GVPCP Goulburn Valley Primary Care Partnership

Working together...Going forward

Quality Toolkit

A resource for member agencies

Version 2: May 2016

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Primary Care Partnership members acknowledge and respect the Aboriginal and Torres Straits Islander peoples and their culture, and values the cultural, religious, racial and linguistic diversity of local communities.

Goulburn Valley Primary Care Partnership acknowledges the support of the Victorian Government.

REFERENCES:

- Australian Aged Care Quality Agency - http://www.aacqa.gov.au/
- Australian Commission on Safety and Quality in Healthcare - http://www.safetyandquality.gov.au/
- Community health integrated program guidelines; Direction for the community health program, Victorian Department of Health & Human Services, March 2015 - Guidelines
- Victorian Service Coordination Practice Manual 2012, Primary Care Partnerships Victoria, June 2012 - Manual
- Victorian Continuous Improvement Framework 2012, Primary Care Partnerships Victoria, June 2012 - Framework
- The Australian Council on Healthcare Standards - http://www.achs.org.au/

GVPCP Quality Toolkit 2016 – Version 2

Introduction

Continuous quality improvement is an underlying principle guiding all Goulburn Valley Primary Care Partnership (GVPCP) activities. Taking into account the needs of member agencies, GVPCP staff have become increasingly aware of the potential to align GVPCP key priority areas and associated agency activities with agency quality improvement plans and related accreditation standards and criteria. This toolkit has been developed, in collaboration with member agencies, to enable identification of relevant activities, and demonstrate how participating in these activities can contribute to each agency's quality plans, and provide evidence for accreditation.

Background

Goulburn Valley Primary Care Partnership (GVPCP) is required, through its service agreements with Department Health & Human Services (DHHS), to collaborate with and support member agencies, within the parameters of Primary Care Partnership (PCP) Program Logic 2013-2017 (Appendix 1). This is reflected in the *Members' Strategic Framework 2016-2018* (Appendix 2).

The plan outlines 3 key priority areas:

Key Priority Areas:

- Community Connections
- Health for Life
- Quality Connections

The priority area quality connections can be aligned with agency requirements in regards to quality plans and accreditation standards. The intent of this document is to assist member agencies link their GVPCP activity to accreditation requirements.

Overarching strategic documents

- *National Chronic Disease Strategy 2006*
- *Victorian Public Health and Wellbeing Plan 2011-2015*
- *Victorian Health Priorities Framework 2012-2022 – Rural & Regional Health Plan*
- *Hume Chronic Care Strategy 2012-2022*
- *Hume Integrated Aged Care Plan 2010-2015*
- *Hume Integrated Health Promotion Strategy 2011-2015*
- Recommend individual agency strategic plan aligned with above where relevant, and subsequent business/operational plan for individual departments

Quality Standards

There are numerous quality standards and accreditation processes and this toolkit does not attempt to address all standards. The standards reviewed relate to those member agencies receiving primary and women's health funding, HACC funding, services in community based outpatient sector and aged care. Specific sectors such as mental health, disability, palliative care, youth and family services have not been included. GVPCP can however assist member agencies to assess what alignment exists between current PCP reporting activity requirements and those accreditation requirements. Quality Improvement Council (QIC) Health and Community Service Standards 6th edition, applied through Quality Innovation Performance (QIP) have also not been included.

The toolkit relates to administering body and standard applied;

- Australian Commission on Safety and Quality in Health Care -National Safety Quality Healthcare Standards 1 & 2 (Note Version 2 Standard PC: Partnering with consumers has been released in consultation draft – awaiting final V2)
- Australian Council on Healthcare Standards –EQuIPNational
- Australian Aged Care Quality Agency - Home Care Common Standards
- Australian Aged Care Quality Agency - Residential Aged Care Accreditation Standards

How to use this resource

The PCP audit tool/resource is in identified in the left hand column and corresponding accreditation standard in right hand column. Where alignment exists, this is identified and will guide agencies (as the quality experts) to explore how activities undertaken in partnership with GVPCP may be used as quality measures and provide evidence for accreditation.

Caveat

GVPCP is not a member of The Australian Council on Healthcare Standards and subsequently has limited access to accreditation information documents. Suggested alignment therefore, is currently at a broad overview level. The toolkit will be reviewed annually, and additional standards and detail included, as directed by member agencies.

Audit Tool - Community Health Indicators Project (CHIPs)	Quality Standards & Accreditation			
	NSQHS	EQuIP National	Home Care Standards	CHIP Program Guideline Domain
Indicator #1 Response to urgent referrals - Referral acknowledgement sent within 2 working days of receipt of referral		11.2	2.1	Access & initial contact
Indicator #2 Response to routine referrals - Referral acknowledgement sent within 7 working days of receipt of referral		11.2	2.1	
Indicator #3 Timely Initial Needs Identification (INI) - INI commenced no more than 7 working days of initial contact	1.8	11.1 11.2	2.1	Initial Needs Identification (INI)
Indicator #4 Consent for disclosure of personal information - Consent for disclosure of personal information is required under privacy legislation	5.1-5.4 1.18.2	11.3	3.2	
Indicator #5 Interpreter use - % clients who have indicated need for an interpreter actually receive interpreter on their 1st contact with service/program area		11.5	2.1	Assessment
Indicator #6 Waiting time for highest priority clients - Average number calendar days from INI to service specific assessment		11.2	2.1	
Indicator #7 Waiting time for mid priority clients - Average number calendar days from INI to service specific assessment		11.2	2.1	
Indicator #8 Waiting time for lowest priority clients - Average number calendar days from INI to service specific assessment		11.2	2.1	

Audit Tool - Community Health Indicators Project (CHIPs)	Quality Standards & Accreditation			
	NSQHS	EQuIP National	Home Care Standards	CHIP Program Guideline Domain
Indicator #9 Adverse drug reactions (ADR) & medication allergies - % clients who have been asked about ADR & medication allergies	4.0 Medication Safety			
Indicator #10 Did not attend - % clients that DNA a booked service			2.1	Care planning & implementation
Indicator #11 Diabetes Care Data - % clients with type 1 or type 2 Diabetes referred for any type of diabetes related management who have diabetes related results recorded in client file		12.1 12.3		
Indicator #12 Care plan (CP) present - % clients with multiple or complex needs with a CP	6.1-6.4	12.1	2.3	
Indicator #13 Communication to general practitioner (GP) re CP - % clients with chronic and complex disease with evidence of communication regarding a CP from the service to client's GP		12.3	2.3	
Indicator #14 Complete care plans - % clients with multiple or complex needs with a complete CP		12.1	2.3	
Indicator #15 Care plan review - % clients with CPs that are reviewed systematically within 4 weeks of the planned review date		12.3	2.3 2.4	Monitoring & review
Indicator #16 Goal achievement - % of objectives/goals of care that have been fully met in timeframe stated		12.3	2.3 2.4	

Audit Tool - Community Health Indicators Project (CHIPs)	Quality Standards & Accreditation			
	NSQHS	EQuIP National	Home Care Standards	CHIP Program Guideline Domain
Indicator #17 Diabetes Best Practice Care Review - % clients with Type 1 or Type 2 Diabetes who have received the recommended reviews as part of best practice care		12.3	2.4	
Indicator #18 Consumer self-management - % clients/carers satisfied that the intervention helped them manage their problem	1.20			Transition & exit
Indicator #19 Consumer involvement in decision making - % clients/carers satisfied or highly satisfied with their involvement in decisions about their care or treatment	1.20	11.4		
Indicator #20 Communication to GP re end of episode - clients referred by GP with evidence of discharge/end of episode communication from community health service to the client's GP		12.3		
Indicator #21 Complaints acknowledgement - % complaints acknowledged by the organisation within two working days of receipt of complaint			3.3	
Indicator # 22 Complaints closed - % of complaints closed by the organisation within 30 working days of receipt of complaint	1.15 2.9		3.3	

Audit Tool - Service Coordination Survey	Quality Standards & Accreditation		
	NSQHS	EQuIP National	Home Care Standards
E-health - Secure electronic messaging/e-communication system used - Number of secure transmissions - Client information management software system used - SCTT version in client information system used		14.1 14.4	1.3 1.5 1.6
Shared care planning - Local agreement has been developed to support shared care/case planning between services - Local agreement has been implemented to support shared care/case planning between services		12.1 12.3	2.3 2.5
GP Communication - Documented & aged communication processes with general practice have been developed - Documented & agreed communication processes with general practice have been implemented			2.3 2.5
Initial Needs Identification (INI) - Greater than 70% of consumers had an INI conducted - Greater than 70% of INI processes have resulted in documented decisions about referrals and assessments		11.1 11.2 11.5 11.6	2.1 2.2
Service Coordination Tool Templates (SCTT) - Greater than 70% of referrals were sent (internal & external) using the SCTT			2.5
Shared care planning (SCP) - Greater than 70% of consumers with multiple or complex needs who are receiving services from more than one service provider have a SCP - Greater than 70% of SCP have been communicated with the GP, if the consumer has a GP		12.1 12.3	2.3

Audit Tool - Assessment of Chronic Illness Care (ACIC)	Quality Standards & Accreditation		
	NSQHS	EQuIP National	Home Care Standards
1. Organisation of healthcare delivery system			
- Overall organisational leadership in Chronic Illness Care (CIC)	1.1	15.1	1.1
- Organisational goals for CIC	1.2	15.2	1.2
- Improvement strategy for CIC		15.3	1.6
- Incentives & regulations for CIC			1.7
- Senior leaders			1.8
- Benefits			
2. The community			
- Linking patients to outside resources	2.0	11.1	1.4
- Partnerships with community organisations		11.4	
- Regional health plans		11.6	
3. Self-Management support (3a)			
- Assessment & documentation of self-management needs & activities	1.18.1	12.1	2.2
- Self-management support (SMS)	1.18.2	12.3	2.3
- Addressing concerns of patients & families	1.18.3		2.4
- Effective behavior change interventions and peer support	4.1		2.5
4. Decision support (3b)			
- Evidence based guidelines	1.7	11.1	
- Involvement of specialists in improving primary care	1.10	13.1	
- Provider education for CIC	1.12		1.7
- Informing patients about guidelines			
5. Delivery system design (3c)			
- Practice team functioning	1.10	12.3	1.5
- Practice team leadership	1.11	13.2	2.4
- Appointment system	1.13		
- Follow-up			
- Planned visits for CIC			
- Continuity of care			

Audit Tool - Assessment of Chronic Illness Care (ACIC)	Quality Standards & Accreditation		
	NSQHS	EQuIP National	Home Care Standards
6. Clinical information systems (3d) - Registry (list of patients with specific conditions) - Reminders to providers - Feedback - Information about relevant subgroups of patients needing services - Patient treatment plans	1.9	14.1 14.2 14.3 14.4	1.3 2.3 2.5
7. Integration of CCM components - Informing patients about guidelines - Information systems/registries - Community programs - Organisational planning for CIC - Routine follow-up for appointments, patient assessments and goal planning - Guidelines for CIC	2.0 1.7	14.0 2.0 15.1 15.2 12.3	1.3 1.4 1.4 1.2 2.4

GVPCP Portfolio Areas – Hume Chronic Care Strategy (HCCS) Priorities for action	Quality Standards & Accreditation		
	NSQHS	**EQuIP National**	**Home Care Standards**
Adopt the National Chronic Disease Strategy & service improvement frameworks in all local services, to support consistent evidence-based practice			
Develop agreed service delivery frameworks, roles and pathways for care across the continuum		11.1 11.2	2.1
Embed self-management approaches in all aspects of care		11 12	3.5
Provide clear and consistent information for people with chronic conditions and their carers	4.1-4.3 1.7 2.2 2.3 2.4	11.1	3.1
Maximize information technology opportunities	1.7 1.8 1.9	14.1 14.2 14.3 14.4	1.3
Align workforce development and capacity across all strategic priorities	1.10 1.11 1.12 1.13	13.1 13.2 13.3 13.4	1.7
Explore opportunities for new and innovative service models and/or funding and reporting mechanisms to support improved care	2.5		

GVPCP Portfolio Areas / projects – Diabetes Care Centre Accreditation	Quality Standards & Accreditation		
	NSQHS	EQuIP National	Home Care Standards
Partnership project involving: - Cobram District Health - Numurkah District Health Service - Primary Care Connect - Yarrawonga Health - GV Health - GVPCP	1.0 2.0	11.1 11.2 11.6 12.1 12.3 13.1 13.2 13.3 14.0	1.0 2.0 3.0

GVPCP Portfolio Areas / projects – E-health	Quality Standards & Accreditation			
	NSQHS	EQuIP National	Home Care Standards	Residential Aged Care
- Secure messaging systems – e.g. ConnectingCare - Optimum utilization of client management system/s - E-care planning – Hume region project in progress - Promotion of National Health Services Directory (NHSD)	1.9	14.0	1.3	1.8

GVPCP Portfolio Areas / projects – Workforce Capacity	Quality Standards & Accreditation			
	NSQHS	**EQuIP National**	**Home Common Care Standards**	**Residential Aged Care**
- Elder Abuse Prevention training and Interagency Protocol As required - Aged care showcase Annual event - GV Multi Agency Network Meeting Meet quarterly - Training opportunities o Asking Better Questions - 2016 West Hume Chronic Care Collaborative Meet quarterly - Integrated Health Promotion Network Meet quarterly - Integrated Health Promotion Working Party Bi-monthly	1.10 - 1.13 Performance & skills management	13.1 – 13.4 Workforce Planning & Management	1.7 Human resource management	4.3 Education & staff development

GVPCP Portfolio Areas / projects – Governance/strategic development	Quality Standards & Accreditation			
	NSQHS	**EQuIP National**	**Home Care Standards**	**Residential Aged Care**
- Member of GVPCP Executive Committee - Member of GV Aged Care Planning Group - Member of project steering group (various)	1.0	15.1 15.2	1.1 1.2 1.5	1.1 1.2 1.9

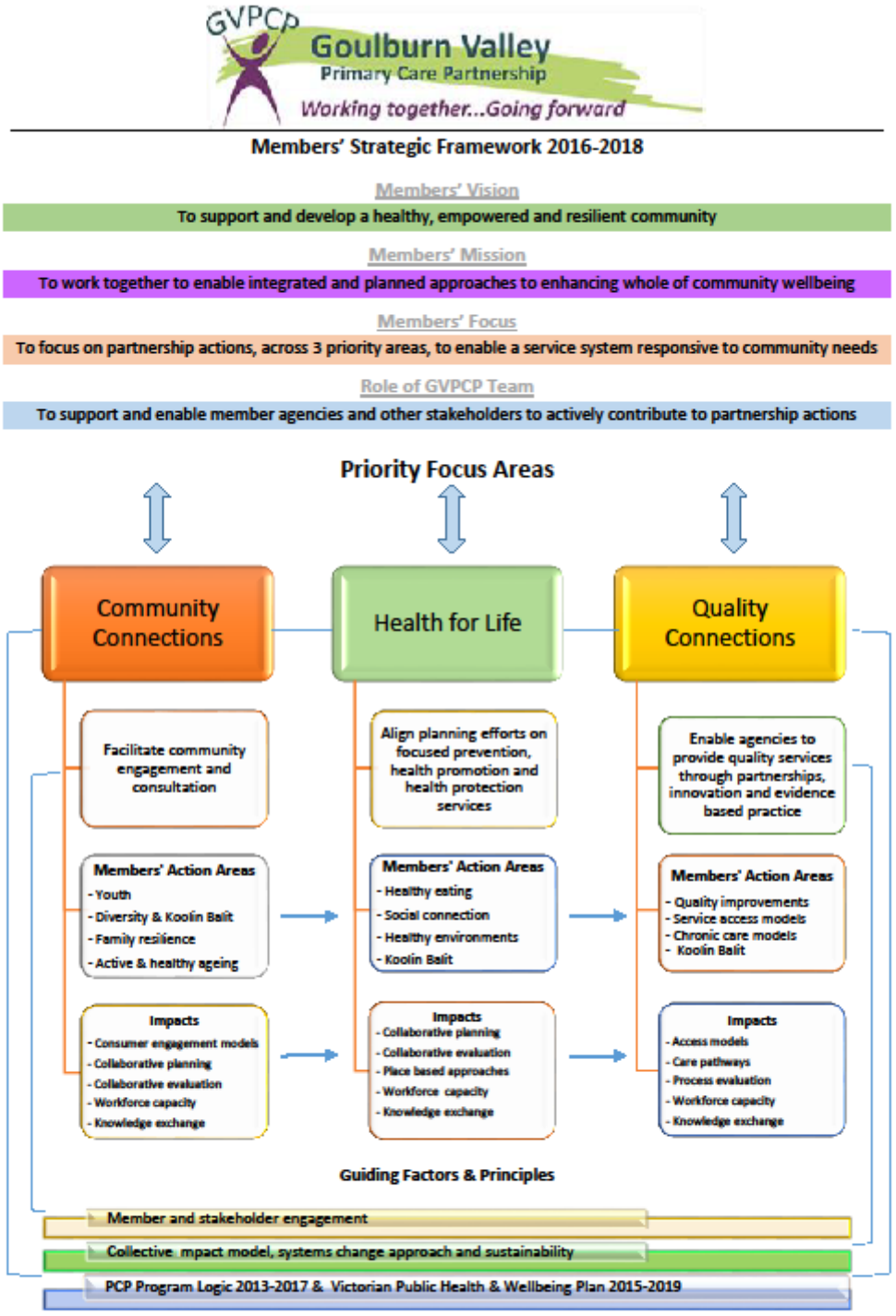
GVPCP Portfolio Areas / projects – Integrated Health Promotion	Quality Standards & Accreditation			
	NSQHS	**EQuIP National**	**Home Care Standards**	**Residential Aged Care**

- Social Connections
  o Act Belong Commit campaign
 	
- Healthy Eating
  o GVPCP Integrated Health Promotion Plan 2013 2017
	2.0 Partnering with Consumers	11.6 Better health & wellbeing are promoted by the organisation	1.4 Community understanding & engagement	3.7 Leisure interests & activities

GVPCP Portfolio Areas / projects – Resources	Quality Standards & Accreditation		
	NSQHS	**EQuIP National**	**Home Care Standards**
- Victorian Service Coordination Practice Manual 2012 - Victorian Continuous Improvement Framework 2012 - Victorian Service Coordination Tool Templates user Guide 2012 - 2013 Goulburn Valley Health & Well Being Profile - 2014 Health Planning Toolkit Hume Region		11.5 11.6	1.4

Appendix 1: Partnership Goal from Primary Care Partnership (PCP) Program Logic 2013-2017

Appendix 2: GVPCP Members' Strategic Framework 2016-2018



GVPCP Strategic Framework 2016-2018 V.3