lessons from this. There are also a smaller number of publications that look at promotion of large scale quality improvement across a health system, not just in individual services.

Narrative reports of the studies

McFarlane et al(1) interviewed nine people about how they improved their health improvement skills at an Aboriginal Community Controlled Health Organisation (ACCHO) in North Queensland. They identified a range of measures, which essentially can be broken down into educational activities and maintaining a network of trusted people able to give guidance, and drawing on sources of information. To be effective, they needed to be seen as relevant to remote health and Aboriginal and Torres Strait Islander health; they needed to be embedded in the organisation; and they used what the researchers termed side-by-side learning.

Still in North Queensland, Campbell and colleagues(2) looked at the implementation of the Baby One program, an Australian Indigenous family-centred program for improving child health. Using semi-structured interviews and a focus group, they identified 3 key enablers, that needed to be in place for successful implementation, and three key strategies of implementation.

The enablers were:

- *resourcing program delivery – health workers were often under-resourced, and had limited capacity, which affected program implementation*
- *working towards a team approach – the way health workers and other health professionals worked together affected the program delivery, and became clearer as the program went on.*
- *negotiating the cultural interface – there needed to be flexibility and negotiation around the role of health workers and their cultural commitments in community, and how this affected their role in the health system.*

The key implementation strategies were:

- *engaging families – getting families themselves engaged in the program, and the flexibility in way of working to achieve this were seen as crucial.*
- *exchanging knowledge through yarning – informal conversations with families on whichever health issues they wanted to talk about, with support from the program, developed the relationships between families and health workers.*
- *strengthening the workforce - training and support for the health workers was an important component of implementation.*

Most important of all of these was the relationship with participating families. "The study confirmed that the central factor in program implementation is the quality of the relationship developed between health practitioners, especially Health workers, and families."

Woods and colleagues(3) looked retrospectively at the systems in Indigenous health services that support quality clinical care. They also summarised the findings of other research in this area, and the research all consistently pointed to systems required for high quality clinical care.

These included:

- Engagement with other organisations
- Engagement with the community
- An adequate and oriented workforce
- Adequate IT support

Importantly, in a service with good leadership, these factors allowed services to provide high quality care in complex and changing environments.

McCalman and colleagues(4), in looking at the conditions that allowed the Family Wellbeing program to be rolled out successfully, they found that Aboriginal control of funding and support, in the context of government policy was crucial. Aboriginal leadership and networks were important, and the program had to be built on an evidence base. However, one of their most important suggestions was to quote Adele Clarke: *"There is no such thing as 'context'". Instead, the "conditions of the situation are in the situation… The conditional elements of the situation need to be specified in the analysis of the situation itself as they are constitutive of it, not merely surrounding it or framing it or contributing to it. They are it…"* It is an error to thing that there is an "ideal" context-free program that then gets adjusted to particular areas or service.

The main insight from Percival and colleagues(5) about implementation of health promotion tools in Indigenous health services, was that implementation was that implementation must be seen as a social process. "The implementation of health promotion tools was influenced by the presence of change agents; a commitment to reciprocity and organizational governance and resourcing." The components of the social process were consistent with the findings of other research in this area. "In practice, culturally responsive health promotion manifested as four inter-related and overlapping processes of: engaging and relating; strengthening capacity; tailoring for diversity in programmes, groups and settings; and developing and using evidence."

The main message from Mcaullay and colleagues' audit(6) is that sustained participation in continuous quality improvement activities is associated with improvements in preventive health interventions in children, though not with all interventions.

Bierbaum and colleagues(7) looked at education in cancer resource, and showed that education is valued by health professionals, and results in an intention to use the resources, but it didn't result in an actual increase in use of those same resources. This points to the need for more complex, system based interventions to improve quality than just education targeted at individuals.

Matthews and colleagues(8) demonstrate that clinical decision support integrated into the electronic medical records system increased the documentation of absolute cardiovascular disease risk. They also demonstrated that follow up systems still needed to be improved to make the most of this improvement.

MacLean and colleagues performed a systematic review(9) looking at health and wellbeing programs that included cultural interventions. It showed that programs which include cultural strategies addressing diet,

physical activity, birthing and emotional wellbeing, can improve outcomes for Indigenous peoples. However, not all programs including cultural interventions improved wellbeing. The cultural interventions and settings were very diverse, and involvement of Aboriginal and Torres Strait Islander people in some of the included studies was unclear.

Bailie and colleagues(10) used practice audit data from 137 Primary Health Care centres to determine priorities in preventive health care in services and how they might be closed. Key stakeholders were interviewed about their interpretation of the audit findings to determine the priorities and strategies for improvement. Seven priorities were identified:

- Follow-up of clients with abnormal blood pressure, blood glucose levels and lipid profile
- Completing absolute cardiovascular risk assessments
- Recording of urinalysis
- Recording of lipid profiles
- Recording of enquiry about environmental & living conditions, family relationships and substance abuse
- Providing appropriate support and follow-up for clients identified as being at risk with respect to emotional wellbeing
- Strengthening 'team structure and function' and 'continuity of care'

It was also seen as important that identification of individual biomedical measurements didn't distract from the provision of holistic care across the whole of a person's wellbeing.

Four key drivers for working on these priorities, and each of these had particular strategies identified.

- Strong Indigenous participation in the primary health care service
- Appropriate primary health care team structure and function
- Corporate support functions and structures
- Meaningful use of data to support high quality care delivery and continuous quality improvement processes

Stoneman and colleagues(11) from the Kimberly audited their records of patients with Type 2 Diabetes. For their services, high quality clinical care was supported by having Aboriginal Health Workers and well co-ordinated Allied Health services, clearly defined staff roles and effective patient recall systems. Effective continuous quality improvement was supported by timely data collection, local ownership of CQI, and a willingness to admit deficiencies and embrace change.

Graham et al(12) report on a quality improvement project in NSW called SHIMMER, designed to improve the detection of chlamydia and gonorrhoea. The Quality Improvement Program used practice data from the medical record and facilitated discussions with staff in the service, to determine local changes that could be made. They succeeded in improving their rates of testing, and their rates of STI detection. This increase occurred during consultations for health assessments, reproductive problems and mental health consultations, but much less so in general medical consultations.

Reeve and colleagues(13) showed that quality of care, in routinely collected measures, and probably in mortality, could be improved and sustained in a remote area with substantial socioeconomic disadvantage, by strengthening and investing in primary health care and with good community leadership.

Gibson-Helm and colleagues(14) showed that participation in a Continuous Quality Improvement Program improved metabolic screening during pregnancy, and this continued and improved over several CQI cycles.

Reilly et al(15) conducted a systematic review of primary health care programs for renal disease. This wasn't looking at continuous quality programs, but did describe the features of programs that got better outcomes for patients with renal disease, though there weren't able to establish these as causative, just characteristics in common. These were:

- the integration or coordination with primary care;
- nurse-led or Indigenous Health Worker-led care;
- intensive follow-up including home-visits;
- the provision of anti-hypertensive medication following a step-wise protocol;
- addressing barriers to adherence such as cost and lack of transport.
- education delivered in ways that accounted for literacy and culture.

Lyle et al conducted a review of seven service evaluations, to determine what features enabled new models of primary health care to succeed in rural and remote areas. The consistent theme they found was that all the successful services were good at consultation, negotiation and shared decision making with their communities, tailored to their own context.

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