VicHealth Koori Health Research and Community Development Unit

Summary of Findings from Hospital Case Studies & Recommendations for Accreditation

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FOREWORD

I am very pleased to write the foreword of the Aboriginal and Torres Strait Islander Hospital Accreditation Project Community Report.

As the first manager of the Koori Health Unit of the Health Commission of Victoria in 1982, one of my first challenges was to implement the recommendations of the working party report into Aboriginal health in Victoria.

I started my role in April 1982 under the direction of the Aboriginal Health Resources Consultative Group. This group advised the Government on Aboriginal health issues and developed the Aboriginal Hospital Liaison Officer program that would be located in hospitals in towns where there was a large Aboriginal population. This was to be the first major step in changing the hospital environment to meet the cultural needs of the Koori community.

The Aboriginal Hospital Liaison Officer recommendation in the working party report was for 43 positions but we got 16 positions. It gives me great pleasure and pride that the Aboriginal Hospital Liaison Officers Program is still effectively serving Aboriginal people in Victoria and parts of New South Wales along the Murray River after 21 years.

I have always said, "To be an Aboriginal Hospital Liaison Officer you have to be a very special person." Several of the officers I appointed are still today in their positions and will always be special people to me. I would like to see, though, a support framework put in place for these workers that maintains the structural changes they work toward. Accreditation would not only support the Aboriginal Hospital Liaison Officers in their role of facilitating change but would also provide the accountability needed to sustain it.

There is a continuing trend for hospitals to rely on Aboriginal Hospital Liaison Officers to identify Aboriginal patients. Hospitals need to take more responsibility for the identification of Aboriginal families using their services. An accreditation process would ensure that systems are in place that would allow accurate information to be collected. This would allow for both hospitals and the community to benefit with identified funds working towards a better service.

For this to work effectively there needs to be a two-way process of cultural awareness training for hospital staff and an awareness campaign for the Aboriginal community.

In closing I enthusiastically commend this report.

KEVIN R. COOMBS OAM

March 2004
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ACKNOWLEDGEMENTS

The project team would like to acknowledge and thank the Steering Committee, and the Victorian Aboriginal Community Controlled Health Organisation for their expertise, guidance and contribution. The team would also like to acknowledge the hospitals that participated. A special thank you to people who provided additional comments.

PROJECT TEAM

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USAGE

As this project took place in Victoria, the word Koori has been used interchangeably with Indigenous to include all Aboriginal and Torres Strait Islander people.

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INTRODUCTION

The aim of the project

In 2001, the Department of Human Services commissioned the VicHealth Koori Health Research and Community Development Unit (University of Melbourne) and the Australian Institute for Primary Care (La Trobe University) to jointly carry out the Aboriginal and Torres Strait Islander Accreditation Project with the aim of developing ‘a strategy for the accreditation of public hospitals in regard to the reporting of Indigenous status and the provision of hospital services, including discharge planning, for Aboriginal and Torres Strait Islander patients’. This report describes the different stages of the project, and discusses the findings and recommendations.

Background

Australian Indigenous people have a fourth world health status with a 20-year lower life expectancy than that of the mainstream population. In helping to bring about an improvement in the state of Koori health, hospitals play a two-fold role: they provide treatment to patients and they are also valuable sources of information. Accurate data about Kooris’ use of hospitals is essential for policy-making, planning, and service improvement, so in 1993 the Victorian Government mandated that public and private hospitals must identify all Koori patients. The question ‘Are you of Aboriginal or Torres Strait Islander origin?’ was introduced to gather information to:

- monitor changes in the health of the Koori community
- decide on Koori health priority issues and programs
- obtain adequate resources for health programs and health services for Koori people
- develop appropriate health promotion programs and health screening programs
- make sure that mainstream health care services are providing culturally appropriate and accessible health services for the Koori community.

The Indigenous status question provides the data for another government program - the Weighted Inlier Equivalent Separations (WIES) payment. In January 1999, the Department of Human Services introduced a 10% supplement for hospitals based on the number of Aboriginal and Torres Strait Islander people admitted as inpatients. There was no accountability structure built into this payment.

SUMMARY OF KEY ISSUE

VACCHO supports the release of the report.

VACCHO makes the following points for discussion, consideration and possible inclusion:

- VACCHO feels the report does not document the ongoing support issues of current or future Aboriginal Hospital liaison Officers (AHLO). As part of the 10% WEIS supplement, VACCHO would support an "accreditation package" that including the issue of ongoing professional development of AHLOs. This should include the formation and built-in structural support for an AHLO State network.
- VACCHO would recommend the report including Aboriginal representation on all hospital committees including mandatory Indigenous places on Hospital Boards, as one of the strategies about building relationships with Aboriginal Organisations and Services.
- VACCHO has role to play in both the building relationships with Aboriginal Health Organisations and the coordination of an AHLO network.

RECOMMENDATION

The feedback from VACCHO is discussed, and possibly included in the Aboriginal and Torres Strait Islander Hospital Accreditation Community Report.

Victorian Aboriginal Community Controlled Health Organisation

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1 Department of Human Services 2001, Koori Health Counts, Koori Human Services Unit, Department of Human Services, Victoria.
To date there has been little analysis of the Koori identification process or of the impact the WIES payment has had on the services provided to Aboriginal and Torres Strait Islander patients. While the accuracy of the Indigenous status data is unknown, it does appear to depend on two main factors:

- the effectiveness and consistency of hospital administration practices and systems
- the willingness of Aboriginal people to disclose their Indigenous status when using health services.

Against this background, the Aboriginal and Torres Strait Islander Hospital Accreditation Project is a timely and valuable piece of research. It has uncovered problems with the identification process, and revealed where hospitals could improve their provision of culturally appropriate services to Koori patients. It has found weaknesses in discharge and referral procedures, and has identified a need to strengthen the relationships between hospitals and Koori organisations. The project has highlighted the achievements of the Aboriginal Hospital Liaison Officers (AHLOs), and has found many examples of good practice within the hospital system. Finally, the project has come up with some ideas on how to fix the problems, build on the successes, and improve the way hospitals serve the Koori community.

**HOW THE PROJECT WAS STRUCTURED**

The VicHealth Koori Health Research and Community Development Unit and the Australian Institute for Primary Care divided the Accreditation Project into four phases:

- **Phase I** Eight Victorian hospitals were studied in regard to their Koori identification practices and provision of services.
- **Phase IIA** Review was conducted of national and international literature relating to the identification of, and provision of services to, Indigenous people, the impact of funding incentives on these, and accreditation systems designed to improve identification and services.
- **Phase III** The findings from the hospital and literature reviews were used to develop the Quality Framework. This was structured as a series of questions about policies, procedures and monitoring practices, with accompanying explanatory notes and training sessions.
- **Phase IV** The Quality Framework was given to hospitals from Phase I. The hospitals were asked to evaluate the Quality Framework’s usefulness as an accreditation system. A report of the findings was submitted to the Department of Human Services in November 2002.

Phases I, III and IV will be discussed here in more detail. The results from Phase II are available through the VicHealth Koori Health Research and Community Development Unit.
THE HOSPITAL CASE STUDIES

Which hospitals were involved?
The project team selected eight hospitals in consultation with representatives of the Victorian Aboriginal community and the Department of Human Services Steering Committee. The aim of the selection process was to involve a range of hospitals in relation to size, location and the presence or absence of an Aboriginal Hospital Liaison Officer (AHLO). The hospitals were purposely selected. A random sample may have missed examples of good practice, upon which the Quality Framework would be based, hence the use of Koori community opinion in the final decision. Eight hospitals were approached but one declined to participate, so another hospital of a similar size in a rural area was found. The following eight hospitals agreed to be part of the case study:

• Austin and Repatriation Medical Centre, Heidelberg
• Mercy Hospital for Women, East Melbourne
• The Northern Hospital, Epping
• Royal Children’s Hospital, Parkville
• Central Gippsland Health Service, Sale
• Portland and District Hospital
• Mildura Base Hospital
• Southern Health, Dandenong.

The findings from the case studies
Overall
Although the case studies of the eight hospitals revealed some examples of good practice there were also some common trends identified:

• The case study hospitals had no specific policy framework designed to direct Koori identification, service provision or community involvement.
• There was a generally held view that the identification of Koori people was accurate because patients are routinely asked the question about their Indigenous status.
• Whilst Koori cultural and educational events contribute to making services more appropriate for Koori people, they were mostly initiated by individuals and were not driven by an overall strategy or policy.
• Where hospitals employed Aboriginal Hospital Liaison Officers (AHLOs), there was the view that cultural issues were the business of the AHLO exclusively.

The hospital accreditation project has highlighted the need for hospitals to be more accountable to the Koori community about how they use the WIERS money and that it should be specifically used to provide training for Liaison Officers or to fund Koori health programs. The project also helped to identify gaps in the hospital system that need to be improved (eg support for Liaison Officers to provide cross cultural education) to create better access for the Koori community and that making sure there is good access for Koori families is not just the job of the Koori workers but all hospital workers.

Brooke Nam
Aboriginal Family Support Worker – Royal Children’s Hospital

• The discharge process worked well when AHLOs were involved and appropriate referrals were made.
• Few hospitals had strong relationships with Koori community organisations.

The project team examined these trends in more detail and found some specific areas of concern. These are discussed below.
Accuracy of the data

The data collected by hospitals, including Indigenous status, is known as the Victorian Admitted Episodes Data (VAED). The case studies found some common factors that help explain why the data is inaccurate:

- The question about Indigenous status is not always asked when patients are admitted.
- Kooris do not always choose to identify themselves at admission. If administration staff do not understand why they are collecting the data and do not explain to patients why the question is being asked, Kooris may be reluctant to identify themselves.
- Admissions staff do not always review information sent in advance with the patient upon admission.
- There are no specific systems in place for Kooris to be identified after the admission process at a later stage during their hospital stay.
- Clinical staff rely on AHLOs to tell administration staff about a patient’s Koori status when it has not been recognised on admission.
- A number of Koori identifications rely on the AHLO. Because AHLO positions do not allow for 7-day, 24-hour coverage, some Koori people are unlikely to be identified, particularly if they present in emergency after hours.
- Some Koori people choose not to identify themselves as Koori but receive services from the AHLO. They are then included on the statistics provided to the Department of Human Services by the AHLO, but do not appear in the hospital administration’s data.
- A baby’s Indigenous status may not be identified because the hospital fails to inquire about the baby’s father. Of the eight hospitals studied, only one maternity service asked about the Aboriginality of the father.

The accuracy of the Koori identification process remains unknown. It is difficult to estimate the percentage of under-reporting due to a failure to ask the question about Indigenous status versus under-reporting due to people choosing not to identify themselves as Koori.

Information technology systems

The case studies found that the accuracy of the Indigenous status data is compromised when different computer systems within the hospital are incompatible with each other. If a person’s status is indicated on one system, there is no guarantee that it will be communicated to the other systems. This may lead to inaccuracies in the Patient Master Index (PMI), the main record of patient information.

Other problems with the hospitals’ information systems were identified:

- There is no way of recording when a Koori person is identified in the system, if this is done after they are admitted.
- The PMI only allows for a ‘yes’ or ‘no’ response to the question ‘Are you of Aboriginal or Torres Strait Islander origin?’ If a patient is unable to answer the question during admission, hospital staff generally select ‘no’, further increasing the proportion of unidentified Koori patients.

Providing appropriate services in an appropriate cultural context

‘It doesn’t matter if people are black, white or any other colour, they all get the same treatment.’

This quote reflects an attitude shared by many staff throughout the hospital system, and helps explain why Koori patients are not receiving the most appropriate service. It is well documented that Koori people have longer than average lengths of stay in hospital, and are more likely to suffer from multiple medical conditions than the non-Aboriginal population. These factors indicate that a difference in treatment may be required.

Longer hospital stays mean that Koori patients may be separated from family and community for longer periods. Hospital staff should be sensitive to issues that may arise from this situation. More complex health problems among Koori patients mean there is a greater need for coordinated treatment between hospital departments. Hospital staff should ensure that patients are fully informed and consulted about the range of treatments they may be receiving. AHLOs or Koori community services should be available to
assist patients who choose to receive treatment from Koori health services rather than mainstream health services. The referral process should also offer patients a choice of mainstream and Koori health services for ongoing treatment of multiple medical conditions after discharge from hospital.

While it is appropriate, and desirable, that hospitals deliver a uniform quality of clinical treatment, other factors may impact on a patient’s medical condition. Recognition of a Koori person’s cultural needs may improve uptake and maintenance of treatment, which is critical for long-term health. For hospital staff to provide culturally appropriate service to Indigenous patients, they must have education, skills and access to information about local Koori services and organisations. There was little formal training for staff in these matters at any of the hospitals in the case study.

In most of the hospitals, the information flow between clinical, support and AHLO staff relied upon established relationships and was not supported by formal procedures or guidelines. Staff who don’t have these established relationships (e.g. agency nursing staff) will therefore not be aware of the common practices.

A requirement for being able to provide culturally appropriate services is that a patient’s cultural background be known. However, the case studies confirmed what was already well documented and widely known by Koori health workers – many Koori patients choose not to identify themselves because they do not feel that the hospital environment is ‘culturally safe’.

A ‘culturally safe’ place is one that is culturally affirming for Kooris and where cultural matters are respected. Developing an inclusive and empowering environment that filters all levels of hospital service delivery is a concept that was not addressed or fully understood by most hospitals in the study.

In hospitals without an AHLO, creating a ‘culturally safe’ environment was found to be a low priority, and did not go beyond displaying posters and incorporating Koori issues within a multicultural framework, rather than addressing Koori issues independently.

Those hospitals with an AHLO appeared more pro-active in changing the hospital environment to create a positive cultural context. Some of their initiatives included:

- Organising cultural events. Although these events were ad hoc and not part of an overall strategy or specific policy framework, they helped create a better level of understanding among hospital staff about issues facing Koori families.
- Promoting professional development and cross-cultural training as a key strategy to initiate change and enhance understanding.
- Developing an area in the hospital that is identified as ‘Koori space’.
- Establishing links with local Koori community services and organisations. Even in these cases, however, there are few formal arrangements to ensure the continuity of relationships. Maintaining these relationships seems to depend on the initiative of the individuals involved.

Mildura has a very strong and committed group of Kooris who over the years have built up and maintained a very good working relationship with mainstream services. Together we have been able to streamline referrals and appointments between Koori and mainstream services better than anywhere else that I’ve seen. However, we do believe that all hospitals need to be accountable to their local Aboriginal Community on how the WIES money is being spent, as there are no current requirements that have to be met by hospitals from government funding. As a Community we have no idea where the hospital is spending this money and believe that we should be consulted on how it is spent to improve local Aboriginal health.

Ken Knight
Manager - Mildura Aboriginal Health Service
**Appropriate referral**

The case studies found that most hospitals had no protocols or procedures to help staff make appropriate referrals for Koori people. In hospitals with an AHLO, the discharge process does work well when the AHLO is involved. Unfortunately, it was found that clinical staff sometimes make discharge arrangements without consulting the AHLO.

The hospitals involved in the study do not collect information about referrals into or out of the facility beyond what is required for funding accountability purposes. Consequently there is no data that profiles the referral patterns for Koori patients.

Apart from some attempts by the AHLOs, none of the hospitals in the study maintain a centralised database of Koori community organisations and services to where discharge referrals can be made. Clinical staff need access to this information if they are to make culturally appropriate referrals. This is particularly important in the bigger metropolitan facilities where there are more referral options.

**Implications of the findings**

The findings of the case studies indicate that the hospitals would benefit from a systematic management focus on Koori identification, service provision and discharge planning. Without executive-level policies, the hospitals often rely on individuals, such as AHLOs, to correctly identify Koori patients and provide appropriate services and referrals. Hospital polices should cover administrative and staff development issues, and also encourage cultural events and better relationships with local Koori organisations.

The case studies revealed some instances where individuals and departments are working together to develop effective procedures. These models of good practice should be formalised within a policy framework and adopted throughout the organisation.

Technical issues must be addressed to ensure that the identification of Koori people is accurate and that the services are culturally appropriate. Computer systems should be compatible with each other and allow information to be easily transferred and retrieved. The PMI record should have a third option besides ‘yes’ and ‘no’ for answering the question ‘Are you of Aboriginal or Torres Strait Islander origin?’ If admissions staff could select ‘unknown’ when a patient is unable to answer the question, the record could be updated at a later stage. All hospitals should develop a central database of Koori community services for guidance in making appropriate referrals.

Human resource management issues also need to be addressed. Education and cross-cultural training programs would make hospital staff more sensitive to the needs of Indigenous people. Respect for cultural differences should be as much a priority as the nature and quality of clinical services. It should also be emphasised that Indigenous issues are not just the concern of the AHLOs. The current division of responsibility represents a barrier to wider cultural understanding, and also prevents the skills and connections of the AHLOs being used more extensively within the hospital system.

The case studies suggest that the accurate identification of Koori people may depend on the cultural credibility the hospital has with the Koori community. The experience of services as ‘culturally safe’ appears to be closely linked to the strength of relationships between the hospital and Koori services and organisations. The effectiveness of strong relationships in building a culturally safe environment would be enhanced by management approval and the support of formal arrangements and agreements.

Drawing on the findings of the case studies, some clear directions are indicated for developing an ‘accountability framework’ for hospitals receiving the WEIS supplement for services to
Aboriginal and Torres Strait Islander people. Executive policy, technical systems, human resource management and relationships with Koori organisations are all factors that should be considered.

The hospital accreditation project community report looks at gaps within the hospital structure and what is clear is that hospitals need to be accountable to the Aboriginal community. This report needs to be implemented to ensure the Victorian Admitted Episodes Data (VAED) information becomes more accurate. Aboriginal Hospital Liaison Officers program needs to be reourced at an appropriate level to ensure quality of care in providing culturally relevant services to their community thus giving the Aboriginal people a community driven program, this is in line with community control.

It is an important process that the hospitals have an Aboriginal component to their existing accreditation for hospitals to be more accountable to the Aboriginal community. The Wathaurong Aboriginal Community have built and maintained an excellent working relationship with Barwon Health and other mainstream services within the Barwon Region providing culturally relevant services to the Aboriginal Community of Geelong.

Lyn McInnes
Aboriginal Hospital Liaison Officer - Geelong Hospital.

Most importantly, the accountability framework should be based on the premise that the accurate identification of Koori people is linked to the cultural credibility a hospital has with the Koori community. The framework should therefore take a developmental focus and promote continuous quality improvement. It should recognise that building credibility is not a technical exercise but a social one. A focus on the numbers of identified Kooris as the most accurate measure of change in a hospital’s cultural sensitivity would be misguided. It would take the focus away from the systems development that is needed to create a Koori-friendly environment and maximise the health benefits to Koori patients.
THE QUALITY FRAMEWORK

The structure

Once the hospital case studies and literature reviews were complete, the next phase of the project began. The case studies had revealed some reasons why hospitals were failing to accurately identify Koori patients and provide appropriate services and referrals to them. The literature review highlighted accountability models that had proven effective in creating change within other organisations. The project team took the findings from both phases and designed a program to guide hospitals in addressing their problems with identification and service provision. The result was the Quality Framework. 2

Structured as a series of questions, the Quality Framework asked hospitals to review their policies, procedures and monitoring systems in six areas:

1. Staff values, skills and knowledge.
2. Relationships with Koori organisations.
3. Inter-agency and interdisciplinary planning and evaluation processes.
4. Resources for making appropriate referrals.
5. Information technology (IT) systems for recording Indigenous status.

The style of the framework is developmental in that it does not imply minimum levels of performance. It does not set targets that must be reached in order to ‘pass the test’, and does not rank the issues in a hierarchy of importance. Instead, the framework guides hospitals in examining each area so that they can see where they are succeeding and where they need improving. The framework does not prescribe any methods for implementing change. Rather, it encourages hospitals to incorporate the self-assessment process into their existing continuous improvement strategy.

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2 The complete Quality Framework is contained in Appendix I.
Applying the Quality Framework

The eight hospitals involved in the case studies were invited to a three-hour training session on how to use the Quality Framework. Six hospitals attended:

- Austin and Repatriation Medical Centre, Heidelberg
- Mercy Hospital for Women, East Melbourne
- The Northern Hospital, Epping
- Royal Children’s Hospital, Parkville
- Mildura Base Hospital
- Southern Health, Dandenong.

Sixteen hospital staff members attended the workshop, representing the following professional areas:

- nursing
- information management (IT)
- health information management (admissions, medical records, etc.)
- social work
- patient liaison
- Aboriginal liaison
- multicultural liaison.

The training session explained the background and goals of the Aboriginal and Torres Strait Islander Hospital Accreditation Project so that the participants could understand the context of the exercise. The different components of the Quality Framework were discussed, and suggestions were made about how the hospitals could use it as a tool for self-assessment. There was no set timeframe for using the framework. The hospitals were encouraged to view it as an evolving process and examine the issues at their own pace.

Feedback from the hospitals

The project team asked the hospitals for their feedback on the Quality Framework. They were asked to evaluate its usefulness as a tool for assessing Koori identification procedures and service provision. They were also asked to comment on the effectiveness of the training session.

Generally, the Quality Framework was found to be a user-friendly document. A number of changes were suggested, and the project team made some modifications to the terminology based on this feedback. The Quality Framework proved to be an effective self-assessment tool because it encouraged the hospitals to examine their policies and procedures. It highlighted some examples of good practice that the hospitals could build on, and it also revealed areas where improvements could be made to identification procedures and services.

All the hospitals agreed that the training program was essential in helping them understand the purpose of the Quality Framework and how to apply it. Two major features of the training were considered to be fundamental to its success:

- the inclusion of Aboriginal people (e.g. AHLOs) to validate the systems and practices that are implied in the Quality Framework
- the inclusion of several hospitals so that different ideas could be discussed and innovative practices could be shared and adopted by other institutions.
RECOMMENDATIONS FOR ACCREDITATION

What is accreditation?
The purpose of accreditation is to provide a guarantee that the quality of goods or services provided is at an acceptable level. In the health sector, accreditation generally requires:

- a set of standards against which performance is compared
- an assessment of compliance with those standards by independent personnel.

This is the most common system of accreditation in the Australian health care industry. 3

Minimum standards

‘Minimum standards’ is a term used to describe the minimum with which a service must comply in order to gain accreditation. Developing a set of minimum standards for Koori identification and service provision is not a straightforward matter, especially if it is to apply to all public hospitals.

Accreditation systems commonly use quantitative minimum standards – they are concerned with quantities or numbers. If reliable data is available, this approach can be very effective. The project team considered whether a quantitative standard could be used here. Given the questions about the current accuracy of the data collected in hospitals, it was decided that this type of standard would not be appropriate.

The literature review in Phase II revealed another type of minimum standard that is used extensively in the Australian health care industry. To achieve accreditation, services must have systems in place for regular performance surveillance. Self-assessment ensures that hospitals examine their internal systems and consider how well they are performing. This exercise is valuable when it promotes an interest in quality and encourages ownership of the findings. If hospitals accept responsibility for problems identified through self-assessment, this paves the way for change.

To meet this minimum standard of self-assessment, hospitals could use the Quality Framework. The framework could be introduced progressively over several years, depending on the size of the hospital. For instance, an identification audit4 may be an appropriate minimum standard for hospitals with a large throughput of Koori patients. In smaller hospitals with a low throughput of Koori patients, such an audit is unlikely to be a

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3 Commonwealth Department of Health and Aged Care 2000, Standards and Quality Improvement Processes in Health and Community Services: A Review of the Literature, Quality Improvement Council Ltd, Bundoora.
4 See policy issue 6 in the Quality Framework (Appendix I).
sensitive indicator of performance. In these cases, a more appropriate minimum standard might be an examination of referral arrangements.5

A good starting place for all hospitals, regardless of size, would be a focus on staff values, skills and knowledge relating to cultural sensitivity. A Another minimum standard that should apply to all hospitals is the development of relationships with Aboriginal organisations.7

During the past 2 years since Mercy Hospital for Women (MHW) participated in the Aboriginal and Torres Strait Islander Accreditation Project, there have been several important developments in the Mercy’s care of our Aboriginal women and their families:

- After 20 years at MHW, our AHLO, Beryl Thomas, has been joined by Aboriginal Health worker, Michelle Hickey-Donovan. Michelle’s main responsibilities are: to deputise for Beryl when she is not available, to assist in the development of programs which aim to improve health outcomes for Aboriginal women & families and, with Beryl, to provide cross-cultural training for MHW staff. Together, Beryl and Michelle form MHW’s Aboriginal Women and Family Support Unit. We received a grant from DHS to produce a pamphlet about the Unit – the pamphlet has been designed by Beryl & Michelle, and features "Mother, Child", a painting by Lyn Briggs which she donated to the Mercy. The Unit was officially launched in November 2003 by Gavin Jennings, Victorian Minister for Aboriginal Affairs. The Launch featured a memorable speech by Beryl, Joy Murphy as Guest speaker, a didj player, and was MC’d by Michelle.

- Increasing numbers of Aboriginal women are attending our Transitions Clinic, which provides ante-natal care to 3 categories of women with complex needs. There are currently 19 Koori women attending the Clinic, almost all of them are doing Shared Care with VAHS.

- Posters about our Aboriginal Women and Family Support Unit, and encouraging Aboriginal and Torres Strait Islander women to identify themselves to MHW staff, have placed at all locations where patient registration takes place, eg Outpatient reception, Admissions, Emergency Dept, postnatal wards. Staff members in all these areas of the hospital receive ongoing education re the importance of accurate identification of Aboriginal and Torres Strait Islander women and babies. We are also working with our IT staff to ensure that when a patient is identified, the information is not "lost" between the different IT systems used within the hospital.

- Since June 2003, a small Aboriginal flag sticker is placed by Beryl or Michelle on the inside cover of medical files of women who identify themselves or their babies to MHW staff as being of Aboriginal origin & who give permission for the placement of the sticker.

- Work on a written policy about MHW’s care of our Aboriginal patients is continuing, and has included some discussion of shared issues with the RCH Aboriginal Family Support Unit.

- Work on production of a resources folder, for use by MHW staff caring for an Aboriginal and Torres Strait Islander patient After Hours or when Beryl & Michelle are not available, is almost complete.

Beryl Thomas – Aboriginal Hospital Liaison Officer
Michelle Hickey-Donovan – Aboriginal Health Worker
Mercy Hospital

5 See policy issue 4 in the Quality Framework (Appendix I).
6 See policy issue 1 in the Quality Framework (Appendix I).
7 See policy issue 2 in the Quality Framework (Appendix I).
The accreditation process

The project team investigated different accreditation models and found that the two most widely used systems in Australian hospitals are the Australian Council on Healthcare Standards program EQuIP, and the Quality Improvement Council program QIC. Both programs could be adapted to make them suitable for Aboriginal and Torres Strait Islander Hospital Accreditation. This would be a more practical option than creating an entirely new accreditation program and accreditation body to administer it.

In order to implement an accreditation program, two initiatives would be required:

• As there is currently no accountability structure attached to the 10% WIES supplement, the Department of Human Services should link the payment to an accreditation program. For hospitals to receive the WIES payment, they would have to be accredited by a recognised accreditation body, such as the Australian Council on Healthcare Standards or the Quality Improvement Council.

• The Department of Human Services would have to direct the accreditation bodies to modify their programs appropriately. Existing systems like EQuIP and QIC would need to include a focus on Koori identification practices and service provision. Adopting the Quality Framework would ensure that these issues were addressed and that the minimum standard of self-assessment was fulfilled.

Additional accountability requirements

As well as undergoing accreditation by a recognised accreditation body, hospitals could be asked to meet a range of other requirements. Together these requirements would form an ‘accreditation package’.

Hospitals could be asked to report regularly to the Department of Human Services on data trends identified in the information collected about Koori patients. Without breaching State and Commonwealth privacy legislation, hospitals could submit data on:

• total numbers of Aboriginal people using the hospital
• age range of Aboriginal people using the hospital
• referrals from Aboriginal services and organisations
• the locality (post code) profile of Aboriginal people using the hospital
• the locality profile of Aboriginal people using adjacent hospitals’ facilities (e.g. nearby hospitals with an AHLO on staff).

This data would assist the DHS with policy-making, planning and service provision. It would also give the hospitals useful feedback about the impact of strategies designed to improve the accuracy of Koori identification and service provision.

Hospitals could be required to participate in regular forums, perhaps on an annual basis. Each hospital would describe the strategies they have used to improve identification procedures and services to Koori patients. International research and experience suggest that this type of benchmarking is an effective stimulant to service development because it encourages hospitals to monitor and improve their systems. The forums would give recognition to hospitals that have implemented effective strategies, and allow these examples of good practice to be shared. The impact of the forums would be enhanced by visits between hospitals so that effective systems can be examined directly.

In addition, hospitals could be asked to report regularly to local Aboriginal organisations or co-ops on the nature and progress of strategies designed to improve Koori identification processes and services.

10 See the Institute for Healthcare Improvement website <http://www.ihi.org>.
A flexible approach to accreditation

An accreditation package is recommended because it would give the Department of Human Services the flexibility to introduce accreditation requirements over a period of time.11 A progressive increase of requirements would make it easier for hospitals to comply, and would also improve their acceptance of the accountability process.

Another advantage of an accreditation package is that requirements can be applied selectively to suit each hospital, depending on its size, location and the scale of services provided to Aboriginal patients. For example, the data reports to the Department of Human Services could be modified for different hospitals. Changing trends in the postcode data for Koori patients may not be a sensitive indicator in rural and remote areas because of low throughput levels. It might therefore be appropriate to remove this reporting requirement.

For small, rural services, the numbers of Koori patients, and therefore WIES payments, may be so low as to make the accreditation compliance costs uneconomical. In these cases, a collaborative approach between several regional hospitals may be appropriate. This might involve strategies for creating better links with health care providers, including Aboriginal health services, to improve information exchange about Koori patients and build more effective referral arrangements.12

Involving Aboriginal people in the accreditation process

There are several ways that Aboriginal people could be represented in the accreditation process. Aboriginal people could be directly involved as part of the audit team. However, there would be major logistical hurdles to this level of involvement, relating to training and skills, payment and availability.12

Hospitals and Aboriginal communities need to sit around a table and talk more about what the local health issues are and how they are going to be fixed. When we all work together a lot can be achieved but it is important that hospitals understand how the community works. Community control is essential in working together successfully and Aboriginal people know better than anyone how it should work to benefit our people. Being guided by the local Aboriginal community/organisations is important if hospitals want to contribute to our health and wellbeing.

Liaison officers play a major role in the hospitals in many different areas such as supporting Aboriginal patients and their families, cross cultural training for staff and contributing to policy and procedures. Liaison officers also break down the barriers between hospital staff and Aboriginal patients and families. Sometimes if information is presented with too much medical jargon Aboriginal people may not always feel comfortable asking questions and this could lead to further medical problems down the track. When liaison officers are properly involved these problems are usually avoided.

Liaison officers are often not recognized for their skills and dedication to their role within the hospital, supporting patients and their involvement in the Aboriginal community. Many liaison officers go beyond their paid work and take on voluntary work outside of work hours and give in many different ways to their community.

Jemmes Handy
Aboriginal Hospital Liaison Officer – Mildura Hospital

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11 See Appendix II, Roll-out Schedule.
A second option is for Aboriginal people to participate in interviews with the audit team. AHLOs or Aboriginal community organisations could help recruit Aboriginal people to take part in these interviews. In some cases, established Aboriginal advisory bodies, such as local Aboriginal co-ops or the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), might participate as a key stakeholder group in the interview process.

A third approach is to invite Aboriginal community groups to make a written submission or participate in a written survey process that can be considered by the audit team.

If regular reporting to Aboriginal community organisations is adopted as part of the accreditation package, no further involvement by Aboriginal people may be necessary.
CONCLUSION

Each stage of the Aboriginal and Torres Strait Islander Hospital Accreditation Project was an important step in developing ‘a strategy for the accreditation of public hospitals in regard to the reporting of Indigenous status and the provision of hospital services, including discharge planning, for Aboriginal and Torres Strait Islander patients’.

The Phase I case studies examined eight hospitals to evaluate their systems for identifying Koori patients and providing appropriate services and referrals. Some common trends were revealed:

- There was a need for explicit policies regarding Koori identification and service provision to give hospitals clear guidelines and help them better coordinate their procedures.
- Some hospitals had effective procedures in place, but often the maintenance of these practices depended on the initiative of individuals, such as the AHLOs.
- Hospital computer systems need to be improved to allow information about Koori patients to be accurately recorded and transmitted between departments.
- Cross-cultural training is needed for hospital staff to help them provide more appropriate services to Koori patients.
- Stronger relationships with local Koori organisations are needed to help transform hospitals into more Koori-friendly environments and increase their ‘cultural credibility’ with the Koori community.

The Phase II literature review revealed that self-assessment is an effective and widely used accreditation technique. On this basis, the project team created the Phase III Quality Framework, a series of questions about policies, procedures and monitoring systems relating to Koori identification and service provision. It was designed to encourage hospitals to examine their current systems, identify effective strategies and locate areas for improvement. The framework was given to the hospitals and they were asked to evaluate its effectiveness as a self-assessment tool. Some modifications were made, based on the hospitals’ feedback, but it was generally found to be a useful program.

In Phase IV, the project team formulated an ‘accreditation package’ for hospitals:

- Accreditation should be conducted by a recognised accreditation body, which could modify existing programs to include a self-assessment component such as the Quality Framework.
- A minimum standard for accreditation should include a requirement that hospitals develop relationships with Koori organisations.
- In addition, hospitals could be required to report regularly to the Department of Human Services on data trends regarding Koori patients.
- Hospitals could report to Koori organisations about their strategies for improving identification procedures and services to Koori patients.
- Hospitals could attend regular forums to discuss Koori cultural issues and share effective strategies with other hospitals.
- The accreditation package could be introduced in stages, and the requirements could be modified to suit the size and location of different hospitals.
- The 10% WIES payment should be dependent on compliance with the accreditation program.

In November 2002, a final report of the project findings and accreditation recommendations was submitted to the Department of Human Services. The project team is pleased to report that several of the hospitals involved in the project are continuing to use the Quality Framework and are making changes to their identification procedures and services to Koori patients. It is hoped that in the future the Quality Framework will be used as part of an accreditation process in all Victorian public hospitals, and that this will lead to better treatment for Koori patients and a much needed improvement in the health status of the Koori community.
# Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHLO</td>
<td>Aboriginal Hospital Liaison Officer</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
</tr>
<tr>
<td>Clinical staff</td>
<td>Doctors, nurses, physiotherapists, psychologists, etc.</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>EQuIP</td>
<td>Australian Council on Healthcare Standards accreditation program</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>PMI</td>
<td>Patient Master Index (computer record of patient information)</td>
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<tr>
<td>QIC</td>
<td>Quality Improvement Council accreditation program</td>
</tr>
<tr>
<td>Support staff</td>
<td>Administration, medical records, ward clerks, etc.</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>VAED</td>
<td>Victorian Admitted Episodes Data</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
</tbody>
</table>
## APPENDIX I: QUALITY FRAMEWORK

<table>
<thead>
<tr>
<th>Policy Issue</th>
<th>Relevant Procedures</th>
<th>Responsibility for implementation</th>
<th>How is implementation monitored?</th>
<th>How can accountability for this policy issue be improved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff values, skills and knowledge related to cultural sensitivity in the provision of services to Aboriginal people.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the health service have explicit policies to support this issue?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes name the source</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Issue</td>
<td>Relevant Procedures</td>
<td>Responsibility for implementation</td>
<td>How is implementation monitored?</td>
<td>How can accountability for this policy issue be improved?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Relationships with Aboriginal organizations and services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the health service have explicit policies to support this issue?</td>
<td></td>
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<td></td>
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<tr>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes name the source</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inter agency and interdisciplinary planning and evaluation processes which focus on the particular cultural and social needs of Aboriginal people</td>
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</tr>
<tr>
<td>Does the health service have explicit policies to support this issue?</td>
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<tr>
<td>Yes/No</td>
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<td></td>
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<tr>
<td>If yes name the source</td>
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</tr>
<tr>
<td>Policy Issue</td>
<td>Relevant Procedures</td>
<td>Responsibility for implementation</td>
<td>How is implementation monitored?</td>
<td>How can accountability for this policy issue be improved?</td>
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<td>--------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Systems and resources to support staff to make timely relevant referrals and seek appropriate involvement of Aboriginal workers and agencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Does the health service have explicit policies to support this issue?  
Yes/No  
If yes name the source |  |  |  |  |
| IT systems which support the recording of Aboriginal and Torres Strait Islander status and communication between staff and departments |  |  |  |  |
| Does the health service explicit policies to support this issue?  
Yes/No  
If yes name the source |  |  |  |  |
<table>
<thead>
<tr>
<th>Policy Issue</th>
<th>Relevant Procedures</th>
<th>Responsibility for implementation</th>
<th>How is implementation monitored?</th>
<th>How can accountability for this policy issue be improved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of the effectiveness of the identification and recording system</td>
<td></td>
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<tr>
<td>Does the health service have explicit policies to support this issue?</td>
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<td>Yes/No</td>
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<tr>
<td>If yes name the source</td>
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## APPENDIX II: ROLL-OUT SCHEDULE

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum standards for accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Large hospitals (over 50 VAED Aboriginal and Torres Strait Islander admissions per year)</td>
</tr>
<tr>
<td></td>
<td>Small hospitals (under 50 VAED Aboriginal Torres Strait Islander admissions per year)</td>
</tr>
<tr>
<td></td>
<td>Additional requirements</td>
</tr>
<tr>
<td>One</td>
<td>Staff values, skills and knowledge related to cultural sensitivity</td>
</tr>
<tr>
<td></td>
<td>Staff values, skills and knowledge related to cultural sensitivity</td>
</tr>
<tr>
<td></td>
<td>Data reports to DHS</td>
</tr>
<tr>
<td>Two</td>
<td>Same as Year One plus:</td>
</tr>
<tr>
<td></td>
<td>• Relationships with Aboriginal organisations</td>
</tr>
<tr>
<td></td>
<td>• Identification audits</td>
</tr>
<tr>
<td>Three</td>
<td>Same as Year Two plus:</td>
</tr>
<tr>
<td></td>
<td>• Communication systems</td>
</tr>
<tr>
<td></td>
<td>• Referral arrangements</td>
</tr>
<tr>
<td>Four and beyond</td>
<td>• issues in the Quality Framework</td>
</tr>
<tr>
<td></td>
<td>• issues in the Quality Framework</td>
</tr>
<tr>
<td></td>
<td>Same as Year Three</td>
</tr>
</tbody>
</table>

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13 See policy issue 1 in the Quality Framework (Appendix I).
14 See policy issue 2 in the Quality Framework (Appendix I).
15 See policy issue 6 in the Quality Framework (Appendix I).
16 See policy issue 5 in the Quality Framework (Appendix I).
17 See policy issue 4 in the Quality Framework (Appendix I).